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ACCULTURATION AND MENTAL HEALTH AMONG GHANAIANS IN THE NETHERLANDS

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ABSTRACT

Background: The current literature on the relationship between cultural adaptation and mental health is premature to offer a comprehensive explanation about the ways acculturation exerts either positive or adverse effects on the mental health of migrants.

Aim: This study is an empirical approach towards understanding the magnitude of the relationship between consequences of cultural adaptation and psychological distress.

Methods: Two samples of Ghanaian migrants in the Netherlands were included: a clinical group ($n = 36$) and a non-clinical community group ($n = 97$). Data were acquired by administering a semi-structured interview. Quantified data were analysed using multivariate techniques.

Results: Contradictory to our hypotheses, the reported level of mental health symptoms in both groups was relatively low, suggesting a substantial resilience among the Ghanaian group. Confirming our hypotheses, specific dimensions of the acculturation process were associated with health status, particularly affiliation with cultural traditions and feelings of loss concerning the country of birth.

Conclusions: Acculturation demands capture critical elements of migrants' experiences that warrant professional interventions tailored to their specific needs. A subtle balance between holding on to the supportive cultural traditions together with moderate involvement in ruminating about pre-migration life, in conjunction with acquiring instrumental skills of the host culture, is a starting position for better health.

INTRODUCTION

The role and significance of acculturation for immigrant health are important scientific inquiries. Migration is motivated by many factors, from economic need to political displacement. On the one hand, the culture of origin may be a catalyst because of poverty, unemployment or political upheaval. On the other hand, the move may be motivated by the attraction of the host culture, such as job opportunities and a higher standard of living. These factors describe key determinants of international migration. Little is known, however, about how aspects of the migration process from a developing to a developed nation could undermine immigrant mental health. Although the mental health consequences of moving into a different culture have been found to be substantial

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(Bhugra, 2004), the specific post-migration demands that lead to psychological distress are still poorly understood. The question remains whether post-migration demands such as learning a new language, building a social network, or integrating new norms and customs all have an equal impact on well-being.

Empirical data on the particular contribution of acculturation demands to psychological distress are rather sparse and findings are inconsistent and sometimes even contradictory. The level of cultural adaptation may have a differential impact on health in different groups. Most empirical evidence suggests that separated and marginalized migrants experience more acculturative stress than well-integrated migrants (e.g., Berry, 2005; Donà & Berry, 1994; Ghaffarian, 1998). This may suggest an overall positive relationship between level of acculturation and health, implying that better acculturation leads to good health, or at least fewer health problems and psychological distress (e.g., González *et al*., 2001; Hovey, 2000; Hovey & King, 1996; Sundquist *et al*., 2000). However, a negative relationship is reported as well. For instance, a higher level of acculturation to the dominant society was associated with more mental disorders (Burnam *et al*., 1987), more symptoms of depression (Nguyen & Peterson, 1993) and an increase in alcohol consumption (e.g., Abraido-Lanz *et al*., 2005; Gilbert, 1991; Whitney *et al*., 1998).

Moreover, specific domains within the acculturation realm may have a stronger impact on mental health than others. Nicholson (1997) reported various aspects of acculturation (such as coping with language barriers, integrating new customs) to be important predictors of disease (like PTSD, depression and anxiety) among South Asian refugees. In two studies among ethnic minority groups (Surinamese, Turks, Moroccans and Bosnians) in the Netherlands, acculturation was defined as a combination of cultural adaptive demands and the stressful consequences of these demands. The operationalization acculturation concerned five different dimensions: the ability to perform the adequate skills for the new society (for instance, learning the language and knowing how to organize the fundamental essentials of life such as housing questions and financial needs); the preservation of the original culture and habits (like the celebration of traditional feasts); social integration into the new society (such as personal contacts with the indigenous people); moral attitudes towards important issues in the new society (for example concerning respect for the elderly); and the experience of feelings of loss about the country of birth as well as orientation to people with the same cultural background. Results of these studies showed that mental well-being was positively associated with knowledge of Dutch customs and social relationships with Dutch people, while cultural traditionalism, such as clinging on to culturally based values and rituals, was associated with the absence of mental disorders (Kamperman *et al*., 2003; Knipscheer & Kleber, 2006).

