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GHANAIAN MIGRANTS IN THE NETHERLANDS: GENERAL HEALTH, ACCULTURATIVE STRESS AND UTILIZATION OF MENTAL HEALTH CARE

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Ghanaians are a relatively unknown migrant group in the Netherlands. Due to a plane crash in a densely populated suburb of Amsterdam, the Ghanaian population in 1992 suddenly became a "hot item" in national media. It was assumed that they would be a group at risk: many Ghanaians were either directly or indirectly victims of this disaster. Moreover, Ghanaians were assumed to be unfamiliar with the Dutch society and the health care system. A study was conducted using self-report questionnaires to investigate mental health and help-seeking orientation. Findings show that migration factors, acculturative stress, and legal status have an impact on health status.

This study was conducted with the financial support of the National Fund on Mental Health Care (NFGV). The Department of Clinical Psychology of Utrecht University in cooperation with "De Meren," the organization for regional, academic, and forensic mental health care in the south-eastern district of Amsterdam, conducted the investigation. We are indebted to the Sikaman Foundation (especially Mr. Kwame Adu-Ampoma) and the RIAGG in south-eastern Amsterdam for their crucial contribution in making this research a success. In conclusion, we gratefully acknowledge all the Ghanaian participants.

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However, Ghanaians do not report more health problems than the Dutch norm group. Furthermore, results indicate that the help-seeking orientation of the Ghanaians differs less from the Dutch than was supposed: the Ghanaian participants consult clergy and traditional healers for their problems as well as the regional ambulatory mental health care center. Satisfaction with the services provided was seen to be quite high. However, more practical help with regard to financial problems and housing facilities is wanted. Implications for improving the mental health care system for migrants and ethnic minorities are discussed. © *2000 John Wiley & Sons, Inc.*

INTRODUCTION

Although migration is a worldwide phenomenon, its influence on the mental health of migrants has not yet been explored satisfactorily. Controversies exist about whether migration and resettlement improve or impair migrants' emotional health and well being (Aroian, 1990; Helman, 1990; Hertz, 1993). It is generally assumed, however, that migrants are more vulnerable to mental disturbances due to their migration experiences and their disadvantaged socio-economic position. Migration is considered to be a harrowing experience, as are the circumstances that have led to the decision to migrate such as poverty, a lack of future perspectives, and repression. The resulting acculturation is a prolonged and often laborious process (Nann, 1982). Migrants have to become accustomed to new climate, language, cultural and political attitude, and roles (Berry, 1994). Furthermore, existing social networks have fallen apart and social surroundings have changed. The lack of perceived and received social support can result in impaired health, including mental health (Cohen & Wills, 1985; Schwarzer & Leppin, 1991). Moreover, migrants are often ethnic minorities in their new homeland. Conflicting opinions exist regarding the relationships between belonging to an ethnic minority and mental health (see Lonner & Malpass, 1994; Nevid, Rathus, & Greene, 1997). Cheung and Snowden (1990), for example, report in their literature review mixed results concerning ethnic differences in symptom expression, varying from more somatic symptomatology, hostility, hallucinations, and manic depressive disorders among Blacks to no inter-ethnic differences at all.

It is not surprising that all these transitions are considered to influence mental health. Moreover, the often confounded factors of ethnicity and acculturation affect psychological functioning and help-seeking attitudes regarding emotional problems. To meet the mental health needs of ethnic minority populations, insights in help-seeking attitudes and behaviors is of great concern. Although it is now generally recognized that help-seeking for mental health problems is linked to cultural and ethnic factors, no clear knowledge exists about how many migrants actually cope with mental problems, how migrants and ethnic minorities disclose their mental problems, and where they go to find help. Nor is it clear how the treatment process can be tailored to the specific needs of ethnic minorities (for reviews see Dinges & Cherry, 1995; Leong, Wagner, & Piroshaw Tata, 1995).

Rogler and Cortes (1993) argue that the nature and the seriousness of the above mentioned distress provide the impetus to seek help but the duration and the direction of this process are structured by the convergence of psychosocial and cultural factors. Research across a variety of community and clinical samples revealed that those at the bottom of the social system experience mental health problems disproportionately and they are less likely to receive professional mental health care, even when care is free.

Many ethnic groups in the US are characterized by this paradox of high risk and underutilization of mental health facilities (for example Hispanic and Asian Americans). African Americans, however, have been found to overutilize mental health services relative to their proportion in the general population for they tend to experience disproportionately higher levels of social, occupational, and economic stress. African Americans also have different attitudes about the mental health system and they use it in a different way: they are more likely to seek help in the mental health services for practical and impersonal problems, such as administrative matters (difficulties with law, social services, and housing) and medication. They tend to view the mental health system more as an ombudsman or referral service than as a service for dealing with personal psychological problems (Leong et al., 1995).

In order to examine these issues with regard to the complex relation between migration and mental health care, we investigated the mental health status and the help-seeking orientations of people who migrated relatively recently from Africa to Western Europe, in this case from Ghana to the Netherlands.

