Meanings of Psychosocial Distress
of Cape Verdean migrants
in The Netherlands

University of Amsterdam
Medical Anthropology Unit
Amsterdam Masters in Medical Anthropology

Huub Beijers
2004
The image on the cover is an engraving by ‘Taylor’ of Porto Grande, the harbor of São Vincente and port of departure of many migrants to The Netherlands

Correspondence:
Huub Beijers
Noltheniusstraat 2
3533 SH Utrecht
The Netherlands
h.beijers@hecnet.nl
People with a Mission

Meanings of Psychosocial Distress
of Cape Verdean migrants in The Netherlands

Huub Beijers
supervisor: dr. Els van Dongen

University of Amsterdam
Amma 2001-2002
“(...) A prayer to God who had helped him to come ashore safely after almost twenty-four hours on the sea and also for all the people who had helped him so kindly. With the help of his prayer, God would protect these people and would help them to keep their jobs. Wilson believed profoundly in the unlimited power of the man with that long beard in heaven. It was not without reason he was called ‘The Almighty.’ God should protect these people from the evil eye of jealous people. Because there were a lot of jealous people. Villagers who had not been able to emigrate or did not get a job as a sailor on one of the big boats or as a taxi-driver. Jealousy embittered them. This was eagerly used by the Devil who gave them the evil eye. By looking in a certain way, combined with the expression of ritual charms, people to whom this evil was directed could get bewitched and become ill. And if they could not reach the medicine man or the master of black magic in time, they were at risk of meeting a horrible death. These stories he had heard innumerable times from the storytellers in his village. And these storytellers sounded so convincing that all the children and also many adults believed in them. Only if you had a strong faith in the power of God and regularly prayed in church, you were protected against evil eyes and spirits, as was told.

The Devil and the evil eye of others were blamed for most things which went wrong in the life of a Cape Verdean. On Cape Verde people were regularly accused of witchcraft and black magic. If someone got this stigma, it was almost impossible to get rid of it again. For example, it was told that when a baby died on the seventh day, this was the work of witches. These witches needed the fat in the armpits and groins of new-born babies to grease their arms at midnight, to make them change into wings that would let them fly from island to island. The witches came to rob the babies between midnight and three o’clock at night of the seventh day; in any case before the first cock-crow. Parents of newly born babies often organized a protecting ceremony on that night; called ‘Guarda Cabeça’ in Cape Verde. This was a kind of night watch and at the same time a festive meeting with food, coffee and ‘grog’, a kind of rum, made of sugarcane.(...)

Preface

The title of this study ‘people with a mission’ refers to the fate of Cape Verdeans, or maybe it is better to see it as a Providential assignment, to endure hardships of every kind for the sake of getting better, for social responsibility, and for fear and respect for the inevitable. The title also refers to the pride with which they, dispersed all over the world, bear this responsibility. It is a mission originating from the islands. These islands in themselves are an ordeal: barren and merciless, but nonetheless dearly remembered and sung of by its inhabitants, always slaving away: a people eternally in transit. It is also a mission originating in a history of suffering through climatological crises and famines, colonial exploitation, and slavery which are part of their shared memory. I think the image of ‘people with a mission’ meets their experience of and view on reality better than the often used description of Cape Verdeans as silent, acquiescent, and invisible.

This study on the Cape Verdean community in The Netherlands finalizes my AMMA-training at the University of Amsterdam. AMMA is the acronym of Amsterdam Master’s in Medical Anthropology’ of the University of Amsterdam, from September 2001 until September 2002. My topic of research originated from my acquaintance with the Cape Verdean community through my work in mental health care and patient’s advocacy in Rotterdam and from a quest for meaning of psychiatric problems. Convinced that meanings are enclosed as ‘true cores’ in the inner structure of a phenomenon, I initially thought the best way to find them was to look inside psychosis by dissecting it. It was looking in vain, meanings are given, constructed, nursed, played with and used as strategic instruments in everyday interpersonal and social warfare. Culture made explicit, is one of these signifiers.

Parts of this study will be included in the report ‘Working the Pathways to Health’ (Beijers 2004) that has been written for the European project ‘Partners in Health.’ This project studied exclusion of migrants from health care services in the countries of the Union. It has been supported in The Netherlands by Mikado, the intercultural mental health centre of expertise and the Medical Anthropology Unit of the University of Amsterdam, and the ‘Keefman Foundation,’ with which I am affiliated.

The progress of my research was discussed periodically with members of the Dutch Learning Community of the ‘Partners in Health-project’: Cemil Bozkir, Etelvina Chantre-Graça, Miriam Mudde, Ursie Graham, Ariana Ortet, Renée Smulders and Sigrun Scheve. I thank them for their comments and support. Aziza Sbiti of Mikado, Rob van Dijk of Bavo-RNO Groep and Els van Dongen of the Medical Anthropology Unit of the University of Amsterdam provided the framework to do this, and advised and corrected me whenever necessary. Carla Staal and Marja de Ruiter of Steunpunt GGZ Midden Westelijk Utrecht and my friend and former colleague Annette Plooy helped me to transcribe the lengthy interviews. They assisted as external raters of the quality of the interviews as well. I also thank the excellent scholars who supported me with anthropological advices and references: among them Deirdre Meintel from the University of Montreal, João Vasconcelos from the University of Lisbon and Rijk van Dijk of the Leiden University. Proofreading of the text was done by Signe Tollesen1.

I was lucky to experience the hospitality and friendliness of the Cape Verdeans in Rotterdam and was impressed by the openness with which they talked about personal experiences and occurrences that very often had negative meanings and connotations. This openness sharply contrasts the commonly communicated image of ‘silent migrants’ and ‘taboo on psychiatric problems’ that rests on this community and hinders them. I thank all my informants for the trust they have put in me. Many thanks and admiration go to Sofia Rocha, who introduced me to the community, brought me in contact with participants, served as interpreter, and was of immense value as a resource and point of reference for information. In Sofia I found a dear friend and advisor and without her, my acquaintance with the Cape Verdeans would have been superficial. The same goes for Horácio Medina, president of the Centro Redentor in Amsterdam. Horácio was very patient and open in introducing me in the world of Racionalismo Cristão and helping me to understand what was going on in the Centro.

Finally, I thank the staff and students of AMMA V for their excellent and inspiring teachings and support. A special thank you goes to Els van Dongen, who supervised my research and this thesis and inspired me.

Huub Beijers
Utrecht/The Netherlands
26 March 2004

1 Signe is an English native speaker and an excellent proofreader: call her at +31-302517511
Contents

Preface .......................................................................................................................... v

Contents ....................................................................................................................... x

SUMMARY

Chapter 1. Introduction ............................................................................................... 1
  1.1 Biomedical versus Cape Verdean understanding of psychiatric phenomena
  1.2 Problem definition, objectives and research questions
  1.3 Methodology
  1.3 Structure of the report

Chapter 2. Pathways to health ..................................................................................... 13

I CAPE VERDE AND THE CAPE VERDEANS

Chapter 3. Cape Verde and Cape Verdean migration ............................................. 19
  3.1 Cape Verde
  3.2 Migration
  3.3 Nos Ku Nos

Chapter 4. The Cape Verdean community in The Netherlands ............................ 32
  4.1 Living in Rotterdam
  4.2 Socio-economic position
  4.3 Family structure and gender
  4.4 Intergenerational relations
  4.5 Religion and spirituality
    4.5.1 Roman Catholic church
    4.5.2 Igreja Universal do Reino de Deus
    4.5.3 Racionalismo Cristão
  4.6 Silence and self-reliance

Chapter 5. Epidemiological data .............................................................................. 65
  5.1 Prevalence and incidence of psychiatric problems of Cape Verdeans
  5.2 Risk factors

Chapter 6. Health beliefs ........................................................................................... 71
  6.1 Etiology
    6.1.1. Spiritual and religious understanding
    6.1.2. Biomedical understanding
    6.1.3. Social factors
    6.1.4. Witchcraft and sorcery as explanatory factors
  6.2 Pathophysiology and course of sickness
  6.3 Time and mode of onset of symptoms
  6.4 Treatment
  6.5 Health beliefs: conclusions

Chapter 7. Social and cultural context of illness and getting better: the lay health system 104
  7.1 Informal and formal social network
  7.2 Treatment action
7.3 The lay health system

Chapter 8. A view on change ................................................................. 118

III CONCLUSIONS

Chapter 9. Conclusion ........................................................................... 122
  9.1 Population at risk
  9.2 The Cape Verdean lay health system
  9.3 Change

Chapter 10. Understanding psychiatric phenomena in the context of culture: a reflection on results of this study and on the anthropological enterprise ........................................... 130
  10.1 Discussion of study and results
  10.2 Text, context and subject
  10.3 The anthropological enterprise: a critique of biomedical psychiatry
  10.4 Meaning
  10.5 Meaning and healing
  10.6 Meaning and delusion
  10.7 Reading, speaking and learning

References ............................................................................................... 156

Appendix ................................................................................................. 168
  I selection of informants
  II preliminary problem analysis diagram
  III filter model Goldberg and Huxley
  IV ethnicity and health: Stronks’ conceptual model
  V interview guide
  VI summary in Dutch / Nederlandse samenvatting
Summary

The Cape Verdean islands are an archipelago off the coast of Senegal and West Africa and have a long tradition of migration. A reason for this steady flow of emigrants from the archipelago is the bad economic situation and the lack of national resources of the country, caused by a harsh climate with long periods of drought and a long history of colonization by the Portuguese since the fifteenth century [1460] until 1975. The Portuguese used the formerly uninhabited islands as a slave trading post and penal colony. Cape Verdeans are predominantly a Creole people from African, European and Asian origin. The official language of Cape Verde is Portuguese, although their everyday language is a blend of Portuguese and West African languages: Crioulo.

Cape Verdeans migrated to all continents. Large communities are to be found in North and South America (USA and Brazil), in Africa (Angola, Guinea Bissau, St. Tomé and Principe), and in Europe (Portugal, The Netherlands, France). The transnational dispersion of Cape Verdeans is often described as a diaspora. Migration of Cape Verdeans to The Netherlands started in 1950’s, for several reasons: (1) people who were looking for better opportunities for living; (2) chain migration, where migrants follow relatives and friends to a new country of residence and are helped and supported by them; (3) family reunification. Most of the Cape Verdeans that live in the Netherlands come from the northern (windward) islands, especially Santo Antão and São Vincente, next to a substantial group from Santiago which is a southern or leeward island.

The Cape Verdean community in The Netherlands is concentrated in the Rotterdam-Rijnmond area. The number of Cape Verdeans in Rotterdam ranges between 16,000 and 20,000. This is an estimation, since the numbers of Cape Verdeans without documents or with a Portuguese passport are not known. Within this conurbation, the community is concentrated in two submunicipalities close to the harbor of Rotterdam: Delfshaven and Feyenoord. Fifty-four percent of the community lives there. The image of these submunicipalities is controversial and ranges from focusing on high degrees of unemployment, crime, violence and public nuisance to young, lively, innovative and diverse. The Cape Verdean community is relatively young: 67 % is younger than 35 years old, compared to 42 % of the indigenous Dutch population. The Cape Verdeans are also a spiritual community, in which religions and spiritist doctrines are important points of reference in everyday life. In this study, three major spiritual/religions or denominations are described: Roman Catholicism, charismatic Pentecostalism of the ‘Igreja Universal do Reino de Deus,’ and Racionalismo Cristão.

Cape Verdeans are known as ‘silent migrants,’ although they only partially acknowledge this themselves. They attribute this image to the fact that their interests are not well taken care of. Reasons for this are the Cape Verde ‘maneira de ser’ which is tacit and accepting; the non-recognition by the dominant (Dutch) culture and finally the splintered organizational structure of the community. The community is often described in a paradoxical way as closed, uniform and built on solidarity on the one hand and as multi-stratified and divided or even splintered on the other hand, based on political controversies, island and villages of origin, educational strata and generations. In this report, the stratification and dynamics of the community are connected to the political situation and power relations in Cape Verde and the need to realize political and social authority within the Dutch society. Health beliefs and health practices are also part and sometimes object of these dynamics. The second generation adolescents seem to be suffering less from these limitations, they have learned how to work the health care system and how to make it work, in contrast with the first generation migrants. The controversies are congruent with social positioning and the range is between ‘modern’ (2nd generation) versus ‘traditional’ (1st generation), and ‘authority’ (1st generation) versus ‘knowledge’ (2nd generation).

Three major social problems determine the image of the Cape Verdeans in The Netherlands and their daily life:

1. Poverty: the labor situation of many Cape Verdeans is bad, although the rate of unemployment is comparatively low. The jobs of Cape Verdeans are on the lower end of the socio-economic scale, badly paid, with little status and bad working conditions. Recent statistical data show that 30 % of Cape Verdean households are on a low income (social security allowance level). Debts are a serious problem.
2. A high percentage of single parent families; in this study, the majority of the families consisted of a single mother, with children from different fathers within one nuclear family. Official statistics indicate that 27 % of the families in the Cape Verdean community is led by one parent (mostly
mother), and in 1996 55% of the Cape Verdean families consisted of married couples, compared to 85% of indigenous Dutch families. The problem is gender-related.

3. Arrearages in educational levels compared to the indigenous Dutch population: looking at the population of unemployed: 55% is illiterate or only had primary school; 34% had only general education or lower to intermediate vocational training. These figures cannot be attributed to the first generation. The second and third generation of Cape Verdean children perform worse in primary school and are overrepresented in special schools for children with learning problems.

There are only limited data on the health situation of Cape Verdeans in The Netherlands. Because the community is concentrated in Rotterdam, they are not identified in the majority of the epidemiological studies on migrants and health which are conducted on a national scale. Internationally, however, there are no known studies either that specify epidemiological data on psychiatric illnesses of Cape Verdeans. The social problems (poverty, bad labor conditions, single parent families, and low educational levels) of the Cape Verdean community in general are identified as ‘risk factors’ that negatively influence the health condition as well as the possibilities of accessing the professional health care sector. There is no evidence found that might indicate that they are no risk factors in the case of Cape Verdean immigrants.

In this study Cape Verdeans made clear that the explanatory models they used in relation to their experiences of psychosocial distress can differ significantly from the ones that are dominant in psychiatry or described in biomedicine in The Netherlands. In all aspects however the informants also had mutually diverse ideas about and diverse understanding and explanation of the problems with which they had to deal, which did not always seem coherent. This diversity represented co-existing and sometimes competing discourses about the origin, understanding and treatment of psychosocial distress within the Cape Verdean community.

Spiritual experience and the conviction that supernatural phenomena are relevant in everyday life are important points of reference for giving meaning to health problems and making choices in pathways to health. This should not be seen as a static and reified vignette of Cape Verdean identity, because beliefs and practices within this community are diverse. Beliefs and doctrines and their moral categories are socially represented and have impregnated everyday social life, also detached from specific religious practices. The Cape Verdean community is ‘Christian-Spiritual,’ in which the values of suffering and endurance for the sake of getting better, of charity and mutual responsibility, and of fear and respect for the inevitable, can flourish. Cape Verdeans are a people with a ‘mission’ and this ‘mission’ is deeply felt and carried with pride. It concerns the obligation to take care of ‘the other’, to try to look beyond present misfortune and setbacks and to interpret a present set-back as an ordeal for better times in the future. It is tempting to see the picture of the Cape Verdean community as patient, silent and invisible, as a postulate of this.

In their understanding of the origin of illness and other types of misfortune and the possibilities of treatment, three interplaying factors can be discerned: (1) personal vulnerability, for which you can bear personal responsibility; (2) negative influences that come from outside (either spiritual, interpersonal, biomedical or socio-economic) and; (3) the inevitable, the ordeals that come to you, which you have to endure and bear. These ordeals can be hereditary or based on evolutionary debt. Historically, these ordeals should be seen in the context of hard climatological conditions and famines on the Cape Verdean islands, but also colonial oppression and slavery can be seen in this respect.

The understanding of sickness can be spiritual, but the treatment and the healing practices often have a clear social component and cognitive and behavioral implications. Diagnosing and understanding the (personal, social, interpersonal, cross generational) etiology of illness never is self-evident, not for the one who is suffering, not for the people in the social network who have to deal with it, nor for the professional who has to treat the sick person. The planning of an effective treatment is therefore problematic as well. Expressing illness in terms of spirit-possession can be understood as an idiom of distress. A good example is the story of an elderly Cape Verdean woman in this study. She explains that a spirit got stuck inside her. This message can be seen as a metaphor for her personal situation that got stranded completely. She suffers from serious psychiatric problems. Pharmacological treatment by mental health care did not help, but in her experience, tied her to her house because of physical disabling side-effects. The relation with her children is spoiled because of the misbehavior of her former husband, that weighs on her; and – damage done – there is not much space for rehabilitation, since he is not part of the problem/social context anymore and the coherence of the community is not strong enough to bring him back in, and keep him responsible. The referrals to spirit possession can be seen as bodily experienced and expressed discomfort with an existing social situation as described in situations in which witchcraft is presumed in African contexts.
It is not easy to be ill as a Cape Verdean and there are several reasons for this. The high number of single-parent families limits the possibilities of legitimized illness related roles shifts (time-off, or time to visit the doctor), unless educational backup is organized. Since most of these families are single mother-families this probably affects Cape Verdean women more than Cape Verdean men. The burden, however, also weighs on the children. Contact with formal mental health care is avoided because there is fear that this will lead to an intervention of the Child Protection Agency. In some cases this avoidance and the non-recognition of this dilemma by mental health care is part of a self-fulfilling prophecy. Another reason for not being able to be ill is the type of work of many Cape Verdeans: work with bad working-conditions and employers who punish sick leave. This phenomenon – paradoxically - is amplified by the idea - not only within the Cape Verdean community, but also outside (company-doctors) - that people who suffer from psychiatric problems cannot take responsibility for their recovery. In terms of ‘illness related role shifts,’ they are dismissed completely and totally.

In general, the history of migration and the relatively low educational level of Cape Verdean immigrants in The Netherlands leads to arrears in knowledge about the structure and protocols of mental health care, in the necessary skills to master the sector, and to a lack of the required skills to behave as an autonomous and assertive consumer of care services, which is a prerequisite to find your way. This limits the accessibility of mental health care. The ideal of the patient as an assertive and autonomous partner in treatment is in contrast with what many Cape Verdeans consider to be good and secure care for people who suffer from psychiatric problems. The political context at large, in which intolerance for cultural diversity is growing, paradoxically limits the possibilities to speak out as an autonomous and self-conscious citizen and patient.

Compared to the dominant ideology of mental health care it is possible to identify differences in explanatory models, arrears and limitations in the fields of information, knowledge and skills and negative social conditions that block the access to mental health care. This makes pathways to the professional health care sector less passable and the attitude of many Cape Verdians defensive and abiding. Instead, Cape Verdians in the first place refer to their social network and the Cape Verdean community. This should not be seen as a local, but as an ‘extended community’: children or parents in The Netherlands or abroad, family members like nieces and nephews and aunts and uncles, friends, neighbors, and the Cape Verdean community at large. Family ties and mutual solidarity are very strong. The other side of this solidarity, however, is the high degree of social control and mistrust, which is reported as much as the element of mutual support. So there is also a self-limiting mechanism. This makes the community self-referential, but also autarkic. People get information from friends and relatives, get addresses, hear stories and are referred to all kinds of doctors, healers, medicines, treatments in the formal and in the informal circuit. This implicates that some of the contacts between health care workers and patients and their family members are fairly accidental and by chance, based on knowledge and presence of people, networking and being known in the community as a resource of knowledge and help.

The community is an important source of knowledge that in no way is compelling, but represents the diversity of resources inside and outside formal health care. This way of referring assures mutual support, self-help and common understanding of your situation. It keeps your problem in the community, debatable and treatable (you are not lost). It also keeps the system of redistribution, which is important in chain-migration, upright. Patients have a syncretic blend of ideas and thoughts about their sickness and walk and work simultaneous pathways: this could be going to an indigenous healer (curandeiro), going to the Roman Catholic Church or to a spiritual centre. In the Igreja Universal and the Centro Redentor double standards are used: the explanation of all kinds of misfortune is primarily attributed to spiritual causes, but in practice referral to allopathic medicine is a path that is brought to the attention as well.

Data from this study have been discussed with representatives of the Cape Verdean community and with mental health care professionals. This reflection rendered a formulation of three community and population related problems:

(1) A knowledge deficit in the field of epidemiology and on the field of knowledge and capabilities within the Cape Verdean community to make the Dutch mental health care system ‘work.’ (2) A recognition deficit in which psychiatric problems are insufficiently recognized and interpreted as problems in which mental health care is relevant. (3) Health-related social problems: focusing on poverty, gender issues and the position of the first generation elderly Cape Verdeans. Three types of interventions are proposed to an assembly of mental health care, public health authority, Cape Verdean organizations and patient’s organizations: (1) on the population level: mainly focusing on giving more and better information and
education to the Cape Verdean population. (2) On a community level: focusing on informing and educating Cape Verdean organizations and the people on key-positions and enhancing the consolidation of accessible grass-root and community-based health and social services. (3) On a public health level: enhancing epidemiological strategies.

Some of the health care and social security institutions in Rotterdam have Cape Verdean personnel and it seems that everybody knows them as a ‘halting-place’ and a source of knowledge, where a good referral can be found. The Apoio project plays a role in this as well. Volunteers and social workers are present in the community and in mental health care, where they are addressed by patients and support them in their contact with health care professionals. They offer assistance as soon as someone is admitted to the mental hospital, has trouble getting or keeping contact with mental health care, as an interpreter and advocate. These ‘bridgeheads’ are vital for the development of the understanding and debate about psychiatric problems within the community as well as for the building of bridges to the rest of society.
1. Introduction

Health and care are goods that are not equally distributed among populations in the countries of Europe. In the process of seeking health, many migrants do not get the care they need and want, and the appropriate care to which they are entitled. Kirmayer and Minas (2000) describe health as a primary good because it is a fundamental condition for the full exercise of civil rights, political rights and liberties. In The Netherlands equal availability and access to health care service are laid down legally. Development of equitable and effective services responsive to cultural diversity, is therefore a contribution to political justice. In this study I will focus on the health seeking process of Cape Verdean immigrants in The Netherlands, because epidemiological data derived from the Rotterdam Psychiatric Case Register (Dieperink et al. 2002) make clear that the use of mental health care services by this group of immigrants in the greater Rotterdam area is significantly lower (15.1 % of the adult population in 1998), not only compared to the indigenous Dutch (36 % of the adult population in 1998), but also compared to the other migrant populations (Moroccan, Turkish and Surinamese/Dutch Caribbean migrants), as seen in table 1.1.

<table>
<thead>
<tr>
<th>Year</th>
<th>Dutch</th>
<th>Turkish</th>
<th>Moroccan</th>
<th>Surinamese</th>
<th>Dutch Caribbean</th>
<th>Cape Verdean</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>29.7</td>
<td>33.1</td>
<td>30.7</td>
<td>18.4</td>
<td>11.8</td>
<td>8.1</td>
</tr>
<tr>
<td>1998</td>
<td>36</td>
<td>36.7</td>
<td>36.2</td>
<td>24.6</td>
<td>16.9</td>
<td>15.1</td>
</tr>
</tbody>
</table>

Source: Dieperink et al. 2002

2 In this study I follow the standard definition proposed by the CBS, the governmental Central Statistics Bureau (Key, 2000): “A person is called an ‘allochtoon’ (foreigner) if at least one of the parents was born abroad”. The word migrant is better fitting since we are talking here about people who settled in The Netherlands and not about people who are visiting. In the total populations of migrants, a division is made between ‘western’ and ‘non-western’ origin. Western countries are: Europe (without Turkey); North America; Oceania; Japan and Indonesia (including the former colonial territory). Non-western are: Turkey, all countries in Africa, Latin-America and Asia (excluding Japan and Indonesia). This definition is used in the statistics of the local Bureau of Statistics in Rotterdam as well. First generation migrants are those people who were born abroad, while at least one of the parents was born abroad as well. Second generation migrants are born in The Netherlands, while at least one of the parents was born abroad. According to this definition: when at least one of your parents is born in Capeverde, you are a non-western, i.e. a Cape Verdean migrant.
On a national scale the Cape Verdeans are a relatively small population of immigrants, because they live concentrated in the Rotterdam-Rijnmond (harbor) conurbation in the west of The Netherlands (n = ± 16 - 17,000). On a European scale it concerns the second biggest concentration of Cape Verdeans in Europe, after the community in Lisbon. Their country of origin is Cape Verde; an Atlantic archipelago off the coast of West Africa and former colony of Portugal. A history of slavery, cruel colonization, harsh climatological conditions and poverty caused the steady stream of migration to North and South America, Europe, and Africa.

Lack of use of services in health care and social security by Cape Verdeans is also observed by other authors (Pieterse 2002), but the knowledge on this phenomenon hardly gets further than speculation. Little is known about their mental health condition, nor about the ways in which they explain and understand psychiatric problems. For a better understanding of differences in admission rates to mental health care a better understanding and more knowledge in these specific fields is necessary.

Because the differences in use of mental health care services are considered to be a ‘lack of quality’ in the provision of collective (legally guaranteed) resources to all citizens of The Netherlands, it was considered important to choose for an interactive type of research (Boog 2002), with the purpose of creating the conditions for empowerment of and advocacy for the Cape Veredian community, particularly psychiatric patients. An important intermediate in this is the Apoio-project.

*Apoio* is the Portuguese word for ‘support’ and the title of a community-based support and advocacy project that was initiated by Basisberaad GGZ. This is the advocacy and
empowerment organization for mental health care clients in Rotterdam and they initiated this project together with the Avanço-foundation, the umbrella organization for Cape Verdean organizations in Rotterdam (Rocha 2002). Apoio started by assigning an independent Cape Verdean intermediate social worker bridging the gap between Cape Verdeans and mental health care. The project, now with numerous volunteers and peer-support groups, gives information to the community, advises and helps individual Cape Verdeans to find the right access to mental health care and advocates for change of mental health care delivery to the measure of needs and wishes of Cape Verdeans. The choice to do the research within the Cape Verdean community in Rotterdam is also based on my (prior) personal involvement with the development of this project as managing director of Basisberaad GGZ. In the research I worked together with the ‘comité’ (the committee of volunteers connected to Apoio), the social worker of Apoio and with Avanço, the advocacy-organization for Cape Verdeans. Through these forms of cooperation and the active feedback of results, this study will fall in nourishing and fertile soil and get more meaning, relevance and practical follow-up.

1.1 Biomedical versus Cape Verdean understanding of psychiatric phenomena

In general, not much is known about the ways Cape Verdeans who migrated understand psychiatric problems, as is also described by Like and Ellison (1981). Historically the treatment of people with psychiatric problems in Cape Verde was determined by neglect and living as an outcast. Now there is a psychiatric centre on the island of Santiago staffed by psychiatrists and several community initiatives to treat and help people with psychiatric problems. In a conference on mental health problems on the 12th of April 2002, key representatives from the Cape Verdean community in Rotterdam reported a wide range of frictions between the community and mental health care. They referred to the issue of taboos and shame for psychiatric problems (people do not speak out), the specific social and cultural background (lack of integration, bad working conditions, the island structure of the community) and their own specific solutions (sending people with problems back to Cape Verde, relying completely on the church). They reported a lack of knowledge in the Cape Verdean community about the mental health institutions and about the way psychiatric problems are treated there. On the other hand there is a lack of knowledge in mental health care about the Cape Verdean community.
Listening to the comments of Cape Verdeans in Rotterdam, Hoorlan’s (1995) description of witchcraft, spirits and evil eye, as causes of illness, is not considered valid anymore, at least for the younger (second) generation. On the other hand, scientist, like Cabral (1980) and Vasconcelos (2002) describe how the central themes and values of apparently past practices have permeated everyday life of Cape Verdeans and influence the understanding of psychiatric illnesses and the pathways to health. Like and Ellison (1981), stress the relevance of understanding the indigenous explanations of illnesses and the supporting role of the extended (Cape Verdean) family in their description of a successful treatment of a Cape Verdean woman in Boston who suffered from ‘sangue dormido,’ or ‘sleeping blood.’ This ‘sangue dormido’ is included in the glossary of culture-bound syndromes of the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) (APA 1994) and this raises the issue of commensurability of illness categories, or the problem that there might be no common standard of measurement or understanding of psychiatric problems. In communication about these problems, an interface is necessary. For example, using a term like ‘psychiatric’ in the communication about psychiatric problems might shift the attention of informants from representing their experiences of fear or emotional distress to experiences where a psychiatric disease explicitly is labeled by a medical doctor. In this case, where limited accessibility to mental health care services is the focus of study and local explanatory models are investigated, this would cause serious limitations in the field of research validity. Rocha (2002) reports a serious lack of knowledge among Cape Verdeans on the dominant mental health categories, as they are common in Dutch society. Usage of the idiom of DSM IV (Faumann 1993, APA 1994) would without doubt limit the scope of this research to the people who have acquired this way of thinking and understanding.

Nichter (1981) talks of ‘distress’ and ‘idioms of distress,’ in an attempt to escape the limitations of the biomedical approach of ‘ethnopsychiatric phenomena.’ He describes distress as: “a broad range of feeling states including vulnerability, apprehension, inadequacy, dissatisfaction, suppressed anger, and other anxiety states which might otherwise take the form of an untenable social conflict or rebellion (1981: 403).” Idioms of distress conceptualize the distress in a way that takes a contextual meaning in relation

---

3 See the cover text.
4 Also see chapter 6.
to particular stressors into account and can be understood and responded to by concerned others because of the way they are expressed (cf. Nichter 1981: 379). People seek ways to express their discomfort in ways that appeal to a socially relevant understanding of their problem and a socially relevant way of dealing with it. The idea of ‘idioms of distress’ is not only a culturally relevant way to address situations of discomfort, but also a way to understand their meaning and a way to address the experience of discomfort in cross-cultural research. Biomedical categories are as much an idiom of distress as the complaints with which South Indian women go to the healer.

Nichter's use of idioms of distress is limited by its presumed base of social conventions. In the cases where people express distress in irrational ways, in delusions, destructive behavior or hallucinations, contextuality and intersubjectivity are much harder to realize, as seen before. Fainzang (2000) refers to the general categories of ‘malady and misery5,’ that refer to physical or psychological disorder, unhappiness, social problems/poverty and the need of a remedy. In my research I will, with nuances, follow the paths of Nichter and Fainzang. In everyday life in The Netherlands, the word illness, even if conceptually empty, is without doubt associated with just biophysically traceable illnesses, which should be treated biomedically. So, the general and undefined description of discomfort as a ‘situations of distress’ seems an appropriate starting point for research. Distress can be defined in the broad sense of ‘feeling states’ (Nichter 1981) which refers to personal, psychological, social, physical and emotional aspects, which request a response of concerned others. This response can be treatment of any kind by any healing system, but also non-professional responses are relevant, for example advice from a good friend, consolation, financial support from the family, togetherness and devotion. For the sake of this study, I will condense this to ‘psychosocial distress’ and use this concept as the interface in communicating with Cape Verdeans.

1.2 Problem definition, objectives and research questions
Based on the description in the previous paragraph, I will present the problem definition and objectives of this study here.

---

5 The title of Fainzang’s book is “Of Malady and Misery”.
Little is known about the reasons for and causes of the lack of use of services in the professional mental health care sector by Cape Verdeans immigrants in The Netherlands. Little is known about this immigrant community, about their mental health condition, about the ways in which they explain and understand psychiatric problems, and about the ways they deal with them. For the sake of this study, a preliminary problem analysis diagram has been developed, with three areas that might contribute to the construction of meanings of ‘situations of distress’ in the Cape Verdean community (appendix I). In this diagram, factors are included that belong to (1) the cultural domain; (2) specific field variables (e.g. living conditions in The Netherlands); and (3) personal variables.

The general objective of this study is to get insight in the ways Cape Verdeans in The Netherlands deal with situations of psychosocial distress in terms of health beliefs and health practices, independent of (i.e. before) contact with the professional mental health care sector, and to analyze if there are factors that explain the difference of use of the professional mental health care sector, compared to other (migrant) populations in The Netherlands. Furthermore, to get a better insight in their health situation as registered and studied, in the context of their history of migration and social situation. Linking these data to the use of services cannot be done to the full extent, because factors that are related to the quality of mental health care are not evaluated in the context of this study. They are evaluated in a follow-up study (Beijers 2004b). The research questions relate to four focus domains and units of analysis: (a) situations of distress; (b) construction of meaning; (c) context; and (d) change.

(a) Situations of distress

1) What are considered to be ‘situations of psychosocial distress’?
2) Which concepts are used to signify these situations of distress, by the people who suffer and the ones who are directly involved?

(b) Construction of meaning

3) Which meanings are given to situations of distress, by the people who suffer and the ones who are directly involved and to what kind of action do they lead?
4) What are people doing to give meaning to these situations of distress? With whom, when, where and how do people interact (apart from possible contact with mental health care), and find consolation or advice? Who do they miss or avoid?

5) Where is the line between fixed convictions and more fluid transitions in the interaction about psychosocial distress?

6) Who is blamed for the illness, to whom or to what is it attributed?

(e) Context
7) What are the contextual factors contributing to or confining the interaction?
8) What are contextual factors contributing to the construction of meaning and in the process of giving meaning? What do people want, what are obstacles and chances?

(d) Change
9) How do representatives of the community judge these meanings and the contextual factors in the light of the under-use of mental health care services by Cape Verdeans? Which advice (empowerment) can be given to the community and to policy makers on the field of mental health care?

1.3 Methodology
To answer these questions, a study is designed in the context of the Amsterdam Masters of Medical Anthropology (AMMA) of the University of Amsterdam. This study evolved to a larger project in which also the experiences of exclusion from mental health care institutions are studied and the complementary medical solutions the community developed. This second part of the complete study is part "Partners in Health, phase 2”; a European project aiming to collect experiences with and strategies against social exclusion of migrants from health services in six countries of the European Community (Vulpiani et al. 2000). In The Netherlands, Mikado, the intercultural mental health centre of expertise, and the medical anthropology unit of the University of Amsterdam, are partners in this project. The final report, in which parts of this study will be included, is published in 2004 as ‘Working the pathways to health: Experiences of exclusion from mental health care services of Cape Verden migrants in The Netherlands’ (Beijers
In the context of this study, a comprehensive model has been developed of the ‘health seeking process,’ which is used as an analytical scheme in which (1) Psychiatric problems on a population level are analyzed, mainly based on epidemiological figures; (2) The ‘lay health system’ is described (health beliefs and health practices of the Cape Verdean community in The Netherlands). This is mainly based on ethnographic interviews with patients and their social network and on participant observation; (3) The experiences of Cape Verdeans with professional (mental) health care are analyzed, based on ethnographic interviews with patients and their social network; (4) Complementary pathways to health are described, consisting of descriptions of healing practices of indigenous healers, religious communities and the domain of the so-called ‘American Bypass’ in which acute services or derivative administrative measures (judicial) are the thread of action. The description of the health seeking process is based on ethnographic interviews with patients and their social network and on participant observation. Reflection on the issue of health beliefs and health practices in the context of service provision with Cape Verdeans (research question #9) is organized in a focus group discussion. Furthermore, the researcher participated in the so-called learning community that was organized in the context of the Partners in Health program by Mikado.

In this report I will describe the first two parts of the Cape Verdean health seeking process: the occurrence of psychiatric problems on a population level, and the Cape Verdean ‘lay health system.’ For the sake of the right understanding, I will describe the methodology of the whole study, because finally, this was the framework of analysis.

The study has an exploratory character because of the limited (scientific) knowledge available on Cape Verdean (mental) health beliefs and practices. Upon request, Cape Verdean organizations neither in The Netherlands, nor in the United States could refer to relevant academic studies about this issue. A literature review rendered just limited resources, mainly on broader themes like immigration and integration in Dutch society and on migrant identity (Strooy 1996; Wierks 1996; Elleswijk 1996; Bosman 1997). The only directly relevant reference is a description of a case of conversion-reaction of a Cape Verden woman in Boston (Like and Ellison 1981).

The phase of data collection was in the period of January 2001 to December 2003 and the techniques used in this research are (1) a review of ethnographies and social science
studies of Cape Verde, Cape Verdean history and migration, (2) ethnographic interviews, (3) participant observation and (4) focus group discussions.

Part of the study consisted of a review of studies on Cape Verdean migrants in The Netherlands, their history of migration, and life in The Netherlands. Resources in this field are limited and not easily accessible. This work was based on theses of university students and polytechnic schools in Rotterdam. Furthermore, internationally known academics and experts on Cape Verde, like Deirdre Meintel from Montreal, João Vasconcelos from Lisbon, and Rijk van Dijk from the Africa Study Centre of the University of Leiden, were very helpful to consult me, provide me with advice, articles and books not available in The Netherlands on Cape Verdeans in the United States, Pentecostalism, and spiritualism. Cláudia Soares de Freitas of the University of Utrecht was helpful in the disclosure of part of the Portuguese studies on Cape Verdeans.

A sample of 38 informants was interviewed, by means of open in-depth interviews, based on a topic list (appendix V) that was refined during the research process. The informants were invited to participate either on the basis of the personal network of the researcher, and the attendance of meetings of the Apoio-project, or through the help of Sofia Rocha, the social worker of the Apoio-project. She provided names and addresses of people, who were thereafter invited to participate. The sampling method should be characterized as a combination of convenience sampling and snowballing. The sample consisted of 19 male and 19 female informants. Twenty-five informants had first-hand experience with psychosocial distress (either personal experiences or experiences of a relative/friend in direct vicinity, with which the person had intense involvement); fifteen of them had been in contact with mental health care as a patient. Five informants of the subsample of twenty-five were interviewed as a married or cohabiting couple of man and wife. Thirteen informants should be considered as key-informants, of which nine were directly related to the Cape Verdean community and four can be best described as circumstantial (e.g. a transcultural psychiatrist). Twenty-nine interviews were recorded and transcribed verbatim. Most (26 out of 36) of the conversations were conducted at the informant’s home or place of work where their daily life takes place. The interviews

---

6 Female informants where overrepresented in the informants with first-hand experiences (16 out of 25) and males in the section of key-informants (9 out of eleven)
7 14 interviews were transcribed completely, and because of time limitations of 15 interviews, a selection of relevant passages of the interview was transcribed.
lasted between one and four hours. The recordings were complemented with field notes about the setting of the interview (time of day of the interview, condition of the informant, presence of other family members etc.). In the course of the study I acquired a basic knowledge and understanding of the Portuguese language, in order to be able to express myself in Portuguese and understand a Portuguese conversation. The interviews nonetheless mainly were conducted in Dutch and with the help of a dictionary sometimes completed in a creole of ‘Netherportulands.’ Four interviews were conducted in Portuguese/Crioulo with an interpreter present; one of these interviews was translated afterwards by a native Portuguese speaker, to double check the translation of the interpreter and to get a better understanding of the course and the nonverbal aspects of the conversation.

Two focus group discussions were organized. One with the team of Cape Verdean volunteers of the Apoio-project. A second, with informants in this study and representatives from the Cape Verdean community after a convocation in an interview about the project on the local Cape Verdean radio station. This last focus group was done mainly in Portuguese and Crioulo, with the help of an interpreter. In the second phase of the research (Partners in Health), the researcher participated in the ‘learning community’ that was organized by Mikado. This learning community consisted of mental health care workers, mental health care workers of Cape Verdean background, representatives of patients’ advocacy organizations, the Apoio project, and the national anti-racism bureau (LBR). The group discussed the problems of Cape Verdeans in and with mental health care in an open debate. The researcher participated in the group and provided it with input from the research. The results of the learning community were reported in a European report on exclusion of migrants and health care services (Van Dongen 2003b). They will lead to a local conference in which the results will be discussed and evaluated in the light of possible and desired policy changes (June 2004) with the cooperation of two psychiatrists from Cape Verde, Dr. Daniel Silves and Dr. Manuel Faustino, and will presented on a final conference in Brussels in June, 2004. The part of the research on exclusion was based on the analysis of Essed (1991) about experiences of ‘everyday racism,’ and will be described extensively in the second report (Beijers 2004).
Participant observation was practiced during conversations with the informants. This especially concerned the interaction of family members and relatives with the person who was suffering from the problems. The main body of participant observation, however, was done in community meetings of the Apoio project during the research period (January 2001 – December 2003), participation in spiritist and religious communities of Cape Verdeans, and Cape Verdiange festivities. Observations started with the formulation of an objective for observation, or sometimes a working hypothesis and was followed by a record and field notes immediately after the event.

The data were subsequently analyzed with the help of Atlas.ti, software for qualitative data analysis. The data were processed by inductive coding. On the basis of the analytical framework (health seeking process) code families were constructed and these families are described in the results. To check for possible biases, an independent rating of a sample of the interviews was conducted by one of the transcribers of the interviews (n = 6), on the basis of the research design, personal experiences of this transcriber as a mental health care patient and professional education (master in social sciences). Furthermore, the results were compared with a recent review of the NIGZ/centre for Review and Implementation (Pieterse 2002) on the health and well-being of Cape Verdeans in Rotterdam, and rated on the match of the resources and findings.

The research was intended to result in an ethnographic description and not at interventions, in the broadest understanding of the word, which should be considered as
burdensome for the informants⁸. People were happy to talk and get information and many times they would ask for help, in retribution for the interview they had granted. The point of departure for inclusion in the sample was informed consent of the informants. Information was in a leaflet in which voluntary participation, goals and proceedings of the research, the contents of the interview and the non-traceability of the results were described and explained verbally. The researcher left his address and the address of the supervising institution with the informant, in case there would be further questions. For referral in the case of the need for imminent psychiatric care, the mobile phone numbers of two social workers were available. In practice: the researcher repeatedly contacted the social worker of the Apoio project. On request of an informant he contacted psychiatrists, social workers, nurses, a lawyer and the managing director of the organization of relatives of people with schizophrenia, to get an advice, or ask for an intervention⁹.

1.3 Structure of the report
The report is divided in three parts. In chapter 2 I will go into the ‘health seeking process,’ as described in paragraph 1.2. This provides the analytical framework for this research. In the Chapter 3 and 4 I will summarize the history of migration of the people of Cape Verde and the social conditions of their life in The Netherlands. The results of the study will be described in the chapters 5 (epidemiological data), 6 and 7 (ethnographic results/the Cape Verdean Lay Health System), and 8 (Change). In chapter 9 I will present conclusions and discussion. Chapter 10 is a reflection on the understanding of psychiatric problems in the context of culture. In this chapter I will describe my views on the issue of culture, meaning of delusional illnesses and the position of the anthropologist in this and the contribution of this study to anthropological knowledge.

⁸ Legal criteria of the ‘Wet medisch-wetenschappelijk onderzoek met mensen (WMO: legally imposed ethical standards on scientific research with people) in The Netherlands.
⁹ These contributions of the researcher should not be seen as interventions because they didn’t follow the interview, but were part of an almost obvious exchange and retribution of services. The informants were willing to receive me and to talk with me, and in exchange they asked for intermediation. Most of the time this was an excellent opportunity to observe how contacts would develop, although the researcher retreated as soon as the contact was established.
2. Pathways to health

What do people, who get ill, do to get better? Where are obstacles and blockades in this process; and why does one person have more success in getting better than another?