In addition, social and economic difficulties can lead to mental health problems. For instance, Pernice & Brook (1996) found that post-migration variables, such as unemployment, poor accommodation, discrimination and social isolation, were all significantly associated with levels of anxiety and depression in a sample of South-east Asian refugees in New Zealand. This is in line with research among Bosnian refugees in which certain demographic features (and especially a low socioeconomic status) were reported to significantly contribute to poor health status (Markovic *et al*., 2002; see also Cuellar *et al*., 2004). As well as these factors, personal characteristics like gender or age can lead to health problems; e.g., women reported more anxiety and depression (Plante *et al*., 2002).

It is not surprising that the life transitions involved in migration and the often confounded factors of ethnicity, acculturation and sociodemographic positions affect psychological functioning and mental health. The exact relationship between these variables is unclear. The fact that empirical

results show both positive and negative effects of acculturation suggests an urgent need for theory-driven research, incorporating complex sets of factors including pre-migration experiences (e.g., trauma, economic deprivation), social and economic structures of the host society, post-migration experiences (stressors and resources), and other settlement processes (e.g., racism and discrimination). This study offers a rare opportunity to examine the process within a situation that is considerably different from situations of Hispanic or Asian immigration in North America or Australia – the current literature is largely limited to these situations. The study was designed to address this empirical gap by examining the relative contribution of cultural adaptation demands and sociodemographic status to levels of mental health status among a group of people who migrated relatively recently from Western Africa to Western Europe, in this case from Ghana to the Netherlands.

The expectation is that a variety of risk factors existed for many Ghanaians, such as belonging to an ethnic minority, living in a 'condición migrante', and being unfamiliar with the Dutch healthcare system (Knipscheer *et al*., 2000). This list of risk factors is not specific for Ghanaians and knowledge about this theme has relevance for migrants of other origins. We chose to include in this study a non-clinical, community sample as well as a sample of individuals attending an outpatient mental clinic. In addition to countering the potential bias associated with using only a clinical sample of migrants, the inclusion of a group of Ghanaians who had not sought out mental healthcare treatment allowed us to examine whether this reflected an absence of psychological distress or a pattern of non-utilization of psychiatric services despite the experience of distress. The research questions were:

What is the general health status of the Ghanaian sample compared with an indigenous Dutch reference group?
What are migration-related (i.e., cultural adaptive demands, acculturative stress) and sociodemographic-related (gender, age) predictors for health status in Ghanaian migrants?

Based on the above-mentioned empirical studies, we hypothesized that health status would be poor and acculturation variables would be relatively powerful in accounting for variance in mental health symptomatology. Specific a priori hypotheses were made regarding the differential components of acculturation. We expected that difficulties with obtaining practical skills in the new society as well as with social interaction would be associated with more health problems. In line with other research with migrants (including Ghanaians) that reported certain demographic features to significantly contribute to poor health status (e.g., Knipscheer, 2000), we hypothesized that sociodemographic characteristics such as educational level play an important role in health status as well.

METHOD

Design

This study had a 'mixed methods, multi-source' design (De Jong & Van Ommeren, 2002; Knipscheer & Kleber, 1999) in which qualitative and quantitative data collection methods were used. First, focus groups and in-depth interviews (conducted according to the Explanatory Model concept (Kleinman, 1980)) were performed (results of these qualitative means are described elsewhere).

Subsequently, a survey containing culturally well-validated standardized questionnaires was administrated.

Participants

According to the Central Bureau for Statistics (CBS), 19,000 Ghanaians were living in the Netherlands in 2004 (CBS, 2005). More than half of them resided in Amsterdam, with more than one-third of the total Ghanaian community living in the south-eastern part of the city. The study was therefore performed in this area. The respondents were recruited at local community agencies (four foundations named 'Sikaman', 'Recogin', 'I Care' and 'Afapac'), forming the *community sample*, and from mental healthcare departments (two centres called 'AMC/De Meren' and 'Nienoord'), combined in the *clinical sample*.

Community sample

Because community agencies generally will not release names and addresses of their clients, we did not have access to the kind of list from which a random sample of local Ghanaians could have been drawn. Therefore, a convenience sample was used, with the recognition that generalizations based on such a sample must be made with caution. Participants in the community sample were gathered through announcements and word of mouth in the Ghanaian centres. Four community organizations run by and for members of the Ghanaian community were included. The centres support Ghanaians in various areas, including with juridical, social and health problems. First, the content of the study was briefly presented by the principal investigator during various meetings at the community agencies. Following this presentation, representatives of the community centres were given instructions to present the study to eligible visitors. Additional community participants were recruited through the 'snowball' method, in which individuals who had already agreed to participate in the study referred us to other individuals in their neighbourhood. A total of 104 individuals were recruited for the community sample.