Migrants in The Netherlands: The Case of the Ghanaians

Over the last decades, the Netherlands has rapidly changed into a society with considerable ethnic minorities including: people from the former colony Surinam, migrants with a Turkish or Moroccan background, and refugees from all over the world. The confrontation with representatives of other cultures has important consequences for the mental health services. Although results of scientific studies in Holland are quite diverse and incomplete, there are strong indications that migrants experience more health problems than do Dutch inhabitants (Uniken Venema, Garretsen, & van der Maas, 1995).

It is expected that an ever increasing number of migrants will consult the mental health service (de Jong & van den Berg, 1996). The assistance offered in these services, however, does not seem to be tailored to the cultural and socio-economic position of migrants. Physicians, psychotherapists, and other service providers in mental health care often experience difficulties interacting with ethnically mixed patients. They are not familiar with the language, the culture, and the needs of their patients, nor with the socio-economic position in which migrants often live. Treatments recurrently fail as a result (e.g., Dahhan, 1993; de Haan, 1993; Giel, 1993).

An illustration of cultural differences in assistance offered versus help asked for can be seen in the events following a plane crash in 1992 in the densely populated and ethnically differentiated residential Bijlmermeer quarter in Amsterdam. After the disaster, many ethnic victims wanted immediate financial assistance, whereas the service providers concentrated on the processing of psychological trauma and related mental problems. Unfamiliarity of the migrants with the Dutch system that separates material and psychological assistance caused a lot of distrust and discomfort. Many victims felt abandoned when social welfare workers showed little concern for their sorrow. As a result, they criticized other service providers which damaged the general confidence in psychosocial assistance (de Jong & van Schaik, 1994).

In the aftermath of the catastrophe, general practitioners frequently experienced bottle-necks in providing services to migrants as well. They also pointed out the gaps in knowledge about the referral patterns of migrants in health care (Knipscheer & Kleber, 1994).

In one respect, the Bijlmer disaster can be considered as an important breakthrough. The local mental health careworkers were forced to adjust their services more

adequately to their poly-ethnic clientele, for never before was the diversity of groups who applied themselves to the community outpatient department so high (Karsten, Koops, & Sookhoo, 1996). Another result of the calamity was the extensive attention (especially in the media) paid to a relatively unknown group of migrants that had become victims, directly or indirectly, due to the tragedy. Particular attention was paid to the so-called illegal Ghanaians (it was supposed that many of the Ghanaian migrants had an illegal status in the Netherlands).

The expectation was that a variety of risk factors existed for many Ghanaians: belonging to an ethnic minority, living in a "condición migrante", victimized by the Bijlmerdisaster, remaining illegal, and being unfamiliar with the Dutch health care system. This list of risk factors is not specific for Ghanaians and knowledge about this theme has much relevance for migrants of other origins. Therefore a study has been conducted to investigate the psychological health symptoms, the help-seeking behavior and the experiences with mental health services of Ghanaians. Such a study could clarify the interconnections between migration, acculturative stress, and mental health. The research questions were:

1. What is the general health status of the Ghanaian immigrant sample compared to an indigenous Dutch reference group?
2. What is the relationship between migration related factors (i.e., migration motives, adaptive demands, acculturative stress), social support and health status in Ghanaian migrants?
3. How do Ghanaians evaluate the professional psychosocial services in the Netherlands?

METHOD

Sampling

The number of Ghanaians in the Netherlands is not clear. According to the Central Bureau for Statistics, 7,026 Ghanaians were living in the Netherlands in 1994. Approximately half (3,431) resided in Amsterdam, mostly in the south-eastern region (O&S, 1995). It is estimated that about 3,000–3,500 lived here illegally (Stadsdeel Zuidoost, 1992).

This study was performed in the south-eastern area of Amsterdam. During the first six months of 1996, Ghanaians were approached at two sites: in the Ghanaian community and at an outpatient mental health department. Participants in the community sample were recruited by the Sikaman Foundation, a self-help group that gives support to Ghanaians in the Netherlands for various issues including juridical, social, and health problems. Key figures of this self-help group asked their visitors to participate in the study. Furthermore, key figures of other Ghanaian organisations were asked to request their members to take part in the study. A multiple entry point was herewith accomplished. Respondents in the outpatient sample were asked by their service providers at the regional outpatient mental health department (a local agency for ambulatory mental health care) to participate. This so-called snowball-sampling technique can be used to explore relatively unknown populations, such as illegal immigrants (Kaplan, Korf, & Sterk, 1987). 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 co-operate with researchers (especially due to the illegal status).

Procedure

All subjects were requested to fill out a self-report questionnaire in Dutch or English. Most participants (71, 88%) completed the English version of the questionnaire. Information was obtained from the subjects on the following: (1) demographic details; (2) the occurrence and severity of health problems (according to the GHQ-28) and problems of financial and societal nature; (3) received and perceived social support; (4) migration-related issues and acculturative stress; (5) pathways to health care; and (6) the evaluation of psychosocial services.