In this chapter, I will combine the work of Chrisman (1977), Goldberg and Huxley (1980) and Bhui and Bhugra (2002), who all elaborate different parts of the process of dealing with illness and health seeking, which I will try to frame in a more comprehensive way as ‘the health seeking process.’ Chrisman (1977) describes the process in which an individual with a health problem, who experiences a need for help, attempts to solve this problem (1977: 353) and makes choices or ends up in a certain treatment direction.

Cultural and social factors determine this process and its outcome. This process as described by Chrisman starts with the phase of ‘problem definition’ and the predominantly individual experience of getting ill: “a deviation is perceived from the culturally and historically defined standard of normality established by everyday experience (1977: 355).”

As soon as this experience of deviation is experienced as dangerous or disabling, it becomes social. This phase is described by Chrisman as the ‘lay health system’ (figure 2.1) and consists of four elements: (1) Health beliefs; (2) Lay Referral; (3) Lifestyle; and (4) Illness related role shifts.

In this phase people try to understand what is wrong. Questions that are raised and should be answered, according to Helman (2001), are: (1) What has happened; (2) Why has it happened; (3) Why has it happened to me; (4) Why now; (5) What would happen to me, if nothing were done about it; (6) What is the likely effect on other people in that case; (7) What should I do about it. The answer to these questions is influenced by culturally and socially shared convictions and by interaction within the social environment: health beliefs and life style. The range of lay health beliefs and practices can range from a strict scientific biomedical pole on the one hand, and the popular beliefs and practices on the other, in which for example spirits and possession have primary explaining power. The way in which these beliefs and practices are communicated and the process of channeling towards a specific source of treatment is determined by the social network (life style) and for a good understanding of this process it is necessary to get an image of the social environment and its characteristics. With ‘lifestyle’, Chrisman focuses
particularly on the degree of insularity of an individual or group and the quality of information and knowledge that is held by the relevant group. Relevant factors are the range of extra group contacts (this refers to the social heterogeneity of social contacts and the range of information one gets and the interpersonal skills one acquires), the internal degree of compactness or dispersal of social contacts (compactness refers to having a high number of contacts and social relations but only originating from a limited number of social fields), and the extent of overlapping roles (refers to multiplicity of a community in which the same people interrelate in multiple roles: your neighbor is a family member, teacher of your children and minister in the church). Perhaps lifestyle is not the right term for this element of the model, since it seems to refer to personal choice and ways of living, while Chrisman in his description of the element refers more to the socially and culturally determined position of the group where you belong to. Illness-related role shifts depend on social issues like “Am I allowed or able to be ill?”; “Who takes my responsibilities and gives social support?” and “Where can I get help?.” It is important to be aware that these issues are not a matter of obvious agreement, but that conflicting interests can be involved. This phase of the health seeking process concerns the type of issues that is dealt with in negotiation with and sometimes in conflict or contradiction with the formal (e.g. employers) and social environment (e.g. family members) and with public authority as in the case of infectious diseases or mental illnesses where the patient lacks the basic understanding that he is ill and ‘illness insight.’ This can lead to a legitimized adoption of the sick role, which implies the right to be absolved from certain normal social obligations and the obligation to do your best to get well. However, it also can lead to non-recognition or denial of the illness and the requested privileges and obligations. The outcome is a representation of debate and changes in dominant discourses.

These elements of the lay health system are determined by (1) structural factors, like socio-economic situation and ethnic identity; (2) by explanatory models: “knowledge

10 Chrisman's model seems to use similar explaining factors as the, in The Netherlands often referred to, conceptual model of Stronks et al. (1999) to explain the relation between ethnicity and health and the incidence and prognosis of diseases in migrant populations. They distinguish ‘contextual mechanisms’ which are socio-economic, cultural macro factors and genetic factors, that determine ‘specific determining factors’, which are local and social in a limited sense and sometimes personal. Stonks et al. focus on differences in incidence and prognosis of morbidity. Chrismans model focuses on differences in pathways to health (cf. appendix IV).
and beliefs about bodily physiology, the nature of the environment, the etiology of disease, and available treatments.” (ibid. 1977: 362); (3) by the social context in a limited sense, e.g. the availability and diversity of social network and dispersal of social contacts; and (4) by the coerciveness and threat of the problem: vague or chronic complaints mostly are not considered to be of a very compelling nature.

The outcome of the Lay Health System finally leads to some kind of treatment (medical or not) of the deviation. Treatment action can imply medical treatment, but also prayer or denial and exclusion are ways to treat deviance. Chrisman distinguishes types of treatment (e.g. physical interventions, verbal or ritual behavior etc.) and the source of treatment advice, for example professionals in the formal and informal health sector or lay consultants in the popular sector. Chrisman introduces with his model the possibility of the description of ‘natural histories of illnesses.’ Analyzing a natural history of illness on a social and an individual level can lead to a better understanding of the quality (structural and process factors) of formal health care services. For example, the degree of congruence of lay beliefs and practices with those from the formal health professionals is important to understand blockades in the access to the formal health care system. These structural and process aspects of the health seeking process are elaborated by Goldberg and Huxley (in: De Jong 1996; Bhui & Bhugra 2002).
Goldberg and Huxley formulate the necessary steps (from general practitioner, via community mental health centre or outpatient care) on the pathway to appropriate specialized (mental) health care (hospital-based inpatient services) and filters that can be discerned, that block or enhance further access. Access to specialized mental health care as described by Chrisman is not obvious nor is it similar for everyone and there are differences between different population groups and thresholds for specific subgroups in the total population of people with psychiatric morbidity. Filters as described by Goldberg and Huxley can refer to several factors: (1) features of the patient and the system or social network (behavior, knowledge, attitude, cultural and social context) as described in Chrisman’s lay health system; (2) the expertise and skills of the doctor or therapist to identify psychiatric morbidity; (3) attitude and referral behavior of the doctor or therapist; and finally (4) factors in the limiting conditions, that determine referral and access to specialized services, based, for example, on general policies or capacity.

De Jong (1996) elaborated Goldberg and Huxley’s model to clarify the filters with which migrants are confronted when looking for mental health care in The Netherlands. An overview of the steps, aggregation levels of care and filters is given in Appendix II of this report. Bhui & Bhugra (2002) took a step further and made clear that many migrants do not follow the path, but use ‘side-entrances’ and get access to the mental healthcare system via the criminal justice system or police and that it is not merely the specialized psychiatric service that is at the end of the line, but also the forensic service. They stress the relevance of complementary medicine (churches, indigenous healers, voluntary services etc.) as a separate and influencing pathway. Besides of that the also describe the so-called ‘American by-pass’ through which people get around the general practitioner and outpatient services and access specialized services directly, often after legal intervention as in the case of involuntary commitment, or by by-passing the necessary referral lines and addressing the emergency ward right away. The necessary referrals in such a case often have to be acquired in retroaction. Where Goldberg and Huxley and De Jong focus on the accessibility of successive services, Bhui & Bhugra also stress the importance of actual use and delivery of the health care that is indicated and of adherence by the patient, as is also stressed by Chrisman.
A combination of Chrisman’s model and the model of Goldberg and Huxley and Bhui & Bhugra leads me to the following image of the health seeking process that is used as a model for analysis of the data in this research.

In this model the spiral symbolizes the ‘lay health system’ as described by Chrisman. This leads to treatment action and a choice or (mostly) a combination of pathways. The pathway described by Goldberg and Huxley is pictured in the model as ‘Biomedical Main Street.’ Bhui & Bhugra added at least two extra pathways that should be taken in consideration specifically for migrants, but probably not only for them: ‘Complementary Medicine Avenue’ and the ‘American By-pass.’ It is possible to describe filters or blockades on the pathways (numbered circles in the model), on the basis of research. These data are still not very conclusive and comprehensive where it concerns the health seeking process of migrants. De Jong (1996) concludes that there are serious empirical gaps in our understanding of morbidity, access and use of mental health care services of migrants in The Netherlands. An image of the filter model of Goldberg and Huxley is presented in appendix III.
The distinction in this model between the lay health system, biomedical main street and the complementary medicine avenue parallels the identification of three interconnected sectors of health care by Kleinman (1980): the popular sector, the folk sector and the professional sector. I will describe the Cape Verdean lay health system (popular sector) in chapter 6 of this report. The use of the formal (mental) health care (professional sector) and complementary medicine (folk sector) are described in the follow-up study. By using this model as the basis for my analysis, it is possible to fill in the interrelations between several pathways for a specific group of people and to analyze in a comprehensive way the natural histories of illness and treatment. The limitations of this health seeking model are its assumption that the health seeking process, and illness, is a linear and stepped process when analyzed in the context of the use and access of health care services and that it is incremental, or based on the assumption that the further one gets in the chain of health care providers, the more total, intensive and the more specialized the service gets. In reality the illness, especially when it concerns psychiatric morbidity, follows a much more whimsical pattern of ‘to and fro’ between crisis and feeling better, ups and downs; and with the ongoing deinstitutionalization and differentiation of mental health care the implicit ‘stepladder-model’ (every step brings you higher) in the structure of health care is imaginary. Nonetheless, it seems that the idea of looking at health care as a chain of institutions and analyzing points of access, transitions and filters that limit transition can give insight in the relevance and effectiveness of the formal health care system for different groups in the general population. Following Bhui & Bhugra (2002) and Chrisman (1977): It offers a framework within which health service research, service development and the delivery of quality care may be organized and natural histories of illness can be constructed and conceptualized.
3. Cape Verde and Cape Verdan migration

The Cape Verdan islands have a long tradition, since the nineteenth century, of migration to North and South America, Africa and Europe. In this chapter I will give a concise introduction to the history and the current situation of the archipelago and the history of migration, especially to The Netherlands.

3.1 Cape Verde

Cape Verde is an archipelago of eighteen islands (nine inhabited) and part of a group of middle-Atlantic islands sometimes described as ‘Macaronesia’ (the islands of bliss), which include Cape Verde, the Canary Islands, Madeira, and the Azores.¹¹

---

¹¹ The word ‘Macaronesia’ originates from the English marine-biologist and geologist Philip Baker Webb (1793-1854) who visited these islands in 1828; four years before Charles Darwin traveled there with his ship Beagle. The word is said to be more often used in the northern islands (Canary islands and Azores) than on Cape Verde. In Greek, Roman and Phoenician mythology many referrals are made to the islands: Atlanta, ‘fortunaturum insulae’, Elysean Fields, Garden of the Hesperides; islands with an undetermined location not far away from Mount Atlas in Africa in the far West. On the picture of the ancient map the Cape Verdan archipelago is designated as ‘Gorgades’ and ‘Hesperides’, next to ‘Capo Verde.’ *Pliny Natural History* 6.200 (http://www.theoi.com/Thaumasioi/Skiapodes.html - Gorgades) explains these
Cape Verde is the most southern part of this group and is situated 500 kilometers off the coast of West Africa (Senegal). The archipelago is divided in windward (barlavento) and leeward (sotavento) islands of which 12 islands are most commonly described to be part.

<table>
<thead>
<tr>
<th>Barlavento (Windward) Group</th>
<th>Sotavento (Leeward) Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Santo Antão</td>
<td>Ilheu Branco</td>
</tr>
<tr>
<td>São Vicente</td>
<td>Ilheu Raso</td>
</tr>
<tr>
<td>Santa Luzia</td>
<td>São Nicolau</td>
</tr>
<tr>
<td>Sal</td>
<td></td>
</tr>
<tr>
<td>Boa Vista</td>
<td>Sotavento</td>
</tr>
<tr>
<td>Brava</td>
<td>Santiago</td>
</tr>
<tr>
<td>Maio</td>
<td>Fogo</td>
</tr>
</tbody>
</table>

Figure 3.2: Map of Cape Verde  Source: Magellan Geographix

words: "Opposite this cape (of the Atlantic coast of Western Aithiopia or Africa) also there are reported to be some islands, the Gorgades, which were formerly the habitation of the Gorgones, and which according to the account of Xenophon of Lampsacus are at a distance of two days’ sail from the mainland. These islands were reached by the Carthaginian general Hanno, who reported that the women had hair all over their bodies, but that the men were so swift of foot that they got away; and he deposited the skins of two of the female natives in the Temple of Juno as proof of the truth of his story and as curiosities, where they were on show until Carthage was taken by Rome. Outside the Gorgades there are also said to be two Islands of the Hesperides; and the whole of the geography in this neighbourhood is so uncertain that Statius Sevosus has given the voyage along the coast from the Gorgones’ Islands past Mount Atlas to the Isles of the Hesperides as forty days’ sail and from those islands to the Horn of the West as one day’s sail.” The Hesperides where daughters of Hesperus (the Night), who guarded the golden apples of Hera (Juno) in the garden of the Gods. The apples came from a tree that grew from the goddess Gaia’s (Earth) womb.
The archipelago covers an area of 4,033 square kilometers\(^\text{12}\) and is situated in the southern part of the zone of Sahel countries. The climate on the islands is harsh with long periods of drought and the land is described as ‘rugged, rocky and volcanic’ (Fogo), with poor national resources and threatened by deforestation and desertification. The estimated population in 2002 was 408,760 inhabitants.

Cape Verde was a Portuguese colony from the fifteenth century (1460) until 1975. The Portuguese used the formerly uninhabited islands\(^\text{13}\) as a slave trading post and penal colony. For others it was a refugee place: e.g. for Jews from the Iberian Peninsula. For fishermen and whalers Cape Verde was an important coaling harbor. Independence from Portugal was realized in a liberation war mainly fought out in Guinea-Bissau by the Partido Africano da Independência de Guiné e Cape Verde (PAIGC) of the still legendary Amilcar Cabral.

\begin{figure}[h]
\centering
\includegraphics[width=0.5\textwidth]{Amilcar_Cabral.png}
\caption{Amilcar Cabral}
\end{figure}

Amilcar Cabral. This party was in power as a unity-party until 1991. Since then Cape Verde is a plural democracy with the MPD: Movimento Para a Democracia, as most important countervailing power that took over administration of the country from 1991 until 2001. Then the PAIGC, now known as the Partido Africano da Independência de Cape Verde (PAICV), came to power again. The government is seated in the capital Praia on the island Santiago.

Cape Verdeans are predominantly a creole people from African, European and Asian origin: 71% of the population is referred to as creole; 28% as African and 1% as

\(^{12}\) Data derived from ‘The World Factbook 2002’

\(^{13}\) It is presumed (Silva, 1997; Almeida, 1997) that before the Portuguese came, also the Arabs and probably sub-Sahara Africans frequented the islands, because of the natural salt resources, but did not settle permanently.
European. With a certain degree of irony, Almeida (1997) describes the first official census records (1513) for the population of Vila de Ribeira Grande (‘the great stream’ on Santiago), as representative for the future demography of Cape Verde: 162 inhabitants including 58 ‘whites,’ 12 priests and 16 ‘free blacks,’ soldiers and Portuguese convicts and approximately 13,000 slaves.

The everyday language of Cape Verde is *Crioulo*, a blend of Portuguese and West African languages. Every island has its own dialect of *Crioulo* and these differences can cause difficulties in communication: in this study people originating from São Vincente report to have difficulties understanding people from Santiago. *Crioulo* is a real ‘creole language’ used for everyday communication mainly spoken and not written. This, however, is rapidly changing. *Crioulo* is cherished by Cape Verdeans as part of a national and cultural identity, and grammar, dictionaries and courses in *Crioulo* are developing rapidly not only in the archipelago, but certainly also in the Cape Verderan diaspora. Manuel Veiga, who developed a grammar of *Crioulo*: “From *Crioulo* we derive our identity opposite the rest of humanity. Through *Crioulo* we can show our culture, not only in a phonetic sense, but also in a syntactic and semantic sense. In this we confirm that we, although we speak Portuguese, are Creoles; that we, while we think and live in Portuguese, feel and live in *Crioulo*. We can ‘act’ in Portuguese, but we will only succeed to ‘be’ and to ‘live’ thanks to *Crioulo.*” (Veiga 1997:16). The language used in formal situations (education, administration) is the language of the former colonizer: Portuguese. Vasconcelos (2002) describes his struggle with the many inexplicit rules of situations where to speak Portuguese and where to speak Creole, when doing fieldwork in São Vincente. Portuguese is the language that communicates the message that you want to keep distance. The use, however, can have performativ qualities as well: Portuguese can be used to show that you master the language especially in contact with foreigners. He explains, however, that finally “*Creole* is the language that draws people close to one another, the language that expresses affection and familiarity” (2002:8). Portuguese, on the other hand, is not only the language of power and authority, it is power and authority.

---

14 Creole languages are blends of different languages, mostly in a context of colonization. At first they develop as secondary languages (pidgin languages) but then evolve to a language that is passed on from generation to generation, with a vocabulary and internal structure that evolves to the extent that it becomes a distinct variant of the originating languages. Creole is derived form the Portuguese word ‘Crioulo’ originally meaning: ‘a servant born in the master’s house’ (Bolaffi et al., 2003). In Portuguese the word now designates: ‘a white man born in the colonies’ (Portugal), or ‘a black man born in Brazil’ (Brazil).
Economically, Cape Verde suffers from high trade deficits and is dependent on foreign aid and remittances from emigrants. Fundamentally, the economy is built on agriculture and fishing, and small-scale cattle breeding mainly for self-subsistence. Export (bananas, lobster, shoes, garments, and fish) and the tourist industry have been growing since the beginning of the nineties, but are still limited. The Gross Domestic Product (GDP) in 2001 was estimated at € 1,072 per capita. External debts of Cape Verde amount to € 301 million in 2000, equaling € 750 per capita. (World Factbook 2002). Silva (1997) reports that twenty percent of the GDP is based on financial remittances of emigrants.

Thirty-six percent of the inhabitants is below the poverty-line\textsuperscript{15} (Letra das Ilhas 2003) and 21% of the workforce is unemployed (2000 est.). Over the years many inhabitants suffered from poverty and famine caused by the droughts and the indifference of the colonial regime of the Portuguese to the hardships of the Cape Verdeans. Colonization irreparably ruined the fragile ecosystem of the islands (Almeida 1997). Looking at the history of the islands, droughts and famines are recurring phenomena, since the first reported famine at the end of the sixteenth century. In the 18\textsuperscript{th} century, eight major droughts and famines are reported on the islands: “1774 (September) to 1775 (February) 22,666 people die in the archipelago. Some people are sold into slavery in exchange for food. All of the livestock died in Maio and Brava” (Almeida 1997: 7). In the 19\textsuperscript{th} century at least two major famines are reported (1830s and 1860s), and in both instances between 20,000 and 30,000 people died from starvation, the number of inhabitants dropped respectively 25\% and more than 30\%. These famines were accompanied by major outbreaks of dysentery, small pox and yellow fever (Patterson 1988). The very steepness of the death tolls, however, is also attributed to the weakness and corruption of the local colonial authority and its inability to resist the usury of the trading companies, as well as to the almost always returning failure of the Portuguese authorities to send effective relief (Patterson 1988). This chain of major ‘crises’ goes on until recent history: the famines of 1941-43 and 1947-48 resulted in a combined loss of some 45,000 lives. In a recent

\textsuperscript{15} Data of the Cape Verdean Instituto Nacional de Estatísticas (INE) show how the number of poor people on Cape Verde has risen during the nineties from 30 to 36\% of the total population, while the GDP rose in the same decade from € 755 (1990) to € 1072 (2002). Not only the overall number of poor people has risen, but also the proportion of ‘very poor’ people in this population. Twenty percent of the total population is ‘poor’ (below € 328 on an annual basis) and 16\% ‘very poor’ (below € 219 annually) compared to an average income level of € 547 per capita annually in 2002. The INE-data further make clear that poverty is not a problem of city populations but of the rural communities, and that the island of Santo Antão is affected most by this problem: 54\% of the population on this island lives below the poverty line.
outbreak of cholera (1995) more than 10,000 cases were reported and at least 210 casualties. Silva (1997) describes the harsh climatological circumstances as of major unifying and blending influence on the people of Cape Verde. The inhabitants had to work and live together to survive.

3.2 Migration

During Portuguese colonization it was not obvious for the Cape Verdeans to migrate from their homeland. The Portuguese forbade migration, but also used it as an instrument of labor policy and oppression. Many Cape Verdeans were forced to migrate to plantations in São Tomé and Angola, when labor force was scarce there or when Cape Verde suffered from a crisis (droughts, epidemics, etc.). A way to find better chances and escape poverty and oppression, was by signing on to one of the big Atlantic ships that used the harbor of São Vincente to get supplies. And sometimes it was subsequently more lucrative to settle in another country and sign on a foreign ship, which would render more income. Meintel (2002) describes the migration of Cape Verdeans to different continents as a diaspora and a transnational community (Gowricharn 2002). This is not a recent development, but a diaspora that goes back to the nineteenth century, when Cape Verdeans settled in the north-eastern parts of the United States (Cape Cod), to do seasonal work in the cranberry fields, via signing on American whalers that coaled on Cape Verde (Halter 1993; Da Graça 1999). When restrictive immigration laws made moving to the USA more difficult, a second migration wave followed to Brazil and the African continent in the beginning of the twentieth century, and recently, followed in the second half of the twentieth century, by emigration to Europe (fig 3.4). Vasconcelos (2002) explains: “Like the rest of the Cape Verde islands, São Vincente is a land of people in transit.” Being in transit is an element to be found in Cape Verdean symbolism, for example as expressed in Racionalismo Cristão.

A diaspora is generally determined by a shared experience and memory of (mass)violence that forces people to leave their country of birth. However, separated people in a diaspora still think of themselves as “having a shared condition, one that is continually reconstituted by travel and visits, and bound together by ties of kinship, commerce, sentiments, values, etc.” (Meintel, 2002:26). Transnational migration is inspired by the need of economic survival and improving economic conditions. Transnationalism is determined by the development and maintenance of strong political and economic ties between different nation-states, particularly the country of residence and the homeland (Gowricharn, 2002:17). As Silva (1997) makes clear, transnational ties are constitutive for the situation and identity of Cape Verdeans in The Netherlands.
Migration of Cape Verdeans to The Netherlands - as told - started in 1955, when an ill sailor, João Silva\textsuperscript{18}, was brought into the harbor of Rotterdam for treatment (Strooy 2000). Later he became the first Cape Verdean Consul General for The Netherlands, Belgium and Luxembourg, and known for his advocacy work for Cape Verdean migrants. João Silva settled as a sailor on Dutch ships and his example and experiences made others...

\textsuperscript{18} João Silva, better known as Junga de Beluca, still is a very well known and honored man in the Cape Verdean community in Rotterdam.
to follow in a chain reaction of migration to The Netherlands. Silva (1997) describes three waves of migration of Cape Verdeans to The Netherlands. The first wave of migrants came in the years before the Cape Verdean independence of 1975, they planned to work on a temporary base and return to their country of origin afterwards. The second wave that started after 1975, consisted of people who were disappointed about the new political situation, better educated and ‘retornados’; former Cape Verdean civil servants who worked in the African colonies, serving the Portuguese. The final immigration wave, since the beginning of the nineties, is partly inspired by family-reunifications or marriages. Nowadays it is almost impossible to immigrate documented.

D. Teresa (63) tells me how she moved to Lisbon as an adolescent to work as a housekeeper for a Portuguese family. She looks at it as an opportunity to develop, find a better living, better education and learn a new language. She marries a Cape Verdean sailor who takes her to The Netherlands where she lives since then. In the first years she lives in a gloomy, concrete suburb of The Hague, where she is the only Cape Verdean. It is a situation that does not meet her aspirations and expectations. Later, after her husband left her, she moves to The Hague and to Rotterdam, to live closer to her children and other Cape Verdeans. Ana, another informant, still young, basically followed the same route many years later, settling in Portugal and then marrying into The Netherlands.

Paula (23) moved to The Netherlands recently, when she was 20 years old. She reunified with her mother, whom she knew only for the first years of her life and whom she saw only once in almost twenty years. She was raised by aunts and her grandmother on Cape Verde. These relatives maltreated her. Paula lives with her mother and (half-) sisters now, is illiterate and only speaks creole. She is said to be mentally retarded and has trouble mastering Dutch society. Her mother dominates and she earns a living by moonlighting. She has no documents, because, according to Dutch immigration laws, she is an adult who has to take care of herself. Paula left a child in Cape Verde from a forbidden relationship. The same relatives, who took care of her, raise the child. They urge to bring the child to The Netherlands as well.

Nuno (44) came to The Netherlands all by himself. He was raised on São Nicolau by his grandmother, while his parents were living on San Vincente. His father was a sailor and he first met him when he was 5 years old. He left Cape Verde a year after independence and still talks with bitterness and disappointment about (the quality of the) Cape Verdean administration after independence. On Cape Verde he was involved in different jobs in construction and finally became a sailor, like his father, and ended up in Rotterdam. There he met a cousin, who took care of him and gave him a place to live. He settled, married a Dutch woman and worked on the inland navigation.

These stories are exemplary for the reasons of migration of the informants in this study: (1) Men as well as women looking for opportunities for a better living, sometimes for themselves, sometimes also for family members they left behind; (2) Chain migration, where migrants follow relatives, friends, people they know to a new country of residence and are helped and supported by them; (3) Family reunification, (extended) family
members and relatives followed to come and live with a father or couple who left sometimes many years before.

Cape Verdean migration to The Netherlands is often described as a process of chain-migration. Strooy (1996) and Elleswijk (1997) write about the transnational networks which paid for transfers and took care of the newcomers after arrival in the numerous Cape Verdean boarding houses in Rotterdam.

Figure 3.5: Pensão Delta, one of the boarding houses

The network helped to get a job and incorporated the newcomer, as a way of strengthening itself. This forged strong mutual ties and obligations. Silva (1997), however, puts this in the light of the Cape Verdean system of patronage and the accompanying dependency of peasants and potential migrants on a patron. This system of representatives, or ‘extended arm’, is not unknown in the history of Cape Verde.\(^\text{19}\) The patron tries to use his influence by offering clients, who have become dependent on him,

---

\(^\text{19}\) Several authors refer to the Capitania-system (Cabral 1980) and to the existence of ‘lançados’ (Meintel, 1980), who served as middlemen on the Guinean coast. Often these lançados were Cape Verdeans, married to local women, and used by the colonizing power as a starting point of the slave trade. Meintel describes how ambivalent Cape Verdeans were in this respect. The Portuguese put them in the privileged position of ‘assimilados,’ in contrast with ‘indígenas,’ the indigenous ‘savage’ people of subsaharan Africa, who, in the eyes of the Portuguese, were not worth investing in. In reality their treatment did not differ substantially, according to Meintel.
services. These are services that are needed, and sometimes asked for, but also services that were not needed or requested (Silva 1997:51).” The patrons are described as pivotal ‘middle-men,’ who operate in a political vacuum, as is also described by Blok (1974). This system of patronage gets a transnational dimension by its role in the facilitating of the process of migration: a new migrant gets a ‘carta de chamada’; a guarantee that links him to a former (patronized) migrant. This linking creates and maintains a network of influence and dependencies, from a homeland to new countries of residence. This is extensively described by Van Dijk (1997) as part of the transnational character of the West-African Pentecostal churches, which are spreading over the world and are branches of the original (international) church and its charismatic minister in the country of origin. It seems that in the case of the Cape Verdeans not the churches, but the numerous organizations and clubs are the patrons’ stronghold abroad, as is argued by Silva (1997).

3.3 Nos ku Nos
Henny Strooy (1996), in her pioneering work ‘Eilanden aan de Maas’ describes the Cape Verdeans in The Netherlands as a community of islanders, who are aware of mutual differences between the islands and where a common identity as Cape Verdean only arises when they are addressed from outside. One of the participants underlines that: “We have ten islands, ten languages, very different. And of these ten, you can see which is more African and which more European.” Most of the Cape Verdeans who live in The Netherlands come from the ‘Barlavento’ islands, like Santo Antão and São Vincente. This is also the case for the people who participated in this research. Only a few informants originate from ‘Sotavento-islands’ like Maio and Santiago.

The differences are experienced as different insular-cultures and vividly described in daily conversations that I witnessed. For example, the people from São Vincente are seen as more open, westernized and liberal. São Vincente is the cultural catalyst of Cape Verde, as Silva (1997) explains. Some of the informants mocked with friends from Santo Antão by calling them ‘farmers’ (understood as simple), while these ‘farmers’ in response describe their island as a green oasis, and the most beautiful island of Cape Verde. The

---

20 Original title: ‘Eilanden aan de Maas’ (Islands along the Maas). The river ‘Nieuwe Maas’ cuts Rotterdam in a northern and southern part.
21 Or São Tiago, the biggest island of Cape Verde with the capital Praia and seat of the government.
people from Santiago are often described as ‘more African,’ with different music, ‘funana,’ “Which is not my music” as one of the informants (from São Vincente) explains. He likes ‘mornas’\(^2\) better. In everyday conversation I heard people check the island of origin in an incidental way. On the other hand ancestral origin is a point of reference. D. Teresa presents herself as: “My father was a child of the Europeans; my mother is a grandchild of a European. But I have an aunt, an older sister of my mother, who says we are descendants of the slaves, the richer slaves, who came together with the Europeans.” This refers to two important things: (1) the importance of ancestral origin as an expression of status, for example descending from the rich (= free) slaves; and (2) the memory of slavery and the relations between slaves and Europeans that apparently still are vivid and relevant in everyday understanding of the history of Cape Verde. This memory is fading, since the second generation Cape Verdeans, born in The Netherlands is losing the feeling for it as is reported by one of the (older) participants in the research.

The relevance of the different islands is also seen in the structure of Cape Verdean social and community life as the ethnographers of the Cape Verdean community describe: the numerous organizations and clubs are often organized according to island of origin, so people can get together with their own people, i.e. from the same island. This differentiation, however, also has gotten some mythical proportions, as one of the informants explains: the competition between different soccer teams is so strong that island-bound soccer teams prefer to have a good player from another island above a bad player from their own island. Only in the name giving the teams represent islands. Silva (1997) nuances the island-culture by referring to the transnational connections, described earlier. The highly differentiated structure of associations and clubs supports ‘nossa maneira de ser’ (our way of being) and the connections to the homeland. ‘Nos ku nos,’ according to Almeida (1995), an expression “colloquially used to convey the attitude that Cape Verdians are a people who make sense to each other, whether or not their cultural identity makes sense to others outside the group.”

\(^2\) Mornas are described as slow quadruple-time songs, and most characteristic for Cape Verde, dealing with themes like the sea, the love for the homeland and love in general. Funana is up-tempo music in two-four time, originally played with a diatonical accordion and ‘ferinho’ (rhythm instrument) and nowadays with electronic instruments and a strong resemblance to West-African music (Brito, 1998). Other styles are: the ‘coladeras,’ described as more lively music than mornas, the belligerent ‘tabanca’ and the ‘landu’ (weddingdance). Most controversial in the eyes of the Portuguese and the Roman-catholic church (traditionally) are the ‘Batuque,’ because of its sensual character and the ‘Finançon,’ a combination of singing and story-telling. Both have strong African influences (Van Koningsbruggen, 1997).
The issue of national identity is debated among the Cape Verdeans and among scientists. Meintel (2002) and Halter (1995) describe the indefiniteness of the identity of Cape Verdean immigrants to the United States. They were seen as ‘black Portuguese’ or ‘Bravas’ (originating from the island Brava), not accepted by immigrants originating from Portugal, treated as African-Americans and feeling Cape Verdean. Silva (1997) also describes this initial vagueness about ‘black Portuguese’ and discerns three distinctive identities within the Dutch Cape Verdean community: (1) the ‘Eurafroverdianists’ who stress the mix of cultures and the diverse roots of Cape Verdeans; (2) the ‘Africans’ who stress the African roots (several informants in this study describe themselves explicitly as Africans and oppose the idea that they are Portuguese or European, as many outsiders often (like to) treat them; (3) the ‘Cosmopolitas,’ or the people who adopt a transnational identity and are seen as adaptive to a receiving society. The interesting point in the argumentation of Silva is, however, that he does not try to pinpoint the community on an ethnic emblem or a fixed identity, but stresses the possibility to ‘work’ with it by ‘over-communicating’ or ‘under-communicating’ a certain identity depending on the context, and the dynamics of opposing forces within the community that build and transform a felt identity. This reasoning follows the work of De Ruijter (2000) and Van Binsbergen (1999) in The Netherlands, who stress the relevance of the working of the ‘cultural arena’ that produces identities and the performative aspects in cultural identity. D. Teresa
explains her confusion: “Long ago I started to think for myself, (…) I am a daughter of Africa, maybe, I … yes …. I sometimes think of my country and other times think Dutch. Then I cannot figure it out anymore.”

The migration of Cape Verdeans to The Netherlands started in the 1950s but not until the 1960s to the 1990s, it came to a full development. This migratory process is part of a long history of migrations of Cape Verdeans, voluntarily and involuntarily, to the four continents which enclose the Atlantic Ocean. According to the records, it seems to be by chance that The Netherlands became a target country for migration for Cape Verdeans. Motives for settlement were: looking for better chances, escaping poverty and political oppression; chain migration; and family reunification. Cape Verdeans make sense to each other, whether or not their cultural identity makes sense to others outside the group. ‘Nos ku nos,’ according to Almeida (1995). It is relevant to look at the situation of the Cape Verdeans in a wider context of their history of migration and their settlement in different continents, since issues of national identity, recognition, common interests, political influence, visibility, and cultural expression develop along transnational pathways. For this reason it is important to connect the social scientific research on the Dutch Cape Verdean community to the international schools of anthropological and sociological research in the United States and Canada, in Southern Europe (Portugal, Italy and Spain) and to the Scandinavian studies.
4. The Cape Verdean community in The Netherlands

In this chapter I shall give an overview of the social conditions of life of Cape Verdeans in The Netherlands. I will concentrate on different domains of life: physical environment, social environment, work and income, education and family life.

4.1 Living in Rotterdam

Rotterdam is the second biggest city in The Netherlands with 592,000 inhabitants and centre of the Rijnmond-region, a highly industrialized conurbation of 1,25 million inhabitants, which developed around the harbor with all its connected economic activities and industries. This harbor, the largest in the world, is an economic magnet, which attracts people from all over the world. In 2003, almost 47% of the inhabitants of Rotterdam had a background as a migrant, divided over 30 major groups of different (former) nationalities. The seven biggest migrant populations are: Surinamese, Turkish, Moroccan, Dutch Caribbean\(^\text{23}\), Northern Mediterranean, Cape Verdean and the largest group: immigrants from rich countries (9%) (ISEO/COS 2003).

<table>
<thead>
<tr>
<th>Indigenous Dutch</th>
<th>Immigr. from rich countries</th>
<th>Turkish</th>
<th>Moroccan</th>
<th>Dutch Caribbean</th>
<th>Surinamese</th>
<th>Northern Mediterranean</th>
<th>Cape Verdean</th>
<th>Immigr. from other poor countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>53</td>
<td>9</td>
<td>7</td>
<td>6</td>
<td>3</td>
<td>9</td>
<td>3</td>
<td>2</td>
<td>8</td>
</tr>
</tbody>
</table>


In 2003 (1 January) a total of 14,919 Cape Verdeans lived in Rotterdam on a total population of migrants (with documents) of 281,187. This probably is an underestimation since a considerable number of them lives in The Netherlands with a Portuguese passport and is counted as immigrant from a Northern Mediterranean country. Furthermore, there is a growing number of Cape Verdeans without documents. The immigration policy of

\(^{23}\) Netherlands Antilles and Aruba
The Netherlands is so strict that it is actually impossible for foreigners to immigrate. It is estimated by the Avanço-foundation that there are between 2000 and 3000 Cape Verdeans without documents living in Rotterdam.

Cape Verdeans are a young population: 28% is younger than 15 years old, only 2% is older than 64 years (ISEO/COS 2001), 67% is younger than 35 years old, compared to 42% of the indigenous Dutch population. 54% of the Cape Verdeans is concentrated in two submunicipalities: Delfshaven (43%, n = 6,373) and Feyenoord (11%, n = 1,651). In Delfshaven 9% of the total population is Cape Veredian, in Feyenoord it is 2%. In both areas migrants are the majority of the inhabitants (Delfshaven: 73% and Feyenoord: 64%).

![Figure 4.1: 'Welcome to Rotterdam' (in front of the main railway station)](image)

To get a better image of the living conditions of Cape Veredian migrants in Rotterdam I will focus on the submunicipality ‘Delfshaven’ where 43% of the Cape Veredian community lives. This view is based on figures of the Centre for Research and Statistics (COS 2001; 2002; 2003) of Rotterdam, descriptions from the participants in the research, personal impressions being present in the different neighborhoods, descriptions from articles in the press and descriptions of the socio-economic situation given by the submunicipality and community workers. The difference with the submunicipality
Feyenoord, with the second biggest concentration of Cape Verdeans in Rotterdam, is only gradual. My description is not representative for the Cape Verdan community, but describes the context in which the biggest part of them lives.

Figure 4.2: Map of Rotterdam – location of Delfshaven submunicipality, and detailed map

Delfshaven is a submunicipality with six neighborhoods, with a total of 72,507 inhabitants (1 January 2003) of whom 58% is younger than 40 years old. The neighborhoods are clamped between the city centre and the harbor, on the northern bank of the river ‘Nieuwe Maas’ and were built at the end of the 19th century mainly for people who came to work in the harbor. The population density of Delfshaven is the highest in the whole Rijnmond region: 13,986 inhabitants per square kilometer (1 January 1999). The area is predominantly populated by migrants from different origin: 73% of the total number of inhabitants: 6,373 of them have a Cape Verdan background (1 January 2003).

Table 4.2: distribution (percentages of total population and absolute numbers) of inhabitants of submunicipality Delfshaven according to ethnic category on 1 January 2003

<table>
<thead>
<tr>
<th>Indigenous Dutch</th>
<th>Turkish</th>
<th>Moroccan</th>
<th>Dutch Caribbean</th>
<th>Surinamese</th>
<th>Northern Mediterranean</th>
<th>Cape Verdan</th>
<th>Rest</th>
</tr>
</thead>
<tbody>
<tr>
<td>27.5</td>
<td>14</td>
<td>12.3</td>
<td>3.8</td>
<td>13.5</td>
<td>4.6</td>
<td>9</td>
<td>15.3</td>
</tr>
<tr>
<td>(19,912)</td>
<td>(10,498)</td>
<td>(8,931)</td>
<td>(2,543)</td>
<td>(9,779)</td>
<td>(3,364)</td>
<td>(6,373)</td>
<td>(11,107)</td>
</tr>
</tbody>
</table>


Together with Moroccan, Turkish and Surinamese migrants and the indigenous Dutch inhabitants, the Cape Verdeans are the biggest ethnic group in the area. The percentage of indigenous Dutch inhabitants in this submunicipality is decreasing at a fast pace. In recent years (since 1998) 3,652 of them left Delfshaven and their contribution to the total population dropped from 32% to 27.5% in 2003.

The organization of community workers (Delphi Opbouwwerk 2002) describes different parts of Delfshaven in negative terms: “Empty buildings and pauperization in parts of the neighborhood, combined with public nuisance caused by drugs and prostitution, affect the livability.” Spangen\textsuperscript{25}, one of the neighborhoods, is described in a national magazine by one of the inhabitants (Van Casteren 1998):

This is not a street anymore. It looks like the Bronx\textsuperscript{26}. I had a lot of trouble caused by drug users. Now everything is bricked up. There is a plan. Within five years the houses will be renovated or demolished. Soon I will be moving. All this trouble. My car broken open regularly. Noise and nuisance all night long, junkies fighting over a couple of guilders, sirens of police cars, spotlights shining inside.

The Cape Verdeans also experience these negative aspects; for one of the participants in the research (Carlos) this was reason to move:

Carlos: In the old neighborhood (Delfshaven, HB) where we lived, I almost went crazy and my children as well.
Interviewer: What bothered you?

\textsuperscript{25} In this neighborhood more than 10% of the inhabitants is Cape Verdean.
\textsuperscript{26} In the public debate on livability of the cities in The Netherlands of the 1990s, the Bronx (New York City) was considered as the ‘absolute zero’ of liveability.
Carlos: Drugs, noise and all those kinds of things. And of course we were worried about our child, who got worse and worse.

Another participant, however, describes the neighborhood - in contrast with the public opinion - as a ‘safe place for Cape Verdeans,’ because the diversity of people is so high that tolerance is imperative. This positive side is also recognized in public policy:

It is a neighborhood with a very diverse population. Young and old, migrants and indigenous Dutch, people with a low and with a high education, rich and poor; people are living in a melting-pot. The neighborhoods in which these people live differ as much as their inhabitants. Every neighborhood has its own problems and possibilities. (…)
The neighborhood is highly populated but has a variety of buildings: renovated housing in the public rental-sector; many privately owned houses. Houses with beautiful stately façades, streets with lots of trees, shopping areas, renovated houses and newly build ones, squares, and brick-like narrow streets. At the high end is historical Delfshaven: with its characteristic old houses all around the harbor and with a history that goes back to the years before 1600 (Delphi Opbouwwerk 2002).

This first glance of this submunicipality seems not to be very positive. But there is reason for optimism. Delfshaven is an area of extremes; poor neighborhoods contrast parts that belong to the top of the tourist attractions and housing market of Rotterdam. In between is a line of neighborhoods that is so young, diverse and colorful that it more and more harbors promising new initiatives, galleries, restaurants and businesses. The inhabitants of the neighborhoods are well organized, to counter deterioration of their living environment and their initiatives, often without any compromise, did get attention in the national press. The European Fund for Regional Development recently started supporting the neighborhoods financially to enhance the living and working conditions, the quality of education and schools and the care for children and adolescents.

4.2 Socio-economic position
An assessment of the socio-economic situation of Cape Verdeans will be made based on occupational standard, income level, and educational level. Unemployment under Cape Verdeans is low compared to other migrant populations. A little over 9% of all Cape Verdean inhabitants of Rotterdam are registered as unemployed or looking for a job. In 2001, more than 15% of the adult inhabitants of Delfshaven was looking for a job (COS

\[27\] In the description of the socio-economic position of Cape Verdeans I will base myself on data about the community of Cape Verdeans. When these data are lacking, however, I will refer to the context in which they live (basically figures about submunicipality Delfshaven).
2001; 2002)²⁸; a number that steadily decreased from a level of 28.5% in 1995²⁹. These figures are among the highest in Rotterdam. The municipal authority describes the problem (www.deelgemeenten.rotterdam.nl): “Delfshaven has a persistent and complex problem of unemployment. The problem especially concerns the number of long time unemployed, with a great distance to the labor market.” COS-figures make clear that more than 64% of the unemployed in Delfshaven is registered more than one year, almost 46% of them more than 5 years (COS 2001).

The jobs of Cape Verdeans are on the lower end of the socio-economic scale, they are badly paid, have little status and most of the time the employees have bad labor conditions (legal and material) (Elleswijk 1997). The jobs reported in this research are, for example; mechanic, warden, or sailor on the ocean-going trade or the inland waterways shipping, publicly subsidized ‘additional jobs,’ moonlighting, and cleaning. The cleaning industry and the hotel and catering industry (kitchens of restaurants) employ many of the Cape Verdean women, while the harbor employs many of the men, either ashore or as a sailor being on a ship for months.