Clinical sample

The mental healthcare agencies were part of the national ambulant mental healthcare system in the Netherlands (with each of the approximately 50 centers serving a target population of roughly 250,000 inhabitants). The agency was chosen for inclusion in the present study, because of a relatively large proportion of Ghanaians in their patient population. Outpatients of the mental healthcare facility were solicited via healthcare professionals and letters directed to them personally (written in both English and Dutch). A multiple entry point was thereby accomplished. Regarding the demographic background, this clientele forms a representative reflection of the Ghanaian clinical population in the metropolitan areas of the Netherlands. Twenty-nine outpatients participated. Because seven respondents sampled via the community agencies were being treated in mental health care facilities, 36 participants were included in the clinical sample and 97 people remained in the community sample.

Only adults (18 years and older) who were born in Ghana, or who had at least one parent born there, were invited to participate in the face-to-face interview. If a person expressed an interest in participating in the study, he or she was asked to provide a contact phone number or a direct appointment was made. We aimed to collect data from as many people as possible. Attempts were made to maximize sociodemographic diversity. Approximately 45% of the solicited persons agreed to participate, independent of the recruitment method. It was not possible to compare those who chose to participate in the interview with those who declined.

Procedure

Four female researchers (two with a Ghanaian background and two with an indigenous Dutch background) and six male researchers (five with a Ghanaian background and one with an indigenous Dutch background) administered the semi-structured interview to the Ghanaian participants.

Guidelines on assessment research with ethnic minorities stress the involvement of expert cultural and ethnic consultants (Okazaki & Sue, 1995). In line with these recommendations we consulted various Ghanaian key persons in the community as well as a number of mental health professionals who had ample experience with Ghanaian outpatients during the development of the measures and the interpretation of the results (e.g., during 'experts meetings').

Inter-rater reliability across the interviews was enhanced by means of a protocol and practical training. The protocol guided the interview process and consisted of questions that derived from the themes mentioned in the Introduction. All interviewers followed an intensive training provided by the research coordinator (first author), with several follow-up sessions. The training concerned the way in which the interviews should be conducted, including aspects of culturally sensitive communication. The interviewers came together regularly to discuss extensively how questions were administered, how answers were noted and how special situations were dealt with (such as respondents who refused to answer certain questions or who did not understand certain questions). Following this intensive training programme, the level of agreement for the interviewers was considered to be satisfactory. The 10 interviewers reached consensus in more than 90% of the interviews.

Participants read and signed informed consent forms. It was emphasized that anonymity would be guaranteed. Evidently, participation was voluntary. The interviews took place at the mental health agency, at the office of the community agency, or at the home of the respondent, as preferred by the participant. The interviews were conducted in English ($n=71$), in one of the Ghanaian languages ($n=35$; mostly Twi ($n=17$), irregularly also Akan, Ga or Ewe), in Dutch ($n=3$) or in a combination of languages, according to the preference of the respondent. The duration of the interviews varied from 40 to 90 minutes (mean duration about one hour). The answers were noted on paper by the interviewer and later processed by the researcher. Participants received a 15 Euro token gift.

Instruments

A preliminary version of the questionnaires was pilot tested and both content and format were revised on the basis of the results.

General health (GHQ-28)

To assess the occurrence and severity of general health symptoms, the General Health Questionnaire (28-item version) was used (Goldberg & Hillier, 1979; Dutch validation by Koeter & Ormel, 1991). This questionnaire measures the recent state of subjective well-being in four areas: (a) psychosomatic symptoms, (b) anxiety and insomnia, (c) social dysfunction, and (d) (severe) depression. Each subscale consisted of seven items. Examples are 'Have you recently been getting any pains in your head?' (somatization); 'Have you recently lost much sleep over worry?' (anxiety and insomnia); 'Have you recently been able to enjoy your normal day-to-day activities?' (social dysfunction); 'Have you recently felt that life is entirely hopeless?' (depression). All items were endorsed on a four-point Likert-type scale: (a) less than usual; (b) as usual; (c) more than usual; (d) much more than usual.