Variables Examined

Independent variables. Ethnicity, age, gender, marital status, educational level, length of stay in the Netherlands, employment status, religion, legal status, and agency were examined. The variable ethnicity was designated as Ghanaian or Dutch in the between-groups analyses, but was categorized into three main Ghanaian subgroups (Fanti, Ashanti, and Kwahu) in the within-Ghanaian sample analyses. Age, which ranged from 13 to 48 years, was used as a dichotomous variable in the multivariate analyses. Marital status was dichotomized into currently married or living together and living alone. Education level was categorized into three groups. Length of stay in the Netherlands, which ranged from 0 to 17 years, was used as a dichotomous variable in the multivariate analyses. Employment status was dichotomized into employed and jobless. Religious support was dichotomized into perceiving no to little support and perceiving much to very much religious support. Legal status was dichotomized into currently legally or illegally staying in the Netherlands. Agency was dichotomized into self-help group visitors and outpatient mental health care clients.

Dependent variables

Health. For measuring the occurrence, nature, and severity of the health symptoms, the General Health Questionnaire (28 item version GHQ-28) was used (Goldberg & Hillier, 1979; Dutch translation by Koeter & Ormel, 1991). This questionnaire measures the recent state of subjective well-being in four areas: psychosomatic symptoms, anxiety and insomnia, social dysfunction, and (severe) depression. All items were endorsed on a 4-point Likert-type scale. The scores ranged from 2 to 73. Subscales and the total score of the GHQ-28 were used to evaluate general health status. Internal consistency was estimated using Cronbach alpha coefficients. Internal consistency reliability was good (Cronbach's alpha for the subscales ranged from .82 to .91 and was .95 for the total GHQ-28 scale). Cross-cultural validity of the GHQ-28 has been established with samples in former Yugoslavia (Radovanovic & Eric, 1983), Nigeria (Oduwole & Ogunyemi, 1989), and Brazil (Mari & Williams, 1985). The GHQ-28 "performed well" in these studies (Leff, 1994). Open-ended questions regarding health and social well-being not captured by the GHQ-28 were also asked regarding problems with financing, housing, and jobs.

Acculturative stress. The Demands of Immigration Scale (DIS; Aroian, Tran, & Schappler, 1995) was used to measure acculturative stress. The DIS, in contrast to the more common "stressful life events" scales was developed specifically to measure stressors directly related to migration. This 18-item scale includes six dimensions: loss, novelty, adaptation to work, adaptation to language, discrimination, and not feeling at home. All items were endorsed on a 6-point Likert-type scale. The DIS-total is a continuous scale with values

ranging from 25 to 108. A high score indicated that immigration posed substantial demands for the individual in question.

Internal consistency of the total score of the DIS is quite satisfactory (Cronbach's alpha .85). In addition, migration related issues were investigated. In open ended questions, information concerning reasons for migration, expectations about the new situation, and circumstances during and after the travel to the Netherlands were investigated.

Social support. Received and perceived social support was measured by a moderation of two social network scales (Flaherty, Gaviria, & Pathak, 1983; van Wijngaarden, 1987). This scale consisted of 16 items, all endorsed on a 4-point Likert-type scale. The sum-scores range from 4 to 15. A high score reflected high perceived social support.

Help-seeking behavior and evaluation of services. The section on the pathways to mental health care included questions derived from earlier studies concerning the mental health of migrants in the Netherlands (Karsten et al., 1996; Mooren & Kleber, 1996; van der Velden, Eland, & Kleber, 1994). Help-seeking behavior was assessed by questions concerning utilization and consultation of psychosocial health services. The evaluation of the services (in terms of satisfaction) is an ordinal scale with scores varying from 0 (many complaints) to 4 (very satisfied).

Analyses

The data were analyzed using SPSS, version 5.0.1. Levels of significance were tested using Chi-square, Fisher's exact test, non parametric tests (Kruskall Wallis) or *t*-tests, where appropriate. Multivariate comparisons were carried out by logistic or multiple regression analysis to distinguish independent predictors of general health, demands of immigration, and pathways to mental health care. Because this research project was the first study on this level, no valid parameters could be attained in order to perform a power analysis for this group.

RESULTS

Sample Characteristics

Sixty-six visitors of the self-help groups and 15 clients of the outpatient mental health department participated (see Table 1).

Gender and age. According to demographic investigations, Ghanaians in the Netherlands are mostly single men and women coming from a city in Ghana and aged 25–40 years (Nimako, 1993). Our sample reflects that the study sample is representative of this population: almost three fourths of the respondents (57) ranged from 25 to 40 years of age and the majority were raised in a city in Ghana (71). However, more men (55) than women (26) took part in the research.

Marital status. About one third of the respondents (25) were single, a few (14) lived together with their partner, and a quarter (21) lived with partner and children. Furthermore, some lived with their children (8), with other family members (7), or with parents (5).