The treatment of Cape Verdeans by employers is very often experienced as unfair, especially since they consider themselves to be disciplined with a high work ethic, they do not speak up for themselves easily, and are always considered good enough, but also willing to do the dirty jobs (Strooy 1997). Elleswijk (1997) reports similar experiences of Cape Verdeans and explains that social exploitation by employers and the limited socio-economic mobility, even if highly educated, are experienced as racial discrimination. The Cape Verdeans report feeling undignified and exploited: doing hard work for low wages and doing work that endangers and damages their health. In an international conference ‘Cape Verdeans in the Cities of Europe’ that was organized in Rotterdam in 1996, discrimination in labor situations was mentioned as the biggest problem with which Cape Verdeans internationally have to deal (Rotterdams Dagblad 1996b). This also became painfully clear during the so-called ‘Ned Lloyd-affair’ in 1983. A Dutch trading company fired 222 seamen, most of them Cape Verdeans. None of the applicable regulations or

²⁸ Seventy-one percent of them are migrants, this is in accordance with the demographic figures of this submunicipality.
²⁹ To compare: the unemployment rate on the Cape Verdean islands was lower: 20% in 2002. The percentage of Cape Verdeans living below poverty standards, however, was 20% as well. (World Fact book, 2002)
legal rights - neither before, nor after the discharge - had been translated in Portuguese or Crioulo. These were not known to the seamen and could not be invoked by them. It became a national scandal and only after the intervention of the national anti-racism organization (LBR), these dismissals were canceled (Strooy 1996).

On average, the incomes of Cape Verdeans fit into the picture of the jobs they are doing. The national bureau for statistics (CBS 2001) marks that 30% of Cape Verdean households is on a low income (social security allowance level). Nineteen-and-a-half percent of them is dependent on social welfare allowances. In 1998, in Delfshaven, the average income per household was € 16,881, the lowest income level in Rotterdam; 69% of the households have a yearly income below € 18,471. For the sake of comparison: the submunicipality with the highest (average) income level is at € 25,457. In table 4.3 these income levels are compared to the national average income and to the level of social security allowances: Delfshaven is at 69% of the national average. Eighty percent of the inhabitants of this submunicipality live in the public renting sector, where rents are low: less than € 125 a month.

Table 4.3: Average income level in Delfshaven, compared to national average and minimum income levels

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>€</td>
<td>23,915</td>
<td>16,881</td>
<td>11,350</td>
<td>10,962</td>
</tr>
</tbody>
</table>

Financial problems are related to social and cultural factors and gender. Elleswijk (1997) reports misconceived rights to social security allowance and sometimes abuse of this right, which lead to debts. Comparison of poverty figures within the European Union makes clear that poverty in The Netherlands is admittedly not as vast a problem as in some other European countries, but when it occurs, it is more intense: poor families in

\(^{30}\) Different definitions are used: a common definition used by the Federation of Labor Unions (FNV, 2003): poverty line lies 10% below social security minimum allowance. The national office of Statistics in The Netherlands (CBS, 2001) uses the 60% of the overall average income line. The FNV-norm is used here.
The Netherlands suffer from high monthly income deficits, among the highest in Europe (CBS 2001). Miguel talks about the perseverance of poverty and of income fall:

I worked here for 30 years, so I thought I should not go backwards, but earn more over the years. And that doesn’t happen. Now I get an allowance that goes directly to the bank. I wait because sometimes it does not come in time. And then you pay health insurance, rent, and things like that and after that you talk about food, and that does not come. At that moment you stay in that situation. (...) Now I get € 600, and what I spend is € 800, so there is a deficit of € 200 every month.

Elleswijk also identifies the importance of status as a social or cultural trait, which, traditionally, is based on lineage, the degree of education or being a ‘wise person,’ but nowadays is based on the ability to show expensive things or to organize feasts within the social network or the community. People compete for status (‘status consumption’).

Elleswijk: “Cape Verdeans make clear to each other, by means of ‘beautiful goods’ that they succeeded in society” (1997: 87). This luxurious lifestyle can be caused by the hope that The Netherlands is the ‘promised land’ where the trees are dreamt to reach the sky… so they should reach the sky. A luxurious lifestyle, however, can be a reaction to the poverty of Cape Verde as one of the participants explains. The average income does not match this aspiration level and developing debts, moonlighting and criminal behavior (second generation) are ways to solve the problem.

However, Elleswijk does not distinguish between status and reputation. Reputation is a more socially dynamic concept that fits into the overall picture of mutuality, a phenomenon also described by Elleswijk. Reputation can be obtained by status symbols, like organizing feasts or possessing luxurious goods. Traditionally it is known from the Cape Verde islands that feasts, also returning festivities of Saints, are ‘given’, and it is an honor to wealthier citizens to organize a public feast (Meintel 1984b), as a way of retribution and community service. In times of shortage, people can share the responsibility to ‘give.’ A poor man who fulfills his social obligations and ‘gives,’ builds a good reputation as well. This is circumstantially explained by Miguel, who is unemployed and does not manage to get by on his monthly social security allowance without deficits. At the same time, however, he tells how he is addressed by many people who want him to give money… and he does. A way to escape this obligation is to avoid places where Cape Verdeans come together. In this way, poverty breaks down the

---

31 In 1997 the income deficit of poor people in The Netherlands was € 2,088 per year, or 29% below the poverty line.
personal resilience of people, but also their social context and the possibilities of mutuality.

Giving is also a factor in the contact of migrants with the homeland. Migration and keeping in contact with family members and relatives in Cape Verde can be a costly enterprise as well. On a yearly base (2002), 13 million Euros are transmitted (registered) from The Netherlands to Cape Verde as remittances from Cape Verdeans who migrated to the homeland (Vuijsje 2004). These remittances, however, put an enormous burden on the migrants and on their visits to Cape Verde (Reekers 1997). The expectations about the possibilities to bring money and other kinds of presents back home are high and many migrants want to live up to these expectations and show a more exuberant lifestyle than they can afford. Some people have to contract a loan to meet these expectations.

The high prevalence of poverty is also attributed to the high number of single parent families (27%, COS 2002) in the Cape Verdean community. Single parenthood is a major indicator for poverty (CBS 2001; FNV 2003), because of the long term dependency on social security allowances and lack of alternative income out of labor. Gender is also mentioned as a relevant factor in another way: because of the financial misbehavior of husbands (before divorce), several Cape Verdean women reported that they were confronted with huge debts after divorce and an ex-spouse who disappeared.

The overall level of education and school performances of migrants in Delfshaven is a serious problem. A manager of a elementary school in Spangen, one of the neighborhoods, explains:

The educational and professional level of the parents is low and the number of migrant children in the schools is high: more than 90%. There is a growing number of children with social-emotional problems. (...) Many of these new (migrant, HB) pupils had an enormous arrearage, especially in the field of language (Delphi Opbouwwerk 2002).

This educational problem is especially relevant for the Cape Verdeans. The great majority (89%) of the unemployed Cape Verdeans has a limited educational level (1999); 55% is illiterate or only had a elementary school; 34% only had general education or lower to intermediate vocational training. Research on performances of migrant children in elementary school (ISEO-COS 2001) shows that Cape Verdean children perform worse on final school tests (CITO-score: 66% of the boys and 63% of the girls are below
average; ISEO-COS 2001) and are overrepresented in special schools for children with learning problems. Da Graça describes the relatively high ‘age-arrearage’ of Cape Verdean children in elementary schools. Five% of the children suffer from this arrearage compared to only 1% of the indigenous Dutch children. In secondary school, 19% of the Cape Verdeans drop out, compared to only 7% of the indigenous Dutch students. These arrearages are attributed to the bad education of the parents, language problems also for second generation Cape Verdeans, lack of knowledge about the schooling system in The Netherlands, and lack of insight in the performance of the children; differences in expectations about the educational attitude of the school (Pieterse 2003).

Elleswijk (1997) describes how Cape Verdean parents expect their children to do better than they did (in Cape Verde). However, they are unable to give sufficient support to succeed in the Dutch schooling system and the Dutch educational standards and goals, which are adopted by their children, do not match their own experience and history (migration and working hard). This puts high ambition pressure on Cape Verdean kids, which is hard to meet and the risk of dropping out is realistic. One of the risks is criminal behavior, which is described in the news, but also reported based on the monitors of the Rotterdam Public Health Authority (Pieterse 2003). A lot of young Cape Verdeans are tempted to drug trafficking: “In a weekend they can earn a couple of thousand Euros if they deliver a package, for example to France” (Banning 2003).

4.3 Family-structure and gender

Silva (1997) describes the Cape Verdean family structure as hierarchical and the style of education of the children as austere and based on authority of the parent. This corresponds with the description by Cabral (1980) of the family structure on the Cape Verdean islands. In this paragraph I will give a global and explorative description of family structure, topics in the current debate on gender roles and positions and educational style within the Cape Verdean community in The Netherlands. Although family structure of Cape Verdean migrants in The Netherlands is not merely a reflection of the situation in the archipelago, this may be seen as a point of reference. Cabral describes how marriage and concubinage within nuclear families are a basic unit of social structure in Cape Verdean society, although there is a difference between city life and country life. Families outside
the cities of Cape Verde in the country should be placed in a macro-familial context in which reciprocal obligations and mutual help and support is built and ensured as if it concerns an extended family, while family life in the cities tends to be nuclear. Cabral describes the system of ‘compadrage’ in which parents look for similar families within the village with whom they form a bond to exchange children for baptism. The parents of the connected family are the compadres of your child and should be respected (by the child) as if they are an own mother or father. Within the system of compadrage the interconnected families commit themselves to respect for the other family and assistance in case of illness and decease. Although not embedded in a system like this, these strong feelings of interconnectedness and commitment between families definitely are visible within the Cape Verdean community in The Netherlands. Cape Verdeans have a strong social texture within the community in which it seems that especially the ups and downs of family life are of social concern, by taking care of each other’s children and mutually supporting the continuity of family life, which in many cases is defective and in need of support from a wider circle of people than just the nuclear family. Families mutually take care of each other and upholding a respected position within this network seems to be important. In this study I witnessed several examples: Graça, who doesn’t have much family in the immediate vicinity is helped out by (female) friends when she has problems combining her job with raising her children (alone). Friends are paid-for services, but the economy of it is completely informal. Mr Dos Santos, father of a schizophrenic son, is particularly worried when his son, who sometimes causes nuisance in the neighborhood, starts bothering his uncle, Dos Santos’ brother. This behavior directly affects his father. When the Apoio-project organizes meetings in which information and advice is given about mental health care problems, it is always self-evident that this is a family happening and to have a special room or space where some of the women volunteers can take care of the children.

Gender refers to social meanings attributed to differences between sexes. Durieux (1997) describes the extra burdens of the life of migrant women in general, who more often have to combine earning an income with the care for the family, and who are confronted with worse labor conditions and lower incomes than migrant men. This is an extra burden specifically for Cape Verdean women, taking into account that many of them are single
mothers. Within the Cape Verdean community the position and role of the Cape Verdean man is controversial. He is subject of much debate and complaining, but also of mocking by Cape Verdean women. In a family the father is the authority, and Cabral describes the role of women as one of devotion and servitude and the role of children as one of respect and obedience. This servitude expresses itself in many respects. Women are the central responsible agents who have to take care of raising the children, often next to working outside the house to earn sufficient income for the family. This style of living is not uncommon for Cape Verdeans in The Netherlands. Ana:

I had a cleaning job, which is heavy work, and then bringing and getting the child all the time. I do not agree with that. I work outside the house and then I have to do everything inside as well. Sometimes he took care of the child, but he says he's doing me a favor when taking care. He never did something for us; when I asked something I always got in trouble. I was very depressed and was crying at the doctor's. (...) I came here for my husband, but he didn’t want a wife, but a robot.

Cabral also describes the common practice of Cape Verdean males of having extramarital sexual relations and having children from these relations. This type of male promiscuous behavior is common through all social strata of Cape Verdean society, and these extramarital liaisons sometimes lead to extramarital children. It was, according to Cabral, not unusual for women to be obliged to raise these children as well. In this study the majority of the families consisted of a single mother, with children from different fathers within one nuclear family. Official statistics (COS 2001; 2002) indicate that 27% of the families in the Cape Verdean community is led by one parent (in 94% of these cases, the mother is the head of the family), and in 1996, 55% of the Cape Verdean families consisted of married couples, compared to 85% of Dutch families (Elleswijk 1997). There are high percentages of single parent families and compared to the data of Cabral, who describes the degree of promiscuity that is tolerated and does not affect the bond of marriage, it seems that in The Netherlands marriages break up more often. Several of the informants in this study explicitly see that as a problem. Miguel (his wife left him) talks about it extensively. He admits that the image of men is not very positive, but attributes this to the Cape Verdean male temperament and explains that it is important for women to be tolerant and compassionate, for the sake of preservation of their marriage. The women, he says, too easily rely on the solution of divorce. Migration to The Netherlands gave women a stronger, legally sanctioned, economically independent social position, compared to the situation in Cape Verde. Compared to men, their gains are bigger and this
makes it, according to several informants, easier for women to divorce: there is no exclusive dependence on the income of the man. This is recognized as being an acquisition, but this process of emancipation, however, comes with the costs of a high prevalence of single motherhood. Father Stevens, the pastor of the Roman-Catholic church, points out this reverse side of the process of emancipation of women and also Graça (three children with three fathers) is known with it:

Here in The Netherlands it is different compared to Portugal. Here in The Netherlands there really is an economical background. - that’s for sure. Because, here, women can be independent. They can advocate for themselves. In Portugal you are with a man, you have to take everything from him, because you need his income. (…) But I regret that Cape Verdeans do not talk about that. When I tell this in public then they will say that I do not keep this secret of ours (laughs).

The high divorce rate and the high number of single mothers are also explained as a result of the history of migration and separation due to slavery (Hoorlan 1995; Banning 2003). Male slaves used to be separated from the women, sometimes to work abroad on plantations in Africa; the Portuguese forced many men to work on the plantations in Angola or St. Tomé and Principe. Even after the abolishment of slavery, the only way to leave the country or earn sufficient money was to go out as a sailor and stay away for a long time, or do seasonal work abroad. The explanation of the current relative instability of nuclear families is that the separation of men and women and breaking of families - unwillingly - is part of the Cape Veredian way of live. Women have learned to take care of themselves and their direct family members and with the help of the social network and sometimes dependent on remittances from a husband abroad or in expectation that one day she will be able to leave as well. Typical to the migratory process of Cape Verdeans is the transnational dispersion of families as is also reported by Meintel (1984). In the first place the men migrated, leaving women and children behind. Sometimes the women followed them later or married abroad, leaving the children to the custody of family members: grandmother or aunts. Families are dispersed as in the case of one of the respondents (49 years old) whose brothers and sisters live in France, Portugal, Senegal and Cape Verde, and who thinks of himself as being Brazilian. Or in the case of Graça, who was born on Cape Verde, has a Portuguese nationality, a father in Portugal, a mother and a sister in northern Germany and a brother in the south of Germany. Sometimes the family that stayed in Cape Verde was forgotten. When talking with Cape Verdeans many of this type of stories can be heard:
He went to another country to work and to help us, but then he forgot us. He went to Portugal, met another Cape Verdian woman there and married her. (…) He left my mother with four children and did not help her (Ana).

When I was 16 months, my mother left for Italy. Four children stayed behind in Cape Verde and were brought up by my grandmother from my mother’s side. When the oldest child was ten years old she was brought to The Netherlands. When I came to The Netherlands I was twenty years old. I had seen my mother only once in the period between 16 months and 20 years of age (Paula).

Fathers are absent and when present, the father is a stepfather to at least some of the children. Promiscuity of Cape Verdian men as described by Cabral is an issue in The Netherlands as well. Lindsay Silva (2003), in her research on sexually transmissible diseases, asked Cape Verdens about the frequency of variable sexual contacts: 40% of the adult Cape Verdian males reports not having a steady partner, having an average of 11.6 different contacts over the last five years and 60% of the men reports having had sexual intercourse when visiting Cape Verde. This deviates from the reports of Cape Verdian females and Dutch males as is seen in table 4.4

Table 4.4: Frequency of variable sexual contacts of Cape Verdian men, compared to Cape Verdian females and Dutch males

<table>
<thead>
<tr>
<th></th>
<th>Cape Verdian male</th>
<th>Dutch male</th>
<th>Cape Verdian female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage not having a steady partner</td>
<td>40</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Number of changeable contacts over last 5 years</td>
<td>11.6</td>
<td>2</td>
<td>1.8</td>
</tr>
<tr>
<td>Percentage having sexual contact visiting Cape Verde</td>
<td>60</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

Source: Silva 2003

The machismo of Cape Verdian men almost gets proverbial dimensions, as Graça makes clear:

What I see here is that women really are victims of the situation. I’ll give you an example: here Cape Verdian men have five or six women. They do not have a house, but …….. (makes a circling movement with her arms) …..round: today I sleep here, tomorrow there, I eat there. They have the life of a playboy. They really have a good life. A friend of mine says: ‘Here Cape Verdian women grow old early.’ And those men, when they are fifty, they look like they are thirty-five, because they do sports in the gym all day long… no responsibility…

Several of the female informants blame Cape Verdian men for their urge for total control. This is not always done by words, but also by physical and sexual abuse and maltreatment, although no figures are available that might give an indication on the relative prevalence of abuse by males. The Belgian anthropologist Massart (2000) confirms the reality of the dominance of Cape Verdian men over women. He does not want to look at
it as a simple contrast, and places the gendered language of Cape Verdean young men in Praia in the context of the political changes (transition to plural democracy) in the beginning of the 90s. Massart shows how Cape Verdean men assert and reaffirm their masculinity in situations, which go further than the gender relations to which they refer. They discuss and present the control they have in private situations and use these presentations of control metonymical to position themselves vis-à-vis the ‘doutores’, or the ones in power. Massart regauges macho language and macho behavior and argues that this is not just directed at confirming power over women (which is real), but should also be seen as a ‘genre’ to take a position in the political context.

It is recognized by women (conference on sexuality, 25 may 2003) that the phenomenon of being raised by a stepfather, a fact that almost every family knows, bears an extra risk of sexual abuse of children within the family. Sexual abuse is a taboo subject and is difficult to talk about, because of shame and feelings of guilt, and out of fear for the well-being of the children and dependency on the man. This sometimes makes it hard to get help from friends or family. You can ask for help, or sometimes somebody notices you are in trouble. But then it is hard to find a way out, without dishonoring the trust and help that is given. Several of the women who participated in this study tell that at a certain moment their husband did not come home and stayed away for a couple of days to come home again after having spent large amounts of money. According to one of the informants, they want the pleasures without the problems: “as soon as there is a child, they quit.” On the other hand, women report that they never learned to say: “no.” They are always ready to serve everyone, are emotionally dependent and are afraid to speak out: women are part of the problem. The one-sided focus on male machismo is an ethnocentric view on the problem as Agostinho Santos (1997) seems to object: “Are Cape Verdean women who married a Dutch man better off? (…) I cannot say that my mother got happy from her marriage with a Dutch man.” With these remarks Santos brings the issue back

32 Doutor is a word used in Creole to refer to being educated. According to Massart everybody on a B.A. level is formally called a doutor. It always refers to power relations as well and to respect for the position of the other, as I experienced when I was addressed in my research as ‘doutor’ by Cape Verdeans (women). ‘Doutores’ is also used as a mocking term, to ridicule the ones in power and to distinguish oneself from them.
33 Massart defines a ‘genre’ as a conventionalized discourse type, and cites Hanks (1996:246): “Analyzed as modes of practices, [genres] … are among the best examples of habitus as a set of enduring dispositions to perceive the world and act upon it in certain ways.… They articulate with social fields through indexical centering, orientation to reception and dominant structures, and different kinds of finalization. (Massart 2000:147)
inside the arena of gender relations and his remarks make clear that the (over)exposure of masculinity is partly enacted (as a habitus) with different objectives, as also Massart (2000) argues.

Although fathers represent authority within the family, mothers are pivotal in the education of children and grandmothers and aunts (mother’s side) are often referred to as co-responsible. Traditionally, parental authority is a moral category that cannot be questioned by children. For children it is furthermore a social obligation to support their mother. If that is not possible or not likely, as seemed to happen in the situation of Sofia, this can cause anxiety and insecurity about the future. Children are supposed to learn the kinship-terminology and to respect the hierarchy it represents. Parental authority, however, is apparently wearing away, due to several causes: (1) the high number of broken families. Mother has to work during day and take care of the children as well. The necessary care cannot be given, or has to be delegated to a child-care facility or family member; (2) the cultural controversies between parents who were raised in Cape Verde and their children, brought up in a modern western city, streetwise, with extensive schooling and an excellent control over the Dutch language.

Single motherhood is a risk factor for financial and educational problems. The phenomenon of ‘key children’ is often described as part of the Cape Verdean way of living: young children at elementary school level have their own key with which they get access to the parental house when school is finished. They are raised by the oldest sibling, or have to take care of themselves. Since there is no supervising parent, they are at risk of getting into problems. Single motherhood also interferes with the ways women are able to solve their personal problems. Because there is no parental supervision and only limited educational back-up for the children, getting into trouble means there is a danger to loose your child. This is reported by several mothers who participated in the research: they lost their child to the child protection agency and it is a reason to avoid contact with health care providers.
4.4 Intergenerational relations

In the Cape Verdean arena, Silva discerns the controversy between the second generation and the first generation migrants. The first generation cultivates the often described Cape Verdean ‘maneira de ser’: decency, docility, adaptability, restraint, self-sufficiency and thrift\(^\text{34}\), originating from a history of poverty and racism, while the young people are seen as lacking discipline and being tempted by the more exuberant life-style of modern times and of The Netherlands (Strooy 1996, Elleswijk 1997). The fist generation blames the young Cape Verdeans for their normless behavior, that is seen in line with the selfishness of Dutch society and contrasting respect and thrift of the Cape Verdean community as it should be. A mother who raised her children as a single parent complains that the children do not take care of her when she is ill. She tells that the children do not respect her, she is afraid of physical abuse by her son and she fears the moment that she will be left alone. The children blame their parents for being ‘old-fashioned.’ Mr Dos Santos: “My son told me: We are not in the mountains of Cape Verde, you cannot correct me anymore.” The second generation, however, suffers from this old ‘maneira de ser’ and their feelings of being thrown to and fro:

Dina: “It has to do with my origin in two cultures. I’m born in The Netherlands, but I have two Cape Verdean parents. And that is a little bit difficult. … I am the oldest of the children and in Cape Verdean culture as the oldest child you have to be responsible and caring. You are the role-model and you have to be always ready to serve the family. Sometimes that is a little bit annoying, because you cannot fall back on yourself. You get a responsible role from your parents, because they were raised that way. And most of the kids do not want that. That can cause troubles. In Dutch culture it is important to be yourself and explore things. That can lead to collisions.”

Suzana reports that her mother supposed that a spirit was bothering her and that it might be good to go somewhere to get rid of it. She explains: “I made it clear to her that I do not need those kind of things and do not believe in it. … I leave these things behind. If someone tries to hurt me, that could have happened in any way; and not necessarily by a spirit.”

According to Silva the controversy with the second generation however is not about their embrace of western culture and the cultural cleft between them and their parents, but, on a social level, about their adoption and apparently usurpation of an own ethnic identity, which is Cape Verdean-African and distinct from the one cultivated by their parents. They compete for (political) power, in a way that is productive in the Dutch context, but that represents (and is also linked to) the political debate in Cape Verde. This, although in less

---

\(^{34}\) In this context Silva (1997:23) cites the Norwegian anthropologist Eriksen: “This kind of self-contempt is characteristic of powerless groups in poly-ethnic contexts.” This self-contempt blocks intercultural communication and change.
explicit terms, is also described by Da Graça (1999), who depicts the emergence of the second generation as a factor of political influence, contrasting and opposing the old (first generation) community leaders whose position was mainly derived from power relations and positions in the homeland and who oriented on Cape Verde. The old leaders were engaged in furious political polarization, while the new generation is living in the present Dutch society, without bothering with the old politics so much. Furthermore, Da Graça describes the emergence of a stratum of young professionals and executives of Cape Verdean descent which is gaining influence and authority. Silva’s and Da Graça’s analyses are interesting because they give a view that values the agency and the dynamics of the community, in a way that is not seen in the work of the other ethnographers of Cape Verdeans in The Netherlands and probably is hard to find for an ‘outsider.’

It is remarkable to see how the second generation distances itself from the first (parental) generation by adopting values of modern city life, and how they couple this with an explicit identification with an African identity, in which the motherland is the main point of reference. Some of the informants are explicit in their opinion that they are born in The Netherlands and brought up here, that they adapted and found their way, but never will be Dutch. The adoption of a distinct self-formulated Cape Verdean identity, distinct from the old ‘maneira de ser,’ perfectly fits into the modern Dutch society where self-realization, performative qualities and coming out are productive and valued. This is publicly praised, for example in a recent article in a national newspaper on Suzana Lubrano, a second generation Dutch-Cape Verdean singer, who is praised for her international success (not in The Netherlands) as part of a self-made and self-run Rotterdam-based Cape Verdean music scene in which elements of the old mornas and modern electronic Rhythm & Blues are combined (Carvalho 2003). Furthermore, spreading the message of representing a coherent culture is appealing for politicians who want addressable and predictable citizens.

4.5 Religion and spirituality

Cabral (1980:102) describes how many Cape Verdeans live in the light of an ongoing struggle between good and bad on a spiritual and supernatural level, e.g. between the ‘guardian angel’ and the devil, in a universe where vagabond spirits seek weakness and
try to bring evil. This seems to be a very central theme in the experience and spiritual life of many Cape Verdeans. When in need of relief from any misfortune, religious or spiritual organizations are of major influence in the Cape Verdean community. They organize social and cultural activities and make it possible to get hold of life in a psychological and moral way and they organize individual and social services (Da Graça 1999:69). Not religion per se, but any solution that appeals to the demands of this supernatural and mystical order. This could mean going to an indigenous healer (curandeiro), going to the Roman-catholic Church or to a spiritual centre. In this paragraph I will describe the three major spiritual and religious communities or denominations (Roman-Catholic church, ‘Igreja Universal do Reino de Deus,’ and ‘Racionalismo Cristão’), which are followed by Cape Verdeans in The Netherlands. In this chapter the description will be general and partly historical, later I will go into corresponding explanatory models and healing practices.

4.5.1 Roman-Catholic church
The majority of Cape Verdeans (90%; Cabral 1979) is Roman-Catholic; this is the case in the Cape Verdean islands as well as in The Netherlands (60-80% according to the priest of the Cape Verdean parish in Rotterdam). The history of Roman-Catholicism in Cape Verde is relevant for the understanding of religious beliefs and practices of beliefs of Cape Verdeans in The Netherlands. Many historians and ethnographers have described the strong interconnection of the Roman-Catholic institute with the Portuguese colonizing power on the Cape Verdean Islands. Clergymen followed the colonizers only shortly after the occupation of the islands: the first parish was established in 1462 and the first Bishop arrived only 70 years later, in 1533. In 1570 the first seminary was established for the education of local priests, the ‘padri di terra.’ All this happened within a century and with a total population at the end of that century on the islands of not more than 2000 inhabitants. The Roman-catholic church served and in many ways legitimized the slave trade. Cape Verde was a trade post where the slaves were brought to be Christianized (baptized and given Christian names).

This does not mean that the relation between the colonizing authority and the church always has been good and that they should be seen in line. In contrary, Cabral (1980) describes the Cape Verdean church as ‘neo-Catholic’: more tolerant than the
church of the Portuguese metropolis and with a popular religious practice that was mixed with laic-led services and traditional African beliefs. It was considered normal to combine the visit of the church and ecclesiastic celebrations, with more traditional practices, like visiting the *curandeiro* (indigenous healer), manism and practicing spiritism. The local practices of popular Roman-catholicism (e.g. of the Rabelados) and spiritism were politicized, marginalized as subversive, forbidden and oppressed by the colonizing authority.

Cape Verdeans in The Netherlands are described as mainly Roman-Catholic. A visit to one of the masses in the parish of ‘Nossa Senhora da Paz’ shows how piously they practice their religion. The services are attended by hundreds of Cape Verdeans and accompanied by live music and a choir singing powerful spiritual songs in Crioulo. Originally, the church was frequented by Portuguese immigrants, but when the Cape Verdeans got a numerical majority, they retreated. This discordance between Portuguese and Cape Verdeans is also described by Halter (1993) in the history of immigration to the United States. Father Stevens:

> Basically we are a parish for Portuguese speaking people. But…….initially it was a parish for the Portuguese, and then the first Cape Verdeans came. Eventually their numbers increased and exceeded the Portuguese. Well they didn’t appreciate that. The Portuguese had a really dominant attitude. Some of them still come, but most of them go to the Spanish parish, rather than coming here. It is also because we also speak and sing Crioulo here in our church. When a Cape Verdean preaches, it is most of the times in Crioulo, and I encourage that, because 95-98% is Cape Verdoan.

Next to the official Roman-catholic liturgy, there existed an extensive parallel popular liturgy conducted by laymen and obviously mixed with more traditional African, particularly manist rituals. Examples are laymen-baptizing, laymen-masses for devotion to a saint or salvation for the deaths, several funeral rites and the ‘guarda cabeça,’ or the seventh day watch over a newborn child. The extensive funeral rites are described by Silva (1997) as still relevant in the Cape Verdean community in The Netherlands.

The religious and pastoral praxis of the clergymen did not respect any celibate rule: it was normal for the priests to have wives and children and churches were, except places of worship, described as trading posts. The relative wealth of the church and the clergymen and their influence on the local community made them a source of political influence as well, and this led to frequent conflicts between the locally trained priests, the central Roman-Catholic authority and the local political authorities. In the nineteenth century the diocese was transferred to São Nicolão and the authorities tried to marginalize the influence of the local church. This praxis continued until the beginning of the twentieth century, when, during the Salazar dictatorship in Portugal, new European clergymen were brought to the islands that imposed strict rules and regulations.

The Rabelados are a group of Cape Verdeans on Santiago that rebelled against the restoration of central authority of the Roman-catholic church. Their religious protest was interpreted as resistance against the colonizing authority and they were heavily oppressed by the Portuguese secret service (PIDE), tortured and sent into exile as is filmed in the documentary ‘Rabelados’ (Truscheit-Rocha Fernandes, 2000). There still is a small Rabelado community in Santiago, living in isolation and known for not acknowledging central state authority, not revealing family names and refusing to live in stone houses.
Regular visitors of the parish are described as coming from Santiago, contrasting Cape Verdeans from the Barlavento Islands (São Vincente, Santo Antão), who practice Racionalismo Cristão. Many of them nonetheless are Roman-Catholic, but not regular visitors of the church. Being a believer and a follower of Racionalismo Cristão can perfectly go together as also the priest of ‘Nossa Senhora de Paz’ thinks.

4.5.2 Igreja Universal do Reino de Deus

The Igreja Universal do Reino de Deus (Universal Church of the Kingdom of God) is a charismatic Pentecostal church, founded in Brazil in 1977 by Bishop Edir Macedo, a former civil servant. Pentecostalism came to Brazil in 1911 (Seeber-Tegethoff 1998). Since the 1960s these churches have been developing in a charismatic direction. ‘Charismatic’ in this context refers to the orientation of these churches on the (supernatural) ‘charismata’ or endowments of the Holy Spirit to serve the extension of the Kingdom of God. Charismatic movements can be found in many religions. They are based on the conviction that it is possible to have a direct personal experience of His existence and to know Him through the endowments of the Holy Spirit. Examples of these charismata are ‘speaking in tongues’ (Pentecostalism); appearances of mother Mary and ‘bleeding statues’ (Roman-Catholicism); receiving prophecies from God, and healing and exorcism practices (Protestantism, Pentecostalism, Sufism and Roman-Catholicism). But also the experience of suffering, hardship, states of trance and living as a hermit are seen as ways to experience (the longing for) God (Beijers 2004). Bishop Souza of the Igreja Universal in The Hague explains: “We believe in miracles, we believe that God can make the impossible come true.”

The Igreja Universal was founded in 1977, and has since then been developing rapidly and on an international scale. The church is controversial. The priest of the

37 Random House Dictionary: “speaking in tongues: a prayer characterized chiefly by incomprehensible speech, originating in primitive Christianity and now practiced by Pentecostal groups in ecstatic forms of worship. Also called gift of tongues, glossolalia.”

38 The Igreja Universal is described as a church for Brazilians of low socio-economic classes and a church that does not serve a community of believers but has a ‘clientele.’ It is actively marketed and advertised, with proven effectiveness and sold as a product with a price. In 1995 this church counted in Brazil at least 6 million members and at the end of the nineties it is portrayed as an empire with great economical power (bank, construction company, travel agency), an extensive publicity network (newspapers, magazines, 30 radio stations and one of the largest tv-networks), politically active (elected deputies on a federal and state-level in Brazil and participation in a political party) and as striving for hegemony in the evangelical domain,
Roman-Catholic church depicts the church in a condescending tone as the ‘miracle-church’ and the president of a Centro Redentor refers to it as a ‘sect’ that capitalizes on normal human talents (clairvoyance) and exploits people. In his turn, the bishop of the Igreja Universal in The Hague refers to Racionalismo Cristão as witchcraft, occultism and work of the demon. The church is not only controversial, but there is also a lively practice of intercommunal slashing. Seeber-Tegethoff (1998) refers to the presumed wealth of the church, and the international criminal and public investigations against its founder, Bishop Macedo. The success of the church is attributed by this and other authors (e.g. Freston 1998; Oro and Semán 2001:184) to active marketing strategies. It embraces the resources and ideals of neo-liberal modernity in its evangelical action. However, at the same time taking into account the human anxieties and frustrations caused by the destructuring through this neo-liberal market ideology, and the longing for traditional securities like paternalism and a stark hierarchy.

But not only the church is ‘sold’ this way, also the mercy and the glory of God is obtained in a process of transactions. The reasoning behind this, is the so-called ‘prosperity gospel’ which is adopted by the Igreja Universal. The mission statement of prosperity theology is: ‘do ut des’ (Freston 1998). The ‘prosperity gospel’ defines ‘giving’ as an affirmation of subjection to God, and as part of a process of liberation which allows one to receive blessings (Oro & Semán 2001:184). Man is created according to God’s image and is predestined by Him to lead a happy and rich life. This happiness is not something that is projected on the hereafter like in Catholicism, but an actual and obtainable truth in the current reality, something that you are entitled to. It is possible to obtain this life in a reciprocal relation of ‘giving and receiving’ with the Lord.

Money, which is human, should be our contribution, while the spiritual power and the miracles, which are divine, are Gods contribution. (...) It is obvious that the ones, who regularly pay a tithe, have the right to demand from God the fulfillment of His word in their life. And the Lord is obliged to do so (Macedo in Seeber-Tegethoff 1998:92/93).

which leads to fierce disputes between different churchleaders. The Igreja Universal has since 1977 expanded transnationally to 65 countries on all continents (Freston, 1998, 2001; Oro & Semán, 2001). Currently the church is in charge of one of the radio stations of Cape Verde as well.

39 ‘Do ut des’ is a Latin expression meaning: ‘I give that you may give’, based on the principle of reciprocity.

40 A tithe is a tenth of one’s personal income.
Bishop Souza of the Igreja Universal in the Hague explains that ‘giving’ is not only about giving money, but also about giving your life:

(…) If we read the Bible, we shall see that the relation between mankind and God is determined by ‘giving and receiving.’ (…) The Lord Jesus once said: ‘I told you, if you believe, then you will see the glory of God.’ So you have to give in the first place, believe in God, and then you will see His glory. (…) So we say: give your life to Jesus and convert. You have to fight for a change of your style of living, in order to bring it in accordance with the things Lord Jesus Christ taught us. You shall set aside your opinion about life and everything you thought was good, and you will have to accept the laws of God. (…) you will come to a personal compromise with God, to live from now on according to Christian norms and values and according to the bible, (…) to give God your life.

In scientific studies of Pentecostal churches, this aspect of reciprocity and the here-and-now character of salvation are stressed, next to the meaning and relevance of giving in West African cultures and the emphasis on transformation by laying down one’s former, cultural, barbaric or demonic identity.

Freston (2001) describes the church as a Third World Church which, compared to other similar Pentecostal churches, loses cultural or ethnic specificity and successfully roots in the rich (western) world, by addressing ethnic minority groups and establishing a base among them. This seems to be true in The Netherlands as well. The church (still) has a limited expansion, but it is clear that the parish in Rotterdam is a Cape Verdean church: services are in Portuguese and at least 80% (estimated) of the congregation is Cape Verdean. The church in The Hague, however, where the bishop resides is a Caribbean church, mainly for Dutch Caribbean migrants and services are in Dutch. Language, however, never seems to be an obstacle for attending any of these churches because the
lengthy services are simultaneously translated by ‘obreiros’ (helpers) for speakers of other languages. I witnessed simultaneous translations in Dutch, French, Portuguese and Crioulo. Furthermore, in a service in The Hague, during a phase of intensive and forceful praying, the pastor (Bishop Souza) changed his language in an almost performative way. In the middle of a prayer he suddenly starts to pray in English and then again in Portuguese or in French. This while the majority of the parishioners only speak Dutch or Papiamento. This demonstrates the ‘speaking in tongues’ in a performative way, but also contributes to the image of universality and transnationality of this church as is also argued in anthropological studies on Pentecostalism (Van Dijk 1997; Meyer 1998). It is a remarkable paradox of ethnic specificity of the different parishes and universality of the message.

4.5.3 Racionalismo Cristão

Racionalismo Cristão or Christian Rationalism is presented by its followers as a philosophy or a doctrine and explicitly (in capitals) NOT a religion (Fidalgo 2003). In Dutch studies on Cape Verdean migrants (e.g. Strooy 1996) this doctrine is depicted as ‘spiritist,’ ‘Brazilian in origin’ and ‘mixed with indigenous African beliefs.’ The African link, however, is as questionable as the Brazilian origin of the doctrine. As seen before, African influences are more present on the Sotavento islands, while most of the followers are to be found on the Barlavento islands (São Vincente is the Cape Verdean cradle of Racionalismo Cristão). Tracing back the origins of the doctrine, leads us to nineteenth century Europe and learns that Christian Rationalism should be understood in the tradition of reactions to the 18th century European Enlightenment and an attempt to harmonize and overarch the laws of the metaphysical and physical world (science). Spiritualism (communicating with the world of spirits, the phenomenon of dancing tables) and Theosophy should be placed in this tradition as well. For example, Theosophy in its current organized form was founded in New York in 1875 by the Russian-born aristocrat Mrs H.P. Blavatsky, a self-declared reincarnation of a Buddha. Racionalismo Cristão dates back to 1910 and is founded by Luiz José de Mattos and Luiz Alves Thomaz in Brazil and present in Cape Verde since 1911 (São Vincente). During colonial rule the

41 Papiamento is the creole spoken on the Dutch-Antilles.
practice was forbidden and its followers were prosecuted by PIDE, the Portuguese secret service. Nowadays there are 21 Christian Rationalist centers in Cape Verde.

Not much has been written about this doctrine by social scientists, which is why I will elaborate the principles of this doctrine a little further. The principles of Racionalismo Cristão and Theosophy are comparable and both are 'supra-religious.' They claim to surpass the religions of the world or ‘to unite all religions, sects and people in one common ethical system, based on eternal truths (Ryan 1989:4).’ This line of thinking emerged in a period in history that was marked by the interest for spiritualism in Europe and The United States, and the interest for sciences and religions of the Far East (India), as a reaction on the emphasis on ‘reason’ during the period of Enlightenment in the 18th and 19th century. Racionalismo Cristão is based on images of a cosmological structure, and process and a moral (cf. Ryan 1989);

(1) There is a universal, ever present, eternal and unchangeable source of everything. It is not a God, but, as the Christian Rationalists call it, the creating force of the universe or ‘Grande Foco,’ the great focus or middle point. Christian Rationalists consider Jesus Christ as just a man, though, and one of the greatest men that ever existed on Earth, as Fidalgo (2003) explains. The adjective ‘Christian’ does not refer to the religious faith, but to the adherence to Christian morals. The Universe is made of two elements: force and matter. Force is Life, Intelligence, the principle that creates and activates everything. Matter, on the other hand, is the passive, pliable element. The Universe is divided in two: the material and the non-material universe. The former is the one astronomers study everyday and the latter is the one our eyes cannot see: the Spiritual Universe. The Spiritual Universe is full of spiritual planes (spiritual worlds) more or less advanced in accordance with the evolution of the spirits that inhabit them. Human beings are particles of the universal force that descended into the material world to gain experiences and to find the way back to the source;

(2) The universe is propelled by eternal and never ending cyclic movements of dying and rebirth. This not only concerns humans, it concerns everything, planets, plants, animals, etc. It is described as a pilgrimage: the particle of force that belongs to the

---

42 Exception is João Vasconcelos of the institute of Social Sciences of the University of Lisbon, who conducted anthropological research on spiritism on the island of São Vincente and kindly explained to me the relation between Christian Rationalism and Kardecism.
universal intelligence (God) starts its evolutionary trajectory in the atom, and throughout millions of years goes through different stages of evolution. It will eventually take over a human body and then becomes a Spirit (Soul);

(3) Every spirit in the universe (they are fundamentally equal) is obliged to follow a cycle of (evolutionary) rebirths in which higher forms of knowledge and experience are achieved. An example is the evolution of the spirit through repetitive incarnations in a human body. ‘According to Spiritism, everything and every being in Creation is in continuous evolution. All spirits are created simple and ignorant and they evolve through innumerable reincarnations until they reach perfection, which is reaching the full potential of wisdom and goodness a creature can afford to reach’ (Fidalgo 2003). This evolutionary trajectory is unidirectional and its progress is based on accountability and a balancing principle: leading an immoral life will lead to standstill and ordeals in future reincarnations and will hold up or stop evolution. It will make a next reincarnation harder, but one cannot fall back to a lower evolutionary stage. The only way to find the right path is to lead an unselfish life of compassion, charity and brotherhood, mastered by ‘discipline.’ In a good life, family values are cherished. These morals are the motor behind evolution. On the basis of these principles one can explain the occurrence of misfortune, suffering here and now can be attributed to a loss of discipline in the present life or faults in the past (former incarnations).

The bridge between 19th century European and American interest in spiritualism and spiritism and the development of Racionalismo Cristão in Brazil is the French spiritist Allan Kardec. Kardec and Blavatsky are contemporaries. Kardec was a spiritist, but was rejected by Blavatsky because of his belief in God (De Tollenaere 1996). This reproach is shared by the Christian Rationalists:

Allan Kardec was a great spirit but in the end of his studies, he did not accomplish his mission. (…) he made the mistake of mixing the Bible with spiritism, thus creating an evangelical, reincarnationist doctrine. Christian Rationalism on the other hand, followed the path of scientific spiritualism, rejecting the Bible (Fidalgo 2003).