Koeter & Ormel (1991), in line with Goldberg & Hillier (1979), recommend scoring the two first cat-egories by assigning a value of 0 while assigning a value of 1 to the last two answer categories. The GHQ total score is obtained by summing the item scores. The scores for the GHQ total in our sample ranged from 0 to 27.

The currently recommended cut-off point based on studies of general populations in 15 countries (Goldberg *et al*., 1997) suggested a score of 5 or lower, to be consistent with absence of non-specific psychiatric morbidity. Persons who answered 6–11 questions positively had moderate psychiatric morbidity, and persons answering 12 or more questions positively had substantial psychiatric morbidity (see also Mooren *et al*., 2003). For the subscales, it is recommended to use Likert scale scoring (0–3), where a higher score implies more and more severe symptoms.

Cross-cultural validity of the GHQ-28 has been established, for example with samples in Nigeria (Aderibigbe & Gureje, 1992). The internal reliability for the GHQ-28 in our total sample was high: Cronbach's α varied between 0.83 for Social Dysfunctioning and 0.86 for Somatization to 0.91 for Anxiety and Insomnia and 0.94 for Depression.

Acculturation (LAS)

The Lowlands Acculturation Scale (LAS; Mooren *et al*., 2001) was used to measure the degree of cultural adaptation and acculturative stress. The LAS was developed specifically to measure stressors and affiliations directly related to migration. This 25-item scale includes five dimensions: Skills, Traditions, Social integration, Values and norms, and Loss. The sets of items were designed to distinguish between a global orientation towards the past (and land of origin) as opposed to the orientation towards the future (and country of current residence). Time of reference was the past three months. All items were rated on a Likert-type scale (1–6; 1 reflects the tendency to totally disagree with the item, 6 is an expression of total agreement with the item).

The scale labelled Skills contained five items that expressed confrontation with integrative tasks, for example 'I have difficulties understanding and reading the Dutch language'. A higher score on Skills implies less capacity and ability to perform the adequate skills for the new society. The scale Traditions (four items) deals with the preservation of culture and habits (an example is 'It is important to me to celebrate the Ghanaian traditional feasts in the Netherlands'). A higher score on Traditions means a more conservative attitude towards life. The scale Social integration consisted of four items that referred to social contacts with Dutch people (for example 'I have much contact with Dutch people'). A higher score on Social integration refers to a more integrated attitude and position in Dutch society. The scale assessing moral attitudes was labelled Norms and values (five items); an example of an item is 'I feel Dutch people don't have enough respect for the elderly'. A higher score on Values and norms implies a more conservative or critical view on issues in Dutch society. The scale Loss was made up of seven items such as 'My country of origin is always on my mind and in my memories'. A higher score on Loss means a greater experience of feelings of loss concerning the country of birth and a greater orientation to people with the same cultural background.

Internal consistency of the subscales of the LAS is satisfactory (Cronbach's α varies from 0.62 for Social integration and 0.75 for Traditions to 0.80 for Skills, 0.80 for Loss and 0.81 for Values and norms).

Sociodemographic information

A demographic questionnaire was used to obtain information about gender, age, nation of birth, length of stay in the Netherlands, living circumstances, highest educational achievement, religious affiliation, urbanization rate of childhood surroundings and source of income.

Statistical analysis

All variables were summarized using standard descriptive statistics such as frequencies, means and standard deviations. To determine which covariates had to be controlled for, the variables gender, age, length of residence in the Netherlands, childhood surroundings, living circumstances, highest educational level, source of income, and religion were univariate analysed with the dependent variable, the GHQ-28 total score. Dichotomized variables were analysed with the χ^2 test or Fisher's exact test if any expected cell frequency was lower than 5. Provided that the distributions were approximately normal or non-skewed (criteria $< 0.5\ \alpha > 1.5$), mean scores on continuous variables were analyzed with parametric methods using Student's *t*-tests for independent samples and one-way analyses of variance (ANOVAs). Severely skewed continuous variables were analysed with the Mann–Whitney *U*-test.