Table 1. Descriptive Statistics of the Ghanaian Sample for Relevant Variables (N = 81)

Variable	*N*	*%*	*M*	*SD*	*Range*
Sample Agency					
Self help group	66	81.3			
Outpatient department	15	18.7			
Sociodemographics					
Ethnicity					
Fanti	19	23.5			
Ashanti	16	19.8			
Kwahu	13	16.0			
Other/Unknown	33	40.8			
Gender					
Male	55	67.9			
Female	26	32.1			
Age			33.2	8.4	13–48
Length of stay			6.9	4.2	0–17
Marital Status					
Living Alone	25	30.9			
Living Together	56	69.1			
Educational Level					
Primary	9	11.1			
Junior Secondary	11	13.6			
Senior Secondary Low	24	29.6			
Senior Secondary Upper	22	27.2			
University	15	18.5			
Employment status					
Job	47	58.0			
Benefit	34	42.0			

Education. The average education of the Ghanaians in Amsterdam is of secondary to higher level (Nimako, 1993). In our study, most of the respondents also had had their education in Junior Secondary Course (24) or followed Senior Secondary Course (22). One-fifth (15) had completed their academic studies. More than one-fifth only had Primary school (9) or Junior High School (11) education. In almost all cases the subjects had completed their education in Ghana.

Employment status. More than half (47) of the respondents had a paid job; four persons had no income at all; the rest received some kind of benefit.

Ethnicity. As noted before, the Ghanaian population is very heterogeneous. In Ghana there are at least five major ethnic groups which differ in language, rules of inheritance and religions (Lamensdorf Ofori-Atta & Linden, 1995). Our sample consists of about eight different ethnic subgroups, the largest being the Fanti (19), the Ashanti (16), and the Kwahu (13).

Agency. The community sample is largely represented by people who are married, working, and remaining here legal. A logistic regression analysis with the earlier mentioned independent variables as predictors yielded marital status (single), employment status (benefit), and legal status (illegal, trend) as the most predictive factors of being in the

Table 2. Logistic Regression Coefficients of the Agency Sampling (N = 81)

Variable	*B*	*S.E.*	*Wald*	*df*	*Sig*	*R*	*Exp(B)*
Gender	−1.6636	1.1054	2.2652	1	.1323	−.0601	.1894
Education	1.2981	1.0249	1.6041	1	.2053	.0000	3.6625
Period of staying	−.7911	1.1162	.5023	1	.4785	.0000	.4533
Age	1.4152	1.1062	1.6367	1	.2008	.0000	4.1171
Marital Status	−3.1767	1.1634	7.4558	1	.0063	−.2726	.0417
Employment Status	−5.1734	1.5040	11.8313	1	.0006	−.3659	.0057
(Constant)	4.3097	2.5372	2.8852	1	.0894		

Model Chi-Square = 39.716; df = 6; $p < 0.0001$.

outpatient sample (Table 2). (At the outpatient department more Ashanti were in treatment (40%) than the Fanti (10.5%) and the Kwahu (0%) (Chi^2 (2) = 8.84, p = 0.012).)

Migration. Most Ghanaians came to the Netherlands in the 1980s owing to the political instability and economic depression in their country and the violation of human rights under the regime of Rawlings (Noordergraaf & Grunsven, 1994). The participants in our study migrated to the Netherlands in the period from 1979 until 1996. They have lived here for about seven years (6.9 years, SD 4.2). Two thirds (54) of our sample reported economic reasons as the main motive for migration.

The political situation also motivated people to leave Ghana (12). Furthermore, family reunionfication was often mentioned (10). As for the majority of Ghanaians in Amsterdam (Tichelman, 1996), three-quarters of the Ghanaians in our sample (58) came to the Netherlands on their own. The rest came with their partner or family. More than one third of the sample (32) had nobody to welcome them upon arrival in the Netherlands.

The Ghanaians often had high expectations about life in Holland. They thought it would be easy to find a job and earn money (Tichelman, 1996). Hence, respondents mentioned expectations such as a good life and a better future (27), opportunities for starting and completing education (16), and a better labour perspective (14). People also expected hospitality, tolerance, and legislation (17), and political peace and stability (4). Ten respondents had the opinion that their expectations did come true, ten others thought this was partly so, while almost half of the respondents (35) said that life in the Netherlands felt short of their expectations. One-quarter (22) mentioned that they had not fulfilled their expectations at all: the tightening up of foreigner legislation and a lack of jobs were reported reasons. A minority (12) of the Ghanaian sample had never experienced discrimination, more than half (48) reported these experiences sometimes, whereas a quarter (20) regularly perceived discrimination.

Demands of Immigration. Scores on the DIS indicated that one-fifth (17) did not suffer much from demands of immigration, a third (25) experienced these moderately, and more than a third (30) had suffered very much from demands of immigration.