---

43 Christian Rationalists make a tripartite division of the world in a ‘mineral kingdom,’ the ‘plant kingdom,’ and the ‘animal kingdom’ of which the human being is the highest form of evolution where the particle of force evolves into a spirit.
Kardecism develops in the last decades of the nineteenth century in southern Europe and is brought to Brazil by Portuguese emigrants. The doctrine gets very influential there (De Tollenaere 1996)\textsuperscript{44}. Kardecism also rooted in the Caribbean as a relevant and popular spiritist cult (e.g. in Puerto Rico: Espiritismo or ‘Mesa Blanca’) from where it spread to migrant communities in other parts of the world. Harwood (1977) describes how Mesa Blanca in the Puerto Rican community in New York City is complementary to regular psychiatric treatment. In many ways this is comparable to the meaning Racionalismo Cristão has to Cape Verdeans in The Netherlands. Christian Rationalism developed next to Kardecism in Brazil and these doctrines probably have a shared origin. Both Kardecists and Christian Rationalists are explicit in their statements (Fernando Fidalgo, personal communication) that they are not related. Fidalgo, however, adds to that that there are certain aspects both doctrines share, like the belief in reincarnation and evolution.

The differences are discernible in the populations of followers and the everyday character or practice of these three successive doctrines: Theosophy was a doctrine followed by the international elite and still is associated with intellectuals and higher social class (De Tollenaere 1998). It is organized in ‘lodges’ and focuses on study. The Allan Kardec Association in The Netherlands (as witnessed in this research\textsuperscript{45}) has a very clear middle-class character with (mainly Brazilian) well-to-do citizens, interested in the religious and scientific implications of the doctrine and the correspondence of Spiritism and medicine. The debate in a meeting of the Dutch study-group partly had a practical character by focusing on ways of healing and the exchange of experiences on healing. Christian Rationalism is practiced by ‘ordinary people.’ Da Graça (1996) describes the followers of Christian Rationalism in Brazil as ‘petty-bourgeois and semi-intellectuals’ (1996:38). Vasconcelos (2002) describes how Christian Rationalism in São Vicente has several thousand followers, mainly from the poorer classes and lower middle class. In Rotterdam the followers certainly do not represent the upper social layers of the community. The population of followers seems to be a cross-cut of the Cape Verdean community: people who apparently are most interested in the practice of the weekly

\textsuperscript{44} Later Kardecism came back to Europe with Brazilian migrants. In The Netherlands they formed several study groups (with Brazilians) that practice (prayer) and study this doctrine. It is possible to attend meetings in and around Amsterdam and in the east of the country (Overijssel).

\textsuperscript{45} Allan Kardec Association: lecture of Marlene Nobre, Brazilian gynecologist, on: ‘The medical-spiritist paradigm, where medicine and spiritism touch’; Hoorn, 12 October 2002.
services and the support they experience there. It is more seen as a practice that brings salvation, as a place for reflection and a place that empowers in order to be able to survive everyday hardships. Half of the sample of informants with first hand experiences with psychosocial distress told me they were a regular visitor of the Centro Redentor. But also the non-practicing Cape Verdeans admitted that spiritual influences might be involved in experiences of distress. This makes clear, as is also described by Harwood (1977), that the basis for the relevance of spirits as an explaining factor is broader than only Racionalismo Cristão and its followers.

Figure 4.4: Centro Redentor, Lombardkade in Rotterdam

In The Netherlands the first ‘Centro Redentor’ (centre that brings salvation) where this doctrine is practiced, opened in 1981. Currently there are 4 centers: two in Rotterdam, one in The Hague and one in Amsterdam. Every centre has a president and a group of dedicated volunteers (‘militantes’) and mediums, who come together every evening, on weekdays.

Three times a week people gather in public sessions and twice a week in closed sessions. In the oldest centre in Rotterdam (Lombardkade) I estimated the number of visitors of the public sessions between 50 and 160 people. For the two centers in Rotterdam together, Da
Graça (1999) estimates the number of participants on 250 per session. In Amsterdam, the community of Cape Verdeans is limited in number and only a small group of 15 to 25 people frequent the meetings, mainly from Amsterdam and Zaandam (a city close to Amsterdam). Fidalgo (2003) writes in the discussion forum of the ‘Gazeta do Racionalismo Cristão’:


It deals with ontological questions and it provides answers. Geertz (1973) describes religion as a cultural pattern, a model of reality, but also a model for reality. Racionalismo Cristão orders the world and explains the things that happen, prescribes and imposes a (right) way of living and maintains a healing practice in which it is possible to deal with specific problems. These elements fit into Geertz’s definition of religion as a cultural system as described before, and although Christian Rationalism is explicitly defined by its followers as NOT being a religion, it definitely has similar cultural features.

4.6 Silence and self-reliance

In the public discourse in The Netherlands the Cape Verden community is described as a self-reliant community of *silent migrants,* who took care of themselves by migrating from a country plagued by poverty. When they are in the news it seems to be almost accidentally and the community is depicted in an almost cuddling style. When a little Cape Verden boy is killed for throwing snowballs (Banning 2003), one of the national newspapers wrote:

46 The data on Racionalismo Cristão are mainly based on the meetings in the Centro Redentor in Amsterdam and conversations with the president of this centre.

47 Sedar is a Cape Verden adolescent who was playing with friends in the snow in January 2003. They threw snowballs and the boy got hit by a gunshot and died, apparently because someone, a passer-by, got annoyed or was hit by a snowball. The criminal escapes. The incident gets a lot of public attention and people in The Netherlands are shocked and look at it as an example of the hardening of society and the ruthlessness of criminals.
The Cape Verdeans came by themselves; they were not called for, like the Turkish and Moroccan migrant workers. They are called ‘silent migrants.’ (…) They love soccer and carnival. (…) They solve their own problems and only address the authorities if there is no other possibility. It is also because for a long time they didn’t know where to go. Especially the first generation came to work. They didn’t learn the language, (…) and still are very focused on themselves and each other. (…) they are not integrated very well.

A scan of the ‘Rotterdams Dagblad’, the local newspaper in Rotterdam, since 1996 shows limited news coverage of the Cape Verdean community. It is an almost ritual annual cadence of reports of Cape Verdean festivities: coverage of the Cape Verdean contributions to summer carnival, articles on Cape Verdean music, and the annual São João celebration. Only once in these eight years the newspaper reported about the social situation of the Cape Verdeans and the problems with which they have to deal (Rotterdams Dagblad 1996 a-b). Cape Verdeans themselves have a more nuanced idea about their silence. Many of them do not see themselves as silent and think their interests are not well looked after. Several factors contribute to this opinion:

(1) The Cape Verdean ‘maneira de ser,’ or way of being, which is often associated with modesty, invisibility, taciturnity, acceptance and retreat. In this research, many of the conversations with first generation Cape Verdean immigrants started with excuses on the part of my interlocutors for their lack of control of the Dutch language and an invitation to postpone the conversation, so they could ask a family member to interpret. Others asked me to write my questions down on paper and send these to them, so they could give me better answers. Every time I insisted to continue and noticed that the invitation to postpone the meeting was a way for the informants to excuse themselves for their presumed lack of knowledge of language. Another reason for this modesty can be illiteracy of the informant. The social worker of the Apoio-project explains that illiterate Cape Verdeans are very reluctant to expose themselves within the Dutch community. A conversation with me would possibly reveal these limitations and background. Most of the time, in spite of the modesty of the informants, the conversations were natural and informative, although sometimes it was not easy to understand the pronunciation of Dutch words with a Portuguese accent. In case of problems it was possible to resort to a Portuguese dictionary. Miguel blames the Cape Verdeans because they are not assertive enough, compared to other migrant populations: “Turkish and Moroccan people are more ‘enterprising’; they try to find things out by themselves. (…) They do not speak the
language very well either, but they go to a social worker when they are in need of a rent-supplement, and they succeed. Cape Verdeans take such a step only if they have heard from ten people that it is possible to do so.”

(2) Discriminatory treatment by the dominant culture: some of the informants are very explicit about the fact that they think they are not ‘silent,’ but that the people who deal with them do not know much about them: they are not seen or recognized. It is also the dominant culture who is to blame, because it uses double standards and discriminates against migrants. If a migrant is not assertive, he is blamed for being inactive or too passive, but if he is too active, than he can expect to be reprimanded for being too bold. Miguel asserts that in labor situations the employer tries to use the migrants as a scapegoat, making use of their limited knowledge of the Dutch language, their lack of assertiveness and vulnerability as a migrant. He admits he is afraid of society and of getting involved in discussions with a doctor, the health care provider or the social security agency: “Most of the time they want the foreigner to perform better and to adjust to Dutch society. But I ask on the other side: are the Dutch people willing to work with us?” The depiction of Cape Verdeans as ‘silent migrants’ apparently also means that they should not complain about any adversity. There are not many informants, however, who are explicit in labeling this as discrimination. Most of them attribute differences to bad luck or lack of competence in getting what they wanted. Meintel (1983) makes clear that Cape Verdean immigrants in the United States are not ‘seen’ because they are not ‘imported’ immigrant workers and are no separate category in the immigration policy. They also develop only limited political relevance and influence. This apparently is also the case in Rotterdam: in the local elections of 1998 only 42.7% of the inhabitants of Delfshaven voted, the lowest number of Rotterdam (COS 2001; 2002). The funding policy of the municipality of Rotterdam concerning Cape Verdean interests and advocacy, initially is rather arbitrary and splintered and only since recent years (1995) this policy is gaining comprehensiveness. Now Cape Verdeans are better and more frequently represented in the public and scientific discourse on migration and well-being (e.g. Verwey-Jonker Instituut 2002, Rotterdams Dagblad 1996a). This does not mean Cape Verdeans are indifferent to politics; on the contrary. Da Graça (1999) describes a continuing and strong involvement with the political situation in Cape Verde. Political
controversies during and just before independence of Cape Verde sometimes paralyzed the community and obstructed the improvement of the social position and empowerment of the Cape Verdians in The Netherlands.

(3) Organizational infrastructure: dispersal and discordance. Initially in the 1960s, before the independence of Cape Verde, when the immigration of Cape Verdians to Rotterdam was growing, there was no formal organization of Cape Verdians and their interests were advocated by the Portuguese consulate. All initiatives were informal and focused on mutual help and the chain of immigration. In 1967, the Cape Verdians organized a social fund, to help the neediest within their community and they founded the ‘Associação,’ to advocate for Cape Verdean immigrants and support them. Nowadays, the Cape Verdians in Rotterdam have an extensive infrastructure of about 70 organizations in which Da Graça (1999) distinguishes five different types: (1) religious communities, churches and spiritual groups (Roman-Catholic church, Racionalismo Cristão, Jehovah’s Witnesses, Igreja Universal, etc). These organizations have a spiritual function, but according to Da Graça also a very important practical and complementary social function for support and advocacy, and they raise and cultural awareness by positive labeling of and focusing on the creole aspects of Cape Verdean culture. I will describe the churches in the next chapter; (2) Solidarity organizations, which try to support local communities in Cape Verde by raising money and funding developmental projects (for example a radio station, kindergarten, etc.). These organizations have a strong orientation on a focus area (village, region, island) in their homeland and are based on strong personal relationships with and sometimes governance by Cape Verdians of influence in Cape Verde, for example the mayor of a certain town in the focus area of the organization; (3) Social and cultural organizations. These developed after independence of Cape Verde and are the most extensively developed part of the organizational infrastructure. They include many sports organizations and organizations based on a mutually shared origin (coming from the same village or region). Often these groups are domed by an island-specific organization; (4) Political organizations: who are a reflection of the political structure and the political developments in Cape Verde; and (5) Advocacy organizations which are founded to support Cape Verdean immigrants in The Netherlands and advocate for them.
Da Graça (1999) describes how these advocacy organizations and the political organizations begin to overlap in the beginning of the 1970s and how these organizations are infected by the political controversies that accompanied the struggle for independence in Cape Verde. The Associação Caboverdiana in Rotterdam is closely linked to the ideals of the revolutionary PAIGCV and object of severe and splitting political contrasts within the Cape Verdean community. This political paralysis is one of the factors enhancing the development of social and cultural organizations. These initiatives offer possibilities to move upward or use ones talents in a society that does not have much to offer to Cape Verdeans. Da Graça also describes the reluctance of the (funding) Rotterdam municipality to actively involve in the Cape Verdean community and take a more structuring role. When they finally combined funds and supported a federative umbrella organization (FOCR, The Federation of Cape Verdean Organizations in Rotterdam) in 1987, they did this in a rather brute way and ruined a lot of initiative by cutting subsidies. FOCR is succeeded by the Avanço Foundation in 1999. Avanço is actively supported by one of the aldermen, who interacts with the community and helps to realize a new spacious facility for Cape Verdean organizations. A very strong second advocacy organization is ‘Cabo,’ for young Cape Verdeans.

In The Netherlands the gaze of Cape Verdeans is directed inward, and the community is self-supporting and autarkic in the same way as the Chinese immigrants often are described. They are organizationally fragmented (maybe even overorganized), they are not effective advocates for their own community, and are not present in national statistics. These same Cape Verdeans, however, are also strongly oriented on the political and economical situation in their homeland. Slutzky (2002) speculates on factors which contribute to invisibility of immigrants in The Netherlands: heterogeneity of the population (too diverse to manifest as a group); lack of intellectual leaders; absence of wealthy representatives and; the will to integrate (= submerge) in Dutch society. These factors might be relevant for the Cape Verdean community as well.

This concludes the general description of Cape Verdean history and their socio-economic position in The Netherlands. In the next three chapters I will present the data on the Cape Verdean health situation and their lay health system.
5. Epidemiological data

It is clear that immigrants in The Netherlands experience their health as being worse than the indigenous population and that they suffer from more psycho-social and psychosomatic problems (De Jong 1996). However, it is not clear how these data should be interpreted. There are growing numbers of epidemiological studies, also in The Netherlands, focusing on the increased incidence and prevalence of psychotic disorders among migrants and use of health care services (Harrison et al. 1997; Mortensen et al. 1997; Selten et al. 1997, De Jong 1996b; Schrier et al. 2001; Stronks et al. 2001). These studies identify increased risks to schizophrenia and other psychotic disorders in different migrant populations. Most of these studies, however, are somehow related to the actual use of hospital or outpatient facilities and give insufficient insight in non-treated incidence and prevalence rates, nor in pathways or natural histories of illness. The studies suggest a higher incidence of psychotic disorders, particularly schizophrenia in migrant populations from Caribbean, Surinamese and Moroccan origin, attributable to socio-economic position, to ethnic background and migration. One should be cautious, however, because the studies all report methodological limitations, that make the findings less conclusive (also De Jong 1996b). Stronks et al. (2001) report differences in use of the health care services (lack of use) due to ethnicity and a worse general health status in the four major migrant populations in The Netherlands (Surinamese, Moroccan, Turkish and Dutch-Caribbean), based on self-report. In this chapter I shall summarize data on known risk-factors to health problems and the limited data about the prevalence and incidence of psychiatric problems of Cape Verdeans.

5.1 Prevalence and incidence of psychiatric problems of Cape Verdeans
Because Cape Verdeans by and large live in Rotterdam, they are not identified in the majority of the epidemiological studies, which are conducted on a national scale. Internationally there are no known studies that specify epidemiological data on psychiatric illnesses in Cape Verdeans, and several authors (Pieterse 2001; Huiskamp et al. 2000; Schrier 2001) stress the fact that little is known and even less is understood of
their use of mental health care services and incidence and prevalence rates for major psychiatric disturbances. One of the few remotely relevant studies available is a comparison of psychosocial factors of loneliness among Cape Verdean and Portuguese students (Neto and Barros 2000). This study does not show any difference in the prevalence of relevant psychosocial variables like neuroticism and dissatisfaction with life. A (sociological) study of the Cape Verdean community in Portugal (De França 1992) revealed no special health problems in the population, compared to other populations in similar conditions (sic). Most common diseases described, are: skin infections, pulmonary infections and bronchitis, diarrhea and intestinal infections, and malnutrition. No mental health problems are mentioned. De França relates these health problems to living conditions (bad and clandestine housing, in rundown neighborhoods, with defective sanitary conditions) and economical problems (unemployment and moonlighting).

It is interesting to look at the data that are available on a local level. As seen before, the use of mental health care services by Cape Verdeans is significantly lower (Dieperink et al. 2002) compared to the indigenous Dutch and to other migrant populations.

<table>
<thead>
<tr>
<th></th>
<th>Dutch</th>
<th>Turkish</th>
<th>Moroccan</th>
<th>Surinamese</th>
<th>Dutch Caribbean</th>
<th>Cape Verdean</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1990 tot.</strong></td>
<td>29.7</td>
<td>33.1</td>
<td>30.7</td>
<td>18.4</td>
<td>11.8</td>
<td>8.1</td>
</tr>
<tr>
<td>male</td>
<td>25.2</td>
<td>30.6</td>
<td>41.2</td>
<td>18.5</td>
<td>14.2</td>
<td>7.1</td>
</tr>
<tr>
<td>female</td>
<td>35.2</td>
<td>37.4</td>
<td>16.5</td>
<td>18.7</td>
<td>9.8</td>
<td>9.5</td>
</tr>
<tr>
<td><strong>1998 tot.</strong></td>
<td>36</td>
<td>36.7</td>
<td>36.2</td>
<td>24.6</td>
<td>16.9</td>
<td>15.1</td>
</tr>
<tr>
<td>male</td>
<td>30</td>
<td>31.3</td>
<td>43.2</td>
<td>21.7</td>
<td>16.7</td>
<td>8.9</td>
</tr>
<tr>
<td>female</td>
<td>46.1</td>
<td>47</td>
<td>32</td>
<td>29.7</td>
<td>18.8</td>
<td>22.6</td>
</tr>
</tbody>
</table>

Source: Dieperink et al. 2000

The use of services by Cape Verdeans is growing in the last decade, but this growth is determined by the growing number of young female adults (20-44 yrs), who found the way to outpatient mental health care or the community mental health centre. The use of mental health care by male Cape Verdeans hardly rose since 1990 (Dieperink and
Wierdsma 2000) and the difference between men and women under adult Cape Verdeans is striking compared to the other populations. Cape Verdean males use services three times less than indigenous Dutch males and still twice less than the next bottom-line group (Dutch-Caribbean males). Furthermore, Dieperink and Wierdsma report that although the prevalence (people in care) rose over the last decade, this is not true for the incidence (the number of new patients in care). The lowest incidence rate concerns Cape Verdean males of 44 years and older: 2 promille.

There is no reason to believe that the Cape Verdeans differ substantially from other migrant populations on the field of experienced health as is reported by Stronks et al. (2001). However, Huiskamp et al. (2000) of the public health authority in Rotterdam report lower rates for Cape Verdeans on quality of general health and a lower experienced health situation, based on their periodical health monitors.

Table 5.2: experienced health and psychosocial problems for different migrant populations in Rotterdam

<table>
<thead>
<tr>
<th></th>
<th>Dutch</th>
<th>Turkish</th>
<th>Moroccan</th>
<th>Dutch Caribbean</th>
<th>Surinamese</th>
<th>Mediterra Nean</th>
<th>Cape Verdean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experienced health</td>
<td>1.00</td>
<td>.61</td>
<td>.77</td>
<td>.89</td>
<td>.86</td>
<td>.81</td>
<td>.81</td>
</tr>
<tr>
<td>Psychosocial problems</td>
<td>1.00</td>
<td>1.54</td>
<td>1.32</td>
<td>1.22</td>
<td>1.45</td>
<td>1.61</td>
<td>1.19</td>
</tr>
</tbody>
</table>

Source: health monitors of Public Health Authority (GGD) in Rotterdam

Table 6.2 makes clear that the differences with the indigenous Dutch are not as big compared to other migrant populations. The same goes for the experience of psychosocial problems. In accordance with the general image, Cape Verdeans experience more psychosocial problems, but less than other migrant populations (Turkish (1.54), Moroccan (1.32), Surinamese (1.45) and Mediterranean (1.61)). De França (1992) compared (reproductive health) service use of Cape Verdeans in Portugal with Cape Verde. It is hardly remarkable to see that the use of professional health care services is much higher in Portugal since the availability of services is not on a comparable level. Only 9% of the interviewed Cape Verdeans experienced their health in Portugal to be

---

48 GGD Rotterdam e.o.
49 Experienced health: percentage compared to indigenous Dutch (= 1.00)
50 Psychosocial problems compared to indigenous Dutch (= 1.00)
better than in Cape Verde; 41% thought that their health in Cape Verde was better, and 48% reported they did not feel any difference\textsuperscript{51}.

Schrier et al. (2001) are the only ones who report epidemiological figures on Cape Verdeans in Rotterdam. They measured the point prevalence (1994) on schizophrenia of different migrant groups in Rotterdam outpatient mental health care centers. Although the total number of included Cape Verdean patients with schizophrenia is very limited (4 males and 8 females), Schier et al. conclude that the odds-ratio for being in treatment for schizophrenia in an outpatient facility (indigenous Dutch is 1.00) for Cape Verdean males is 0.70 and for Cape Verdean females 2.1. Schrier et al. conclude, however, that there are no available comparable data to explain the higher prevalence among Cape Verdean women, except studies on increased frequency of schizophrenia among West-Africans in the United Kingdom.

Conclusion: there is no reason to believe that Cape Verdeans deviate from the general picture of migrant populations who have a worse health condition than the indigenous Dutch. The differences with the Dutch norm however are limited and less than that of the other major populations of migrants (Turkish, Surinamese, and Moroccan). The most important conclusion, however, is, that there are not enough epidemiological data specifically focusing on the (mental) health of Cape Verdeans, neither in The Netherlands, nor internationally.

5.2 Risk factors
People with a low socio-economic status (SES) have an increased risk of mental disorder (Ten Have, 2003). SES in epidemiological research is operationalized by combining educational level, income level, and occupational standard. Stronks et al. (1999) developed a model\textsuperscript{52} to explain differences in the incidence and prognosis of health problems in different ethnic populations. They distinguish ‘contextual mechanisms’ like socio-economic position; migration; culture and acculturization; and social context, which influence ‘specific determinants’ of the incidence of health problems. Among them

\textsuperscript{51} This makes clear that availability of services, service use and experienced health are not directly related. Self reported health care utilization corresponds with officially registerd registration of utilization. (Reijneveld 2001)

\textsuperscript{52} See appendix IV
are lifestyle\textsuperscript{53}, physical and social environment stress and use/effectivity of health care services\textsuperscript{54}. Stronks describes migration as a source of stress and health problems (e.g. higher accident risk) and low socio-economic status and prolonged cultural distance as negatively correlated with health. In a later study Stronks et al. (2001) identify migration and a low socio-economic status as major risk factors for bad health and bad access to health care services for migrants. Pannekeet (2004) describes how migration comes with a loss of fields of reference (people, environments, positions, authority, etc.) and familiarity and the making up of a balance between the (image of) the homeland, the needs of the people who had to stay behind and the demands of the new country of residence. This loss is not temporarily, a phase of transition, but a condition that is felt in returning circumstances. On a psychological level this ‘condition migrante’ comes with a process of ‘existential mourning.’ On the other hand, the migrant has to build up an existence and find a way and a meaningful place in the new country of residence. This is not an obvious process, because migrants, whatever background they have, end up in the lower socio-economic strata or at least in a position below the level of ambition. In a number of cases the emergence of problems is related to the process of migration. All the informants speak with dear remembrance of their homeland, of their island, the food, family members on Cape Verde, the countryside, their type of music, the communal sense of the Cape Verdeans and the hardships of living there.

Specific determinants that negatively influence health are: (1) Living conditions; the majority (54\%) of The Cape Verdeans in Rotterdam lives in two ‘black’ (migrants are the majority of the inhabitants) neighborhoods (Feyenoord and Delfshaven) that are areas with a ‘reputation,’ because of crime and violence, poverty, drug use and bad housing conditions; (2) gender problems; high percentages of teenage motherhood and single parent (mother) families. These situations cause educational problems and limited ability

\textsuperscript{53} Stronks et al. (1999) use lifestyle in a different way than Chrisman (1977) does. Stronks’ lifestyle concept is based on the so-called ‘Lalonde factors’ which are widely accepted and used as health determining factors in the field of public health in The Netherlands. Lalonde (1974:32) defines lifestyle as: “The Lifestyle category, in the Health Field Concept, consists of the aggregation of decisions by individuals which affect their health and over which they more or less have control.” The logic behind this is that bad habits cause (self-imposed) risks to health. This definition also includes the repertoires and styles of behaviour people have to their disposition, by choice or by lack of choice, for example smoking behavior, dependency on alcohol and drugs, living in bad housing conditions, different educational styles, etc.

\textsuperscript{54} In the model genetic factors are also mentioned as of possible influence. No data on genetic differences are available and this factor is not included in this study.
to bear and to take psycho-social stress; (3) Debts and very limited progressive income mobility. This is reported by the informants in this research, but also often seen as one of the complicating factors by service providers and also mentioned by other authors as a major problem area (Elleswijk 1997; Pieterse 2003). Many of the informants in this research report contacts with specialized agencies, which help them to manage debts; (4) Heavy work which causes physical problems and feelings of bitterness. In one of the meetings of the Apoio-project women tell stories about hard labor, working with aggressive detergents and cleansers, which damage their health. D. Teresa worked as a cleaning lady for thirty years and had to stop a few years before retirement, because her “body was finished,” as she explained. Labor positions seem to be marked by higher levels of dependency and higher levels of exploitation and usurpation; (5) A low level of education; the majority of the first generation Cape Verdeans has elementary school as the maximum level of education and a high percentage of them is illiterate. The problem moves across generations, since school performance of the second generation Cape Verdeans is lagging behind. Ten Have (2003) makes clear that low education is related to a higher incidence of physical and psycho-social problems and that people with low education rely on the general practitioner in stead of mental health care for help.

Based on the description of the Cape Verdean community in The Netherlands and on the epidemiological data, Cape Verdean immigrants are a population at risk of extended suffering from health problems and bad access to health services. The contextual variables on which this is based are: the ‘condition migrante,’ the closed and self-referential character of the community and limited recognizability and a comparatively low SES-score55, occupational status is mainly on the level of unskilled or low skilled manual work. Income levels and poverty are a persistent problem and educational levels are low.

---

55 Without pretending to have measured this in a valid and reliable way in the informants in this study. This is a general observation, based on demographic figures.
6. Health beliefs

Thinking in terms of explanatory models and analyzing sickness and treatments of sickness in these terms, as proposed by Kleinman (1980; 1988 a, b), administers justice to local, i.e. culturally specific, ways of understanding illness and dealing with it. Explanatory models offer “explanations of sickness and treatment to guide choices among available therapies and therapists and to cast personal and social meaning on the experience of sickness” (Kleinman 1980:105). The questions that are posed in the case of an experience of distress are: Why me?; Why now?; What is wrong?; How long will it last and how serious is it?; and How will I get rid of this problem? The description of explanatory models of populations, however, harbors the risk of creating new fixed categories and labels, which can accommodate homogenization of a group of people, by simplifying views and not focusing on the patient’s total experience (Bhui and Bhugra 2002a), when treating people, for the sake of reducing ‘confounding variables.’ They can even lead to culturalization or cultural blaming (cf. Van Dijk 1989). The life of migrants in a new cultural environment and the work with that environment are not static data but essentially dynamic processes as is also stressed by Bhui and Bhugra. They state that explanatory models “do not consist of a coherent set of beliefs, but a variety of explanations that are either held simultaneously or taken up and dismissed rapidly” (2002a:6). Kleinman (1980), who introduced the concept, is also explicit in this respect. He makes a division between general illness beliefs, belonging to the health ideology of different health care sectors and existing independently of specific sickness experiences. Explanatory models are based on these belief systems and are composed in response to the specific experiences and should be understood in specific contexts. They should not be treated as strictly rational interpretive schemes - at least in the popular health sector - but as loose systems of interpretation that are rarely falsified by experience. Kleinman (1980, also Lloyd et al., 1998) describes five basic questions of relevance to the understanding of an illness episode: (1) etiology; (2) time and mode of onset of symptoms; (3) pathophysiology; (4) course of sickness; and (5) treatment. In this paragraph I will structure the data following this division. This does not lead to a description of explanatory model(s) held by the Cape Verdean community, but a general
and explorative description of general health beliefs present in the Cape Verdean community in The Netherlands. The total sum of explanatory models, meanings given and treatment choices are described by Kleinman as a semantic sickness network (1980:107). Treatment choices are worked out in the follow-up study (Beijers, 2004b).

6.1 Etiology
In this study the respondents gave meaning in four distinctive ways: (a) in terms of a spiritual or religious understanding; (b) in terms of biomedical understanding; (c) in terms of the structural factors described in the previous paragraph; or (d) in interpersonal terms or terms of witchcraft.

The words used to designate psychosocial distress are common in biomedical psychiatry. This does not simply represent the understanding of the illness but probably is also caused by the fact that most of the informants were or had been in contact with mental health care. Within the context of the Apoio-project, initially the word ‘depressão’ (depression) is used as a general marker of a situation of mental illness. Later, the word schizophrenia is used as a reference to a very serious mental health problem that also is hereditary. In the Christian Rationalist community several words are used. In my conversations some informants talked about ‘patients’ as a general reference to people needing help and attention within the Centro Redentor. In the readings on Christian Rationalism, the authors consequently speak of ‘obsedados’ (people who are obsessed and often used as possessed) or ‘perturbados’ (people who are disturbed). The president of a Centro Redentor explains: “When people begin to talk to themselves, crying and things like that for nothing. Yes these kinds of things. In Portuguese we say ‘estar obsedado.’ That’s the same.” In the books on Christian Rationalism (Centro Redentor, 1986) a long list of signs is described that refer to a beginning obsession. Among them: laughing or crying without reason, obesity, enjoying ‘doing nothing,’ ostentation, querulousness, mechanically repeating the same sayings, swearing, living in a faraway dreamworld, etc. In conformance with the doctrine of Christian Rationalism, this phenomenon of ‘obsedado’ refers to something that comes from outside (lower astral spirit) and not from within, although personal moral weakness is an important

56 It is my impression that there was a learning effect in the course of the Apoio-project in which the people involved mastered the meaning of different diagnostic categories.
intermediate variable, because it increases the vulnerability. Within the Roman-Catholic parish, the idiom of formal mental health care is dominant. The social worker and the pastor work together with the mental health care institutions and actively try to bridge the gap between the spiritual explanations and healing practices and biomedical understanding and treatment.

Special attention should be given to ‘sangue dormido’ (sleeping blood); a phenomenon which is included in the glossary of Culture Bound Syndromes of DSM IV (APA, 1994:848). The syndrome is mentioned in an article of Like and Ellison (1981) and the manual describes it as: “This syndrome is found among Portuguese Cape Verde islanders (and immigrants from there to the United States) and includes pain, numbness, tremor, paralysis, convulsions, stroke, blindness, heart attack, infection, and miscarriage.”

This horrible parade of misfortune, however, seems to lead its own life. A quick scan of international scientific databanks rendered only references that literally copied this phrase from the DSM IV-manual. In my study, no reference to this syndrome was ever made and a posting on Cape Verdean Internet Forums did not render any result either. A direct inquiry of Graça on this topic rendered more information. She explains that it is something old-fashioned, belonging to what Kleinman describes as the popular sector of health care. Sangue dormido is not common or familiar in the European Cape Ver dane diaspora anymore, but might still be used on Cape Verde, to point out a situation in which ‘the blood stopped.’ When the blood stops it gets old. The word ‘dormido’ is used to point out that something is ‘one day old’ and is not only used in the context of blood, but for example, also to describe a quality of water: ‘água dormida.’ Graça tells how her mother always put a glass of ‘água dormida’ next to the front door of the house for the spirits to drink, and how they were warned as children not to come close to it. Graça also tells the story of a young boy who lived close to her on Cape Verde, when she was young. He suffered from ‘ataques,’ because, according to her mother, his blood had stopped: sangue dormido. An ataque meant that he would fall down and then people would sprinkle him with water, open his shirt, make a cross on his chest with a piece of a particular plant and would pray. Another remedy was to sprinkle the affected person with ‘urina dormida’ (three days old urine). When this was done, Graça tells, everyone would come to look; it was an event. Another situation of sangue dormido would be when women, after having given birth to a baby, would feel depressed (Actually Graça
explains: “Now I know they were depressed”). Her mother would say: “They have *sangue dormido* in their head.”

The fact that this culture-bound syndrome is hardly recognized in the Cape Verdean diaspora, is described as old-fashioned and that the scientific reports on the phenomenon of the last decade are merely repetitions of the original description, shows how apparently diagnostical categories reify and start a journey all over the world by themselves, without reference to the lived experience where they originated.

6.1.1 Spiritual and religious understanding

Cape Verdeans are a very religious people and the majority is Roman-Catholic. Next to the Catholic belief, the doctrine of Racionalismo Cristão and the charismatic Pentecostalism of the Igreja Universal de Reino de Deus are practiced by many of them. When looking at a more general level of Cape Verdean understanding of life, they place (mis)fortune in the light of an ongoing struggle between good and bad on a spiritual and supernatural level. ‘Spirits’ are part of this ‘world’ and are relevant as a point of reference for giving meaning to health problems. Cabral (1980) describes how individuality on the Cape Verdean islands is a prerogative, and that respect for the ancestral regulations is part of Cape Verdean mentality. Disrespect not only leads to the anger of the living, but also to the anger of the deceased and of God.

Thirteen of the twenty-six informants with first-hand experience with a form of psychosocial distress\(^{57}\) associate their problems with some kind of supernatural\(^{58}\) phenomenon. Either because they interpret the origin or manifestation of their problem as related to a spiritual or supernatural cause, or because they consulted some type of complementary (spiritual) healing. Others (n=8) were either not explicit about it, or stated they did not believe in it, but also made clear not wanting to mock at it either. Five people explicitly rejected all kinds of spiritual understanding and healing of illness.

When I have a conversation with Lucinda about the problems she experienced, she talks in a very obvious and natural way about spirits. She explains: “No, I am not haunted by a spirit anymore. When I lived in Spangen I saw doors open and shadows on the wall and I frequently dreamt of my father who deceased long ago. But after my marriage I didn’t see these things anymore. Then I was

---

\(^{57}\) First-hand experiences are either personal experiences or experiences of a relative or friend in direct vicinity, with which the person had intense involvement.

\(^{58}\) Supernatural as I use it her, should not be understood as ‘unreal,’ or ‘not belonging to the nature of life,’ but as ‘not belonging to the material or physical world.’
only afraid of my husband.” Rosa is also convinced that a spirit is bothering her, sent by her former husband, who wants to inflict evil on her. She tried all kinds of treatments and remedies but did not until now succeed in getting rid of this spirit, because it got ‘stuck.’ Carlos is also convinced that a spirit is bothering his son. In fact, he thinks it is the same spirit that troubled him when he was young. Fatima is haunted. In her case it is a witch (bruxa) that is bothering her. She knows who he is: the pastor of the Igreja Universal, who wants her to come back to the church. Mrs Soares refers to the evil eye of her neighbors (In a whispering voice: “They are jealous on my good looks”) and to sorcery (“They scatter cadaver-powder around.”). In her house she almost completely retreated to her bedroom and lives there because the rest of the place is full of spirits, which she tries to restrain by smearing garlic on the walls and ‘Satan-be-gone’-oil in her hair. It helps.

Antipsychotic medication (Zyprexa) she receives from the community mental health center is interpreted in this scheme: it helps because it chases spirits away. She tells me she will end her contact with the community mental health center. She knows that the medication works this way, and will try to get the pills directly from the pharmacist or the general practitioner. Nuno strongly believes in the doctrine of Racionalismo Cristão and is also convinced that his problems are not just material. However he seems to be a little reluctant to openly admit that spirits are bothering him, as if he does not want to provoke them. He stresses the relevance of antipsychotic medication to suppress them.

Without doubt the different religious and spiritual belief systems, religions or doctrines, as described in chapter 4, are important points of reference for Cape Verdeans to give meaning and to deal with psychosocial distress. In the general understanding of the relevance of spiritual life also other understandings are relevant, as described by Harwood (1977), like evil eye and sorcery. But they are more complementary than the churches and doctrines described here, and are seen as folk beliefs in the Cape Verdean context as well. However they are not folk believes without a meaning. They are not explanations without hesitation and doubt, but can be important to understand and deal with interpersonal relations. It is important not to disrespect them; they are always important as a last resource. For example, to look for healing, as we shall see later. This focus on spirituality and religion does not mean that Cape Verdeans are just simple, pious and sanctimonious believers. These beliefs and doctrines and their moral categories are socially represented and have impregnated everyday social life of the Cape Verdeans, that is the place where they materialized and are most interesting to study. I will briefly go into the ways the doctrines of Racionalismo Cristão and the Igreja Universal influence everyday life.

Vasconcelos (2002) describes how Racionalismo Cristão is of major influence on everyday life and experience in São Vincente. In line with this doctrine it is normal to think of everyday life (my current situation, my current incarnation) as restraining and

59 She shows me a small essence type of bottle with an oily substance: ‘Satan-be-gone’-oil, according to the label. She purchased it from a Surinamese shop in Delfshaven.
looking at yourself as somebody with more possibilities. In my contact with the followers of this doctrine I concluded that the conception of ‘self’ is not only something that is identical to yourself as a person, but something that lives on, that is spiritual and with a personal responsibility, not only for the present life, but also for future reincarnations and for the final eternal well-being. The ‘self’ in a way is also ‘the other,’ someone you have to take care of, or a spirit for whom you are personally responsible. The ‘self’ is someone that lives within this time frame and reality and limitations and possibilities, but also within a universal time frame and cosmology, where it is lived by other forces and laws.

In this context, future and past seem to merge to a unity that can weaken motivations, tone down prospects, drives and scope of personal agency, can make suffering endurable and acceptable, personal loss acceptable as part of an eternal scheme, and focus on the personal responsibility on a small (manageable) scale. The promise of a bright future and the ‘chosen role’ is curbed by the limiting laws of a larger metaphysical scheme.

Vasconcelos speaks of an essential ontological ambiguity (‘Who are we: African, European, Portuguese?’) and postulates even a migration motive: “Cape Verdeans seem to be more themselves when not in Cape Verde” and “Cape Verdeans are a people in transit and ambiguity is at the very heart of creoleness” (2002). In the same line of thinking it is possible to postulate a strong sense of ‘social responsibility,’ or mutuality. Carla is very explicit about the ambiguity and the drive not only to find a better, but also a more appealing life. She explains:

We do not complain. In general we always are content with what we have, however bad things might be going. (…) I think this is in our nature. We are a people who love to always look for something else, something better, but nonetheless we are always content with what we have. I once said: “We have a little bit of gipsy blood in our veins.” Because then you go somewhere. (…) For example, I have an uncle who is born on Cape Verde. He married when he was young and left for Angola with his wife. There he had a good life. But before the problems of the independence he left again with his wife. Back to Cape Verde, he had a very good job there and his wife as well. But he thought: “No now I have to look for something else.” He went to America. But nonetheless he is thinking about returning again. So always this thought of looking for something further. (…) Looking for new challenges; I think this really is in our blood. Generally we are content with what we have, but we love looking for something else all the time. I do not know why...

In the philosophy of Racionalismo Cristão everything has a reason, for example: roaming spirits, whose evolutionary process suspends, can be a causal factor. Based on the stories of informants in this study; getting into (spiritual) trouble seems to be interplay of three factors:
(a) Personal vulnerability.

Associated with moral weakness (irresponsible behavior, not following family values etc).

(b) Negative influences from outside.

These influences can be spirits from the 'lower astral plane' which bother you, but also places that are negative where negative energy is centered, that will make you vulnerable. Fidalgo (2003) explains:

So when somebody dies, does the spirit of the deceased immediately ascend to its own spiritual plane? It may or it may not. It all depends on how the spirit lived his or her physical life on Earth. If someone lived a materialistic life full of vices and bad habits, its astral body is impregnated with astral matter and usually is mentally agitated. So they roam the earth's atmosphere without a destiny. In time those spirits also find out they can transmit thoughts and feelings, thus influence people, sometimes with morbid, evil and obsessive feelings. Needless to say that most people are unaware of the existence of those spiritual beings. After all, they are invisible to the eyes of matter. Only those with visual mediumnity can see them. (And then, answering a question about tendency to suicide) That's why some people have tendencies for suicide. Most of those thoughts come from outside, from spiritual beings who approach them and give them bad intuitions, among them the intuition of suicide. The way to oppose those negative intuitions is to learn how to control thought and learn how mediumship works. Without exception we are all intuitive mediums. This means that we can all receive intuitions from outside, from spiritual beings.

(c) Karmic, or evolutionary debt.

Based on the philosophy of evolution. For example: a life with disfigurement or with Down’s Syndrome might have been selected ‘as a way to work out karmic debt or lessons for them or the others in their life to learn or work through.’

The morals of Racionalismo Cristão are related to these three aspects: it is based on individuality and individual responsibility, on controlling ‘thought’ through studying and living according the doctrine. Part of the doctrine is to stress that people have to do their work, or do their best, in the here and now, to be able to grow to a better situation. This is a personal responsibility and the image of a good and responsible life is based on family values, being a responsible and good employee and a committed, unselfish and magnanimous member of the community. The president of a Centro Redentor: “We

---

60 This idea of ‘karmic debt’ is also part of the doctrine of Allan Kardec. In the Dutch Allan Kardec Association, schizophrenia is explained as the ‘debt’ one has to pay for having Down’s syndrome and committing suicide in a prior life. (Allan Kardec Association: lecture of Marlene Nobre, Brazilian gynecologist, on: ‘The medical-spiritist paradigm, where medicine and spiritism touch’; Hoorn, 12 October 2002).
always say: you have to trust yourself (…) if you do not do that, you cannot trust other people.” This leads to the conclusion that Cape Verdeans are not only self-sufficient, as is often described, but also self-referential and autarkic. However, there is also a social responsibility: by mutual positive energy it is possible to give individuals the strength to overcome their problems. Also the practice of *desdobramente* \(^{61}\) is an example of this social responsibility. Finally, there is an aspect of inevitability and endurance: A current life (incarnation) with all its limitations is an ordeal you have to live through in order to be able to go on with your spiritual evolution. This ordeal is not an individual task but also a social experience: being a Cape Verdean is an ordeal that distinguishes this population.

One of Vasconcelos’ informants states: “I think that although the Cape Verdeans may lack everything, or may be very poor, we are very spiritual. The spirits that become incarnate on these islands, I think they have been chosen by the Superior Force (…) We help all the world” (Vasconcelos, 2002). Their fate is to bear their spiritual responsibility, and suffer, for the good of others. By taking personal responsibility and through the working of individual (spiritual) potencies, are able to contribute to a better world. In this respect it is a doctrine that seems to fit in a modern humanist tradition. It is tempting to see the endurance, silence and invisibility of the Cape Verdean community as described by Meintel (2002) and Strooy (1996) and registered in this study, as a postulate of this.

The spiritual component is also very important in the Pentecostal cosmology of the Igreja Universal. In the total spectrum of churches and spiritual doctrines the Igreja Universal is seen as a rising star on the Cape Verde islands (Vasconcelos, 2004) as well as in The Netherlands. In the Igreja Universal a completely different idea of the origin of human problems dominates in which the spiritual component of psychiatric problems and the individual responsibility for deliverance to God are stressed\(^{62}\). Human misfortune is connected to negative influences coming from outside and lack of personal strength and responsibility. Mankind is in an unfriendly environment and has, as a defensive, the opportunity to build a personal treaty with higher powers, through his connection with

---

\(^{61}\) Christian Rationalists know the practice of ‘desdobramente.’ These are weekly sessions at the Centro Redentor in which by telepathic positive force the participants try to positively influence negative events in the world.