In the total sample the demographic variables gender, length of stay in the Netherlands, childhood surroundings, living circumstances level, and religion, as well as the predictor variable LAS Skills, were not significantly correlated with the outcome variables. To maintain an acceptable ratio of predictor-to-outcome variables, these variables were not included in the subsequent regression analyses. Based on these results and the associations between several variables it was decided to perform multivariate analysis to correct for spurious effects. To estimate the relative importance of predictors of general mental health, direct multiple regression analyses were conducted (Tabachnick & Fidell, 2001). The set of covariates for the total sample included sample (community or clinical), age (years), education level (low, middle, or high), source of income (paid job or social benefit), and the LAS subscales Traditions, Social integration, Values and norms and Loss.

RESULTS

Participant characteristics

The descriptive statistics for the Community sample and the Clinical sample are presented in Table 1.

Subjective health state

Community and clinical samples

The mean GHQ-28 total score (0,0,1,1) within the sample ($n = 133$) was 6.06 ($SD = 7.28$, range 0–27). The proportion of respondents having an above-threshold score (using the cut-off of 4/5) on the GHQ-28 was 43.9% ($n = 50$). In line with the Goldberg *et al*. (1997) criteria, a fifth of the total sample ($n = 22$, 19.3%) answered 12 or more questions positively, implying substantial psychiatric morbidity. As Table 2 shows, outpatients in the clinical group ($n = 36$) reported more health symptoms than the community group ($n = 97$), $t_{somatic}(119) = -3.68$, $p < 0.001$; $t_{anxiety}(121) = -4.64$, $p < 0.001$; $t_{socialdysfunc}(46.76) = -2.50$, $p < 0.01$; $t_{depressive}(44.50) = -3.79$, $p < 0.001$.

Comparisons with indigenous Dutch samples

Comparisons of the total mean GHQ-28 score between the community organizations ($n = 97$) and a sample of the indigenous Dutch general population ($n = 485$) (Koeter & Ormel, 1991) revealed no differences in health problems, except for a lower Ghanaian mean score on Anxiety and Insomnia, $t_{somatic}(85) = -1.68$, $p = 0.096$; $t_{anxiety}(87) = -2.06$, $p < 0.05$; $t_{socfunc}(88) = -1.72$, $p = 0.09$; $t_{depression}(89) = 1.43$, $p = 0.16$; $t_{ghqtotal}(79) = -0.055$, $p = 0.96$ (see Table 2).

Table 1
Descriptive statistics of demographic variables of the community ($n = 97$) and the clinical sample ($n = 36$)

Variable	Community			Clinical		
	M	*SD*	range	*M*	*SD*	range
Age	**36.9**	**8.6**	**18–62**	**40.8**	**7.4**	**20–60**
Years in the Netherlands	**10.9**	**5.9**	**1–25**	**11.7**	**4.8**	**2–23**
	n	%		*n*	%	
Sex						
Male	39	40.2		16	44.4	
Female	58	59.8		20	55.6	
Childhood circumstances						
Rural	19	20.4		6	16.7	
Urban	74	79.6		30	83.3	
Living status						
Alone	40	41.2		17	47.2	
With family	57	58.8		19	52.8	
Education						
None or primary	14	14.4		8	22.2	
Junior and secondary	44	45.4		17	47.2	
Secondary upper	30	30.9		9	25.0	
University	9	9.3		2	5.6	
Employment status						
Paid job	79	81.4		10	28.6	
Social benefit	18	18.6		25	71.4	
Religion						
Christian	62	65.3		15	41.7	
Catholic	6	6.3		5	13.9	
Pentacostal church	7	7.4		6	16.7	
Other	11	11.6		6	16.7	
Non-religious	9	9.5		4	11.1	

A comparison of the Ghanaian clinical sample ($n = 36$) with a sample of indigenous Dutch outpatients ($n = 175$) (Koeter & Ormel, 1991) showed that Ghanaians reported fewer health symptoms than their Dutch counterparts, $t_{somatic}(34) = -2.99$, $p < 0.01$; $t_{anxiety}(34) = -3.47$, $p < 0.01$; $t_{socfunc}(33) = -4.60$, $p < 0.01$; $t_{depression}(34) = -2.82$, $p < 0.01$; $t_{ghqtotal}(33) = -3.75$, $p < 0.001$ (see Table 2).

Acculturation

Table 3 presents detailed information on the acculturation rates. The total Ghanaian sample reported relatively higher acculturation rates compared with other migrant groups in the Netherlands (i.e., Surinamese, Turks, Moroccans and Bosnians). The only significant difference between the two Ghanaian samples concerned the traditions preserving tendency and the loss experiences. Ghanaians recruited at the community agencies reported more preserving traditions and more experiences of loss than Ghanaians in the clinical group, $t_{traditions}(48.20) = 2.73$, $p < 0.01$; $t_{loss}(128) = 3.01$, $p < 0.01$.