General Health

Comparisons on the community level. The mean scores on the General Health Questionnaire (GHQ-28) of the Ghanaian community sample (N = 65) were compared to those of the

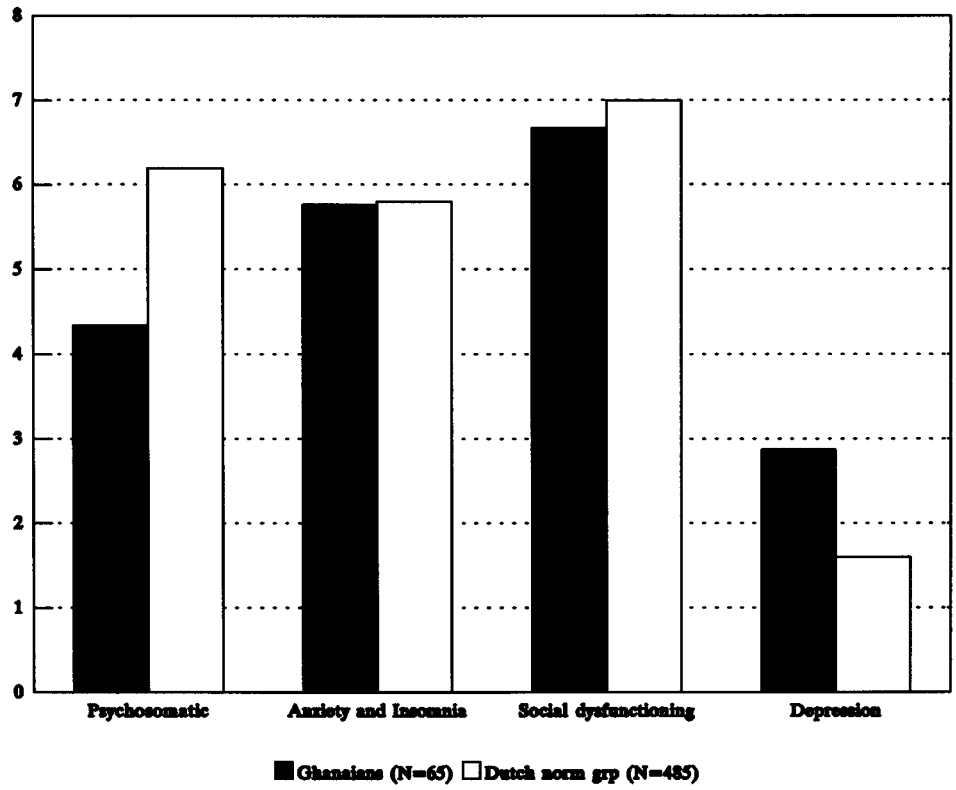

Figure 1. GHQ comparisons between Ghanain and Dutch communites.

Dutch population in general (N = 485) (Koeter & Ormel, 1991). Interestingly, this comparison revealed no statistical differences (see Figure 1). The results suggest that the Ghanaian respondents have no more psychosomatic difficulties compared to the Dutch population in general. However, Ghanaians report more symptoms of depressive nature.

Comparisons on the Community Mental Health Care level. A comparison of the Ghanaian outpatient sample (N = 15) with a group of Dutch outpatients (N = 32) who participated in another study concerning mental health status and help seeking behavior showed that the Ghanaians reported more health symptoms, especially psychosomatic complaints, and anxiety and sleeplessness. A multiple regression analysis, entering in a stepwise method the independent variables (nationality, gender, educational level, age, marital

Table 3. Standardized Regression Coefficients (Betas) of the Determinants of the GHQtotal Score of Ghanaian (N = 15) and Dutch (N = 32) Clients in the CMHC

Variable	*B*	*SE B*	*Beta*	*T*	*Sig T*
Nationality	14.771889	5.570504	.374902	2.652	.0112
(Constant)	21.099078	7.745471		2.724	.0093

Multiple R = .37490.

Table 4. Standardized Regression Coefficients (Betas) of the Determinants of the GHQtotal Score Within the Total Ghanaian Sample (N = 81)

Variable	*B*	*SE B*	*Beta*	*T*	*Sig T*
Agency	28.238945	4.184164	.624913	6.749	.0000
Legal status	10.219661	4.375227	.216643	2.336	.0230
Ethnicity	2.577541	1.265776	.179240	2.036	.0464

Multiple R = .74769.

status, and employment status), indicated nationality as the only significant predictor for the general health status (Table 3).

Differences within the Ghanaian sample. A multiple regression analysis, entering in a stepwise method the independent variables, indicated agency, judicial status, and ethnicity (Ghanaian ethnic subgroups) as the significant predictors for the general health status. Clients in the community mental health care, as well as Ashanti and illegally staying respondents, reported significantly more health symptoms (Table 4). Interestingly, the length of the stay in the Netherlands was not related to the state of health.

Self mentioned problems. Participating Ghanaians were asked if they suffered from other problems or symptoms not mentioned in the GHQ. The respondents mentioned a variety of problems; two-third had to contend with financial problems (49). Furthermore, societal problems (20), working problems (14), legal concerns (11), and housing problems (9) were mentioned. Only one fifth of the respondents (17) had no symptoms or problems at all. Several Ghanaians mentioned the onset of financial problems when a staying permit was delayed. Unemployment and problems finding a job, also frustrated various respondents.