\(^{62}\) On the other hand, suffering and grief are expressed collectively and openly, contributing to a new ‘communítas’. 
this church. The main practice of the church is to fight the devil through God. The spiritual factor is linked to material wealth and a lack of guidance, as the pastor of Rotterdam-Diergaardesingel explains:

When someone has everything in life, for example here in The Netherlands, they cannot complain about the fact that they have no job. Here this person has everything. But suddenly there is unbalance. They miss the power to persevere; they need someone to lead them. Then we speak of a spiritual problem, because someone has to be more positive.63

Cure and happiness (paradoxically) are connected to prosperity and material wealth, based on the prosperity gospel. When looking at this promise of the Universal Church of the Kingdom of God in the context of escaping poverty as a motive for many Cape Verdeans to migrate, it is easier to understand that this church must be appealing to many people and fitting into the ontological ambiguity, as described by Vasconcelos (2002). In the Igreja Universal evil is represented in different images in which tradition and modernity are combined:

(1) Evil forces and spirits.
Spirits and witchcraft symbolize ‘evil’ and evil influences (often personified as existing creatures). Evil is represented in images of demons, as the pastor of Rotterdam-Diergaardesingel makes clear:

There are evil spirits, like you said the devil. The devil is surrounding people, he tries to grab people. By prayer we punish him, ask him ‘In Jesus’ name to leave this person.’ And when we say this prayer this person will feel differently.
Witchcraft is an issue as well. Bishop Souza:
“Witchcraft is real. Especially in our days, because it is growing. (…) It is horrible, for people who take it seriously but also for people who think it is a fairy tale or a joke (…) some people make a living out of it. It is growing. (…) And if you ask me if it can influence a person? It can! I have seen horrible things over the years. (…) People see this as part of culture and it is horrible what we sometimes witness. The way a person sometimes becomes absorbed in this. And indeed we believe in the existence of demons of evil. We, however, also believe in the existence of God.”

Personification makes the devil real. In services of the Igreja Universal evil is a demon that enters and possesses our body and comes to us, for example, through television. Evil is forced to leave by strong prayer and exorcism. But spirits and witchcraft per se are not seen as the only problem, but also the traditional, i.e. the non-modern and non-Christian way of living. The depiction of evil as part of an obsolete and (culturally based)

63 The translator notes that ‘positive’ here refers to being content with ‘material wealth.’
traditional (= African) way of living, makes clear that it is something outlived and less real.

(2) Personal weakness and secularization.

In many respects this seems paradoxical, but tradition as the symbol of evil focuses more on the individual responsibility to surrender to God. This evil does not come only from outside, but can also refer to a personal inclination. Bishop Souza:

If a person is under the influence of certain rituals and the person is involved in it, we strongly advise this person to quit, because it brings great and horrible spiritual damage. Even without talking about demons. It concerns the rituals themselves, the way they deal with things that is harmful for people. For example, I saw such a ritual on television long time ago, where people had to drink until they lose consciousness. So when a person does this, it does not have to be a demon that is inflicting this to the person. But the behavior itself; what they are doing ritually, would destroy this person. Completely wrong behavior, a dangerous thing. Such things. Please distance yourself as soon as possible from these things.

In this case it is not just tradition but also modern secularization, individualization and the growing distance to God. Bishop Souza of Igreja Universal in The Hague:

I would say that one of the first causes (of problems, HB) is the way people distance themselves from God. Everyone wants to go their own path which they think is best, […] while we know that the Bible is a book that leads people to the right path, to prevent bad surprises in the future. […] When a person distances himself from God, he is left to his own fate. And through this, all these problems come that bring people to depression, psychiatric problems and drugs. […] A Christian family is much more solid more together than people who do not believe.

Evil as verbalized by the representants of the Igreja Universal in The Netherlands is represented by an evil force that influences us or possesses us and comes from outside, sometimes on the sly. An adaptation, however, seems to be the referral, not primarily to the loathed context of tradition but to the motivational and behavioral traits of the person involved as a representation of evil and the public life, which is secularized. This evil comes from the inside, and is a reflection of the modern secular style of living that threatens us. Getting better is a personal responsibility in the first place that asks for perseverance and devotion.⁶⁴

---

⁶⁴ Oro and Semán (2001:194) make clear that the message of the Igreja Universal is not as universal as the name of this church wants us to believe. In its expansion the Igreja Universal is adapting to local situations and transforming and adapting its discourse on the devil to the local needs and understanding. Argentinians believe that deliverance is the expelling of demons. These demons are not personified in the African-Brazilian images of the demon and the accompanying practices, but the demons are identified with disease as a psychological tendency, a state of spirit. It is a transformation and cultural adaptation of the traditional Brazilian practice. The demon is expelled by understanding and resolving evils.
6.1.2. Biomedical understanding

Many families are aware of the biomedical understanding of psychiatric problems and also adopt and follow it. For example, the Tabarez family rejects the magic and spiritual explanations and attributes illness and misfortune to the (inevitable) course of nature. Mr Tabarez explains his belief in the ‘course of nature’:

I do not believe in the existence of these kind of things. (…) Yes people think like that: “Why do I get something like this and others do not?” Is the Voodoo in his house? No, I do not think so. In my opinion something exists in nature. Nature arranges everything. I get ill, my neighbor doesn’t; others get money, I get money; others get a job, I do not. I have to accept what is the law.

Mr Tabarez seems to understand biomedicine as something that is inevitable and not influencable. In other conversations people refer to heredity as a factor. This can be genetic heredity but also social heredity. When talking about Nuno, Manuel, as well as the president of the Centro Redentor refer to the fact that his problem is ‘in the family.’ They explain that Nuno’s problem is the same as his father’s. Nuno himself blames spirits for his problem. Graça makes clear that genetic heredity is something to be feared; when she talks about schizophrenia in families, she seems to be talking about ‘fate’ and the inevitability of the spreading of this heretic preposition over the family. Carlos refers to a kind of social heredity when he tells that the spirit that bothers his son is the same that was annoying him in the past. Mr Dos Santos, father of a schizophrenic son (paragraph 4.3), is convinced that his son is hypersensitive for narcotics and that his psychotic episodes have to be ascribed to his use of street drugs. It cannot be avoided.

The biomedical interpretation can be made very explicit to underline the division between first and second generation migrants and the young (modern) and the old (traditional) Cape Verdean way of life, as is made clear by Suzana, when she substantiates her personal conviction that psychiatric problems are a (biological) illness:

The problem is that most people do not look at it (psychiatric problems, HB) as an illness. So, to start with, you need a kind of cultural change, or an awakening that we are dealing with an illness.” Suzana rejects the spiritual explanations of other Cape Verdeans: “They have to understand it is a disease.”

Biomedical explanations and treatments are strongly propagated by the Roman-Catholic parish and the priest and the social worker who work there. They work together with the community mental health center and the mental hospital, they refer people and support
them in their contact and they propagate the message that biomedical understanding and treatment is essential and most effective, and that people should comply. When the priest refers to the richness of ritual and symbolic practices of the church, he does so in an almost apologizing way. Next to this practice, however, they have a strong and widely organized network of self-help groups, and the parish is a place where people can meet each other and a place of community and possibility to be a Cape Verdean. The parish is an important place for advice and support.

**6.1.3 Social factors**

Next to these spiritual and biomedical interpretations, Cape Verdean migrants in The Netherlands give there experiences of distress other meanings, in which social factors, poverty, housing conditions, migration, gender, discrimination and racism are directly involved. Debts were named before as a risk factor and stressor, but also as a complicating factor in the provision of care. Miguel ascribes his physical problems and his stress to social causes: bad employers, discriminatory treatment in labor situations, lack of upward movement in his career and heavy work. Several Cape Verdean women did the same when referring to the hard physical work in the cleaning industry and the exploitation by bad employers. Women are not able to take care of their children after school, because they have to work during early morning hours or late afternoons, when cleaning offices. The children perform badly at school, miss parental guidance and are at risk to get involved with criminal activities. Women also frequently referred to the ways they are treated by Cape Verdean men. Ana talks about the combination of work and husband that brought her in the doctor’s office:

Cleaning is a heavy job. And then picking up the child and taking it away. I didn’t like that. I’m working outside the house and then inside, at home I had to do everything as well. Sometimes he (the father, HB) took care of the child, but he told me he was doing me a favor by taking care of my child. He never had attention for us. I ask something and then I get problems. I was very depressed and was crying at the doctor’s office.” Later: “I think this is typical for Cape Verdean men. It all started with his father, who left us. After that I had boyfriends who could not cheer me up, they all made me sad. Cape Verdean men want women who do everything for them, but they themselves, do not help. They do not do nice things for their wives. I told the father of my child: ‘This is not Cape Verde. We are in The Netherlands now and here you have to do something for me as well.’ But he didn’t do a thing.

Carlos complained about the bad neighborhood he had to live in: he was confronted with criminal activity, drug use and negative influences. According to Carlos, this brought his
son on the wrong track. He got in contact with the police and ended up in a juvenile prison. Every time he got out of prison, his bad friends knew how to find him again.

The process of migration and the long-term separation of family members or spouses could also lead to problems. Paula’s experience is a poignant example of this: during her youth and adolescence she saw her mother only twice. When she finally came to live with her, they experienced serious trouble living together. Paula thinks her mother dominates her, her mother thinks she is good for nothing.

6.1.4. Witchcraft and sorcery as explanatory factors
Witchcraft and sorcery can be explanations for the occurrence of misfortune as well. Not many informants are explicit about this, however, without denying it. In this study, Luiza explains that the illness of her mother, who suffers from a chronic psychiatric problem, is caused by her parents-in-law:

(…) I think my mother-in-law had gone to a kind of curandeiro\(^{65}\). And then, they say, they sent spirits, because she was such a strong woman, my mother. And she still is strong (…). Then, talking about a conjurista.

Interviewer: (…) So, the moment you dislike someone, or want to do evil to someone, or are jealous about somebody…

Luiza: … then you go to such a man and you ask if he can help you, to do something against this person.

Interviewer: And he sends evil spirits?

Luiza: Yes, most of the time they do it with spirits. I am not involved with these things, but at home in Cabo, they are real. Yes, but not only in Cabo, here as well, here as well.

Rosa and her partner talk about the spirit that troubles her:

Partner: I know of this spirit. I am Catholic, but Catholics also talk with these spirits. This spirit is stuck, it cannot leave, and that’s the problem. (…) And it is sent by other people who are sick.

Interviewer: So other people send this spirit and it makes you sick?

Partner: Yes.

Interviewer: How can you get rid of it?

Partner: I go to other people with my wife, but nothing helps.

Interviewer: She says it is caused by her family.

Partner: I think the family. I do not know. People tell, but they do not know. (…) But she thinks the problems are caused by the father of her children.

Interviewer: the father of her children?

Partner: Everybody says so, the father of her children. But I do not know.

Interviewer: Was he a bad father?

Rosa: Yes he was evil; that is really true.

Luiza’s and Rosa’s examples illustrate cases of sorcery. Evil causes evil, and evil is not only caused by sorcery, but also by witchcraft, although the referral to a witch (‘bruxa’) is

\(^{65}\) A curandeiro or a conjurista is an indigenous healer/sorcerer.
not made frequently. Witches represent an evil force per se, but can be called upon to assist in treating problems, when they are open for it. When I talk about it with Antonia and a friend of her, they laugh loudly and tell me they do not believe in witchcraft and curandeiros, because they only cost money. When I insist, they explain: “A ‘bruxa’ can fly… a bruxa wants things of you, to break them. (…). But a ‘bruxa’ can also solve evil things. (…) A bruxa can be a man or a woman.” When discussing the issue, some informants report that these beliefs and practices are particularly strong with people originally from Santo Antão.

Helena also talks about a bruxa, she does not laugh him away. She hears knocking sounds in her house at night and can see the curtains move in her bedroom. She was a member of the Igreja Universal but she got in serious financial trouble and left the church. She feels threatened by the obreiros and the pastor of the church, who want her to comply to the regime of the parish. She feels threatened by them and explains the pastor is a ‘bruxa’ who comes to her house, invisibly, to bother her and to make her sick. Parsons (1921) gives a description of a ‘bruxa’ or a ‘f’itice’ra.’ Her lively description of Cape Verdean folklore (tales from migrants in the USA) from the beginning of the twentieth century, however, should be seen primarily as a historical description, although not irrelevant. A witch, according to Parsons, is a young or old woman (never a man) who practices black magic, for example by using ‘evil eye’ and by entering people’s bodies to make them sick. They can possess people and animals and are also feared for wanting to eat one’s children. Parsons describes numerous ways in which a witch can bother you and as much ways to exorcise her, for example by burning a piece of her clothes or shoes under the nose of the possessed. Bruxas can fly: “Flying f’itice’ra may be recognized by moving lights in the air, ‘like a torch,’ said one informant; ‘they drop fire as they fly,’ said another informant (…); ‘it is a green light’ said another. (…) But wherever a f’itice’ra is off flying, if you make three knots in your handkerchief and say an adequate prayer, she will have to return (…). The right prayers will always tie up a f’itice’ra.” (Parsons, 1921:99). Cabral (1980) explains that witches are blamed for misfortune, but on the other hand also are expected to contribute to the solution of the misfortune, by getting involved and giving the right advice. When witchcraft is suspected, the witch who caused the situation had to confess guilt in public. Witchcraft is considered threatening, because it is easily transferable. Graça:
I lived there on the Cape Verdean Islands, when I was a child. And a little further away lived a woman who appeared to be a witch – we were all scared to death of this woman. And when she came walking to our place, a neighbor always said: ‘There comes fire, there comes fire.’ And all the kids ran inside. And every time she came to ask my grandmother for water. My grandmother didn’t like that, because she didn’t want somebody like her in the house. I do not know what my grandmother did. They sometimes tell when there are witches who want water or something like that, that you have to put the glass on the floor and jump over it a couple of times. And if you give the witch this glass, she will not drink it, because …. well … she cannot handle it. And my grandma did this and this woman didn’t drink it. Then you would almost believe it to be true…or maybe she was not thirsty (laughs).

Later, Graça explains that a bruxa is born as a witch, because witchcraft is innate; it is in the family. Bruxas are of a higher order than f’itice’ras, who have acquired witchcraft through learning. Both differ from conjuristas and curandeiros, who should be seen as sorcerers. They tell what is wrong with you and can predict the future; a conjurista mostly works with cards and a curandeiro with stones. Graça tells from her memory that on Cape Verde people who were ‘different’ were at risk to be identified as a witch, especially when something bad happened. When a child died, which shortly before would have been in contact or near a suspected witch (or her children), the witch would be blamed. This could lead to a caça às bruxas, or witch-hunt, in which the witch would be molested and forced to undo the evil. Her own mother was called a bruxa. She deviated because she had a lighter skin, loved to read books, had long, black hair and lived a life in retreat.

Sometimes people would come to her to get cure (egg, mixed with honey and milk) for children who were ill.

Parsons mentions the curador or saib’ as the opposite of a witch, since he (they are always male) suggests means for exorcism or undoing the influence of a bruxa. Such a curador is, like bruxas, able to travel in spirit; “and he goes to their place of spirit-assembly, and overhears their talk and how they have injured persons. Thus he knows the proper antidote. He is said, however, to be able to work with black magic too. But on the whole, he appears to work beneficently, curing sickness in general, curing barrenness, finding lost articles.” (1921:100)

Witches posses the power of evil eye, something that can also be caused by the jealousy of other people. Evil eye as an agent in all kinds of cases of misfortune seems to be a part of everyday life and common understanding of everyday events. Graça tells how her mother always used to be on her guard against evil eye and how she tried to protect her
children against it. When they had good marks at school, they were not allowed to show them to relatives or neighbors in order to avoid evil eye. Four informants explicitly relate their problems to jealousy of people in their vicinity. Mrs Soares refers to the jealousy of Dutch people and explicitly connects this to discrimination she experiences as a migrant:

No, it is all here in The Netherlands. But my problems are all in my head. Because this voodoo started with bad…. I say this is jealousy. Sir, I am, I was a beautiful woman. I was beautiful when I was born and I always kept beauty. Everybody has the evil eye on me. That is the problem. Want to kill me for voodoo. It’s bad, isn’t it? (…) Because this is jealousy, discrimination. Jealousy and discrimination. I do not think this is normal. This is bad for everybody, not just for the persons, but for everybody. It was here a year ago; it caused cancer, with this man of that woman there. (Points to one of the neighbors, HB).

D. Teresa also suggests that her problems (intruders in her house) are caused by people who are jealous, because she has a good life, a job and works hard. Rosa and Carlos both suggest that family members are involved. Rosa tells how her former husband got into trouble constantly, while she didn’t. They divorced and he was jealous and caused problems. Carlos doesn’t know, he thinks it might be a family member who sent a spirit. But he is not sure. There are also skeptics, like Manuel

Manuel: Look, jealousy is real. Look, when someone…when I have something and someone wants to have it as well. And he says: “Well I have worked as well and I didn’t get it or couldn’t buy it. Then he just is jealous. But the rest, the rest not.”

Interviewer: “You mean, it doesn’t make you ill?”

Manuel: “No!”

This skepticism is reported to be more common than the overt referral to witchcraft which many Cape Verdeans do not consider as an acceptable line of thinking or something to be open about within the context of Dutch society. For example, Dina tells:

My mother started about that when my job ended. A woman told her that I had to go somewhere, pay € 300, and then everything would be fine again. And then I told her that I do not believe in these things. She accepted that. But I hear these things a lot, from aunts. They do not have money, but for these kind of things, they want to pay.

Graça explains that many people defy these beliefs and fears, but secretly wear a ‘contra mau olhado,’ an amulet against evil eye. A simple denial of witchcraft as an outdated phenomenon, passed by modernity, is a much too simple reproduction of reality as is argued by Comaroff and Comaroff (1993) and Stewart and Strathern (2004). They discuss meaning and transformations of witchcraft in the context of Africa’s transition to modernity. In this context, witchcraft is not only reproducing social values and functional
in strengthening social ties, as is argued by Evans Pritchard (1937), but it is also a means to comment on and react to social transformations. As I argued in the case of Racionalismo Cristão, it might be possible that many Cape Verdeans defy the existence of witchcraft or sorcery, but this does not implicate that it is not present anymore. For example, Carla is very explicit in her repudiation of the phenomenon, but in her way of expressing herself she makes clear she does not want to mock at it either. It might be very possible that, although the practice is not widely spread and people are not open about it, it is present in derived (modern) forms or left its traces in the minds and behavior of the Cape Verdeans. Stewart and Strathern (2004) describe how rumor and gossip provide a link between classic witchcraft scenarios and their transformations in contemporary affairs\(^{66}\). Both in classic and modern social contexts, accusations of witchcraft and sorcery are most of the time preceded by rumors and gossip. Gossip definitely is something that Cape Verdeans associate with their community, as becomes clear in many of my conversations and is illustrated on one of the forums of www.caboverdeplaza.nl, where young Cape Verdeans discuss gossiping:

| Spawn\(^{67}\): | Gossiping belongs to Cabo’s. |
| Creolinha: | Know all about that!!! It happened to me before, that something came about and that my family in Cabo knew what happened before my mother here knew it. Well, CAN YOU TOP THAT!!! Only Cabo’s can go around the world so fast with a gossip. |
| Cabobaby: | (...) People have to do what they like, you only live once. Cabo’s gossip a lot; Anti’s fight a lot and Suri’s ‘dieken’ too much\(^{68}\). |

Rumors and gossip within the community are feared by people who suffer from psychiatric problems. Lucinda is explicit about this. She fears the Cape Verdeans, because they can do bad things to you. Also other informants, especially the Dos Reis family is very reluctant to give information. They leave everyone out of the problems they have with their son, even their direct family members and relatives. It would only lead to

\(^{66}\) Classic Cape Verdean ideas about witchcraft are not per se of African origin as, for example, Hoorlan’s (1995) description of the fear for baby-stealing witches makes clear (stealing baby fat, see inside cover of this report). This type of witchcraft is described by Stewart and Strathern (2004) as a classic European image of witchcraft. The description of Parsons (1921) and of Graça (informant), however, do refer to classic African images of witchcraft, in which the witch enters the body to make you sick and eats babies (cf. Stewart and Strathern 2004).

\(^{67}\) The names are nicknames used on the internet.

\(^{68}\) Here Cabobaby talks about Anti’s (Dutch-Carribean migrants) and Suri’s (Surinamese migrants). Cabo’s of course are Cape Verdeans, especially young Cape Verdeans. Dieken is used for ‘giving evil looks.’ In the forum a lot of streetlanguage is used, like the word Tata’s (indigenous Dutch).
gossip and misunderstandings, as they explain. In the public debate people often refer to taboo and shame when the issue of psychiatric problems within the Cape Verdean community is at stake. In my conversations with informants I never noticed this in a degree that differed from the feelings of shame that are common in The Netherlands with other populations. People were open and willing to talk. However, they more often expressed fear for gossip and stigmatization within the community. It might be thinkable that the widely spread image of taboo on psychiatric problems is not correct and should be rephrased in a strategy to prevent gossip and uncontrollable evil that is inflicted to you within the community, or a remnant of a fear of witchcraft and sorcery. Father Stevens:

Many people come here who maybe should go to the official health care services. (...) Why this happens? Well, they….they simply wait and do nothing. (...) Cape Verdeans do not trust each other enough. That’s true as well. Sometimes people come here who have depressive feelings. And then I think: “What a pity that you come talking with me, it’s better to talk to a good friend. That’s much better, because a friend can understand you better.” And then I ask: “Don’t you have someone?” And then I always get the answer: “I do not trust anyone.” So it takes a long time before they trust someone. But when they trust someone, then it is complete trust.

Stewart and Strathern (2004) describe several studies of witchcraft in classic and modern contexts, which are interesting to reflect on in further study of the Cape Verdean community. For example, they cite the research of the anthropologist Gluckman who describes the prevalence of witchcraft in multiplex communities in which people interrelate in multiple roles as is the case in the Cape Verdean community. Conflicts that arise in one relation can be played off in another context with the same person by witchcraft accusation. They also describe the work of the Comaroffs (1993) who state:

“(…) contemporary rituals and ideas represent a search for closure and solutions to, the pressingly fragmented problems of existence that people experience. Expressing social problems in terms of body imagery (as is often done in witchcraft accusations, HB) is a way of trying to cope with those complexities and to develop some defenses against them. (…) We should not regard contemporary witchcraft notions as simply metaphors or ways of referring to social processes. Since they are grounded in the body and the emotions, they directly recognize that as people’s bodily energies and their mental faculties that are used up or ‘consumed’ in the stresses of life.” (2004:76)

The story of Rosa is exemplary in this respect where social and emotional hopelessness and bodily suffering go hand in hand with the conviction that a bad spirit, in this case send by a sick person, is stuck inside the body. Although it is not explicitly said that this spirit is consuming something, Rosa is explicit that it consumes her life (energy) and is
exhausting. Finally, Stewart and Strathern describe studies that focus on economic aspects of witchcraft in modern context. For example, the differences in wealth, which develop by forced dislocations of communities and migration:

Monetization perhaps also tends to increase the range of differences of wealth between people in village communities because of their different life opportunities. And it may enable people to withdraw from or deny the different kinds of ‘leveling’ obligations of reciprocity and redistribution entailed by the norms of village life. Or if they try to maintain such obligations, they soon find that they cannot meet their ends and that others are still unsatisfied. A pervasive aura and fear of jealousy is thus set up (2004: 730).

It is tempting to put the fine interplay of mutual obligations, with all its limitations and attempts to prevent problems and misunderstandings (cf. Reekers 1997; Silva 1996; Vuisje 2004, Carling 2002) following migration and transnational bonds of the Cape Verdeans in this context. Da Graça (1996) describes the elaborate system of charity organizations within the Dutch Cape Verdaen community and their village-wise types of organization. Charity is following the paths of personal contacts between the country of residence and the homeland.

Attributing a problem to spirits, sorcery and witchcraft does not mean that the origin of the problem is self-evident. It can be hard to find out ‘who did it’ and even harder to treat it. The understanding of misfortune in terms of spirits in a classic or modern sense presupposes social cohesion and sufficient social network. This is not self-evident in Dutch society, even within the tight Cape Verdaen community. And social contacts can be blocked by medication as Rosa keeps on telling. Rosa received long-term psychiatric treatment and gets anti-psychotic medication (Risperdal) which causes serious side-effects. She is constantly tired, complains about bodily pains and has heavy feelings in her legs, which prevent her to go out. Her experience is expressed in terms of physical exhaustion and pains throughout the body. She has an apartment on the fourth floor, without an elevator and she cannot walk the stairs on her own. The community nurse cannot assist her in getting another house. The image I get is that not only the spirit is stuck, but she herself is stuck and is losing contact with the social environment and her community, which causes the spirit to get stuck. Here the idiom of spirit possession and
strong physical discomfort go hand in hand (Stewart and Strathern 2004; Comaroff & Comaroff 1993). Rosa consulted curandeiros, but reports that they were not able to help her and cost her a lot of money. Luiza talks about the problems of her mother and the spirits that bother her. Her mother keeps on swearing to these spirits and their voices, but the problems persist because people who have ‘this illness’ never admit that they are ill. Consequently it is hard to treat them.

Witchcraft and sorcery are explanations of sickness which, in the Cape Verden community The Netherlands are hard to find and are hardly found in their classic appearance, or are marginal. In this paragraph it is hypothesized that they nonetheless seem to have left their traces and deserve further study.

6.2 Pathophysiology and course of sickness
When talking about psychiatric problems in a general way, Cape Verdeans see gradations. In the first place a difference seems to be made between ‘having problems’ and ‘being crazy.’ Having problems refers to having stress and is associated with social and socio-economic factors: financial problems, problems at work, educational problems, or marital problems. It is a reason to go to the community mental health centre (Riagg) or to the social worker. It is possible to deal with them in their social context: family, community, neighborhood, on the job. ‘Being crazy’ is a more serious state and associated with ‘the inevitable,’ something that came from outside and now sneaks into your life. There is less unanimity about the etiology and responsibility for these states of mind and behavior. To interpret them in terms of social etiology or deal with them in a social way, is less evident.

‘Having problems’ is considered stressing, but attributable, understandable, traceable in the specific context of the bearer of the problems and also considered to be part of life. These types of problems are often referred to as ‘psychosocial’ by mental health care and not seen as their prime responsibility. In the context of this research it is remarkable that Cape Verdeans, however, connect them to help by the community mental health centre. These centers apparently are the places where they treat ‘solvable’ problems, while the mental hospital deals with the ‘unsolvable.’ Miguel is referred to the
community mental health centre by his general practitioner, because his physical problems apparently are stress-related. He talks about the prejudice against psychologists, about his motives to go there (no problems, but troubles and feelings of exclusion) and the helpful, but non-useful dismissal:

Yes, sometimes people say there must be crazy things in your head. I say: ‘no.’ I go there and everything I can explain, I will explain. If I get into trouble and a psychologist is misunderstood, that’s their problem. I am not crazy, but some things are not going well; with finances, I do not do a lot of things, I cannot go on a holiday. That’s no problem, but it troubles me. I want to get opportunities like everybody else, to go on with my life. (…) The last visit, the psychologist said: ‘I do not want to see you anymore.’ Yes I understand very well what he means. It’s not because he doesn’t want to see me living. But okay Miguel you are welcome to come and see me, but on the other side, go on with your life. (…) I am somebody who says: ‘You can never learn enough.’ So you go there and this man talks with you. Of course you need more time. Advice: Miguel, you’re not satisfied with your employer, go somewhere else. Try it through another service provider…..

‘Being crazy’ is a much more serious state. In this study I discerned seven (sometimes overlapping) dimensions in the descriptions of these serious mental conditions by Cape Verdeans:

1. Developmental dimension and powerlessness:

Madness is something that sneaks into your life and comes in small steps. People are not aware of changes. It is associated with external influences, like drug-abuse or the weather, that are hardly influenceable. Mr Dos Santos about his son:

Yes he hears voices, but only after he uses drugs. (…) I do not think he has psychiatric problems. Yes he is psychotic, but that is caused by drugs. I think he is hypersensitive to drugs. Every small substance causes big harm in his brain. Or Lucinda: Except for the weather…the weather here makes me feel bad. In winter I feel dark in my heart. Then I do not have the courage to go outside through the cold and then I feel pain in my head.

The powerlessness is not only connected to the onset of the problems, but also to the understanding and the treatment. The causation of a psychiatric problem is not always obvious and when it is a lasting problem in which a spirit is involved, it is hard to influence the problem as well as the (social) cause of it. Da Silva puts problems in a larger life scheme of social relations, obligations and hopes:

All kinds of suppressed things, not having everything clear, dreams you couldn’t realize, and so on. Not only for yourself, but also for other people. You did wrong to some people and ask yourself

69 In fact, Miguel is referred by his general practitioner to any possibly relevant medical specialist to get a grip on his (vague) complaints.
how to mend that. I think it’s more like a moral pressure that constantly is at stake. (…) I think it is a painful situation and without support people are not able to get out of it.

2. Behavioral and sensatory dimension:
Being crazy is something serious and fearful. The following negative attributes were mentioned: potentially aggressive, unpredictable and with changing moods, passive or motionless or unable; with many thoughts in your head; hearing voices; despair and grief; not able to take personal responsibility; not able to keep agreements. In this study Bemvinda, the Dos Santos family, Luiza, and Graça all refer to serious acts of violence by their relatives. These vary from fights, to smashing and breaking things in the house, damaging cars and causing a nuisance in the neighborhood. But also suffering and not being able to do normal things are part of it. The pastor of the Igreja Universal Rotterdam-Diergaardesingel explains: “It concerns people who cannot sleep at night. (…) In the evening they hear knocking; they get bad thoughts and nightmares and cannot sleep. In this way there are all kinds of spiritual problems.”

3. Cognitive dimension:
Being crazy is something that is hard to understand and not an obvious state of mind. Words like ‘incomprehensible’ and ‘without illness-insight’ are used. Antonia talks about her sister but seems to have given up every attempt to understand her. I often see her shrug her shoulders in ignorance when I ask her what she thinks happened to her sister and what motivated her. Manuel and João talk about how hard it was to understand and follow their friend, who suffered from a bipolar disorder. João eventually went to the community mental health center to get a better understanding.

4. Motivational and moral dimension:
The person suffering is to blame. Attributed to motivational weakness, ‘spinelessness,’ lack of discipline, passiveness, clumsiness, restlessness and being noisy, not keeping agreements. The problem is associated with loss of the right of self-determination, only treatable by exclusion and confinement, acknowledged only when hospitalized (delegated responsibility) and non-negotiable. Bemvinda about her daughter:

She talks a lot with her brothers and sisters, but won’t listen. She fought with her big brother. (…) That is why my son does not want to get involved with her anymore. They want to help, but this is
really difficult to accomplish. She is really difficult, sick, and with a bad attitude… I do not know where it comes from.

Mr Dos Santos about his son:

His biggest problem is that he always wanted to be the smartest and the strongest. That’s where it started. His teachers used to say: ‘He is a super student but he has one weak point: he always wants to be the best.’ (…) He knows no limits: not with eating, not with drinking. Sometimes he puts the music on very loudly and opens the windows, just to provoke people. (…) Once he defecated in the wastebasket in his room. Then I said: ‘Now we have enough of you.’ I called the police.

5. Social dimension:

It is hard to communicate with mad people. The problem itself is without (comprehensible) language or words, not expressible. Being crazy is also something that is hard to deal with within the family or the social network, because it is impossible to address the ill person without having trouble, to communicate or to reach an agreement. Luiza about her mother: “When people have this kind of illness (…) they never admit that they are ill.” On the other hand, the patients themselves report that they are confronted with mistrust and that their questions for help are not treated seriously when people they talk to, suspect psychiatric problems. This is reported of contacts with the police, but also of general practitioners and doctors that are connected to social security agencies, or Arbodienst. Being crazy is something you do not talk about and that can lead to moral condemnation. People start gossiping about the person. Ana explains how she is accused of being a prostitute, when in trouble. This can lead to isolation: people are left to their fate, also by family members. Silva (1997:37):

The Cape Verdeans, who are deviating concerning ‘nossa maneira de ser,’ often are marginalized. Often certain men are marginalized because they, in the eyes of many, insufficiently take care of their families. But also Cape Verdeans, who were imprisoned for whichever reason, often are marginalized. (…) People take notice of appearance and if there is negligence, there is enough reason to get doubts about his or her behavior.

Sometimes, however, it is also hard to mobilize the necessary social support because of the fact that close family members still are in Cape Verde, or elsewhere in the Cape Verdean diaspora. Lucinda tells about the way she is treated by her family after arrival in The Netherlands with psychiatric problems:

70 company medical service
My niece went to work every morning, but her husband was at home because he was declared unfit to work. I stayed there some time. And then they brought me to the Salvation Army, to a house especially for women. After a year and a half I got a house. (…) For months I couldn’t talk, I couldn’t go very far by bus or subway, and I didn’t know where other Cape Verdeans lived.

Carla, however, also blames the patients themselves for this isolation:

When people need help with practical things, when they have to go somewhere, and need help to get there or to accompany someone, then I’m ready to assist. Or to move someone: practical things. Most of the time it is this kind of help people ask. But if someone has psychiatric problems, they do not ask things from you very often. I have someone, someone who I know, yes, he is also a relative, who has psychiatric problems. He doesn’t ask. You try to support this person a little bit, asking how he is doing and things like that. (…) You try, yes you try. Or give advice, for example people with medication: ‘remember to take your medication, because when you do not do it, that’s not good.

6. Fear for contagion: the hygienic dimension

Some people experience the problem as contagious. Cabral (1980) describes the fear on the Cape Verdean islands that possession by bad spirits which comes with all kinds of misfortune can pass to other family members. It is not unusual, according to Cabral, to have a sick child being treated by the compadres, since they are expected to be more effective in administering the medication, also when it concerns allopathic medication. In a previous paragraph I described the current fear for social and genetic heredity: when there is someone in the family with a serious psychiatric illness, the risk that it will pass to you is feared and sometimes seen as an almost 100% chance. It passes through genes; they are inside you, but these genes are feared as if they are germs, coming from outside. But the contagion can also come from moral condemnation. Elleswijk (1997) stresses the importance of the social network in the Cape Verdean community. Family ties and mutual solidarity are very strong. The other side of this solidarity, however, is the high degree of social control and mistrust, which is reported as much as the element of mutual support. So there is also a self-limiting mechanism. Asking for help with financial problems can cause the news to spread and bring shame on you. When a relative refuses to help, this can bring shame on him too. Some of the informants are cautious when talking to friends, because this can lead to gossip. Sometimes the shame which is resting on the one with the problems is transferred to you, when the sick person does things, which are unacceptable to the rest of the family. Mr Dos Santos is indebted to his brother since his son bothered him, and the shame that rested on his schizophrenic son struck him as well. The Lopes family, who have a son with serious psychiatric problems, are very definite in their
opinion that they have to keep their problems indoors. Particularly; keep family or relatives out, as Mr Lopes explains, because they would surely misunderstand what is happening and start gossiping. Lucinda is also explicit about her fear for Cape Verdeans in the Dutch community, who can do ‘bad things’ to you.

7. Physical dimension:
Almost all the informants who were diagnosed as suffering from psychosis and received and used anti-psychotic medication, complained about physical discomfort, especially pain, but also weakness and powerlessness of the limbs. The complaints refer to pain in the back, pain in the head, in the arms, and around the waist. Some of the informants attribute these pains to spirits that entered the body, and as these spirits move in the body, the pain also moves. Mrs Soares talks about the direct relation between spirits and pain:

Interviewer: “(…) You got pain in the body?”
Mrs Soares: “Pain, spirits move in my body. (…) pain everywhere.”
Interviewer: “In the legs and in the arms?”
Mrs Soares: “Arms, here (points at her back) got stuck here.”
Interviewer: “In the back?”
Mrs Soares: “Here, at the side, and made my breath smell.”
The pains are experienced as spasmic and tense pains, but in other moments Mrs Soares talks about stings. Medication (anti-psychotics) helps against the pains:

Mrs Soares: “Yes this medicine is really special; this medicine really is the best. (…) I forget that the spirit moves in my head. I am sick, deaf. But now I feel better.”

Rosa complains constantly about pain that moves through her body:

Rosa: “I do not know; it walks in me, to my ears, to my head, to my back. It is in my back; many problems, it is pain, everything (…).”
Partner of Rosa: “Only the legs are a little bit tired, no pain but powerless.”

Lucinda and Sofia also complain about pains in the head and in the back and heart palpitations. The pains, however, are not only attributed to the problem-complex or to spirits. But the side-effects of medication are also seen as a relevant factor and pain is also used in a metaphorical way, as a word that designates ‘suffering.’ This is made clear by Antonio:

Antonio: “(…) and when I came to the mental hospital they gave me all kinds of therapy and medicines, and then I got pain everywhere. At a certain point I could not move or do anything. I suffered a lot.”
Interviewer: “Physical pain?”
Antonio: “Physical pain, and also psychologically. Fortunately I’ve got a lot of help at home, to clean the house and things like that, and sometimes I didn’t go out to get food to eat. (…) Yes I
think that this pain is caused by an evil substance that enters (the body, HB) and by the working of the medicines. (…) both of them.”

Interviewer: “So the medication has something negative besides of working against this evil substance?”

Antonio: “Yes that is what I experienced.” And then, talking about the effect of medication: “It was too strong, and when I took it, it felt as if I had a heavy sea.”

The physical discomfort (pains and weakness, tiredness) as reported can be caused by the anti-psychotic medication (Risperdal, Zyprexa) which several of the informants used. It is known that these medications have these side-effects, and later the community mental health nurse who supports Rosa explains that she tries to decrease the dose to find a better balance between anti-psychotic effects and negative side-effects of the prescribed drugs.

Finally Dina, who is young, knows how to handle the Dutch medical system, and rejects the traditional Cape Verdean way of understanding psychiatric problems, reports the experience of physical pain as a side-effect of blocked emotions. Dina:

It brought to light that a lot was blocked. I was in a lot of physical pain in that time. I went to the doctor, but he thought it was because of the job, because of stress; not because of all the emotions I bottled up. Recently I went to see him because I had pain on the chest. He said it was because of the pressure, that I was too tense.

These reports of pain should not be understood as a form of somatization in which the physical problem is substituting a psychological problem. The pains are interpreted as caused by spirits that entered the body and as such they are part of the constitution of the problem, or the illness-complex. Finally, pain is also used in a metaphorical way.

### 6.3. Time and mode of onset of symptoms

Time and mode of onset of the symptoms deals partly with the issue of experiences people perceive when they realize something is wrong. When they perceive “a deviation (…) from the culturally and historically defined standard of normality established by everyday experience” (Chrisman, 1977: 355) and on the issue of ‘why it is happening now?’ The data on these issues in this study are limited because most informants had longtime contacts with health care providers, making retrospection harder. As described before, having problems is often attributed to psychosocial circumstances and ‘being crazy’ to less easily detectable causes. These problems come in small steps and changes are hard to discern. One of the aspects of psychiatric problems that make the situation worse is the

---

71 Antonio used to be a sailor.
fact that many Cape Verdeans make clear that psychiatric patients do not recognize their problem and nor admit they have such a problem. The moment when problems arise can be very different, but the moment of migration, divorce or substance abuse, or moments of luck are mentioned as triggers of psychiatric problems. Lucinda tells: “When I came to The Netherlands, the problems started. Headaches, I didn’t sleep well anymore, and then the stress of working. After the job is done, going home and this and that, and then I would collapse completely.” Lucinda is convinced that the weather, especially the coldness, makes her ill. Furthermore, life in The Netherlands does not meet the expectations in all respects.

6.4 Treatment
The described causes of health problems refer to different causal agents: ancestral spirits, jealousy, substance abuse, roaming spirits, heredity, witches and sorcerers, evil eye, all of which need different ways of treatment. Health problems are associated with (1) personal vulnerability, for which you can bear personal responsibility; (2) negative influences which come from outside (either spiritual, interpersonal, biomedical or socio-economic); and (3) the inevitable, the ordeals that come to you, which you have to endure and bear. Treatment has to address these different aspects: given the Dutch health care, this asks for an eclectic type of health seeking behavior. The Centro Redentor deals with roaming spirits; ancestral spirits; personal responsibilities are addressed, personal advice is given and social support averts negative influences, but also gives power and support to endure trouble. Indigenous healers and the Igreja Universal take care of sorcerers, evil eye, Satan and witches and defends against the unavoidable. The Catholic church blesses and sprinkles holy water for protection from spirits. Professional mental health care can avert negative social influences (debts, voices, landlords, the boss) through letters, advocacy and authority and psycho pharmaceutics, gives power and support to endure hardships. It is a type of eclecticism also described by one of the respondents of Seeber-Tegethoff (1998) in Brazil:

All religions are good, but every one of them for its own special occasion. For someone who has no problems in life, the catholic religion is best: one deals with the saints, go to church when you are up to it and nobody bothers you. For someone with financial problems the Pentecostal church is best, because they help you like brothers and sisters, except that one can neither drink, smoke,
dance, nor do something else. But for someone with a headache the best religion is that of the spiritists. Spiritism is exacting, one is not allowed to miss sessions, but it really heals. When God wills, when I am healed from everything, I will return to Catholicism (1998: 96).

The diversity of the different pathways and treatment actions will be described in detail in the follow-up study (Beijers 2004b).

Cape Verdeans looking for health, have a syncretic blend of ideas and thoughts about their sickness and walk and work simultaneous pathways. For example: going to an indigenous healer (curandeiro), going to the Roman-Catholic church or to a spiritual centre. Although the opinion is expressed that serious mental illness should be treated in the mental hospital, there is no convincing evidence that allopathic health care is used when the problem presumably gets more serious and complementary medicine is used to treat ‘the lesser problems,’ as is suggested by Kortmann (2003). When referring to the mental hospital as a desired place of treatment, informants in this study were primarily thinking of the asylum functions and the aspect of custody of these facilities, to contain danger and not of adequate treatment.

These findings of simultaneously used but apparently contrasting explanatory models of spiritual healing and dominant allopathic medicine are also reported in other studies in situations where traditional conceptions about illness compete with modern allopathic medicine. Joel et al. (2003) found that 35% of a sample of South Indian community health workers believed that schizophrenia is a disease, while simultaneously 23.8% suggested that the doctor would not be able to help the patients. The same study described how patients hold beliefs about black magic and evil spirits as cause of their illness (schizophrenia) and yet are willing to be treated and hospitalized for this disease. Similar contrasts are reported in mental health care in The Netherlands (personal communication). Migrants who are treated in a mental hospital are very compliant with the doctor’s view and explanation of their problem. This compliance is interpreted as a form of respect for the authority of the doctor and also fears for the sanctions that can be imposed. When interviewed later by a (non-medical) researcher at home, the same patient tells another story where a spiritual explanation (‘djinns’) is much more prominent. This suggests that also the location (home or the hospital) in which the explanation is relevant

---

72 Conversation with an intercultural manager of a mental hospital in The Netherlands. In this case it concerned Moroccan immigrants to The Netherlands.
and the power distribution per situation are relevant factors in the patient’s statements about his illness. This is confirmed by Kleinman (1980).