Table 2
Means and standard deviations for GHQ-28 subscales in the community (n=97) and clinical (n=36) sample, compared with indigenous Dutch general population and clinical samples (see Koeter & Ormel, 1991)

Sample	Community			Clinical		
	Ghanaian		Dutch	Ghanaian		Dutch
Variable	M	SD	M*	M	SD	M*
Predictor variables						
LAS skills	18.3	6.9		19.3	5.5	
LAS traditions	20.3	3.7		17.7	5.0	
LAS social integration	13.4	4.3		14.0	3.9	
LAS values and norms	19.3	7.2		18.7	5.4	
LAS loss	33.3	6.8		29.2	7.1	
Outcome variables						
GHQ somatic complaints	5.4	4.3	6.2	8.7	5.1	11.3
GHQ anxiety & insomnia	4.8	4.5	5.8	9.4	5.8	12.8
GHQ social dysfunction	6.4	3.2	7.0	8.5	4.4	12.0
GHQ depressive feeling	2.2	4.0	1.6	6.6	6.5	9.7
Total GHQ (0,0,1,1)	4.4	6.1		10.1	8.3	

Note: LAS = Lowlands Acculturation Scale; GHQ = General Health Questionnaire; * no data on standard deviations and total GHQ scores were published

Predictors of subjective health state

In the total Ghanaian sample, health symptomatology was correlated with preserving traditions (r=–0.23, p=0.015) and attitudes regarding values and norms (r=–0.21, p=0.026). People reported more health-related problems when they were less culturally conservative and less critical towards Dutch norms and values. Direct multiple regression analysis for the total score on the subjective health scale revealed the nature of the sample, a tradition preserving tendency, feelings of loss, and the working situation as significant predictors: treatment in mental health care, a lower level of traditional affiliation, a higher level of loss experiences and the receipt of social benefit were related to a higher level of reported health symptomatology (R^2=0.23; F (8,100) = 5.1, p<0.001, see Table 4).

Table 3
Ghanaian mean score on the LAS subscales in comparison with samples of Bosnian, Surinamese, Turkish and Moroccan migrants (Knipscheer *et al*., 2000; Kamperman *et al*., 2003; Knipscheer & Kleber, 2006)

Variable	M (SD) Bosnian (n = 78)	M (SD) Surinamese (n = 268)	M (SD) Turkish (n = 533)	M (SD) Moroccan (n = 81)	M (SD) Ghanaian (n = 133)
LAS subscales					
Skills	15.6 (7.4)	7.4 (3.6)	17.4 (7.1)	13.0 (6.6)	18.6 (6.5)
Traditions	18.1 (5.5)	17.0 (4.5)	21.2 (3.5)	18.6 (4.1)	19.6 (4.2)
Integration	17.9 (4.5)	9.9 (3.5)	12.1 (4.2)	10.8 (4.6)	13.6 (4.2)
Norms	20.2 (4.8)	20.8 (5.1)	20.7 (4.8)	17.5 (4.7)	19.2 (6.7)
Loss	29.9 (8.8)	26.3 (8.4)	31.1 (7.3)	27.3 (7.3)	32.2 (7.1)

Table 4
Multiple regression analysis of acculturation demands and sociodemographic variables related to subjective health state (n=133)

Variable	Standardized Beta	95% CI	
Sample	0.30**	3.26	17.94
Age	–0.01	–0.36	0.33
Education	–0.08	–3.19	1.32
Source of income	–0.19#	–13.57	0.41
LAS tradition	–0.26*	–1.92	–0.14
LAS Social integration	–0.06	–0.95	0.49
LAS values and norms	–0.08	–0.67	0.28
LAS loss	0.20#	–0.07	1.03

Note: adjusted $R^2 = 0.23$; $F(8, 100) = 5.1$, $p < 0.001$; #$p < 0.10$; *$p < 0.05$; **$p < 0.01$

DISCUSSION

This article deals with a fascinating issue that the process of globalization makes more salient every day. It examines the influences of international migration on the mental health of an understudied migrant population using both clinical and community-based samples. This study is an empirical approach towards understanding the magnitude of the relationship between cultural adaptation and psychological distress. It provides answers regarding issues related to stress resiliency and healthful lives for ethnically differentiated migrants, in this case for people of western African descent.