Health and Migration

A multiple regression analysis, entering in a stepwise method migration factors (motivation, accompaniment, reception, perceived racism, and total score of the DIS) indicated political motivation and absence of reception by someone after arrival in the Netherlands as the only significant variables independently predictive of general health status (as measured by the GHQ-28) (Table 5). Ghanaians who came to the Netherlands as a result of the political situation in their country and respondents who had nobody to welcome them after their arrival in the Netherlands, had more health related problems. The multiple regression analysis did not yield the DIS-total score as a significantly predictive

Table 5. Standardized Regression Coefficients (Betas) of the Determinants of the GHQtotal Score With Migration Related Variables (N = 81)

Variable	*B*	*SE B*	*Beta*	*T*	*Sig T*
Political motivation	15.490564	5.289922	.322482	2.928	.0047
Reception	−10.458898	3.772648	−.305300	−2.772	.0072

Multiple R = .49309.

variable regarding general health status. However, a trend was apparent and an univariate relationship between demands of immigration (DIS) and health status (GHQ-28) was found: when migration and the acculturation process was experienced as more distressing, the Ghanaians reported more health symptoms ($r = .32$, $p = 0.007$). This is expressed in those items of the DIS concerning the acquiring of new skills and social interaction norms ($r = .40$) (especially with GHQ-Depression), adaptation to new labour conditions ($r = .34$) (especially with GHQ-Anxiety and Sleeplessness), discrimination ($r = .23$), and the fact that one does not feel welcome ($r = .25$).

Health and social integration. The results concerning social network and social resources suggested that social integration among Ghanaians appears to progress positively. Half of the respondents mentioned having Dutch friends and acquaintances. Besides, the perceived social support correlated with length of stay ($r = .30$, $p = 0.031$). Factors significantly associated with reported health (as measured by the GHQ-28) were social support ($r = -.29$, $p = 0.034$), living together ($T(75) = 2.63$, $p = 0.010$), and religious support ($r = -.33$, $p = 0.007$). Multiple regression analysis entering in a stepwise method social and religious related variables, however, showed no independent prediction of health.

Help-Seeking Orientation: Pathways to Care

The strategies that Ghanaians use to seek help for their symptoms were investigated by examining the help-seeking behaviour of the 62 Ghanaians who reported problems (77.5% of the entire Ghanaian sample). A quarter of these 62 respondents (16) did not seek any help for their problems. Logistic regression analysis (entering the independent variables) showed no independent predictor of help-seeking.

First agency in the pathway. Of the 46 Ghanaians who sought help, almost half of them (18) did so within half a year after the beginning of their symptoms and three-quarters (31) within a period of two years. However, a few Ghanaian participants (4) let five years pass before seeking help.

A fifth of the respondents consulted a general practitioner first and a fifth consulted a general social worker first. Another fifth of the respondents went directly to professional psychological care services (i.e., the outpatient department). Self-help groups (like Sikaman), the clergy, medical specialists, and the labor office were consulted as well. Besides these consults, Ghanaians also reported other complementary sources of help, in the Netherlands as well as in Ghana. Among these the clergy (about a quarter), people with the same cultural background who are experienced in dealing with the kind of problems they have (about 15%), and "traditional healers" (10%), were mentioned in particular.

Disclosure. Half of the help-seeking population (23) had no difficulty in asking for help for their problems. However, a quarter did find this rather difficult and the other quarter (11) were much restrained in asking for help in that they found this extremely difficult to ask for. Unfamiliarity with ways to obtain help, financial costs of seeking help, and illegal status (which elicited fears of detection as well as a lack of insurance) were among the most frequently mentioned reasons. Some Ghanaians also reported difficulty in disclosing their weak side and discussing personal problems with a stranger. Significant independent factors associated with experiencing difficulty in disclosure to a professional provider, as indicated by a logistic regression analysis, were length of stay and education:

Table 6. Logistic Regression Coefficients of the Disclosure of Mental Health Problems

Variable	*B*	*S.E.*	*Wald*	*df*	*Sig*	*R*	*Exp(B)*
Gender	−1.8098	1.0458	2.9950	1	.0835	−.1278	.1637
Education	2.0639	.9918	4.3306	1	.0374	.1956	7.8767
Period of stay	−3.0026	1.1296	7.0653	1	.0079	−.2884	.0497
Age	.8683	.9919	.7663	1	.3814	.0000	2.3829
Marital status	.1574	.9275	.0288	1	.8652	.0000	1.1705
Employment status	−.1169	.8697	.0181	1	.8930	.0000	.8897
(Constant)	1.8039	2.1687	.6919	1	.4055		

Model Chi-Square = 20.763; df = 6; $p < 0.0020$.

Ghanaians who had difficulty in asking for help had stayed about three years less in the Netherlands and were more highly educated (Table 6).

Help requests. The help requests were mostly aimed at two topics: respondents wanted (A) advice for their problems, financial support, and achieving an occupation; and (B) medical help and medication. The processing of psychological trauma and the recognition as being a victim of the Bijlmer disaster were asked for as well.