Treatment opportunities in the folksector (churches, spiritual healing practices) proved to be susceptible for this diversity in needs and wishes of their Cape Verdean ‘patients.’ In the Igreja Universal and the Centro Redentor double standards are used: the explanation of all kinds of misfortune is primarily attributed to spiritual causes, but in practice, referral to allopathic medicine is a path that is brought to the attention as well. This is not contradictory per se: Seeber-Tegethoff (1998) and Freston (1998) describe the combination of modernity and tradition as one of the factors contributing to the success of the Igreja Universal. Modern western understanding about illnesses (viruses and bacteria as causal agents of illnesses) is combined with traditional images of ghosts, devils and jealous fellow men as causal factors. This combination of explanations meets the needs and the practice of many of its followers to use complementary medicine next to biomedical medicine. In the interviews my interlocutors (key informants of the Igreja Universal) reassure me that they act in a responsible way in this respect and do not withhold allopathic treatment73. “We are no surgeons” as often is said and examples that are given in this respect concern serious physical injuries: “we cannot mend broken legs.”

According to the pastor of the Igreja Universal Rotterdam-Diergaardesingel, people come to him: “..who use drugs, alcoholics, people who drink a lot, people without direction, and we help them with what they need and to find rest.” Then he distinguishes between problems that are material, or ‘doctors problems’, and problems that are spiritual:

For example if it is a spiritual problem, we pray. If it is a ‘doctors problem,’ or of any other person, than we’ll find a way to find the right person. Because there is spiritual help and help a doctor should give.” Furthermore: “The psychiatrist sends them here and then suddenly it is not a problem a person, a doctor, a psychiatrist or a therapist can solve, because it is a spiritual problem. It is a problem that only can be solved by praying. Only by praying ‘in the name of Jesus,’ a person can free himself. Because in the field of matter, medication, the doctor and the psychiatrist can help. Spiritual problems are not visible. When the doctor looks with x-rays, he doesn’t see anything. People complain, they have headaches, but the doctor cannot find anything. It is a spiritual problem. Only by praying and forceful prayer ‘in the name of God,’ people can free themselves.

Bishop Souza of the Igreja Universal refers to psychiatric treatment:

73 The Netherlands witnessed several criminal cases in recent years against classical homeopaths who dissuaded patients with a tumor from seeing an oncologist. Several patients died. These cases are seen as a serious offense and a spectre for many practitioners of complementary medicine.
It is remarkable; a person can be saddled with a heavy depression, or a serious psychiatric problem. Of course we treat this person, like we treat other people, by supporting them and talking. We tell him: when this is caused by obscure forces, then these forces will be punished. We always say this person has to find professional help as well. Often people tell us that they already have a long lasting contact with psychiatry: “Psychiatrists have been treating me already for a long time, but it doesn’t help at all. It only seems to get worse. I do not want to go back there.” They complain: “I know this is not a problem for doctors; only God can help me.” But even with this person we stress that professional help is important, apart from our role. Our work is spiritual, according to Gods word, we work according to the faith, but we never studied psychiatry, so we cannot replace their work. But sometimes, to be honest, it is difficult to convince these people that they have to look for professional help. Because some people say: “No I will not go!” It is hard to convince someone this is necessary, because they look at psychiatrists and the mental hospital as an enemy, not as someone who can help. (…) This is not just. Some people who (…) are not believers (…) who never visited a church, (…) recovered completely with psychiatric treatment.

Problems that are hard to handle through prayer are referred. The quality of referrals, however, can be questioned since the pastor of the Igreja Universal Rotterdam-Diergaardesingel and his assistant seem to be completely ignorant about the meaning of psychiatric problems in Dutch society and where to find help in Rotterdam.74

Racionalismo Cristão just focuses on spiritual problems. People with physical problems need to consult a doctor, as is explained by the president of the Centro Redentor.

Acceptance of the help of a psychiatrist, however, is also stimulated as is made clear by the message of a spirit in one of the meetings. This spirit tells, through one of the mediums, how he experienced clairvoyance in his youth and was ignorant about it.

Assistance of a psychiatrist helped to see and interpret this in a positive way:

(…) Since childhood I was attacked by inferior spirits, which scared me sometimes. Other times that force followed me home to my parents and my parents were good parents. In my youth I had many disorders and unrest, I had to ask for a psychiatrist’s advice. And that helped and I became balanced again with my spirit. Since then, instead of feeling fear, I started to use them, knowing that I was being badly assisted. Of course I realized and noticed; when I got bad assistance I saw something in a bad way. When in a period of good assistance, it was something superior and that advice was what helped me, to keep my interior balance, to receive the superior strength and help me to be a great man, and today I feel very satisfied. The time has come to reach my world.” (…) Later in a dialogue the president of the meeting answers this spirit: “Getting lost, caused by evil spirits, which are waiting for the opportunity to act on the beings. And it is very sad that some people give asylum to that bad influence. That is why, like this spirit said, thanks to the professional knowledge of the psychiatrist, he could grow stronger. We imagine that if professional psychiatrists had the knowledge of the great obra (works), that we follow; it is certain that, as we know, they would become better doctors.” (…) Well, spirit of great value and also victorious spirit, we are happy with the beautiful things you are telling, so others will know

---

74 My conversation with the pastor is in Portuguese and simultaneously translated by the assistant-pastor. An extra translation of the recording by a native Portuguese speaker reveals that they are hesitant and apparently ignorant in their way of formulating and answering, when talking about formal mental health care. For example neither of them know the word ‘Riagg’ (community mental health centre).

75 Recorded in the Centro Redentor in Amsterdam, on 6 October 2002.
themselves better, also with the help of a psychiatrist or of creatures that know these precious works (obra), and can give their support, to push away the influence of the bad spirits. We will try to help you go to your world with our irradiações of fraternity.

It is interesting to see how this spirit and the president work together here to make clear that the help of a psychiatrist is appropriate, next to the help of the people who know the great obra. The crux of witnessing this kind of dialogue is to help the followers of Racionalismo Cristão to reflect and self-analyze, and to get advice. This dialogue seemed to be especially relevant for a young Cape Verdean girl who was invited to be present and sit on the ‘patient’s chair’ next to the mediums, where positive influences are optimal. She suffered from serious problems, as the president told me afterwards.

The pastor of the Roman-Catholic church is critical about the results and the work of the formal mental health care, but also very dedicated and loyal to their expertise and way of treating and dealing with psychiatric problems. Initially he is also very averse to any type of ‘miracle practices’ which, according to him, currently are so appealing to many Cape Verdians. He is almost tempted to explicitly condemn them. He trivializes the relevance of spiritual explanations and healing, and clarifies how he co-operates with the community mental health centre and refers people for treatment. Later in the conversation, however, he explains how he complies to the needs and requests of his parishioners to have a ‘touch of magic.’ Father Stevens:

I sometimes see people who are confused because they hear voices. I definitely encounter such things. And then of course I know – I’m not a psychologist – that this often simply is an expression of having so many problems that your head cannot deal with it anymore. And then you start to hear and see all kinds of things and so on. This is a consequence of that. But, yes, sometimes it is also very strongly connected with spirits. I learned that, I think I got it from Brazil76; then I help people with that. You have to help people by means of the things in which they believe. So when somebody comes to me and I know I can help him with a blessing, because I tell him that by this blessing he will be free from certain thoughts and spirits, then I do so, because he believes in this.”

Interviewer: “(…), but this is almost a magical act.”

Father Stevens: “Almost a magical act, yes. There is not much space between them. I once met a woman whose husband was killed, and she was very confused, this lady, because her husband died and she had not been able to tell him she was pregnant of another man’s child. She thought it was horrible, that this man died this way. And now she thought that the spirit of this man hovered above her and inflicted all kinds of things upon her. I depart from the idea that this idea is real to her, and I say: ‘Well then we will talk to this man.’ Then we ask for forgiveness - you have to be open, and we ask for forgiveness.’ And then I use means to appease the spirit of this man, because she believes in this. So this is a little bit of magic, but I help people at a certain moment, that’s my point of departure. And I do not have to tell untruths. Then I say: ‘Well, then we’ll use Holy Water when just a conversation is not helpful. Holy Water purifies.’ Then I sprinkle this person with Holy

76 Father Stevens was a missionary in Brazil.
Water. I went so far to bring in incense, and at a certain moment that helped. That’s what I mean with using the things in which they believe themselves, to free them from the things they suffer from so severely.”

(…) “A young man called me: ‘You have to lay your hands on my head!’ Well, you have to take care with that because you do not want to be seen as a wonder-worker. That’s a risk and that’s something I really do not want. But then I explain: ‘I lay my hands on you, but these are God’s hands. I’m not doing anything. It’s just God’s blessing.’ I explain it like that. I did a laying on of hands and when I have put it in the right context, well…then I think it helps.”

The social worker from the Roman-Catholic parish acknowledges the meaning of complementary treatments, the hope people derive from it when they suffer from health problems, from its effectivity and the risks of consulting and relying on it completely. The parish seems to be especially dedicated to this message and to leading Cape Verdean patients to the Dutch allopathic medical reality:

(…) it is part of our culture and there are a lot of people who practice it. I will give you an example: we had someone here, a girl 28 years of age, who got sick suddenly. The doctor said: we cannot do anything for her anymore. So she went to France to find new hope. And at a certain moment she got so much hope that she said to the doctor: “What do you know? You do not know a thing!” And then she goes there and then she is … uhm… I think it is abuse, to abuse their psychological condition. Because… uhm… a realistic Dutchman would do such a thing out of curiosity: to test if they would tell the truth or could be unmasked. But a Cape Verdean goes there because it gives hope. They grasp something. And when this lady (the healer in France, HB) tells: “Well, when I see that the people, who come here, will die, I will not start a treatment, but with you I will do so, because you are not ready to die yet.” Well, she is dead now! (Hits the table with her fist).

When looking for treatment, Cape Verdeans want to have all aspects of the problem addressed, the spiritual as well as the physical and also the social aspects. In their health-seeking behavior they are eclectic, in order to meet this need and this diversity in needs and wishes is well recognized by complementary health care as practiced in the churches and spiritual communities.

6.5 Health beliefs: conclusions

Spiritual experience and the conviction that supernatural phenomena are relevant in everyday life are important points of reference for giving meaning to health problems and making choices in pathways to health. This should not be seen as a static and reified vignette of Cape Verdean identity, because beliefs and practices within this community are diverse. Beliefs and doctrines and their moral categories are socially represented and have impregnated everyday social life, also detached from specific religious practices. The Cape Verdean community, especially where a Barlavento origin is dominant, is
‘Christian-Spiritual,’ in which the values of suffering and endurance for the sake of getting better, of charity and mutual responsibility, and of fear and respect for the inevitable, can flourish. This ‘mission,’ however, is carried with pride and sometimes seen as a shared Cape Verdean dedication. It is tempting to see the picture of the Cape Verdean community as silent and invisible, as a postulate of this.

In their understanding of the origin of illness, other types of misfortune and the possibilities of treatment, often three interplaying factors can be discerned:

1. Personal vulnerability, for which you can bear personal responsibility;
2. Negative influences, which come from outside (either spiritual, interpersonal, biomedical or socio-economic) and;
3. The inevitable, the ordeals that come to you, which you have to endure and bear. These ordeals can be hereditary or based on evolutionary debt. In a wider historical context these ordeals originated from climatological conditions and famines on the Cape Verdean islands, but also colonial oppression and slavery can be seen in this respect.

The understanding of sickness can be spiritual, but the treatment and the healing practices often have a clear social component and cognitive and behavioral implications. In that respect these different understandings can be seen as ‘idioms of distress’ in the way Nichter (1981) proposes. Diagnosing and understanding the (personal, social, interpersonal and cross generational) etiology and effective treatment of illness never is self-evident, not for the one who is suffering, not for the people in the social network who have to deal with it, nor for the professional who has to treat the sick person. The current social circumstances of living in the Dutch society, in which old social ties and mutual obligations are hard to keep upright or to enforce, make classic understandings of misfortune and functions of rituals hard to maintain. In this process of social change, new rituals probably develop, as is demonstrated by the controversies of first and second generation Cape Verdeans, but not without feelings of fear and being lost.
7. Social and cultural context of illness and getting better: the lay health system.

In this chapter I will place the Cape Verdean health beliefs in the context of the formal and informal social network of the Cape Verdean community and (available) treatment choices. Then I will combine the different elements (including the structural (socio-economic, gender etc.) situation of the Cape Verdeans) in a summarizing description of the Lay Health System of the Cape Verdeans in The Netherlands.

7.1 Informal and formal social network
Health problems surface in everyday life and everyday circumstances: family life, among friends, at school, at work. Within these contexts they are experienced and observed. These everyday situations represent the formal and informal social networks in which the lay health system materializes and in which health problems are experienced, assessed and treated. Chrisman (1977) focuses primarily on the informal social network and on the degree of insularity of an individual or group and the quality of information and knowledge that is held by the relevant group. Important factors are social heterogeneity, quality of information and skills, the internal degree of compactness or dispersal of social contacts, and the extent of overlapping roles. He summarizes these aspects as ‘life-style.’ However, the formal social network is also relevant in this respect: institutions in everyday life where problems become manifest where they are assessed and treated in the sense that a person is let of certain (social) obligations and is permitted (or not) to take some rest, to see the doctor, to stay at home from work, etc. This mostly goes together with the obligation to look for treatment or do your best to get better. The range of formal institutions and professions in The Netherlands that might signalize when something is wrong, is extensive. In the context of this study, the educational system, public housing providers, social security services (welfare, company medical services), and churches are mentioned. For the sake of this research I will refer to them as the ‘zero-line’-institutions. In these instances, quality of information, knowledge and skills next to receptivity to (mental) health problems, and degree of insularity of the organization are also factors that are relevant to the lay health system. The characteristics of both the informal and the
formal social network refer to the socially and culturally determined position of the group you belong to.

The way the Cape Verdean community is described, seems to harbor many paradoxes: the community is closed and invisible, is uniform and built on solidarity, but is also described as multi-stratified and divided or even splintered, based on political controversies, island and village origin, educational strata and generations. How should the combination of these two images be understood and what is its relevance to the Lay Health System? Cape Verdeans experience their community as a solid backup. When in trouble, Cape Verdeans refer in the first place to their social network. Mr Dos Santos: “Within the Cape Verdean community you always come to a solution.”

This community feeling is very self-evident and does not have to be made explicit. Very often people refer to other Cape Verdeans as somebody they know, even if the social distance is large and they do not know the name or the address of this particular person. Cape Verdeans help each other when coming to The Netherlands, with finding a job, finding housing, and providing housing. When in psychosocial problems they help to find help, they show support by going to the mental health care service, they organize trips to Paris to see the clairvoyant Brazilian doctor. Sometimes they take the place of the person who suffers from the problem and go to the doctor themselves. They try to prevent deterioration of the situation. Help with writing and understanding of letters and documents; giving financial support; storage of goods; washing clothes; providing meals; and serving as postal address. This idea of community has to be widely interpreted: children or parents in The Netherlands or abroad, family members like nieces and nephews, aunts and uncles, friends, neighbors, the Cape Verdean community at large (relatives in Cape Verde or in other countries are part of that (references to: Cape Verde, Portugal, France, USA, Brazil, Germany and Luxemburg). The range and social heterogeneity of this network, however, still is limited, as is explained by D. Teresa, who tells how she worked in the cleaning industry for decades, but did not manage to get to learn Dutch, because only migrants do

---

As seen before, this support is limited in the case of serious madness or a situation that Silva describes as desleixado. Marginalization and isolation are solutions that are experienced in these circumstances. Fear of gossip plays a role in this. As argued, gossip not only leads to ‘knowledge that is spread,’ but also is a mechanism to ‘purify’ the community of unwanted elements, as in accusations of witchcraft and in political controversy, as is argued by Stewart & Strathern (2004).
this type of work. Lingua franca on the job was Portuguese. This also limits the possibilities to get acquainted with the Dutch situation. Although the network is transnational, in some respects it seems to be more of the same thing. Some people tell how they are brought back to Cape Verde when there is no solution or effective health seeking process visible in The Netherlands. This happened to Lucinda. Her mother from Cape Verde visited her in The Netherlands and took her back instantly to have treatment for her problems in Cape Verde. There, family and their own doctors, who speak Crioulo, took care. Rosa went there to consult a curandeiro.78

Arrangements are made in an informal way, without appointments, but nonetheless expecting that you will be responding without further delay, as soon as possible. This reflects the relevance of trustworthiness, mutuality and redistribution in personal relations. The helping relation is seen as a personal relation based on mutual and interpersonal understanding. I witnessed a conversation about an insurance problem of a Cape Verdean man with his insurance agent. The man did not bring arguments in the dispute, but instead kept on stressing his good will, their mutual personal commitment, and his strong wish that together they would work everything out:

I am sure everything will be okay…me with you, we’ll try to inform each other, how to do better and go further. We’ll make an appointment, that’s a better solution. (…) But, it will work out fine, you and me.” (Conversation ends).

In my personal contact with Cape Verdeans I experienced this kind of contact many times: having a conversation and then coming in the sphere of redistribution: you give and you take. Almost always people asked me questions, if I could do something for them: write a letter, visit an ill family member, translate something, call the psychiatrist, arrange an involuntary commitment.

In the formal network the churches are important points where problems are signalized and referred. Most active in this respect is the Roman-Catholic parish of ‘Nossa Senhora de Paz.’ In this parish social workers are active, who work closely together with formal professional mental health care, know the pathways and organize different self-help

78 There still is poverty and a lack of jobs and income in Cape Verde. And since Cape Verdeans live on a financial low standard, it is also hard to keep in contact with family on Cape Verde (telephone, internet) or to go there. Many people told me that they also fear the low standard of health care in Cape Verde, especially when they get older.
groups. But also on the job problems surface and several of the informants mention their visits to the doctor of the company medical service\textsuperscript{79}. This doctor mainly prescribes rest as soon as he suspects mental problems. These time-outs are valued but also seen as an intervention that does not affect the problem from which you suffer. The suspicion of psychiatric problems is apparently seen as serious and a reason for an instant change of attitude, as D. Teresa reported:

First she got a physical examination, but when the doctor saw in her file that she had psychopharmacological prescription, the conversation about working or not working stopped: she was not able to work and her attempts to work on a therapeutical base were not granted. These doctors are in contact with the employer, but only rarely they intervene in the working situation, even when the patient reports that the working circumstances caused the problems.

The same goes for schools and public housing providers: they signalize problems of children, problems in families, law problems, drug-abuse, etc. In the eyes of some informants schools as well as public housing institutions are careless. The critical factor for intervention seems to be the incidence of breaking (public) order. Then the student/tenant can be expelled. One of the fathers reports that school referred to the community mental health centre for testing, after which they expelled his son anyway. Silva (2003\textsuperscript{80}) focused on the - in his opinion - pivotal role schools have to play in the assistance of parents, in the referral to specialists and the support of education. This role is not played. Several informants report that the problems their children have as adolescents started at elementary school.

Living in a neighborhood where unemployment, crime, drug-abuse and prostitution are prevalent does not contribute to the chance of successful education, as one parent explains. He moved with his son from the city centre to a quiet neighborhood in the outskirts of the city, to get his son out of the bad influence of inner-city life. This problem is also recognized by the municipality of Rotterdam, which tries to reduce crime, public nuisance and the quality of education in a program that focuses on the quality of life in the submunicipality Delfshaven where most of the Cape Verdeans live.

\textsuperscript{79} Arbodienst

\textsuperscript{80} Antonio Silva during conference on ‘sexuality and Cape Verdean youth,’ in Rotterdam 25 May 2003 (not published).
Conclusion: in most cases Cape Verdeans are the first point of reference, and sometimes people from other migrant populations (especially Dutch-Caribbean and Surinamese), it was only seldom that indigenous Dutch people become part of this.

Social heterogeneity of the Cape Verdean community is low and social roles are highly overlapping. The community is well organized and socially self-sufficient. It is highly probable that you meet the same people in different positions, within the church, within a sports organization, as leaders of the community and within a political party. There are not many Cape Verdeans who have a point of reference outside the community: for example, a Cape Verdean psychiatrist or psychologist. The number of young Cape Verdean professionals, however, with a higher education and who are highly profiled is rising.

The diversity and the scope of knowledge and information that is exchanged should be seen as limited and relatively closed. Its quality questionable, but above all, the access to information seems to be dependent on chance, which makes the quality of the choices made on pathways to health unsure. For example, Antonia tells me how the social worker of the Apoio-project got in touch with her sister: “She saw my sister in the mental hospital. But my sister didn’t want to talk with her. Then she asked the nurses for relatives and she called me. She talked a lot with me about my sister.” When I have an appointment with Miguel he takes me to his aunt at the end of our conversation. Miguel asks me: “I also said, when this gentleman comes, maybe he will come to see you for a couple of minutes. But I do not know if you have much time? She lives nearby. Five minutes is enough, only to look if you can do something.” It is not a solution to give only information to the Cape Verdean community or enhance their skills, but also to empower the community by enhancing social heterogeneity and access points to relevant information and institutions.

In the reports about the formal social network of Cape Verdeans it becomes clear that on schools and on the job, in cultural or political organizations, social and cultural heterogeneity are limited and that manifestations of mental health problems are badly understood. They lead to retreat instead of involvement, to sanctions and enforcing desired behavior and to exclusion and marginalization. A public health strategy directed at enhancing skills and knowledge of zero-line institutions on the field of mental health is
advisable as well as interventions directed at enhancing the socio-economic position and social mobility of Cape Verdeans.

7.2 Treatment action
What determines the choice for a pathway to health? De França (1992) describes how the Cape Verdeans in Portugal prefer to start every treatment with domestic remedies, especially with tea. In this study some informants refer to ‘aloe vera’ as an important strengthening extract. De França further describes how the Cape Verdeans prefer using the emergency health care services. He ascribes this to the difficulties to use regular services, because of a lack of recognized status (in Portugal without documents). Other reasons are avoidance of bureaucracy, language problems, illiteracy and non-matching consulting hours of the regular doctor’s office. These practical and legal problems are relevant in the Dutch situation as well (Beijers 2004b), and looking at the differences in use of services between men and women, also gender seems to be a relevant factor. The use of and access of Cape Verdean men to mental health care services has stayed low and unchanged over the past ten years (see table 5.1). It is possible that part of the male population drops in the domain of the American bypass (figure 2.2) due to neglect and uncontrollable escalation of problems and that they address (mental) health care services via emergency units, end up in homeless shelters, or fall under custody of criminal law. This can hardly be considered a matter of choice. However, no figures are available on this supposition.

The community of Cape Verdeans is an important source of knowledge that is in no way compelling. Differences in health beliefs seem to follow the social stratification of the community as inspired by current (political) dynamics that are connected to the political situation and power relations in Cape Verde and the need to gain political and social power within Dutch society. A considerable number of Cape Verdeans relies on health beliefs, which differ from the dominant biomedical model. The breach with the skeptics, who contest this, partly follows the line between first and second generation Cape Verdeans as is explained by Suzana, who is in her thirties:

(…) it has to do with the way people look at illness. It is not treated as illness. (…) when people feel something then they go to the priest (…) to sprinkle the house with holy water and things like
that. And they definitely believe he can chase away evil spirits. (...) That is the reason why people with mental health problems (...) first ask for a conversation with the priest. In Rotterdam this are especially people from the first generation (...) they do not know how to find the right services. (...) and they are ashamed to tell that they have mental health problems. (...) They hear voices and see things that are not real. (...) Most of the time these are people who died (...) family members.”

Later, Suzana continues, talking about her personal problems:

Interviewer: “You said: ‘I was overworked and confused’.”

Suzana: “Yes, that is true, but you know, in The Netherlands I was overworked. I went to the community mental health centre and now a psychologist treats me. I can do that because I am integrated, I can express myself. (...) But most people do not look at it as an illness. So you need a kind of cultural changeover, an awakening, that it is an illness. (...) They know that something is wrong. But because of shame and feelings of guilt, they do not want to see it. Uhm... this has to do with African culture as well, that people often go to a kind of medicine man when they have mental health problems; it is a kind of voodoo, but not to hurt someone, but for your own health. (...) And of course such a man perturbs them completely. He will say: ‘Well now I know what’s wrong with you! It’s your niece who’s hurting you!’ (...) But people will not admit they go there, because they are ashamed (...)”

Interviewer: “Are they going to curandeiros?”

Suzana: “Yes, yes.”

The sceptis of Suzana is sharply countered by Luiza, who is in her late forties:

Interviewer (talking about the treatment of a relative by a doctor): “(...) they can help him physically. And voices or things he sees, which are not real, can be suppressed…”

Luiza (interrupts): “These are not things that are not real! Because they are real, do you understand? (...) Some people say they are not real, but they are real. They are real. Because they say you are seeing things that are not present, you hear things that are not present. (...) Not only Dutch people think they are not real. (...) Not all Cape Verdeans know it either.”

Luiza points here not only to the realness of her explanation of what is happening and the authenticity of the phenomena, but also on the breach with the dominant Dutch (personified by the interviewer, HB) view, and on the apparently different opinions and views within the Cape Verdean community. First generation informants mention they are hovering between their Cape Verdean origin and the Dutch present and their suffering from loneliness. This intermediate position can also cause confusion when trying to understand a problem. The second generation adolescents I meet during my research seem to be suffering less from these limitations; they have learned how to work the health care system and how to make it work. Dina tells about her course in assertiveness and how she, together with the professionals who are surrounding her, negotiates her problem and finds her way:

“I had heard about this course, from somebody I know. I wanted to learn to say NO, because I said YES and consented to everything, and I wanted to change that. It was a kind of personal development for myself. But then other things emerged. I noticed this myself. And then we

---

81 Suzana used the Dutch expression ‘in de war.’ Confused is a literal translation. She refers in this conversation to the situation in which ‘she lost track.’ Semantically ‘in de war’ also refers to ‘psychotic’, ‘loss of reality-testing’, and to situations of elderly people who suffer from dementia.
decided together that I would continue with a social worker. This happened very fast, because I could enter through this course. Otherwise it would have taken longer. There it emerged that a lot of things were blocked. I had a lot of physical pain during that time. Once in a while I went to the doctor with this, but he thought it was all about job-related stress and had nothing to do with all these emotions I was suppressing.

This type of statement is, however, not a full confession to modern Dutch society. I have seen several examples where children take care of their parents or at least express the intent to do that. A daughter who takes care of her long-term hospitalized mother and the mother who is looked after by her children in furnishing her house and dealing with the infamous Dutch bureaucracies of social security and mental health care.

People advise each other and refer each other to good doctors. This way of referring assures mutual support and common understanding of your situation and keeps your problem in the community, debatable and treatable (you are not lost). It represents the diversity of resources, of health care professionals, curandeiros, social workers, clairvoyants and so on. Complementary pathways are part of everyday life. Using allopathic medicine is never declined, but sometimes is looked at with distrust. Pathways are walked simultaneously and choices sometimes are coincidental, based on lack of information, pressure of the situation (police) or absence of prior intervention; sometimes they are based on a well-understood self-interest. The consequence is that some of the contacts between health care workers and patients and their family-members are fairly accidental and by chance, based on knowledge and presence of people, networking and being known in the community as a resource of knowledge and help. Several people report that the way help is acquired in the lay referral system depends partly on coincidence. They meet people by chance and collect information and knowledge about the health system.

Some of the health care and social security institutions in Rotterdam have Cape Verdean personnel and it seems that everybody knows them as a ‘halting-place’ and a source of knowledge, where a good referral can be found. The Apoio-project plays a role in this as well. Volunteers and social workers are present in the community and present in mental health care, where they are addressed where they mediate patients to mental health care and where they offer assistance as soon as someone is admitted to a mental hospital, has trouble getting or keeping contact with mental health care, as an interpreter and advocate.
One of the informants reports that she got into contact with an employee of the Apoio-project when she coincidentally ran into her in the mental hospital. Apparently the nurses or therapists of the hospital did not refer the patient and family members or were not able to broaden the supportive network, neither of the patient, nor of the worried family-members who, in this case, were very worried but also very patient and shy. These ‘bridgeheads’ are vital for the development of the understanding and debate about psychiatric problems within the community, as well as for the building of bridges to the rest of the society. An important instrument in this is the local Cape Verdean radio station ‘Voz de Cabo Verde’ and the weekly program on mental health of the Apoio-project. This can be interpreted in two ways: the formal mental health care is insufficiently acquainted with the Apoio project and does not connect the project to its Cape Verdean clients; Apoio has an excellent way of reaching the Cape Verdean community. These informal networks have to be addressed when mental health care wants to reach more Cape Verdeans or wants to give information about facilities. Sonja suggests that there is a need for information, but that this, as a single intervention, would not be enough:

Sonja: Yes, she has been ill but now she is in the community again and she is going to take up her life again. She said she didn’t want her family to treat her as a crazy person. That is her opinion. I also think the community should get more information to …… Not only information about diseases, but also to give these people a chance. To let these people come and make space for them. Because when you are getting in trouble with psychiatry, with the general practitioner and with the community. That’s too much for a person.

Public (health) interventions, directed at the empowerment of the Cape Verdean community should encompass information strategies; quarter mastering strategies in which opportunities to settle and develop own ways to cope with the situation can be developed; and enhancing social heterogeneity and socio-economic mobility within the Cape Verdean community.

7.3 The lay health system
As seen in Chapter 2, the lay health system comprises different elements: (a) illness-related role shifts; (b) lifestyle; and (c) health beliefs, which result in lay referral. These elements and their outcome are determined by (1) structural factors, like socio-economic class and ethnic identity; (2) by explanatory models: “knowledge and beliefs about bodily
physiology, the nature of the environment, the etiology of disease, and available treatments.” (Chrisman 1977: 362); (3) by the social context in a limited sense, e.g. the availability and diversity of social network and dispersal of social contacts; and (4) by the coerciveness and threat of the problem: vague or chronic complaints mostly are not considered to be of a very compelling nature, and in need of immediate intervention.

In general, the history of migration and the relatively low educational level of Cape Verdean immigrants in The Netherlands leads to arrears in knowledge about the structure and protocols of mental health care, and arrears in the necessary skills to master the sector. Antonia, with whom I talked to about her sister who is admitted repeatedly to a mental hospital is very shy and reserved in the conversation. She wants her son to join to translate and explain what I ask her. Almost everything I ask her about her experiences with her sister and her view on mental health care is answered with an: “I do not know.” She finally admits she thinks her sister is treated badly because of long-term seclusion and is underserved by the community services, but makes clear that she never discussed this with any of the mental health care professionals. In fact most of the time she tells she is very content with the care her sister gets.

This limits the accessibility of mental health care. The explanatory models Cape Verdeans use in relation to their experiences of psychosocial distress can differ significantly from the ones that are dominant in psychiatry or described in biomedicine. In all respects, however, the informants also had mutually diverse ideas about and diverse understanding and explanation of the problems with which they had to deal, which did not always seem coherent. There is not a single clear-cut Cape Verdean explanatory model, but there are dynamics of competing, co-existing and sometimes mutually strengthening discourses about the origin, understanding and treatment of psychosocial distress. They are represented by a competition between tradition and modernity and knowledge versus authority, as found in the contrasts between first and second generation Cape Verdean migrants. This should be seen as a Christian-spiritual repertoire from which a line of thinking and acting is chosen that best fits the demands and possibilities of the actual situation, where social constellation and availability of solutions of the moment are factors of relevance. Several (key-) informants are worried about the isolated position of the Cape Verdean elderly, who are lacking sufficient skills and knowledge to take their
place in Dutch society and receive appropriate care. They suffer from loneliness and desolation.

The distinction between ‘having problems’ and ‘being crazy’ and the associated difference in coerciveness of the problem and acute need of assertive intervention are important factors in the lay health system. As long as people are ‘having problems,’ it is possible to deal with them in their social context (family, community, neighborhood, job). These problems are understandable, communicable and negotiable. When a serious mental health problem (being crazy) is at stake, Cape Verdeans want an intervention straight away and expect affirmative and intensive help from the medical system.

Being crazy is also a condition that discharges a person from social responsibility. People are not expected to be able to take responsibility for their recovery and in terms of ‘illness related role shifts’ are completely dismissed from every responsibility, even the responsibility to do their best to get better, because they are not considered to be able to take that. This does not refer to a legitimized illness related role shift, but to a social vacuum. This can lead to serious social isolation within the community. This attitude is not unique for the Cape Verdeans as D. Teresa notices when she goes to the company doctor on ‘sick leave.’ She has to do her best to keep contact.

In terms of health beliefs, madness can be considered as something non-personal, something that comes into you and in a way ‘takes control.’ Madness is considered a problem that needs immediate and firm affirmative intervention, to contain the behavioral, motivational and social excesses that come with the problem. Next to this, for some people, a complete solution of the problem would also be to deal with the cognitive and process dimension: understanding what caused the intrusion (on a more spiritual or magical level) and getting rid of it. It is not expected that the interventions of mental health care can contribute to this in any respect.

The final image, however, should not be seen as monolithic as may seem until now. Patients have a syncretic blend of ideas and thoughts about their sickness, and walk and work simultaneous pathways: this could mean going to an indigenous healer (curandeiro), going to the Roman-catholic church or to a spiritual centre. In the Igreja Universal and the Centro Redentor double standards are used: the explanation of all kinds of misfortune is
primarily attributed to spiritual causes, but in practice referral to allopathic medicine is a path that is brought to the attention as well.

The problems are not only on the field of health beliefs and overview over the structure of mental health, but also the requisites to be a good patient (autonomous and assertive consumer) and the public discourse on migration and cultural diversity is relevant. Mental health care is rationalizing and switching to a system of ‘managed care’ in which the claimability of provided care is the leading principle. Access means following strictly prescribed pathways. Recently developed procedures and regulations which guarantee the patient’s rights are not self-evident and are in contrast with what many Cape Verdeans consider to be good and secure care. They are hard to understand as well, since information on these rights and on rules and regulations is not translated in Portuguese or Crioulo. Cape Verdeans (like other migrant populations) are de facto not known with or part of advocacy organizations of mental health care patients and are not within range of these organizations. This should be placed in a context of a rationalizing mental health care system, which is getting more expensive, more complex and more bureaucratic. This especially affects people without documents\(^2\), as is also described by De França (1992).

The political context at large, in which intolerance for cultural diversity is growing, paradoxically limits the possibilities to speak out as an autonomous and self-conscious Cape Verdean patient. This is exemplified by Miguel who makes clear that he is afraid to speak out as a patient: “I am a little bit afraid in this society. What happens, what I see everywhere… I cannot, and do not dare to argue with a doctor or a social worker.” There are, however, also factors which are specific for the process of migration and settlement of the Cape Verdean community in The Netherlands. The community lacks social recognition and adequate organization, and is insufficiently seen and recognized by mental health care institutions. Miguel observes how other migrants, for example from Turkish or Moroccan background, are better recognized and rewarded by the authorities.

\(^2\) In one of the meetings of Apoio an Angolan man complains about the limited accessibility of the community mental health centre for Angolans without documents. The psychiatrist answers that they are obliged to help everyone in a situation of emergency. Every patient, however, has to identify themselves at the front door counter with a social security number, to get access. In practice, this functions as an effective blockade.
It is not easy to be ill as a Cape Verdean and there are several reasons for this. The high number of single-parent families limits the possibilities of legitimized illness related roles shifts (time off, or time to visit the doctor), unless educational backup is organized. Since most of these families are single mother families, this probably affects Cape Verdean women more than Cape Verdean men.

The burden, however, also weighs on the children. Contact with formal mental health care is avoided because there is the fear that this will lead to an intervention of the Child Protection Agency. In some cases this avoidance and the non-recognition of this dilemma by mental health care is part of a self-fulfilling prophecy. Another reason for not being able to be ill is the type of work many Cape Verdeans have: jobs on the lower end of the socio-economic scale, badly paid and with bad labor conditions (harbors, cleaning industry). Employers represent the opinion that sick leave is something to blame and many Cape Verdeans report that they fear the risk of being dismissed (‘when you do not come, you do not have to return’). Migrants are vulnerable, and social abuse is reported: Cape Verdeans who are underpaid, kept on temporary employment contracts or without contract at all, for too long. They lack insurance or are not able to report ill without being threatened with dismissal by the employer. In periods of economic decline, migrants are treated as scapegoats, and dismissed, because they are considered badly informed or not very assertive.

These limitations and the knowledge-, skills-, and explanatory barriers that lie before mental health care make these pathways less passable and the attitude defensive. Cape Verdeans in the first place refer to their social network and the Cape Verdean community: “Within the Cape Verdean community you always come to a solution.” This should not be seen as a local, but as an ‘extended community’: children or parents in The Netherlands or abroad, family members and kin, friends, neighbors: the Cape Verdean community at large. The quality and heterogeneity of this information, however, is limited, because the community has a multiplex character. Family ties and mutual solidarity are very strong. The other side of this solidarity, however, is the high degree of social control and mistrust, which is reported as much as the element of mutual support. So there is also a self-limiting mechanism. This makes the community self-referential, but also autarkic. People get information from friends and relatives, get addresses, hear stories
and are referred to all kinds of doctors, healers, medicines, treatments in the formal and in the informal circuit. This implicates that some of the contacts between health care workers and patients and their family members are fairly accidental and by chance, based on knowledge and presence of people, networking and being known in the community as a resource of knowledge and help.

The community is an important source of knowledge that in no way is compelling, but represents the diversity of resources inside and outside formal health care. This way of referring assures mutual support, self-help and common understanding of your situation and keeps your problem in the community, debatable and treatable (you are not lost). It also keeps the system of redistribution, which is important in chain-migration, upright.
8. A view on change

The final research question referred to the opinions and judgment of representatives of the Cape Verdean community on the experiences of Cape Verdeans with the lack of quality of mental health care, and the advice that should be given to the community and to policy makers in the field of mental health care. This issue is discussed in a focus group discussion and in the ‘learning community’ of the ‘Partners in Health’ project phase 2. The focus group discussion was organized with the Apoio-project. Invitations were sent to the informants in the research and a public invitation was broadcasted on the Cape Verdean radio station ‘Voz de Cabo Verde.’ In the focus group the researcher presented preliminary results of the research and asked the participants to give their reaction and reflect on the issue what should be done about the bottlenecks. The ‘Partners in Health’ project phase 2" is a European project aiming at collecting experiences with and strategies against social exclusion of migrants from health services in six countries of the European Community (Vulpiani et al. 2000). In The Netherlands, Mikado, the intercultural mental health centre of expertise and the medical anthropology unit of the University of Amsterdam co-ordinated this project. The follow-up study (Beijers 2004b) is part of this project; the researcher provided the Learning Community with input from the research. In this chapter I will describe the bottlenecks as formulated in the learning community and the advice that was given in both groups. In general adjustments on the level of mental health care provision and mental health care structure were proposed. In this chapter I will limit myself to the scope of this study: the issues which concern health problems at the population level and the lay health system. Three problems were identified and three necessary types of intervention:

1. Knowledge deficit:
   - There are not enough epidemiological data about the mental health condition of Cape Verdean migrants in The Netherlands.
   - Cape Verdeans are insufficiently acquainted with the ‘directions of use’ of the Dutch mental health care sector, especially how to offer their problems in a way that ‘triggers’ the desired care response.
   - The Cape Verdeans in The Netherlands are insufficiently identified as a community with a specific identity and specific needs.
2. Recognition deficit:
Cape Verdeans name and interpret their experiences of psychosocial distress in a way that differs from the dominant understanding in The Netherlands. Not enough is known about these specific explanations. As a migrant, psychiatric problems are seen as being a failure and are a subject loaded with taboos.

3. Health-related social problems:
There are specific social problems in the Cape Verdean community which need attention, because they are health related. Among them:
- The high number of single-parent (mother) families
- High numbers of teenage pregnancy
- The prevalence of sexual abuse of women and children
- Debts
- The isolated position of the elderly first generation Cape Verdeans

Required interventions:

1. Interventions on the population level:
- It is necessary to develop information materials and information strategies in Crioulo and/or Portuguese, specifically for the Cape Verdean community.
- The local Cape Verdean radio and television stations are effective instruments to reach the Cape Verdean community and (mental) health issues should be a regular and returning part of the programming. In this study half of the informants reported that ‘Voz de Cape Verde,’ one of the Cape Verdean radio stations is an important source of knowledge. The Apoio-project features a weekly radio show on Sunday mornings in which information on mental heath problems and possibilities to find help are given. This program is made without sufficient financial backup, is vulnerable and suffers from lack of continuity.
2. Interventions on a community level

The learning community proposes a strategy directed at intermediates. They think the issue of mental health of Cape Verdeans is insufficiently present on the agenda of the Cape Verdean organizations (churches, social and cultural organizations, sport clubs) and of the people in key positions within these organizations. Possibilities are, for example, organization of support groups or groups and projects on health related issues. The focus group mentioned the relevance of working on gender related issues and trying to open the debate about gender and mental health with Cape Ver dean men. Furthermore a ‘train-the-trainers’ program was suggested, in which the people in key positions are informed and educated in the field of mental health and mental health care.

Some of the health care and social security institutions in Rotterdam have Cape Verdean personnel and it seems that everybody knows them as a ‘halting place’ and a source of knowledge, where a good referral can be found. The Apoio-project plays a role in this as well as intermediate and advocate. These ‘bridgeheads’ are vital for the development of the understanding and debate about psychiatric problems within the community, as well as for the building of bridges to the rest of society. The learning community proposes to establish a ‘health platform’ within the Cape Verdean community as a co-ordinating and signalizing platform. Furthermore, the necessity is stressed of services with a low degree of ‘protocol,’ where people can get all kinds of advice and referral and where basic help is given. The organizations and projects, which function as such, on a temporary basis, should be consolidated and strengthened. The Apoio-project plays a role in this as well. Volunteers and social workers are present in the community.
where they are addressed and offer assistance when someone has trouble getting or keeping contact with mental health care. They are also present in mental health care as soon as someone is admitted in the mental hospital, as an interpreter and an advocate. Arrangements are made in an informal way; without appointments, and expecting that you will be responding without further delay, as soon as possible.

Finally, interventions, directed at the empowerment of the Cape Verdean community should encompass quarter mastering strategies in which opportunities to settle and develop own ways to cope with mental health care problems and lack of access to mental health care can be developed. Als enhancing social heterogeneity and socio-economic mobility within the Cape Verdean community should be part of this.

3. **Interventions on a public health level.**

It is important to make the Cape Verdean population and its mental health condition visible through good registration and epidemiological research. This should be done in a longitudinal way, in order to be able to study the effects of measures to enhance the quality of mental health care. In public health strategies the social problems of the Cape Verdean community should be addressed. Among them are: poverty, gender relations, social abuse, bad housing conditions, bad school performances, and educational problems.

The problems and the necessary interventions will be discussed in a conference in June 2004, with two psychiatrists from Cape Verde, with representatives of the Rotterdam municipality, public health authority, mental health care institutions, patient’s organizations and Cape Verdean organizations.
9. Conclusion

Lack of use of services in the professional mental health care sector by Cape Verdean immigrants in The Netherlands is hardly understood. Little is known about this immigrant community, little is known about their mental health condition, and finally little is known about the ways in which they explain and understand psychiatric problems. The goal of this study was to ‘fill in’ the picture in order to get a better understanding of ‘local’ illness beliefs and practices and their contribution to the differences in the use of mental health care services, compared to other migrant populations and indigenous Dutch inhabitants. It concerns an exploratory and descriptive study. Health care related issues cannot be answered to the full extent, because factors that are related to the quality of service provision are not evaluated in the context of this study. They are evaluated in a follow-up study (Beijers 2004). In order to get a better understanding of the reasons of differences in the use of and/or access to mental health care for both this study and the follow-up study, a comprehensive model of the health seeking process has been developed. It acts as an instrument to get an insight into possible pathways to health in Dutch society, specifically for migrants, and as an instrument for analysis of the data found in this study. This study focused on the first part of the health seeking process, before an ill person and his social network get in contact with formal (professional) or informal mental health care services, or before the situation deteriorates to an extent that assistance should have been given. This is defined as ‘the lay health system,’ in which Cape Verdean health beliefs and health practices are specified within the context of a life as a migrant in The Netherlands.