Health

In order to determine to what extent responses to cultural adaptation demands in a new society relate to subjective mental health, data from Ghanaian migrants in the Netherlands recruited in community and clinical agencies were analysed. About half (44%) of the sample had above-threshold GHQ-28 scores, and specific subgroups (especially respondents recruited at the 'Afapac' and 'I Care' agencies) reported serious health problems. The psychiatric caseness found in the sample is high compared with other studies on migrants (e.g., Fichter *et al*., 2004; Khavarpour & Rissel, 1997; Thompson *et al*., 2002). None the less, the majority of the Ghanaians are in relatively good health. Moreover, Ghanaian respondents in the community and in mental health care reported no more health-related symptoms than Dutch people in the general population and mental health care respectively. Part of the explanation for these positive results can be found in the close-knit social structures and networks that have remained intact through migration and transitions. Social network and types of social support can exert a substantial role on cultural assimilation in protecting an individual against specific psychosocial vulnerability. The Ghanaian community in Amsterdam is booming, with lots of social activities. The organizations included in this study provide social and juridical help and healthcare consultation, and are also used as a place to meet other Ghanaians.

The results of the qualitative study we did in addition to the quantitative data (focus groups and in-depth interviews; described in detail by Knipscheer *et al*., 2004) provided a more narrative perspective on the role of social support in health. Ghanaian respondents reported financial troubles (mainly problems with debts and taxes – often caused by a combination of unemployment and absence of staying permits), relation and family problems, insecurity, and daily hassles and

stressors (especially hard labour) as health-related problems. Social cohesion was often mentioned as a coping resource. Religion was also a key factor in staying healthy – most people found support in visiting the church.

In addition, the predictive power of belonging to the community group or the clinical groups reflects an actual absence of psychological distress among those who had not sought out mental healthcare treatment. People with serious problems thus appear to find their way to mental health care (see also Knipscheer *et al*., 2000; Knipscheer & Kleber, 2001, 2005, 2006).

Still, Ghanaians who are not in care may form a group to pay attention to, since in our qualitative study a taboo concerning the use of mental healthcare agencies was reported. The initiative to find help oneself was low; many respondents feared gossip and there existed a language barrier. Nevertheless, people believed that regular mental health care could provide good services. One believed that counselling would definitely help, but only once the doctor was to be trusted.

Acculturation

Consistent with previous research, acculturation demands contribute to the report of health problems. Acculturation level as such is not a strong predictor of mental distress, but specific dimensions of the acculturation process are. In our study a strong affiliation with cultural traditions (like passing through the traditions in raising children and celebrating religious feasts) is associated with good health (see also Kamperman *et al*., 2003; Knipscheer & Kleber, 2006). Feelings of loss about concerning the country of birth and a greater orientation to people with the same cultural background are, however, associated with a higher level of health symptoms. The results of this study imply that acculturation as a measure of cultural adaptation has an effect on mental health, irrespective of the effects of sociodemographics on both acculturation and mental health. However, this effect was found only among different domains of acculturation, suggesting that a global assessment of acculturation level is, as we hypothesized, not a strong predictor of mental distress. Some domains of cultural adaptation thus promote mental health of migrants whereas others hinder it. In this case implementing cultural traditions and rituals in daily life is beneficial while ruminating over 'the good old times' could be maladaptive for health.

One can conclude that a substantial number of the Ghanaians are relatively successfully engaged in daily life in the new society. These migrants can cope with suffering, adversity and challenges related to migration and acculturation in a resilient way and maintain health. Predictors of belonging to this group are a combination of having a high preservation of cultural traditions together with a low level of rumination. In addition, the influence of poor social demographic status is evident: jobless people reported significantly more health problems. Traditions and rituals are important in preventing health problems, while orientation to the new country and economic independence make people strong. Under these conditions migration can actually lead to good health (see also Bhugra, 2004).