Satisfaction with first agency. Satisfaction among the participants with the services offered ranged from reasonably to very high. A quarter of the respondents (13) were explicitly dissatisfied with the help offered. These people felt misinterpreted or treated uncarefully and without concern. A few Ghanaians were confronted with a racist and prejudiced care giver. A logistic regression analysis showed no independently predictive factors of service satisfaction.

Community mental health care. Almost a quarter of the Ghanaians with symptoms (15) went to the outpatient mental health department. Emotional problems and health complaints were the most frequently mentioned reasons for consultation. Three out of four respondents attributed their problems to the Bijlmer plane crash. People consulted the department especially to find a concrete solution and to get an understanding of and support for their problems. They wanted to be able to discuss their problems in the company of other persons who had the same kind of problems. They also wanted medicines prescribed for them.

Evaluation of the services. Clients were reasonably to very satisfied with the services offered. Though some people suggested that talking alone was helpful, more concrete help was sometimes wanted. Logistic regression with treatment satisfaction as a dependent variable showed no independent predictor of CMHC-service satisfaction.

DISCUSSION

Migrants are confronted with profound changes in all life domains. In this study, we have examined the relationships between reported mental health symptoms and migration experiences of Ghanaians in the Netherlands, as well as their help-seeking orientation and evaluation of community mental health care.

Limitations and Restrictions

Before discussing the findings of our study, there are a number of methodological limitations to mention. As with any survey, this study is subject to the limitations of self-report questionnaires in that the data may be prone to recall error and selective reporting. Furthermore, a considerable methodological challenge was the procurement of a representative and adequate sample size of Ghanaian participants. In order to obtain our community cohort, we recruited Ghanaian visitors of a well known self help group. The risk exists that such a selection will have more problems than a "real" random sample. In the mental health care domain, out-patient community mental health services were targeted by recruiting respondents through the health care professionals. Although these selection procedures could be viewed as biasing the sample selection, we argue that it is an adequate compromise between methodological rigidity and practical feasibility. Given the fact that ethnic minorities are unlikely to participate in psychological assessment research (e.g., Sue, Fujino, Hu, Takeuchi, & Zane, 1991), the response rate in this study was good (especially because a considerable proportion of the people in the sample were illegal). In some analyses, however, the number of cases is less than 20 which may result in poor power; especially the results of the analyses with the Ghanaian outpatients have to be observed with caution (see Cohen, 1992).

The cultural validity of instruments is an other controversial issue. Although the GHQ is cross-culturally validated, there is a chance that the GHQ also measures *complaining* behavior. Validation by independent clinical assessments would have improved the validity. Unfortunately, this was not possible due to financial reasons. Besides, these assessments are not culture free either. Nevertheless, the internal consistency coefficients (alpha's) of the (sub)scales are very satisfying. Moreover, expert ethnic and cultural consultants and service providers were consulted during the development of the measures before the data collection, as well as in interpreting the results of the studies. Therefore, the GHQ appears to be one of the most adequately (standardized) measures of health outcomes at this moment, and is also the only instrument available at the moment (further elaboration of this theme, see Knipscheer & Kleber, 1999).

Health of Ghanaians

A review of the literature led us to infer that mental health problems are more common among ethnic minorities and migrants. Our findings with the Ghanaian sample, however, warrant caution of this rather stereotypical statement. The idea that migrants suffer more from psychosomatic complaints in particular seems to be generally incorrect for this group. Other studies concerning samples of the population of Ghana (Lamensdorf Ofori-Atta & Linden, 1995) found no psychosomatic symptomatology either. Most Ghanaians in our study seem to cope with migration experiences and acculturative stress in a remarkably strong and resilient way. Reliance on these measures must be tempered, however, because a control group was not available. Besides, the Ghanaians experience definite problems in other areas, such as the uncertainty of remaining in the Netherlands and confrontation with the bureaucratic facilities for the organisation of fundamental essentials of life such as housing questions and financial needs. Our findings confirm the much-cited association between health problems, legal status, financial situation, and unemployment. Other studies (Mullings, 1984; Tichelman, 1996) indicate this close relationship between the insecure socio-economic position and the experience of illness and health under Ghanaians as well: material success is defined as healthy, while

economic insecurity appears to be associated with vulnerability to psychosomatic symptoms.

A clear distinction must be made for the Ghanaian Community Mental Health Care consumers (especially illegal respondents). They reported serious problems. The outpatients mainly reported serious posttraumatic complaints as a consequence of the plane crash.

Health and Acculturative Stress

Our data show a relationship between acculturative difficulties and health complaints. When the acculturation process was experienced as more distressing, more health symptoms were reported. In particular adaptations concerning new skills are related to these symptoms. This confirms the so-called social skills perspective on the implications of migration: the consequences of migration are not so much related to loss, tension, or any intrapsychic disturbance, but more to the lack of the essential skills to cope with a new cultural situation (see Furnham & Bochner, 1986). Hence, unhealthiness and the so-called "condición migrante" are related, although the association is moderate. This also has to be seen in the light of the above mentioned fact that the majority of the Ghanaian group does not have more health symptoms than the Dutch population in general. Therefore, our findings support the statement that acculturative stress does not necessarily lead to negative health consequences.