The research questions relate to four focus domains and units of analysis, as formulated in the first chapter: (a) situations of distress; (b) construction of meaning; (c) context; and (d) change. These questions disentangle several aspects of the lay health system. Research questions referring to situations of distress and context will be answered in § 9.1, research question referring to the construction of meaning and its context in § 9.2, and finally the issues concerning possibilities to change the situation for the better in § 9.3.
9.1 Population at risk

Cape Verdeans have a history of migration since the nineteenth century, to all corners of the world, to The Netherlands since the 1950s, and it is justified to speak of a Cape Verdean diaspora. Migration is inspired by a difficult economic situation in Cape Verde, climatological hardships and political oppression linked to a long lasting history of colonization. Migration damaged or destroyed existing social and family networks. The Cape Verdean community mostly settled in the Rotterdam-Rijnmond conurbation where they belong to the lower socio-economic strata of society, based on levels of education and income, school performances, occupational standards and living conditions. The receiving society was not able to recognize and receive this community of immigrants in an appropriate way. Cape Verdeans were known as silent and invisible migrants. The community has been described in a paradoxical way as: closed, uniform and built on solidarity on the one hand, and as multi-stratified and divided or even splintered on the other hand. Although sufficient and good epidemiological data are missing, this study nonetheless offers sufficient (circumstantial) evidence to conclude that the Cape Verdeans in The Netherlands are a population at risk and that the lack of attention from mental health care institutions and from the public health authority for this group of migrants is alarming. Individual histories in this study of bad jobs and bad housing conditions illustrate this. Risk factors are: prolonged low socio-economic position and migration, with some specific determinants like, financial problems, debts, low educational level; prolonged cultural distance, and gender problems. Gender roles are a subject of fierce and recurrent debate within the community. The number of single parent (mother) families is very high and the pressure on (single) Cape Verdean women, who have to combine education of children and earning a living, is high. Related problems with strong psycho-social and mental health components are reports of abuse, teenage pregnancy and educational problems. Valid and reliable epidemiological data, specifically focusing on the mental health of Cape Verdeans are missing, but necessary.

Situations of distress which are mentioned in this study are:

1. Gender-related: especially Cape Verdean women are a population under pressure. Cases of abuse are reported in different degrees of seriousness. Domestic responsibilities weigh relatively more on them, compared to other populations, and
compared to Cape Verdean men, as single heads of family, as primarily responsible for the education of children and for the income of the family. Cape Verdean men participate insufficiently in this.

2. Related to social circumstances: Cape Verdean men and women mention the problems of heavy work in the harbor and in the cleaning industry, which is harmful to their health, and they report cases of usurpation (as a migrant) by employers. Possibilities to ameliorate labor conditions are limited at the bottom of the labor market, and the ‘degrees of freedom’ as employee, for example to report ill or access to kindergartens to take care of the children is limited. Other social problems are the lasting low level of education, and the lasting low level of income which frequently leads to serious financial problems and debts.

3. Related to spiritual influences and cosmological order: these situations of distress refer to misfortune which strikes you from ‘outside,’ coming unexpectedly. These reverses can appear in all kinds of qualities. Experiences of psychosocial distress are readily understood as such, because they come on the sly and are hard to understand or non-communicable. Etiologically they originate in bad intentions of people in one’s social environment (e.g. evil eye or sorcery), or are attributed to roaming spirits, or evil influences in general. In these instances they are mediated by personal moral behavior and increased vulnerability of the sufferer who is not leading a decent life, i.e. not following the conventions of socially defined morals.

3. Symptom-related: ongoing symptoms of a mental illness cause problems and in the course of time seem to start living their own life, detached from the problem of origin. Among them are primary symptoms, like pains people feel in their body, aggression, incomprehensibility (of the behavior of family members) and secondary symptoms, which are particularly social: marginalization, social damage (by family members) and stigmatization.

4. Treatment-related: treatment Cape Verdeans receive does not always match their needs and social situation. Secondary effects of treatment (side-effects of medication, immobility and experienced effectlessness, inertia) and the perceived inability of mental health care professionals to influence the patient’s social situation. Arrears in knowledge about the structure and protocols of mental health care, and arrears in the necessary skills (language, knowledge, social skills) to
master the sector limit the accessibility of mental health care. The skills required, e.g. behaving as an autonomous and assertive consumer of care services, contrast with what many Cape Verdeans consider to be good and secure care. Another stressing factor is the often perceived inability to ‘reach’ someone who is suffering from mental illness and to influence their behavior. The political context at large in which intolerance for cultural diversity is growing, paradoxically limits the possibilities to speak out as an autonomous and self-conscious Cape Verdean patient.

5. Migration-related: migration brings all kinds of problems of adjustment to new situations and circumstances, which are unfamiliar and not easy to live through. Access to facilities and services, which are seen as normal and self-evident in the new context, is blocked by unsuspected blockades. Cape Verdean migrants need new skills to master these tresholds. In the new country of residence the relationship between first and second-generation migrants is perceived as a problem in which tradition and modernity compete and also knowledge and authority compete. It is seen as a struggle for influence in the local (political) arena. It is also perceived as a process of transition in which special attention is asked for the isolation, silence, and loneliness of the growing group of elderly Cape Verdeans. They not only left dear remembrances, but often the new country of residence did not meet their expectations and they have a hard time realizing a new perspective. The ‘Pousada,’ a recently built community housing project for elderly Cape Verdeans deserves follow-up.

The concepts used to designate the psychosocial distress people experience are derived from biomedicine. This does, however, not necessarily that they are also understood as such. Informants use concepts like ‘esquizofrenia’ and ‘depressão’ as mere labels and container-concepts which designate different situations of psychosocial distress and in several instances cover a wide range of experiences and also non-biomedical interpretations. This probably is caused by the prolonged contact many of the informants in this study have with professional mental health care. Sometimes the concepts used were explicitly non-medical, where people describe their problems in terms of a known culturally proliferated Christian-spiritual idiom of evil influences like spirits and jealousy.
In these cases this often goes with a failing communication with professional mental health care.

9.2 The Cape Verdean lay health system

The research questions on the construction of meaning refer to the character of meanings, the process of construction of meaning, the dynamics in the process and the attribution of blame. In the course of the study the model for the Health Seeking Process is developed. This comprises the ‘lay health system,’ which covers these issues.

meaning

Cape Verdean explanatory models to understand and deal with psychosocial distress differ significantly from the ones that are dominant in psychiatry or described in biomedicine. These differences are not insurmountable, but make clear that the point of departure differs, and that a successful contact with the professional mental health care sector is less obvious. Spiritual experience and the conviction that supernatural phenomena are relevant in everyday life are important points of reference. The Cape Verdean community, especially where a Barlavento origin is dominant, is ‘Christian-spiritual,’ in which the values of suffering and endurance for the sake of getting better, of charity and social responsibility, and of fear and respect for the inevitable, can flourish. This should not be seen as a static and reified vignette of Cape Verdean identity, because of the diversity of explanations and beliefs and doctrines. Their moral categories are socially represented and have impregnated everyday social life, also detached from specific religious and spiritual practices.

dynamics

The different health beliefs in the Cape Verdean community represent dynamics of competing, co-existing and sometimes mutually strengthening social dynamics, characterized by a competition between and blends of tradition and modernity and knowledge versus authority. The diversity should be seen as a repertoire from which a line of thinking and acting is chosen that best fits the demands and possibilities of the actual situation, depending on social constellation and availability of solutions. Cape
Verdean health-seeking behavior is eclectic, and sometimes tiled. Apparently contradictory ‘tiles of treatment’ are not only followed, but sometimes also applied or addressed by professionals within single complementary and formal treatment situations.

construction of meaning
When experiencing problems, Cape Verdeans in the first place refer to their social network and the Cape Verdean community. The community is an important source of knowledge that in no way is compelling, but represents the diversity of resources inside and outside formal health care. Leading principles are mutual support, self-help, common understanding of your situation, and redistribution, which is important in chain-migration. This should not be seen as a local, but as an ‘extended community’: children or parents in The Netherlands or abroad, family members like nieces and nephews and aunts and uncles, friends, neighbors: the Cape Verdean community at large. The other side of this solidarity, however, is the high degree of social control and mistrust, which is reported as much as the element of mutual support. So there is also a self-limiting mechanism. This makes the community self-referential, but also autarkic. People get information from friends and relatives, get addresses, hear stories and are referred to all kinds of doctors, healers, medicines, treatments in the formal and in the informal circuit. This implicates that some of the contacts between health care workers and patients and their family members are fairly accidental and by chance.

blame
In their understanding of the origin of psychosocial distress and the possibilities of treatment, often three interplaying factors can be discerned, which are ‘blamed’ for the misfortune: (1) personal vulnerability, for which you can bear personal responsibility; (2) negative influences which come from outside (either spiritual, interpersonal, biomedical or socio-economic) and; (3) the inevitable, the ordeals that come to you, which you have to endure and bear. These ordeals can be hereditary or based on evolutionary debt. In a wider context, historically these ordeals originated from climatological conditions and famines on the Cape Verdean islands, but also colonial oppression and slavery can be seen in this respect. Comparatively, these factors underlying health beliefs, do not seem to diverge essentially from common beliefs in The Netherlands.
The understanding of sickness can be spiritual, but the treatment and the healing practices often have a clear social component and cognitive and behavioral implications. Diagnosing and understanding the (personal, social, interpersonal, cross generational) etiology and effective treatment of illness never is self-evident, not for the one who is suffering, not for the people in the social network who have to deal with it, nor for the professional who has to treat the sick person. Classic ways of treatment, which are familiar and which used to work, are not adequate anymore, because they have changed in the new context, or because the social texture from which they derive their effectiveness is not intact anymore. Bodily expressions (spirits, witchcraft) of discomfort make adequate understanding of the situation and the etiology of the problem by professionals, difficult.

Limitations in knowledge and skills and explanatory differences make the pathways to mental health less passable and the attitude defensive. In terms of the filter model of Goldberg and Huxley, this is the first relevant filter. People recognize their problems and deal with their problems, but do not go to the general practitioner for a referral to mental health care, because they are reserved and unfamiliar with the system and believe that the health care sector cannot offer effective and valid treatment. Complementary routes and a trajectory of deterioration are sometimes viable alternatives or complements for going to the doctor.

9.3 Change
The research question aimed at reflection of relevant ‘actors’ and key persons in the Cape Verdean community on the findings of the study concerning their mental health situation, their social position and advice to change it for the better. Data from this study have been discussed with representatives of the Cape Verdean community and with mental health care professionals. This reflection rendered a formulation of three community and population related problems:
(1) A knowledge deficit in the field of epidemiology and on the field of knowledge and capabilities within the Cape Verdean community to make the Dutch mental health care system ‘work’; (2) A recognition deficit (in mental health care and the Cape Verdean community) in which psychiatric problems are insufficiently recognized and interpreted
as problems in which mental health care is relevant; (3) Health-related social problems: focusing on poverty, gender issues and the position of the first generation elderly Cape Verdeans.

Three types of interventions are proposed by the learning community of the ‘Partners in Health’-project to an assembly of mental health care, public health authority, Cape Verdean organizations and patient’s organizations:

(1) On the population level: mainly focusing on giving better information and education within the Cape Verdean population.

(2) On a community level: focusing on informing and educating Cape Verdean organizations and professionals on key-positions, empowering the community through improving social heterogeneity and socio-economic mobility, and enhancing the consolidation of accessible grass-root and community-based health and social services.

(3) On a public health level: enhancing epidemiological research and public health strategies aiming at solving social problems.

The issue of the presumed ‘silence’ of the Cape Verdean community and their ‘meekness’ are interpreted in terms of bad advocacy for their shared interests, for which they blame themselves; for lack of recognition and support, for which they blame Dutch (municipality of Rotterdam) administration. In this study, however, the image of ‘people with a mission’ is formulated as well, which represents the pride of Cape Verdeans for their origin and heritage and which seems to represent their everyday identifications in a better way.
10. Understanding psychiatric phenomena in the context of culture: a reflection on results of this study and on the anthropological enterprise

In this final chapter I will put this study in a wider context of medical anthropological research and discuss the contribution of anthropology to the understanding of psychiatric problems and the contribution of this study to this debate. In the first paragraph I will discuss validity, reliability and the process of this study.

10.1 Discussion of study and results
Validit and reliability of this study are rated through a comparison of the findings with a recent systematic scientific review on health-related problems of Cape Verdeans and a rating of the interviews of possible interviewer-induced biases. One of the transcribers rated a sample of the interviews (n = 6), on the basis of knowledge of the research design, personal experiences as a mental health care patient and educational level (master in social sciences). This rater reported that the interviews were open without unwanted interfering interviewer biases. She noticed the relevance of redistribution as a factor that contributes to the openness of the conversation. Several informants asked the interviewer to help them, but she concluded that this was done in an open and reciprocal atmosphere, that did not block communication.

The review of the Centre for Review and Implementation of the National Institute for Health Enhancement and Illness Prevention (NIGZ) conducted a systematic review (Pieterse 2002) to get a general image of the health-related problems of Cape Verdeans. In this review they describe the Cape Verdean population, their general state of health (based on epidemiological figures), health determinants, life-style determinants and interventions. They use ‘second-line’ information, i.e. key-informants in the Cape Verdean community in Rotterdam, references from scientific databases, and scanning and analysis of relevant policy documents or developments. The resources are somewhat wider (e.g. public health authority, STD’s, infectious diseases and HIV-AIDS, welfare organizations, etc.), because they do not focus specifically on mental health problems and on the possible effect of community based interventions. This review also concludes that
worldwide there is not much scientific qualitative information on the determinants of health of Cape Verdeans. The review partly focuses on the same scientific resources as this study does. In the list of informants there is just limited overlap.

In their general description of the Cape Verdean community, the two studies match: invisibility, a matrifocal family structure, high degree of self-organization and an introvert and coherent community with a relatively low education and socio-economic position in Dutch society, a general impression that problems in general are expressed and experienced as psycho-social, that delinquency is a growing problem among young Cape Verdeans (second and third generation), lack of use of health care services and health differences between men and women. Psycho-social problems are identified as one of the major problem-areas on which community interventions should be aimed. These problems are among other causes attributed to a lack of use of services; gender issues and a defective educational practice; and a strong social cohesion and introverted life-style. These problems and causes do not deviate from or contradict the findings from this study.

Concerning the lack of use of services, the NIGZ-review stays in general terms: factors related to service provision and to the need or demand for help. In general terms both studies agree on these factors, like illiteracy, ‘the Cape Verdean attitude’ (compliance), isolation of the first generation migrants, lack of information, etc. Compared to the current study there seems to be less attention for social and structural factors that determine the lack of use of services, like exclusion and racism; and for the indigenous complementary solutions to social and health problems. This seems to be related to a possible bias in the NIGZ-review: they tend to identify population or patient-based health determinants as pivotal bearers of problems, since they are aiming at developing a community-based intervention strategy. The lack of first-hand qualitative data on health and illness in the Cape Verdean community is compensated by referral to research done in other migrant communities. This is, however, of limited validity. Comparatively this study succeeded in addressing a large sample of informants, which enhances the quality of the data.

Non-response: the sample of participants in the research is mainly derived from people who are in contact with the Apoio-project. These are people who are experiencing trouble with their contact or are having trouble getting in contact with the professional mental
health care sector. This might cause bias because it limits the sample to people who had experience with mental health care or explicitly expressed a desire to get in contact with the professional (mental) health care sector. Another source of bias: the experiences with care providers might be rated more negative compared to people who have a good contact with mental health care. Repeated instigation on the health care professionals participating in the Learning Community to motivate clients to enroll as informants, did not lead to any result. This might be caused by considerations of privacy or fear (of client and professionals). Another reason could be the very direct style of inviting participants that was used by the representatives of the Apoio-project and the fact that it was an invitation from someone within the community that was considered as more obliging, as part of the mores of the Cape Verdean community and in the context of redistribution. The main findings of the study were presented to informants and interested members of the Cape Verdean community, in a focus group discussion. This feedback of data and the following discussion of data and desired measures, confirmed the credibility and the transferability of the data.

In the phase of data collection, lack of sufficient knowledge of Crioulo and Portuguese was an important limitation of the researcher. Mastering the languages would have enhanced the conversation and contributed to the understanding of the context of a personal story. The double checking of translations to a certain extent gave in to these limitations, but only in retrospect. The language barrier in some occasions was put into service as part of the game of ‘feints’ necessary to start the conversation, or to check trustworthiness or to have an agreement on the conditions of the exchange of information and confidentialities. As soon as this borderline of feints was crossed, the conversation could be conducted in Dutch. Some people, however, only spoke Portuguese or were so insecure in Dutch, that the transfer of information was seriously disabled or could only be given with the help of interpreters. In the course of the research my Portuguese language skills improved so much that I could ask informants to give me the Portuguese word, when they could not find the Dutch word, and was able to understand this.

A critical factor in this study was ‘time.’ Serious medical anthropological research needs and takes time. Research is an intervention in reality of a community and the ‘quick-and-dirty-strategy’ puts a burden and a claim on the future, on the credibility of
scientific research and will limit the openness and willingness of informants or a community to co-operate in the future.

10.2 Text, context and subject
In his book ‘Rethinking Psychiatry,’ Kleinman (1988a) advocates a more serious consideration of culture in the science and practice of psychiatry. Because, in his opinion, more than any other of the medical specialties, psychiatry and psychiatric problems are immersed in culture. In the context of a growing cultural and ethnic diversity of Dutch society, Kleinman’s work has been of great influence on the debate within mental health care about the relevance and validity of the health care services for migrants. There is a growing interest (e.g. Kortmann 1991; De Jong 1996, 1997 and Thung 2000) in culture as an explanatory factor in the experience and manifestations of psychiatric problems and as a constituting factor for the planning and delivery of mental health care. At the same time, however, many authors point to the fact that the understanding of ‘culture’ and the way it ‘works,’ is rather implicit. They do so in their critique on the static use of the concept (cf. Bartels 2002) that looks at culture as a complete, fixed, and demarcated system in which we are immersed and from which we apparently are unable to escape. Culture is seen as fixating (‘our’) identity. This understanding of culture as total, holistic, unique and integral, nowadays makes it into a sharp and splitting argument in political dialogues where it (paradoxically) gets performative quality (Van Binsbergen 1999). Van Binsbergen (1999:7) criticizes this:

Self-identity, referring to ‘culture,’ always and inevitably situates itself in the field of tension between self-evidence and performativity. In that sense ‘culture’ is a modern solution for the very old problem of society: the conjuration of the tension between the individual and society. With that, ‘culture’ has become one of the most important power giving concepts that nowadays are to the disposal of political actors in local, national and worldwide arenas.

Van Dijk (1998) clearly shows this in his argument that culture (in mental health care) is often seen as the filter that colors the behavior and the ways of living of ‘the other,’ in his case the migrant. This depiction of ‘the other’ is an obscuring approach, that transforms culture into the ideal excuse to justify the dominant paradigm (e.g. form of delivery of care), to cover up its shortcomings or contradictions; that just stresses their ‘otherness’ and creates an artificial dichotomy between ‘us’ and ‘them,’ ‘civilized and uncivilized,’
‘modern and traditional’ or ‘the west’ and ‘the rest.’ The thinking about culture and the experience of psychiatric problems and finally the rethinking of mental health care with culture as a differentiating factor will inevitably confront us with the hegemony of our own implicit paradigms and ‘indigenous’ cultural assumptions and conventions (cf. Kleinman 1988a; Van Dijk et al. 2000). Littlewood (2001: 38) states:

As with the earlier colonial psychiatry, the idea of ‘a culture’ has, however, remained one which is fairly homogeneous, with values and social order accepted in the same way by all members: a model which followed the idea of a tightly bounded society once sought by colonial officers and anthropologists, and which ignored an unequal distribution of knowledge and power, of local contestation or global change.

With these questions and critique in mind, I will describe the way in which I will use the concept of culture and explore the paradox of ‘meaning and delusion’ in the context of psychiatry as a token of the problem of interculturality, with the work of Els van Dongen (1994) as my most important point of reference. For the sake of the argument I will use the definition of culture of the cognitive anthropologist Goodenough as a starting point:

A society’s culture consists of whatever it is one has to know or believe in order to operate in a manner acceptable to its members. Culture is not a material phenomenon; it does not consist of things, people, behavior or emotions. It is rather an organization of these things. It is the form of things that people have in mind, their models for perceiving, relating and otherwise interpreting them. (In: Keesing 1974: 77).

Culture in this way of thinking not only organizes our thinking and understanding of the world and our acting in this world (Kleinman 1988a, b), but is also normative, based on a set of ‘models’ people use, that represent a constellation of final norms that tells us what ‘is,’ what ‘should be,’ and ‘what to do’ (cf. Van Dongen 1994:327).

In this view, the task of anthropology is to ‘read’ human behavior and human practices (metaphorically) as ‘text,’ to interpret them and to find meanings that inform us about culture. But text has no meaning of its own. “If you separate text from context, you mistakenly bypass a crucial semiotic issue: “how different forms of discourse come to be materially produced and maintained as authoritative systems” (Scholte, in Keesing 1987:166).

We cannot look at the models of perception and interpretation in human practices without taking the context, which constrains or forms these models83, into account.

---

83 Pappas (1990) reproaches the cognitive-symbolic anthropologists, especially Kleinman, that they are focusing too much on the human agency, and do not take the relevance of the structures into consideration.
Context can be seen as the layers of an onion: interaction is the basic contextual moderator of meaning, every form of interaction is part of a wider ‘field’ (e.g. the institutional environment) and a ‘domain’ (e.g. mental health care in the process of change) (cf. De Ruijter 2000). At large, society or a community can be seen as a series of dialogical contexts, or ‘arenas’ in which culture is a strategic weapon: “(...) images and identifications are the result of processes of making sense in which the power to define a situation is an essential factor” (Ibid. 2000:10). This description of culture, although infused with the dynamics of an arena, still is static, as long as it presupposes that every dialogue is reproducing the dominant given macro-structure.

De Ruijter (2000) elaborates the dynamics underlying the process of interaction and distinguishes two parallel but opposite movements or motives in human practices: the ordered structure and the ordering act (De Ruijter 2000) or in other words, between ‘context’ and ‘dialogue,’ who together form a ‘Gestalt.’ People build, arrange and rearrange their world in an active way on the basis of their knowledge and within concrete forms of praxis (cf. De Ruijter 2000: 40). People ‘work’ with culture in a subjective process of formation and transformation (Jenkins and Barrett 2004).

Bartels (2002, also Van Dijk 1998 and Van Dongen 2001) argues that culture as an objective reality always is shaped by the subjective individual in interaction (and negotiation or struggle) with ‘the other,’ and that human behavior is not a function of culture but also a producer of culture. This leads to variation which is not a sign of imperfection, but a necessary condition for change and development. Keesing (1974) describes the ‘making of culture’ as a socio-cultural ‘performance,’ concerning the ways in which culture as a system of knowledge is constructed in daily life. Cultures are not blueprints, which are reproduced in the work of people’s values and norms and institutions. “Cultures are vague, multi-interpretable, ambiguous and intertwined complexes of opinions and practices that certain people have in common. (De Ruijter 2000: 30). Van Binsbergen (1999) is even stronger in his opinion, stating that cultures do

---

A literal translation of the Dutch text (‘zingevings’) would be: giving sense. With the view of De Ruijter in mind, that meaning is constructed in interaction in mind, I think ‘making sense’ is a better translation.

A literal translation of the Dutch text (‘handelingspraktijken’) would be: practices of acting. Critical anthropology (Singer, 1990; Scheper-Hughes, 1990) is much stronger than cognitive-symbolic anthropology in making the dynamic interaction between agency and structure visible and in relating interaction on a micro-level to macro-structures.
not exist and that it is better to speak of ‘cultural orientations,’ with strong ‘performative’ elements. Kleinman (1998b) also uses the word ‘cultural orientations’ and consistently stresses the agency of the individual and variation within cultural orientations. But where Kleinman places these variations only in the light of the agency of the individual and the interaction of people, De Ruijter, Keesing and Van Binsbergen place variation in a political and ideological framework (Pappas 1990). It might be better to speak of an orienting collection of shared symbols and meanings that orients people in their ways of feeling, thinking and being in the world (Jenkins and Barrett 2004).

Meaning is given and sometimes constructed on the basis of the models people use to organize the world around them, based on and representing a set of values and norms. Dialogue is the funding mechanism of and workshop for knowledge and models to give meaning to the world around us. This dialogue is led and often constrained by the context of power relations in which it is embedded: ranging from the direct institutional environment to structures at large. To get to know the models and the ways in which the interaction ‘works,’ it is necessary for the people who are involved (the subjects in the research) to express themselves. The moderating and registration of this process is part of the anthropological work.

This study among Cape Verdeans makes clear that meaning is given based on a Christian-spiritual repertoire or cultural orientation which is modeled in the social context at large in which history, ethnicity and migration, socio-economic position, and gender, but also in the smaller context of interactions between people and personal history. This transforms meaning into something which is not fixed to a specific culture, national identity or ethnicity, but something which can be made, performed, nursed, and played with in everyday interpersonal relations. Culture made explicit, is one of these signifiers as is made perfectly clear by the explicit identification with a constructed image of African culture by some young Cape Verdeans, in their struggle to take a distinct position within the Cape Verdean community as well as within Dutch society.

10.3 The anthropological enterprise: a critique of biomedical psychiatry
What does this point of departure on culture implicate for the understanding of psychiatric illnesses and their treatment in a specific (medical) context, and what is the relevance of
this point of view for the study of psychiatric problems of (Cape Verdean) migrants in Dutch society? What is the task of anthropology in this and how should medical anthropology position itself in the field of medicine? In the previous paragraph I described a double assignment of medical anthropology:

1. The ‘reading’ (metaphorically) of human behavior and human practices, to interpret them and to find meanings that inform us about culture. In the case of medical anthropology this concerns human behavior, experiences, cognitions, affections, and practices which are related to the occurrence, experience and understanding of illness and the treatment of this condition in a specified context.

2. The moderation and registration of (the expression of) the subjective process of formation and transformation of meaning and symbols: the process of working with culture. This assignment differs from the psychological scientific endeavor, because subjectivity is placed in the context of a field and a domain in which different interpretations of reality compete.

The ‘art’ of medical anthropology is to be present in the field of tension between what is socially determined and personally formed and transformed, to be present and sensitive when different interpretations compete for justification, and study the dynamics of these seemingly paradoxical tasks. Being present bears in itself the risk of being compromised, ranging from ‘being placed in,’ to ‘taking a place in’ the competition of different interpretations of reality by revealing and being an interpreter of the ‘excluded speaking’ (Van Dongen, 1994: 25, quoting Foucault). My choice to study Cape Verdeans is based on the figures about their limited contact with professional mental health care and my personal involvement with the Apoio-project. Since Cape Verdeans are not present in mental health care, their problems are insufficiently recognized and insufficiently dealt with.

When looking at the way in which western societies deal with psychiatric problems, it becomes clear that in the professional mental health care sector a biomedical interpretation of psychiatric problems is dominant. Within this framework, psychiatric problems are seen as disorders of cognitive, biological and physical functioning and of personality, leading to ‘social disabilities.’ This understanding is presented as a uniform and unambiguous body of knowledge that is true beyond any doubt. Kleinman (1988b:
28) describes the emptiness of this interpretation: there is no “teleological perspective on illness that can address the components of suffering relating to the problems of bafflement, order, and evil, which seem to be intrinsic to the human condition”\(^86\). The place where these problems are treated, predominantly is the professional psychiatric health care sector (mental hospitals, community mental health care centers, forensic clinics, psycho geriatric wards, etc.) and the preferred treatment of serious psychosocial distress is a combination of confinement and pharmacotherapy. This world of psychiatry is not undisputed. Patients have fought for acknowledgement of their subjectivity and resisted against the hegemony of the biomedical psychiatric reformulation and reduction of their experience to a disease. Psychiatrists like Romme (1990), Vlaminck (2002), and Van Os (2003) represent a new levy of psychiatrists who discuss and question the validity and universality of the biomedical concept\(^87\). On the other side, there is an actual social and societal pressure to protect society against deviance, which makes psychiatry an arena where patients and staff maneuver between these two cliffs: taking care of madness and protecting society against deviants.

Cross-cultural studies are an important contribution of anthropologists to the field of psychiatry, in which anthropological comparison is the central point of agency. Kleinman (1988a; 1980) introduced the concept of ‘illness beliefs’ (concepts of emotion, body-self and general illness categories) which can differ geographically, cross-culturally and historically; and explanatory models are the materialization of these beliefs. This comparative type of research, for example showed that the course of schizophrenia in many western countries differs from the course of this illness in developing countries: in the west it lasts longer, is more disabling and is treated as incurable. Another example: people in southern-Europe know the phenomenon of ‘the visible saints’: “individuals who

\(^86\) Kleinman (1988 a and b) constantly shifts between the perspectives of the anthropologist and the psychiatrist, but finally seems more dedicated to the latter perspective. He advocates ‘change’ but, above all, wants to avoid radical change. Furthermore, he relies heavily on the typical (psycho)therapeutical optimism of the eighties.

\(^87\) For example, Vlaminck (2002) argues that schizophrenia is a container concept, in which patients of different etiology, symptomatology and pathogenesis are hidden. Their prognosis differs considerably and because of the standardized treatments, many of them are overtreated. Vlaminck concludes that it is necessary to dismantle the concept as is done with the concept of ‘hysteria’ in the 20th century. Schizophrenia, he says, apparently serves other purposes and interests, for example of the pharmaceutical industry and of research institutes and pressure groups of family members, keen on raising funds, or accomplishing secondary goals on this title.
become moral exemplars of the burden of life’s difficulties and the obdurate grain of martyrdom in human nature” (Kleinman 1998a: 31). Or: in one culture ‘feelings of guilt’ are commonly known, while in another society people believe in ‘self-accusation of witchcraft.’ Littlewood and Lipsedge (in Kleinman, 1988a) describe anorexia nervosa as culture-specific illness behavior of the West. Trance and possession, as special dimensions of the self, are commonly known in non-western societies, but in the western world only encountered in charismatic churches. Fainzang (1999) describes the differences between madness of the liver and of the head of the Bisa in Burkina Faso, and the moments they decide to treat or explicitly not treat the condition. The comparison clarifies that:

(…) the western interpretation of illness as nothing more than a pathology affecting an individual organism is not inherently more ‘correct’ than its interpretation, say as a God-ordained punishment for wrongdoing; or (as in certain tribal societies) as the sign of a disharmony in the group; or (as in possession cults) of the usurpation of the afflicted personality by an ancestral of evil spirit. Western medicine, by this account, has exploited its successes in the scientific understanding of disease to claim hegemony for ideas which belong to Western culture rather than to science (Esmail 1996:141).

Recently, medical anthropologists (Kleinman 1988b; Lovell, Corin and Strauss in: Cohen 2001; and Van Dongen 1994) are stressing the importance of a meaning-centered approach of psychiatric problems in the western world and more attention for the subjectivity of the patient who experiences these problems. Looking for meanings not only implies unveiling conceptions that underlie a particular occurrence of misfortune or illness and are mediated by it, in order to make it expressible, understandable, endurable and manageable, but also unveiling the way these illness experiences are treated, how these conceptions are molded, sometimes repressed or selectively treated and how people are alienated from their subjectivity.

10.4 Meaning

Meaning, in the context of illness and treatment concerns a useful and usable explanation that gives the experience, its occurrence, social consequences, the necessary treatment and prognosis a place within reach and understanding to the patient and his social network. Meaning is imperative and in the previous paragraphs described as a function of the triologue of text, context and subject. The crux of Kleinman’s (1980; 1988 a, b) concept
of explanatory models should be explained in this line. Explanatory models offer “explanations of sickness and treatment to guide choices among available therapies and therapists and to cast personal and social meaning on the experience of sickness” (Kleinman 1980:105). They administer justice to local, i.e. culturally specific ways of understanding illness and ways of dealing with it. In line with my plea for a model of culture that takes the dynamics of reality into account, explanatory models should not be seen as fixed cognitive schemes as is also stressed by Bhui and Bhugra (2002a:6). They state that explanatory models “do not consist of a coherent set of beliefs, but a variety of explanations that are either held simultaneously or taken up and dismissed rapidly.” Kleinman (1980), who introduced the concept, is also explicit in this respect. He makes a division between general illness beliefs, belonging to the health ideology of different health care sectors and existing independently of specific sickness experiences. Explanatory models are based on these belief systems and are composed in response to the specific experiences and should be understood in specific contexts. They should not be treated as strictly rational interpretive schemes – at least in the popular health sector - but as loose systems of interpretation that are rarely invalidated by experience. They are flexible and able to resist negations.

Meanings are attached, made to measure, or occurrences nestle themselves in meaning systems. This concerns behavior, attitude and acting of human beings in a circumscribed environment or context and they are associated with boundaries and moral systems in which meanings are connected to ‘good’ and ‘bad,’ are experienced as indisputable, more than real, and are defended, transferred and propagated as an instrument of distinction. This also implicates that meanings are not fixed. They develop change, are contested and often have to be gained in a competitive social arena and, as stated before, the medical anthropologist is the interpreter of these cultural patterns as sources of meaning.

One of the most important points of reference in understanding and interpreting psychosocial distress, comparatively and historically, is religion. This is also confirmed in this study among Cape Verdeans. Religion provides a cosmology, or “a set of principles or beliefs about the nature of life and death, the creation of the universe, the origin of

---

88 Kleinman (1980) describes explanatory models as ‘tacit.’
society, the relationships of individuals and groups to one another and the relation of humankind to nature” (Nanda and Warms 1998:276). That makes the misfortune that happens to us comprehensible and ultimately give us the opportunity to prevent (the experience of) chaos, by resisting “the challenge of emotional meaninglessness raised by the existence of intense and unremovable brute pain” (Geertz 1973b). The idioms of modern biomedical psychiatry and western Christian religion bear strong resemblance, when trying to understand inexplicable occurrences and experiences (Beijers, 2004a).

Hardon et al. (2001:11) point at the importance of tracing social causality. Health problems are to be considered as cultural phenomena because they often find their origin in people’s living and working conditions and lifestyles. Epidemiological research can give an important contribution here when linked to the personal history of the patient. Kleinman (1988a) describes the relation between mental illness and socio-political, socio-economical and socio-psychological phenomena. For example, the relation of incidence of schizophrenia and immigration and harsh labor and the relation of the rating of labor-capacities of schizophrenics and the economic conjuncture. Rousseau et al. (1998) describe how pathology develops in the process of migration of Somali adults. The status of liminality which begins before actually leaving home, continues because the migratory process does not meet the expectations. Pathology is explained as a separation of body and mind, where the mind sets out to travel on its own or where the migration does not meet the expectations of the people back home (extra source of income) and return becomes impossible.

Fainzang (2000:39) focuses on the relevance of personal history and social context: “The categories of illness and misfortune are in themselves ‘empty’ categories, to be filled by individuals in the light of their own history and culture, and according to their family and social relationships.” She shows this in a case study of Lucy in the context of a family in an urbanizing suburb of Paris. It concerns the personal history of the patient with its symbolic particularities that is written and rewritten on the basis of personal experience and specific ways of giving meaning to the things that happen. This type of

---

89 Kleinman relies heavily on social causality, description of social-psychological phenomena (Expressed Emotion and Learned Helplessness) and cross-cultural comparison, to underpin the need to come to a more serious consideration of culture. By doing so he does not link social environments to culture, neither does he explain differences.
meaning is found by interpreting the (text of the) illness as part of the specific biography 
and interpersonal context of the patient and his disorder (cf. Kleinman 1988b), subjected 
to personal interpretations. These are “intellectual constructions in which especially social 
tensions may be expressed” (2000:57). In Lucy’s case this reflects, for example, the 
problematic relation she has with her father. She refuses to go to a biomedical doctor. 

What determines her attitude therefore is not the effectiveness or otherwise of the treatment but the 
desire to find confirmation of the diagnosis which she has herself made of her condition. To follow 
the treatment (of the biomedical doctor, hb) would be to contradict that diagnosis. Her behavior is 
an expression of her interpretation of her illness (Fainzang 2000: 53).

The compromise Lucy and her family made is to use complementary medicine, by going 
to a seer who is not harmful for her perception of the problem and the social situation on 
the background. This type of analysis is in line with the work of Nichter (1981) who 
makes clear how women in South India experience and express, for example, menstrual 
complaints, fasting and a general bodily discomfort as a way to escape their confined and 
isolated situation and express their discomfort with or within that situation. 
The study of Fainzang makes clear that meaning, which is given personally to an 
experience of illness, is a function of meanings that are mediated in treatment. Here we 
cross the bridge to anthropology of medicine.

In this study on Cape Verdeans, mental health problems are put into the context of 
interpersonal, social situation and cultural background, in the contexts of a religiously 
inspired understanding of the world, and personal histories and in the context of 
biological schemes. The number of scientific studies in the field of mental health 
concerning Cape Verdeans is limited. Neither in Cape Verde, nor in the diaspora, the 
knowledge on mental health (care) problems in the context of the Cape Verdean 
community has been precipitated in scientific documents. In this study I explored the lay 
health system and more specifically the health beliefs and health practices of Cape 
Verdean migrants. This exploration can serve as a basis for further research on the health 
situation of Cape Verdeans not just in The Netherlands, but internationally.

90 Here Fainzang criticizes the presupposed rational decision making, underlying Kleinman’s theory of 
different kinds of therapy evidently implies a judgment on their relative effectiveness, this judgement alone 
does not seem to explain people’s choice. Account has to be taken of the whole field of economics and 
symbolism which are factors in the different cases studied.”
In the last decade, several studies have been produced on the situation of Cape Verdeans in The Netherlands, mostly by students of Dutch universities and polytechnic institutes. They are consequently written in Dutch and no international publication resulted from them. This makes a scientifically marginalized community of the Dutch-Cape Verdeans, and a comparative approach between researchers of the diaspora is missing. This study is aimed on breaking the barrier and tries to formulate new insights compared to the existing Dutch studies on Cape Verdeans, which hopefully nuance the somewhat petrified and eroticized image of the Cape Verdeans in The Netherlands as silent migrants. The image of ‘people with a mission’ to me seems a much more valid and complete image. Within the context of this study I gave much attention to the doctrine and the practice of Racionalismo Cristão. Apart from the work of João Vasconcelos this spiritist doctrine hardly has been studied internationally. The model of the health seeking process used in this report comprises complementary pathways and the American bypass, and makes interrelations of these pathways to health visible and a coherent description possible. The model is hypothetical and not tested in this study. It served as an analytical instrument. The different parts of the model, however, are based on scientific research. The possibility to describe natural histories of illness (and health) (longitudinal descriptions of individual case histories) has not been explored in this study, but would be a next step in the analysis of the data.

10.5 Meaning and healing
In his work, Kleinman postulates a ‘symbolic bridge’ between personal experiences, social relations and cultural meanings. Individual experiences are governed by a fundamental “cultural grammar found in the central myths (…) that authorizes the values of a group and that serves as a template for the personal myths of the individual” (1988a:132). Kleinman describes this as a recursive system and with this he focuses on the essentials of the healing process: when an illness experience destroys the symbolic bridge, the assignment of the healing system is to restore this connection. The healer or psychotherapist can do this through initializing the person who suffers in a (new) meaning system and restructuring the symbolic bridge, particularly by the (re)positioning of personal experiences as particularization of the wider cultural grammar. In this process,
techniques of persuasion, the mediation of symbols that are particularized from the
general meaning system and the transformation of experience are essential: it is a process
that moves from cultural meanings to embodied experience. Modern biomedical ways of
treatment can be seen as forms of symbolic healing and Kleinman (1988a) describes
psychotherapy as such; a therapy based on words, myth and ritual use of symbols.
Medication in this context is just palliative; it softens and suppresses the peaks of
emotion.

Fifteen years before Kleinman, Geertz (1973) described a similar process of
reconstituting of experience as ‘the ritual leap,’ in the context of religion and the healing
qualities of religious practices. Religion, according to Geertz, is a cultural pattern: a
system of symbols which enhances strong moods and motivations, which are experienced
as uniquely real by its followers. He stresses that religion not only is a model of reality,
but also a model for reality. It is a process among the members of a society and between
them and their world, which orders society and provides them with meaning, unity, peace
of mind and the degree of control over events they believe is possible (Klass, in Nanda
and Warms 1998). On the one hand, it provides a cosmology, or “a set of principles or
beliefs about the nature of life and death, the creation of the universe, the origin of
society, the relationships of individuals and groups to one another and the relation of
humankind to nature” (Nanda and Warms 1998:276). That makes the misfortunes that
happen to us comprehensible, and ultimately give us the opportunity to prevent (the
experience of) chaos, by resisting “the challenge of emotional meaninglessness raised by
the existence of intense and unremovable brute pain” (Geertz 1973). On the other hand,
religion can make personal problems (personal loss, hearing voices, fear, etc.) bearable or
sufferable. Geertz describes this as a ‘cosmic guarantee’ and a ‘ritual leap.’ In the
religious ritual people experience an undeniable truth, which is considered to be ‘the
really real.’ Moods and motivations (an ethos) and metaphysical conceptions (a world
view) come together and shape the spiritual consciousness of people in which the model
of and the model for the world are mere transpositions of one another. During rituals the
world as lived and the world as imagined turn out to be the same world. This ritual leap
changes man. Religious rituals induce dispositions, color the individuals conception of the
established world of bare fact. It places an approximate fact into an ultimate context,
‘which alters the whole landscape of common sense in such a way that the moods and
motivations induced by religious practices, seem themselves supremely practical, the only sensible ones to adopt given the way things “really” are. In religious symbolism, the affirmation, or at least recognition of the inescapability of ignorance, pain and injustice on the human plane is recognized, while simultaneously denying that these irrationalities are characteristic of the world as a whole (Geertz 1973:108).

It is, in conformance with Kleinman’s argument, possible to assume a ritual leap in psychotherapy, in which, in a phase of not only psychological, but also social and cultural catharsis, the lived (distressing or traumatic) experience and the imagined experience merge and transform a sick person into a healthy one. The dominant model to understand and treat psychiatric problems in The Netherlands is often represented as ‘bio-psycho-social,’ to show that meanings, causations and treatments are a complex of biological, social and psychological aspects. Meanings are given according to the treatment facilities available. The dominant treatment, however, is biomedical. This comparative approach will finally make several healing practices, professional or non-professional; formal or complementary as used by Cape Verdeans comparable. It also became clear that not only the patients have a syncretic blend of ideas, but also professionals within the various healing practices look over the borders of their professional domain and use blends of techniques, in which spiritual and religious elements, and (referral to) biomedical interventions are combined.