These results are in line with the so-called 'alternation model' of second-culture acquisition, which assumes that it is possible for an individual to understand two different cultures and to alter his or her behaviour to fit a particular context. An individual may become fully bicultural and bilingual, and develop a healthy dual identity and a strong identification with two ethnic groups (e.g., Hutnik, 1991). This form of adaptation entails the ability to operate freely and feel comfortable in both cultures. In sharp contrast to this approach, an individual may develop psychological ambivalence relative to the two cultures. In this 'marginal' state of identification the individual has a weak identification with both the minority and majority groups. In a review by LaFromboise, Coleman and Gerton (1993),

bicultural involvement appeared to be a good predictor of psychological well-being. Migrants who had the ability to effectively alternate their use of culturally appropriate behaviour showed higher mental health status than those who were monocultural and assimilated. In the case of Ghanaian migrants in the Netherlands, implementing cultural traditions in daily life in conjunction with obtaining skills to function in Dutch society is beneficial for mental health.

Because the correlational nature of this research does not allow for definitive conclusions regarding the direction of causality, alternative explanations should be considered. Thus, although it seems likely that more cultural affiliation could protect a migrant from mental health symptomatology, it is also possible that an unhealthy condition makes one cling more to cultural traditions and more prone to rumination. In either case, the results suggest that mental health professionals dealing with migrants should not limit their evaluation efforts to mental health problems but also to acculturation stress, cultural affiliations as well as social and economical troubles. Migrant health may deteriorate as a result of the combined impact of post-migration problems and socio-economic predicaments.

Limitations and strengths

An important limitation exists in this study. The use of non-probability samples may hamper the validity of the study. The extent to which our samples represented the target population is not exactly known. The so-called snowball-sampling technique can be used to explore relatively unknown populations, such as migrants. This method is not strictly random and cannot be compared with representative sampling methods. Nevertheless, the method is recommended in cases where one does not know population characteristics and expects a reluctance to cooperate with research (Kaplan *et al*., 1987). Given the frequent reservations of ethnic minorities to take part in scientific research, this sampling technique is advisable (Okazaki & Sue, 1995). Our sample could be biased towards health and acculturation: only relatively healthy people and relatively well-integrated respondents might have participated. A substantial body of the sample consisted of people visiting local community centres and who consequently were part of a social network and able to participate in the outside world. However, the opposite can be true as well: especially people who have a worse health status are driven towards self-help groups and community agencies. Nevertheless, we reached the demands of minimal participation sufficiently. Moreover, the representativeness of samples does not always have to be a danger for the validity of the findings (see Van Loon *et al*., 2003).

Another limitation of the current study is its retrospective nature and reliance on the self-reporting of participants. Retrospective reporting may result in aspects or nuances of particular experiences being forgotten or misremembered. Also, a straightforward comparison between two cultural groups on a standardized questionnaire should be performed with great caution.

A strength of this study can be mentioned as well. The discrepancy between universal scientific objectives and the specific experiences of human beings within local cultures continues to evoke discussion about current psychiatric research methodology. In this research design quantitative data (standardized instruments) were enriched by culture-specific qualitative data (in-depth interviews and focus groups). In this way, a culturally competent and eclectic application of research and analysis techniques was created, assuring culturally valid measurements and adequate interpretability of the results. Moreover, a preliminary version of the questionnaires was pilot tested and both content and format were revised on the basis of the results. None the less, some problems arose in using the GHQ. The multiple-choice format of the answers did not always provide enough room for the articulation of the symptoms and the formulation of some items was complex. The GHQ is adequate

for global group screening of mental health problems but needs adaptation to be a valid indicator of the specific nature of problems on an individual level.

CONCLUSION

This study has established evidence of the existence of the accumulation and multi-determination of (mental) health problems. Acculturation demands capture critical elements of migrants' experiences that warrant professional interventions tailored to the specific needs of this growing population. The impact of acculturation (in particular traditional affiliation and feelings of loss) on mental health is substantial. A subtle balance between holding on to supportive and identity-enhancing cultural traditions and moderate involvement in ruminating about pre-migration life, in conjunction with acquiring the instrumental skills of the host culture to be better equipped for finding suitable employment, is a starting position for better health (see also Knipscheer & Kleber, 2006; LaFromboise *et al*., 1993; Rogler *et al*., 1991). It is precisely this cluster of factors that mental healthcare providers have to address in service application to migrated patients. This means structural attention to the experiences that people have been through and stimulating the acquisition of mechanisms to optimally enhance the coping process. In addition, migrant patients should be encouraged to develop a positive cultural identity, such as participating in activities within their own cultural group, as well as obtaining practical skills to function well in the host society.

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