Furthermore, it is remarkable that the length of the residence in the Netherlands is not related to health condition. This result contradicts Helman's findings (1990) that recent migrants and refugees are more vulnerable to the development of mental problems. However, Helman based his conclusions on the admission rates of migrants at psychiatric hospitals, the number of addicts, and their suicidal attempts, thus rejecting less severe psychological disturbances.

The motive for migration and the situation upon arrival in the Netherlands were found to be crucial to health and well-being. Ghanaians who migrated to the Netherlands because of the political situation need special attention: these persons clearly have more symptoms than Ghanaians with other motives. Their decision to migrate was possibly based on negative *push* factors: it was not the attractions of the West that pulled them but the danger in their own country that pushed them to the West. This could make the loss of their country and loved ones even more painful (Rohlof & Jasperse, 1996). Moreover, people who flee for political reasons to the Netherlands report more acculturative stress: they perceive their competence of the Dutch and English language as less than it should be. They see this as an obstruction in communication. The acquiring of new skills and forms of social interaction is also more distressing for them than for other Ghanaians. In addition, the perceiving of social support appears to be a benign factor in health and well being for all respondents.

Help-Seeking Orientation and Evaluation of Psychosocial Services

The way in which Ghanaians and Dutch people seek help for their problems differs less than was expected. In Ghana, the search for a cure of a serious illness is usually a collective family affair. Mental disorders are often socially stigmatized (Fosu, 1995); traditional healers and the spiritualist church are the most frequently utilized modalities for mental

healing (Mullings, 1984). Therefore, it was hypothesized that only a few people would actually turn to public mental health care. However, from the logistic regression analysis that revealed agency as the most predictive variable of health symptoms, it can be concluded that Ghanaians with severe symptoms indeed do contact the outpatient department; people with severe problems do enter the professional care system. The more recently migrated and highly educated people may be in need of information about the utility of mental health services, because they reported difficulties in disclosure and asking help. However, the highly educated respondents could also have a strong preference for self-reliance.

Ghanaians seem to be mildly prone to consult biomedical physicians and traditional healers for their problems. However, the actual numbers of people who consult traditional healers are put in doubt by possible embarrassment that people have in talking about traditional contacts. Other studies in Ghana revealed a low rating on belief in supernatural causes for illness (Lamensdorf Ofori-Atta & Linden, 1995). Mullings, however, holds an opposite view: many investigators in Ghana have claimed that traditional healers are more effective in treating mental disorders than biomedical healers (Mullings, 1984).

A substantial part of our Ghanaian respondents tried to solve their problems by going both to church community and self-help groups. Other studies confirm that many African Americans do not seek professional help because of the rich network of resources such as churches and other social support groups within their own communities (Leong et al., 1995; Mullings, 1984; Snowden, 1998).

Recommendations for Mental Health Care Services

Health providers working with Ghanaian should take into account the close relationship between the insecure socio-economic position and the experience of health problems. When asked for suggestions to improve mental health services, participants proposed practical services, such as help with administration problems and concrete solutions. The (societal) broadening of the care and an integration of the care facilities is desired: more cooperation between mental health services, social work, employers, social welfare, legal profession, and clergy is important. Other studies addressed as well to barriers to service utilization such as financing and organizational barriers (Takeuchi, Leaf, & Kuo, 1988; Zhang et al., 1998).

Group therapy was clearly preferred by a substantial number of the community mental health care clients. This wish indicates a desire for mental health treatment that is less focused on intra-psychic individual issues than normally is the case in the Netherlands (see for this Kleber, Figley, & Gersons, 1995).

Another matter of concern is the ethnic background of the Ghanaian client: people belonging to the Ashanti have more health problems and a considerable part of them have migrated because of political reasons, which in itself has health consequences. This complex relationship between ethnicity and disease (and help seeking behavior) within one population is also seen in other migrant groups like the Surinamese in the Netherlands, of whom in particular the Hindustani suffer from a considerably poorer health status (Knipscheer, van Klaveren, Kleber, & Jessurun, 1999).

CONCLUSION

The results of our study underline the crucial role of personal characteristics (employment status, legal status, and ethnic background) and migration factors (motives, the way

one experiences the acculturative process), in the development of mental health symptomatology. The effects of other variables such as migration-related factors and legal status were found to be significant. This suggests the assertation that migration should be differentiated by several more proximal variables, such as legal status, social isolation and marginality, or social skill adaptation. There is no direct answer to the question whether there is more or less psychological morbidity in migrants, and attention should concentrate rather on the question under what conditions migrants have a high or low mental morbidity. Our findings confirm the importance of the sociocultural backgrounds and the changing conditions perspective in attending and researching migrants.

A better understanding of the correlates of the orientation toward community mental health care could reduce the barriers to the use of mental health care services and would help planners in designing more realistic and effective programs for adequate mental health services for ethnic minorities. This will enable us to organize effective mental health care services, as well as appropriate educational strategies for both health care providers and the general public.

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