10.6 Meaning and delusion
Different illnesses come with different experiences. Having a psychiatric problem can limit or distort the fundamental ability of giving meaning in any context, as a result of the experience per se or as a result of the lack of intersubjective understanding. In the context of western understanding of psychiatric problems, it is probably not primarily the possibility of giving meaning, but the possibilities of intersubjectivity and sharing, which are impaired. This separates meaning from personal experience and makes the experience void. The detachment of the semantics of communication of the delusional person from the immediacies of present experiences (they are unreal and detached from the here and now and the common sense material reality) bears resemblances with the detachment of
rituals from the “immediacies of the present” as Comaroff & Comaroff (1993) describe. This detachment complicates the work of the medical anthropologist with psychiatric patients. Meaning becomes a complicated concept when rationality and subjectivity of the afflicted subject, the one who is a co-constructor of meaning, are questioned and, on the other hand, the rationality of the given situation is questioned in the delusion. Let’s take as an example; delusions and the way they are treated in (Dutch) mental health care.

Delusions as a psychiatric symptom are defined as erroneous beliefs that usually involve a misinterpretation of perceptions or experiences\(^91\) (DSM IV, APA 1994). The content of a delusion can have different modalities (persecutory, somatic, bizarre, etc.). Delusions are, with hallucinatory experiences, classified as psychotic disorders, and as such, an essential part of the diagnostic category ‘schizophrenia.’ They are seen as an expression of serious mental illness. Essentially the message of biomedicine is that the patient has a disease because he or she is misinterpreting the things he or she perceives and lives. He is wrong, but not just wrong: the problem can be interpreted as being pathologically wrong. The consequence of this message is sweeping. Because of the invasive character of the illness\(^92\) – this wrongfulness invades and soaks the subject completely – there is no rightful meaning possible, intersubjectivity disappears, and with this the possibility of subjectivity. We are facing a fundamental ‘crisis of meaning.’ This again explains and confirms the experience of pervasiveness of the illness: it not only affects me as a subject, but even other people around me, my body, my thoughts and feelings, my complete world is drowned in it. What happens to these experiences in the dominant healing practice of this type of problem in Dutch psychiatry?

Van Dongen (1994) studied mental illness in the context of a Dutch mental hospital and her central thesis is that psychosis is a culturally defined phenomenon, an illness where culture, social conditions and organic conditions converge (cf. Kleinman 1998a). Barrett

---

\(^{91}\) Literally, the description of delusion is: “A false belief based on incorrect inference about external reality that is firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not one ordinarily accepted by other members of the person’s culture or subculture (e.g., it is not an article of religious faith). When a false belief involves a value judgement, it is regarded as a delusion only when the judgement is so extreme as to defy credibility.” (APA 1994:765)

\(^{92}\) “Schizophrenia (…) affects their sense of who they are, their body, their thoughts and feelings, their day-to-day activities, and the people around them. The illness seems to pervade their world.” (Jenkins and Barrett 2004:7)
(1998: 491; 1996) did the same thing and argues that the liminal social position of many people with schizophrenia can provide an analytic framework for examination of the character of delusional and hallucinatory experience. Barrett refers to the indeterminacy of space and time, referral to the supernatural, the extraordinary and bizarre, and the absence of issues of gender-identity in the delusional reality. Barrett (1996:69-70) also describes how the psychiatric patient in the context of the hospital is transformed into a case:

The social structure and culture of the psychiatric hospital thus endowed a person with particular meanings that rendered him or her into a case. The most striking aspect of a case was that it was dissected, triangulated and quartered into a matrix of cross-cutting divisions. The schismatic hospital organization, with its autonomous professional domains, its intraprofessional conflicts and interprofessional alliances, its social divisions of work space and work time, was reflected in this multifaceted cubist object – the segmented case.

He does not look at the experience of distress as an expression or reflection of a personal experience or interpretation of, or a reaction to a social situation in a process of consequential signifying, but looks at the specific construction, expression and experience of pathology as based in a process of circumstantial signifying within the healing context. Here he seemingly describes the heart of the biomedical process of dissecting the person in parts under the supervision of different specialists and subsequently reconstructing the person in a faltering and faulty medical process. This distinction between consequential and circumstantial signifying is as artificial as Kleinman’s (1980) distinction between pathogenetic and pathoplastic characteristics of sickness, because it presumes a central core of disease which is essential and subsequently molded in social and cultural conditions. I think it is not necessary to take a position in this debate.

In my personal conversations with people who suffered from psychosis, delusions are characterized as ‘safety-measures’ which prevent you from falling into a ‘black hole,’ “where you would become really crazy.” This black hole is described as worse than all the frightening moments of psychosis together. “People, who fall into that hole, never come out of the hospital again.” This black hole, apparently represents the place where meaning and culture completely vaporize or where the way back to the world of socially shared meanings has been cut off completely. It is a personally felt state of isolation and desolation, associated with a stay in the mental institution and powerlessness. Barrett’s
analysis, however, communicates a certain fatalism in which the patient seems to be completely delivered to the fate of the psychiatric definition.

Van Dongen analyzed the interactions of patients and mental health care workers, and focused in that context on the patient’s ‘subjectivity’ (the tension between self and culture) as a compass between these competing and co-operating forces, influences and motives (of therapists and patients). She describes how daily life in the mental hospital is determined by the incongruence between mental health care workers who take a pragmatic-normative position: seemingly neutral, focusing on behavior, and patients who act from an existential-valuating perspective: signaling social injustice and fundamental issues of being. Their interaction is determined by processes of countertransference; discontinuities in the treatment (different institutions, varying therapists) and the projected division of the patients’ self in a negative part (ill, destructive, psychotic) that is non-treatable, and a positive part (healthy contributing to the therapeutic process). Within the context of the hospital order, the experience and subjectivity of people with psychosis is fragmented and the experience of wholeness disrupted. The possibilities to reach moments of intersubjectivity within this institutional context are limited. It is not to say that the hospital regime creates the disruption, but to stress that intersubjectivity as a means for finding meaning is not facilitated and that a social (treatment-based) definition of the illness emerges that represses subjectivity and could be seen as self-fulfilling; it splits the person and negates the patient’s subjectivity, and is conditional in a simple educational style of disciplining. This social definition of the illness differs from the textbook descriptions in the sense that ‘to be feared and distrusted’ and the need to be vigilant are added to the person of the patient, due to their illness.

Given ‘the dull compulsion’ (cf. Scott 1986) of relations within the mental hospital, the ways to keep up self-respect and social recognition are along small margins of possibilities. In the reality of treatment of the illness subjectivity does not disappear, it is under siege and gets (further) disrupted. Patients try to keep or reconstruct their experience of wholeness and Van Dongen makes clear that the themes and questions of patients are real, and not standing outside culture. They are intentional, signifying resistance and comments on values, rules and norms. However, because of the taboo on subjectivity, these themes and questions are pressed to the background and get the shape
of an underlying body of ‘unthematic knowledge.’ Van Dongen (1994: 327) shows how people with psychosis “have no other choice than roaming the world of cultural ideas, values, norms and conceptions, looking for knowledge which they can use to signify their experiences.” They use and create all kinds of models to deal with inconsistencies and ambiguities they experience in everyday reality (of the hospital) and glue them together to constantly renewing ‘bricolages.’ In that sense culture is not only a directing principle, but also a goal, something that saves you from falling into ‘the hole.’ The idea of roaming culture and bricolages of meanings can also be found in Cohen (2001) who studied homeless mentally ill people in Los Angeles. Cohen argues that given the condition of homelessness, the reality of the hard life in the Skid Row district, and with no positive, culturally constructed pathways, their search for meaning necessarily follows delusions, fantasy, or self-destructive behavior. In this context the homeless create an eventful life and often make assertions of their normality and being busy, in a hurry or important, they pretend to have a higher education or important and meaningful (undercover) jobs or pretend to be befriended with important people. Furthermore, they create their own moral justification and dimension and schemes of sometimes risky behavior or fixed pathways that are immersed in personally constructed meanings. In this regard, hanging around drug dealers, the use of drugs or a fixed route of roaming the area can create an experience and an image of a meaningful life for oneself and for the people around you. Cohen (2001: 293) argues that “it would be a mistake to regard the delusional nature of (...) fantasies (of mentally ill) as indicative of nothing more than pathology. The meanings of their delusions are far more important to consider.”

Psychiatry reflects a contradictory and irreconcilable world, that is fragmenting and breaking down subjectivity, not leading to sufficient understanding of the subjective meanings of the patient’s problems, and diminishing the chances of healing and improvement of the quality of life. It is important to analyze the context in which subjectivity as a producer of culture and intersubjectivity as a producer of learning and change thrive. Psychiatry has to analyze its own practice and reflect on the available space to give the subjective transformations and formation of meaning a chance. But not only psychiatry, also a life in, or on the edge of the gutter - for many patients the only alternative - represents “an environment that features disaffiliation, violence, boredom and extreme poverty” (Cohen 2001: 279), with the same effect. In this respect the
experience of delusions suffers from intersubjective disability: we cannot make sense of it as a matter of fact, which leads to the conclusion that this essential character is the matter of fact. For example schizophrenia currently is described as an irreversible disease that is imposed on you by biological and physical predeterminants. It is facilitated in social processes and the therapy is directed at management of symptoms and palliative intervention (medication and hospital admission).

This cultural signification of illness experiences can function as a window on society (Kleinman 1988b, Van Dongen 1994) and allows for discovering the negative and harmful aspects of culture and their detrimental influence on the life of people who are vulnerable. Kleinman noticed that explanatory models are loose systems of interpretation that are rarely invalidated by experience. They are flexible and are able to resist negations. Evans Pritchard (1979) refers to this phenomenon as the ‘second spear’ (umbaga)³ and the notion that the infallibility of the oracle paradoxically is proved by its apparent inconsistency and malfunction. This brings the functioning of the oracle back within human reach. The beautiful concept of umbaga makes clear that the explanation and treatment of an illness experience not only is functional in a social order but also is flexible enough to reproduce this social order. The contextualization of illness and treatment makes it possible to see psychiatry as a culture-reproducing and consolidating institution, a moral sub-system of the dominating culture (cf. Kal 2001). Not only Rosa’s story, but also the history of D. Teresa, as presented in this study are examples of this.

10.7 Reading, speaking and learning

Do the contents of delusions make sense, and how to make sense of them? When looking at the arguments of Kleinman and Geertz, they primarily focus on the reconstituting of experience and less on the relevance of the patients’ ‘bricolage of meaning.’ In the case of delusions it is not common to ‘read the text of the delusion,’ but I think it is necessary to strive for a re-appraisal of the text of delusion as an important element of the process of

³ “Zande belief in witchcraft in no way contradicts empirical knowledge of cause and effect (...) If a man is killed by a spear in war, or by a wild beast in hunting, or by the bite of a snake, or from sickness. Witchcraft is the socially relevant cause, since it is the only one which allows intervention and determines social behaviour. (...) Azande always say of witchcraft that is the umbaga or second spear. Hence is a man is killed by an elephant Azande say that the elephant is the first spear and that witchcraft is the second spear and that together they killed the man.” (Evans Pritchard, 1979: 25)
reconstituting and catharsis, and also the contradictions of our social order as they are experienced by the individual who is experiencing and giving expression to these delusions. Traditionally, psycho-analysts are the ‘detectives of meaning’ in the experience of psychiatric problems, investigating the world of intrapsychic dynamics and fixations in stages of childhood development of psychiatric patients. But also psychiatrists and scientists who practiced on the peak of the anti-psychiatric movement were exponents of a therapeutical optimism in which they tried to make sense of madness. Delusions were texts to be read and interpreted and reflections of something else, something of a higher order that was hidden in the experience: ‘the pearl in the oyster.’ The patient was suffering but also wanted to tell us something.

Van Dongen (1994) makes clear that the abilities of a patient to make sense of his experience are distorted in the context of the psychiatric hospital, but that themes and questions of psychotic patients nevertheless are real, and not standing outside of culture and are built of ‘cultural material.’ A factor that complicates ‘reading’ is the restructuring of time: “Time in psychotic experiences should be interpreted as everything at once and the fulfillment of human existence. (…) I had to understand the things that happened in Joris’ (a psychotic patient, HB) life as those from the past, but at the same time the present and definitely the future” (Van Dongen 2003). An example from my personal experience is the story of a woman who had hundreds of white mice in her house running around freely. She protected them and talked about them in a defensive tone, in words and sentences in past tense and sometimes in incoherent sentences, but an obvious tone. She refused anyone to come inside who wanted to address her about the hygienic consequences of these mice in her house. Finally, public sanitation officers intervened. The operation was filmed and broadcasted on television as an example of the ‘obvious’ need and justification of unrequested psychiatric intervention. The mice were not destroyed, but brought to a park following the wish of the woman. Knowing this woman better taught me that in her personal history as a psychiatric patient, several of her children were taken away from her by the child protection agency right after delivery. Taking away her mice was taking away her children again and would, after being defended fiercely by her, certainly lead to raising new ones.

The expressions are not simple intentional or planned and rational acts: the experience of psychosis changes the world around us and leads the patient into another world with
different realities. Stoller (1989, also Hadolt 2002 on the experience of chronic pain) refers to the American phenomenologist Schutz, who describes social reality as consisting of ‘multiple realities’:

> Everyday life is, in a word, chaotic; its bubble is frequently ruptured. Other realities are ‘finite provinces of meaning’ (...). When ordinary reality is ruptured, the individual enters finite provinces of meaning: daydreams, dusk dreams, night dreams, science, fantasy, illness, euphoria. These ruptures, then, take us ‘beyond the world’ - the ordinary world (Stoller 1989: 117).

Gregg (1998) sheds light on the mechanisms of bricolages and on human possibilities to make ‘quantumlike’ shifts which are hard to trace for an outsider. Gregg studied the multiple identities of Moroccan adults and analyzes the ways in which individuals are able to construct different, sometimes contrasting and contradictory identities. Gregg (1998: 144) defines personality as a fundamental self-representational system and identity as the agent who configures personality by promoting or cloaking certain traits, which would be in conflict with the image of the person you want to be. These self-representational systems can consist of multiple discourses and combine and define contrasting and often contradictory identities. In his conversations with Moroccan adults “narratives show individuals who selectively borrow, refashion, and integrate features widely diffused through their culture, each creating an identity by idiosyncratically writing culture small.” Gregg concludes noting that the self is to be differentiated into multiple discourses and subselves, but is also integrated by an overarching symbolic structure in a way that facilitates ‘quantumlike shifts’ among a small set of contrasting configurations. Binding elements are ‘ambiguous key symbols,’ which link cognition and emotion and are generators of energy, or motivators, positive or negative as constructors of what or who I am or want to be, or explicitly not want to be.

The cultural patterns from which meaning is derived can be common, like described before: religion, interpersonal relations, gender, social and economic relations, family, and educational context. The themes that are woven through the myths and stories that represent these cultural patterns serve as points of reference and provide the necessary grip in the bricolages of meaning: evil, the eternal fight between good and bad, fear and seduction, sin, guilt and penance, the destruction of the world. Like Gregg does, Van Dongen (2003) postulates ambivalence in these themes and presumes the existence
of more or less universal archetypes, characterized by a fixed process of renewal- and reconciliation rituals.

With this in mind, it is interesting to see how different experiences can lead to different realities and different ways of interpersonal relations and bodily awareness. For example, Van Dongen (1994: 165) describes how words, in the reality of people with psychosis, can be ‘touching’ and penetrating the body. This is an awareness that is fundamentally unknown in common everyday reality, but should make us aware of the impact our often ‘innocently’ spoken sentences can have. “Looking at a delusion as a rite focuses on the aspects which enjoin a reality and an authority stretching far beyond the immediacies of the present (Comaroff & Comaroff 1993: xvii).” This makes anthropological work on psychiatric problems, but also psychiatric treatment, into a phenomenological enterprise, where, in order to reach intersubjectivity, several ‘finite provinces of meaning,’ unfamiliar to the ones we know, should be explored. The exegesis of these expressions is not simple because people tinker with all cultural material that is available. It is a puzzle, and much knowledge of stories, myths and material is required (Van Dongen 2003). In this study, Rosa’s and Mrs Soares’ stories about spirits intruding and moving through the body should not be seen as just metaphors, but as bodily expressed and intensely felt experiences of a conflicting and confusing social reality (Comaroff & Comaroff 1993). It is important to not be naïve about meanings of delusions and to make a distinction with the functionalism of radical therapeutic and antipsychiatric critiques on psychiatry. In these schools madness was seen as a radical and sometimes self-destructive reaction to oppressive social structures within society. Awareness of meaning and resistance against oppression were seen as ultimate cathartic experiences. Meaning, as understood in the context of this study, is instrumental in the process of making sense of the experience of psychosocial distress; it is not a goal per se, but ultimately an idiosyncratic process which is constituted in social interaction and in a social context. Comaroff & Comaroff (1993) describe rituals - and symbols as the most essential building block of ritual - as the animators and representations of social value and explanations of the perplexities of human existence. But rituals are not only representations of social value, but also opening fields of argument and essentially renewing social value. In this context, delusion and its (ritual) tropes, especially where they are infused with bodily symbolism, can be considered as an opening of argument, or
“a means of experimental practice, of subversive poetics, of creative tension and transformative action; (...) under its (rituals, HB) authorship and its authority, individual and collective aspirations weave a thread of imaginative possibilities from which may emerge, wittingly or not, new signs and meanings, conventions and intentions” (1993: xxxix). The motor of these subversive poetics is found in the irreconcilability of social changes with basic human values. This can be on a social level at large, but also on the micro level of interpersonal interaction, where human beings are shocked and damaged in their essential humanity.

What does this implicate for the work of medical anthropologists, and the issue of validity and reliability of their contextualizations and interpretations? Stoller (1984) and Van Binsbergen (1999) warn against the making of an ethnographic reality as a scientific anthropological construct. Stoller advocates the ‘langage indirect’ (Merleau Ponty, in Stoller 1984: 108), where the event becomes the author of the anthropological text and where the anthropologist becomes the interpreter and the mediator of ‘the author.’ (Ibid. 1984: 110). This is a fundamental epistemological issue that should be taken in consideration, when talking about meanings in human practices: How can we know wether our understanding of the meaning behind the visible, audible and sensible is true? Of what influence is the ‘gaze’ of the anthropologist? Anthropology criticizes the Cartesian dualism of body and mind and a positivistic science that looks for the universal truth of the ‘biophysical reality.’ In anthropology, the debate continues between the phenomenologically inspired anthropologists and the ‘ethnographic realists,’ who presume the existence of a material reality that comes to us in different (culturally determined) shapes and forms (Stoller 1984, 1989). Stoller advocates a radical empiricism, and writes: “(...) there are no right or wrong representations of the world; there are only texts that capture fleeting moments of what is. These texts in turn, are further shaped by our personal orientation to the world as well as by the constraints placed on us by our institutions. (...) The contingency of language and ethnographic fieldwork limits us to making interpretations which are neither true nor false; rather they are either convincing or unconvincing (Stoller 1989: 116). In anthropological research the

---

94 I do not want to go into the issue of validity and reliability of qualitative research but want to look at it as an epistemological problem.
anthropologist is his own instrument and the quality of his instrument is guarded by means of reflection. However, departing from the point of view that meanings are constructed in interaction as a basic assumption of this study, there seems to be no solid argument to confine reflection and the scientific interpretation of fieldwork to the anthropologist, or the academic world of anthropologists, without involving ‘the authors’ of the text. Reflection should not just be an individual and personal exercise, but a confrontation of findings and interpretations with the ‘author’ of the text, i.e. the event or the actors present in the event. In such a confrontation the anthropological findings can be effectively tested on ethnocentric, medico centric or other culturally or personally inspired biases. To be convincing, anthropological findings should be at least explicit in this respect. This implicates that participant and participatory strategies are central to the anthropological enterprise, that do not objectify informants as just ‘producers of data’ and on the other hand do not idolize them. As described in the first chapter of this report I have chosen for an interactive type of research, in which data not only are derived from the community under study, but are also discussed with this community (also Beijers 2004c). The purpose of this was to empower the community in the context of mental health care in Rotterdam. Furthermore, the researcher participated in the context of the learning community of the ‘Partners in Health’- project and supported the organization of the conference ‘Á Ponte – Bruggen Bouwen’ (Rotterdam, 17 June, 2004), in which a dialogue between Cape Verdeans and representatives of mental health care institutions is organized. The problem of culture and psychiatry is not to objectify the presumed schemes: It is not only about reading, but also about speaking. This means that it is important to let the subject speak and to create the conditions to learn.
References

Almeida, R. A.
1997 Chronological references: Cape Verde/Cape Verden American. Online available at: www.umassd.edu/special programs/caboverde/cvchrono.html
APA
Banning, C. and P. de Koning
Barrett, R. J.
Bartels, E.
Bekkum, D. van, M.van den Ende, S. Heezen & A. Hijmans,
Beijering, M.
Beijers, H.
2004a Onderscheiden wat van God komt. Maandblad Geestelijke volksgezondheid, 59, 1: 71-75
Bhugra, D.
Bhugra, D. and O. Ayonrinde
Bhui, K. and D. Bhugra,
2002 Mental Illness in black and Asian ethnic minorities: pathways to care and outcomes. Advances in psychiatric treatment, 8: 26-33.
Binsbergen, W. van;

Blok, A.

Bolaffi, G.; R. Bracalenti, P. Braham and S. Gindro,

Boog, B.

Bosman, P.
1997 Cabo Verde aan de Maas. Rotterdam: Erasmus University, Faculteit der Historische en Kunswetenschappen (masters-thesis)

Brito, M.

Cabral, N. E.

Carling, J.

Carvalho, H.
2003 Lied van Oneindige Passie, Kaapverdische muziek in Rotterdam-West. NRC, 4 July 2003: 19.

Casteren, J. van
1998 Bronx aan de Maas, De Groene Amsterdammer, 13 may 1998

Cohen, A.

Comaroff, Jean. & John Comaroff

CBS (Centraal Bureau voor de Statistiek)
2001 Armoede, Index, 10.

Centro Redentor
1989 Prática do Racionalismo Cristão, 12ª Edição, Rio de Janeiro

Chrisman, N. J.

COS (centrum voor onderzoek en statistiek)
Dieperink, C.J. and A. I. Wierdsma;
Dieperink, C.J., R. van Dijk, and A. I. Wierdsma;

Dijk, Rob van

Dijk, Rob van, I. Boedjarath, F. May, J. de Jong & R. Wesenbeek,

Dijk, Rob van & E. van Dongen,

Dijk, Rijk van

Dongen, E. van,

Dongen, E. van & M. Tankink

Durieux, H.

Elleswijk, P.
Esmail, A.

Essed, Ph.

Evans-Pritchard, E.E.

Fainzang, S.

Fauman, M. A.

Fidalgo, F.

FNV

França, L. de

Freston, P.

Fulford, K.W.M.

Geertz, C.

Goddard, V.A.
Gregg, G. S.  

Gowricharn, R.  

Graça, A. A. da,  
1999 *Een nieuwe horizon, een onderzoek naar de organisatorische dynamiek van Kaapverdianen in Nederland*. Amsterdam: University of Amsterdam, department of sociology and anthropology (masters-thesis).

Haar, G. ter  

Hadolt, B.  

Hahn, R.A. and A. Kleinman  

Hardo, A. et al.  

Halter, Marilyn  

Harrison, G; G. Glazenbrook; J. Brewin; R. Cantwell; T. Dalkin; R. fox; P. Jones; I. Medley  

Hartogh, R. de  

Harwood, A.  

Have, M. ten, A. Oldehinkel, W. Vollebergh, J. Ormel  

Helman, Cecil G.  

Hoffer, C.B.M.  

Hoorlan, P.D.  
1995 *De kansen van een trekvogel, een persoonlijke geschiedenis van de Kaapverden*. Rotterdam: Stichting Buitenlandse Werknemers Rijnmond
Huiskamp, N.; H. Vis; W. Swart; T. Voorham
2000 Gezondheid in Kaart Allochtonen, gezondheidsproblemen en preventiemogelijkheden in kaart gebracht, Rotterdam: GGD Rotterdam e.o..
ISEO/COS
Jenkins, J. H. and R.J. Barrett
Jong, J.T.V.M. de
Kal, D.
Keesing, R.M.
Keij, I.
2000 Standaarddefinitie allochtonen. Centraal Bureau voor Statistiek Index, 10: 24-25.
Kirmayer, L.J. & H. Minas.
Kleinman, A.
Koningsbruggen, P. van
Kortmann, F.
2003  
  Interlutele geestelijke gezondheidszorg in Nederland, een studie naar de ‘state of the art van de transculturele hulpverlening, Rotterdam: Mikado.

Krikke, H.; R. van Dijk, H. Beijers,  
2000  
  Thuis is, waar de ander is. Allochtone cliënten in de geestelijke gezondheidszorg en de cliëntenbeweging, Rotterdam: Basisberaad GGZ.

Lalonde, M.  
1974  

Letra das Ilhas  
2003  
  Notícias de Cabo Verde. Letra das Ilhas, Rotterdam, 2:8.

Like, R. and J. Ellison;  
1981  
  Sleeping blood, tremor and paralysis: a trans-cultural approach to an unusual conversion reaction, Culture, Medicine & Psychiatry, 5: 49-63.

Lipsedge, M.  
1996  

Littlewood, R.  
2001  

Lloyd, K.R.; K.S. Jacob; V. Patel; L. St. Louis; D.Bhugra and A.H. Mann;  
1998  
  The development of the Short Explanatory Model Interview (SEMI) and its use among primary-care attenders with common mental disorders. Psychological Medicine, 28: 1231-37.

Massart, G.  
2000  

Meintel, D.  
1983  

1984a  
  Cape Verdean emigration: solution or problem. Revista de Estudos Africanos, 2

1984b  
  Race, Culture and Portuguese Colonialism in Cabo Verde. Syracuse: FACS, Syracuse University.

2002  
  Cape Verdean Transnationalism, Old and New. Anthropologica, 44: 25-42

Meyer, B.  
1998  

2002  

Mortensen, P.B.; E. Cantor-Graae T.F. McNeil  
1997  
  Increased rates of schizophrenia among migrants: some methodological concerns raised by Danish findings. Psychological Medicine, 27: 813-20.

Murphy, R.,  
1995  

Murphy, R., J. Scheer, Y. Murphy & R. Mack  
1988  
  Physical disability and social liminality: a study in the rituals of adversity, Social Science and Medicine, 26, 2: 235-42.
Nabibaks, X.
2004 De stilte doorbroken. *Contrast*, 4: 14-16

Nanda, S. and R. Warms

Neto, F. and J. Barros

Nichter, M.

Oro, A. P. and P. Semán

Os, J. van

Pannekeet, C.

Pappas, G.

Parsons, E. C.

Patterson, K. D.

Pease, B.

Pieterse, dr. M.E.

Press, I.

Reekers, E.

Reijneveld S.A. & K. Stronks

Richters, A.

Rohlof, H.

Romme, M.A.J. en Escher, A.D.M.A.C. (eds)

Rocha, S.
2002 Eerste rapportage Apoio. Rotterdam: Basisberaad GGZ.

Rotterdams Dagblad
1996a ‘Versplinterde Kaapverdiërs hebben een waakhond nodig’, 22 October 1996
1996b ‘Stilte rond Kaapverdische gemeenschap even doorbroken’, 28 October 1996

Rousseau, C. ; Taher M. S. ; M.-J. Gagné & G.Bibeau

Ruijter, A. de,
2000 De multiculturele arena, oratie Tilburg: Katholieke Universiteit Brabant.

Ryan, C. J.
1989 Wat is Theosofie? The Hague: Theosophical University Press Agency

Santos, A.

Sbibi, A. and L. Bos
2004 Instroom en uitstroom van etnisch en cultureel diverse cliënten in de GGZ. Een inventarisatie van maatregelen die de instroom bevorderen dan wel vroegtijdige uitstroom tegengaan. Rotterdam: Mikado (not published)

Scott, J.C.,

Seeler-Tegethoff, M.
1998 Zum Grossen Erfolg der Igreja Universal in Brasilien. Anthropos, 93, 3: 89-100

Seidel, J. V.

Selten, J.P.; J.P. Slaets; R.S. Kahn


Schiers, A.C.; B.J.M. van de Wetering; P.G.H. Mulder; J.P. Selten
2001 Point prevalence of schizophrenia in immigrant groups in Rotterdam: data from outpatient facilities. European psychiatry, 16:162-166.
Sheper-Hughes, N.

Silva, A.
2003 Key-note lecture during conference on sexuality for young Cape Verdeans, 25 May 2003 (not published).

Singer, M.

Slutzky, M.
2002 ‘Latino’s in Nederland: survivors vechtend tegen clichés’ and ‘Colombianen, de grootste groep Latino’s willen onzichtbaar zijn.’ In ibid.: Holanda Latina, Amsterdam: Arena.

Smulders, R.

Soares de Freitas, C.

Stewart, P. J. & A.Strathern

Stoller, P.

Stronks, K.; P. Uniken Venema; N. Dahhan; L. J. Gunning-Schepers

Stronks, K.; A.C.J. Ravelli; S.A. Reijneveld

Strooy, H.
2000 Eilanden aan de Maas: De Kaapverdische gemeenschap in Rotterdam, in: I. van Kessel & N. Tellegen, Afrikanen in Nederland, pp. 43-61, Amsterdam: KIT.
Sundquist, J.
2001 Migration, equality and access to health care services (Editorial), *J. Epidemiol Community Health*, 55:691-92.

Thung, F.

Tobin, J.
1986 (Counter)transference and Failure in Intercultural Therapy, *Ethos*, 14, 2:120-143.

Tollenaere, H.A.O. de

Truscheit, T. and A. R. Fernandes
2000 *Rabelados, the non-violent rebels of the Cape Verdean Islands* (documentary), Germany/Cabo Verde: Filmakademie Ludwigsburg/Filmareal/ Südwestrundfunk.

The world factbook

Vasconcelos, J.

Vink, M.
2003 *De dokter begrijpt het niet*. Onderzoek naar de ervaringen van migranten met de huisartsenzorg in Amsterdam. Amsterdam: APCP.

Veiga, dr. M.

Vermaas, P.

Veiga, dr. M.

Vlaminck, P.
Appendix I: Selection of informants

1. **Rosa**
   Cape Verdean woman of 60 years old, born on one of the Barlavento Islands; emigrated to The Netherlands in 1970 (33 years ago). Lives together with a Cape Verdean man of about the same age (Sotavento Islands), who takes care of her. Rosa divorced the father of her (married) children. There is a reported history of abuse by the father. Rosa is in bad shape when I meet her, she complains, and tells she is not able to go out anymore, not able to take the stairs down from her fourth floor apartment. Her body feels heavy and her legs hurt, apparently as a side effect from antipsychotic medication. Rosa has contact with the community mental health centre, and has a long history (22 years) of psychiatric problems and several hospital admissions. The support in everyday life activities, which is needed, cannot be given, because of the shortage of personnel. Rosa is convinced that her problems are caused by a spirit that is sent by her former husband. According to Rosa the doctor cannot solve such a problem and she does not know an alternative. She consulted curandeiros in Rotterdam and on Cape Verde, at high costs and without result; she thinks the spirit is trapped. Volunteers of Apoio and the community mental health worker try desperately to get her to go again. Rosa frequently visits the Centro Redentor. Attempts to get her another house didn’t succeed.

2. **Sr. & Sra. Dos Santos**
   Parents - born on a Barlavento Island - of Manuel, apparently schizophrenic, 24 years old, who avoids contact with mental health care professionals and refuses to use medication. Manuel is born in The Netherlands and does not show up on his appointment for an interview. Manuel repeatedly ends up in trouble, causes nuisance around the house of his parents, was convicted and imprisoned several times, and involuntary committed to the mental hospital. They are convinced that Manuel’s problems and his psychoses are not psychiatric, but drug-related. According to them, he is oversensitive to the effect of drugs and that makes him psychotic. The help they and their son get is characterized by deficient contacts with mental health care professionals on the one hand, and asking help from the police and interventions of the law on the other hand. Values, procedures, and concepts of Dutch mental health are hard to understand. They sigh that even when he is involuntary committed in a mental hospital, he is back on the street and homeless again after a couple of days. These parents are looking for help that will not let their son go to soon. Preferably, they would like to see their son committed involuntarily for a long period. Because he refuses help and support, the professionals of mental health care refuse to do anything. A Cape Verdean policeman brought them into contact with mental health care, and currently the Apoio-project is actively involved to keep the contact with the psychiatrist going.

3. **Lucinda**
   Cape Verdean woman of 45 years old, has lived in The Netherlands since 1982 (21 years), and was born on one of the Barlavento Islands. Is divorced and has two children. One of the children is under custody of the child protection agency. She has no contact with the father of the children and lives alone. Came into trouble when she came to The Netherlands. It did cost her a lot of trouble to find good help, because she did not speak
Dutch, could not find her way around and did not have much support from other people. In the beginning she stayed with family members. Finally, apparently when she was experienced as a burden, they dropped her at the Salvation Army, in a centre for the homeless, where she stayed for several years. She got her own house, when she gave birth to her first child. She suffered from several psychotic episodes and involuntary commitments. Is treated by mental health care (depot medication), lives a socially isolated life, isolated as well from the Cape Verdean as from the Dutch community, and is looking for meaningful daily activities (work etc.). After one of her crises she was taken back to Cape Verde by her mother for a period of four years, where she was supported by her family and treated by a psychiatrist on the island of Santiago. Seems to have trouble to reach and trigger the right people, formulate the right goals to mobilize sufficient help and seems to be treated on a minimal basis (medication).

4. **Miguel**

A Cape Verdean man, 45 years old, born on a Barlavento island, formerly married but currently single. His ex-wife, daughter, and his father live abroad (Northern and Southern America), and two sisters still are in Cape Verde. He migrated to The Netherlands in 1973 where he lived with an aunt. Miguel got work via an uncle and worked on the ocean-going trade as a sailor and as a mechanic on the shore. He reports conflicts with employers and colleagues, feelings of not being understood and not being rewarded as well as being subordinated compared to Dutch colleagues. His career is not very successful and finally he ends up in a subsidized (additional) job as a warden. Miguel reports several physical problems (spasms of stomach and intestines and painful arms) which apparently are seen and treated as ‘vague complaints’ by his general practitioner and several medical specialists. He had to quit this job because of his physical problems and is currently unemployed. His contact with (mental) health care, centers around the (quality of his contact with the) general practitioner, who periodically refers him to different medical specialists.

5. **Bemvinda**

A Cape Verdean woman, born on a Barlavento island, mother of a 31 year old daughter, Eunice, who she calls ‘depressed.’ Her daughter was admitted to a mental hospital when she was 24 years old, shortly after she gave birth to her first child, with symptoms of psychosis and aggression. She has a history of involuntary commitments in different hospitals. Her children are under custody of the child protection agency and are being raised by their father, who eventually divorced her. Because of complaints of public nuisance, she was kicked out of the house by her landlord. Her belongings are partly lost, partly stored in her mother’s house. Now and then she comes to her mother’s house, to get and sell something. Her mother suspects that she is financially exploited. Eunice currently is homeless, and in the process of neglect. She still has weekly contact with the community mental health centre, to get medication. Bemvinda thinks that mental health workers do not do enough to help her, because they do not help her with her financial problems and homelessness. She suspects that there might be other things involved, for example spirits, but she is not sure about that. In the past she consulted a *curandeiro*, but finished this because of the costs. Is currently consulted by the social worker of the Apoio-project.
6. **Ana**  
A 30-year-old Cape Verdean woman, with a history of abuse, born on a Barlavento island. She moved to Portugal in 1989 and recently came to The Netherlands, to marry. She worked in the cleaning industry. She accuses the machismo of Cape Verdean men and divorced her husband because he did not want to take any responsibility for the education of their son. She currently lives alone with her three-year-old son and is unemployed. She feels depressed and experiences feelings of sexual inadequacy and all kinds of chronic physical problems (itches, pains etc.). She found help via contacts and advice from her social network. She complains that the mental health centre has a waiting list for social assistance, and does not help her adequately. In the past she consulted a *curandeiro* and joined the Igreja Universal (Pentecostal church), but quit both of them because of the costs. Currently went, at personal expenses, to ‘The French Doctor,’ a clairvoyant Brazilian doctor (registered) in Paris, whom she thinks understood her very well and gave her sufficient medication.

7. **Antonia**  
A Cape Verdean woman, between 50 and 60 years old, born on a Barlavento island. She is married, works in the cleaning industry. She has a 51-year-old unmarried sister who came into contact with mental health care in 1980. Since four years her condition has worsened. She is regularly committed involuntarily to the mental hospital. This is accompanied by open violence and she ends up in a separation cell. Currently she is at home, but Antonia thinks that the community mental health worker does not pay enough attention. She visits her only once a month. And that is not enough to keep her using the prescribed psychopharmacological medication. There is no contact with other service providers. Antonia thinks that the lack of Portuguese-or Crioulo-speaking workers is one of the fundamental problems in mental health care; this is probably related to her own illiteracy. She came into contact with the social worker of Apoio, whom she accidentally met while visiting her sister in the mental hospital.

8. **Carlos**  
A 62-year-old Cape Verdean man, who was born on a Sotavento island and came to The Netherlands in 1962 (41 years ago). He is married, has two children and currently works as a warden in a subsidized job. Carlos has a son who came into trouble when he was four years old. The boy showed ‘strange behavior’ (hyperactivity, lack of concentration) and was expelled from school. He was tested by the community mental health centre, but they could not find anything and they let him go home again. In the years following, he was expelled from several schools and regularly came in contact with the police, due to small crime. Currently (now fifteen years old) he is committed to a half-open children’s penal institution. Carlos is embittered about the neglect and the lack of action of the mental health care and the general practitioner. He consulted *curandeiros* (Caribbean and Dutch) about the problems of his son, which cost him large amounts of money. He is convinced that the same spirit that attacked him when he was young now attacks his son. He never told this to any of the (mental) health care workers, because nobody ever asked him. He frequently visits the Centro Redentor and prays to Jesus and Mary.
9. **Sonja**
A Cape Verdean woman between 30 and 40 years old, single with three children, working in a laundrette, with a history of sexual abuse and psychiatric problems. Sonja's mother is 86 years old and lives in a mental hospital (long stay for the elderly). Sonja complains about the lack of quality of the facilities of the mental hospital: they are rundown. A little while ago her mother moved to a new centre, where the facilities are better. But her mother does not speak Dutch, so she cannot communicate with the staff, only when they speak Papiamento (Luso-african creole, language from former Dutch Antilles). That means they basically only provide accommodation and give her medication. Sonja feels sorry and responsible for her mother. She wants to give additional care, like take her mother out. As a single mother she does not have enough financial means to do that, the facility where her mother stays is rather far away. A relative thinks that doctors do not take time for foreigners or migrants (buitenlanders) and put them off with medication. That fits in the way migrants are generally treated, which she describes and experiences as racial discrimination.

10. **Dina**
A 27-year-old Cape Verdean woman, born in Rotterdam, who participated in an assertiveness training in the local community centre and was referred to a social worker and a haptonomic therapist. Dina was raised in a very strict Cape Verdean family, with, as the eldest child, a lot of responsibilities. The social worker did not understand the meaning and the impact of this; he asked a lot of things and did not do much. In general she thinks that health care professionals know nothing about the Cape Verdeans compared to other migrant populations. She explains that body and mind were out of balance in her life, she experienced all kinds of pains, and that the haptonomic treatment helped her to listen to herself and be assertive. Through her contact with Apoio, she now will attend (self referral) a therapist of the community mental health centre, although there is a lot of bureaucracy involved. She is convinced that mental health problems are a taboo in the Cape Verdean community, they are badly understood, and people are prejudiced about getting help from the community mental health centre. Dina is convinced that getting good help depends on personal initiative and motivation. She declines indigenous Cape Verdean beliefs about magic and spirits.

11. **Sofia**
A 47-year-old Cape Verdean woman, who lives alone (divorced) with two children. She has long history of contact with mental health care and admissions to mental hospitals and currently is in contact with the community mental health centre. When I meet her she is in a bad condition; she is confused and suffers from pain in the back, heartpalpitations heart and side effects of the antipsychotic medications she gets. Her children are also in contact with the community mental health centre for treatment. Sofia thinks that the therapists do not take her seriously because her children make a show of friendliness, while in reality she experiences lack of respect and violence. She complains that her life is determined by raising her children alone, by the lack of care she experiences from them and the prospect of being left alone. Sofia succeeds in mobilizing five different health care professionals in two days, whose interventions are all experienced as incidents.
12. Paula
A 23-year-old Cape Verdean girl, born on a Barlavento island. She has lived in The Netherlands three years, in her mother’s house, without documents. She works early mornings, seven days a week as a cleaner of a bar. She was raised in Cape Verde by her grandmother and reports a history of sexual and physical abuse, which is too terrifying to remember. She reports that as a child she refused to talk and just cried; she was treated in Cape Verde by a psychiatrist. She is very shy, speaks in a low voice, cannot read or write and only speaks Crioulo. Paula has one child, who still lives with her grandmother in Cape Verde. Further contact with the father of the child was forbidden. She is in contact with a (Spanish-speaking) therapist from the community mental health centre in which she trusts. Paula feels a fundamental fear everywhere and for everything that she never talked about to her therapist, because she cannot explain it in another language than her own mother tongue. Her mother is very strict; she is not allowed to go out or to have friends, and all her earnings are taken in, partly for the child in Cape Verde, partly as savings for her personal future. She can ask for pocket money. She dreams of living independently but sees no way out. Young women without documents are reported to be at risk of being sexually abused and exploited by men.

Key-informants:
1. Vitorino Chantre: president of Centro Redentor Lombardkade Rotterdam
2. Djau (pseudonym): practicing curandeiro in Rotterdam
3. Ralph Du Long: independent consultant on anti-discrimination codes
4. Fernando Fidalgo: editor of ‘Gazeta do Racionalismo Cristão’
5. Peter Kapteijn: staffmember of anti-discrimination organization in Rotterdam (Radar)
6. Horácio Medina: president of Centro Redentor Amsterdam
7. Janke Reiding: staffmember of Avanço foundation, Rotterdam
9. Pastor Santos: pastor at the Igreja Universal do Reino de Deus Rotterdam Diergaardesingel
10. Sigrun Scheve: staffmember of national anti-discrimination organization (LBR)
11. Antonio Silva: teacher at polytechnic university InHolland in Rotterdam
13. Father Stevens: pastor of the Roman-Catholic parish of Nossa Senhora da Paz
14. Ferdinand Thung: psychiatrist, DeltaBouman group, Rotterdam
Appendix II: Preliminary Problem Analysis Diagram

Meanings of Distress in the Cape Verdean Community in Rotterdam

- Cultural Domain
  - History of Cabo Verde
  - Rationalizing Psychiatry
  - Missed Interaction: e.g., Insufficient reach of Mental Health Care and Public Health programs
  - Intolerance, Racism
  - Poverty
  - Own Explanatory Models

- Field Variables
  - Religion
  - Formal and Social Network
  - Social Situation
  - Access to MHC/GP
  - Knowledge about Dominant Explanatory Models
  - Interaction missed
  - Level of Social Respect/Stigma
  - Complexity of Problems: Psychiatric and Social

- Personal Variables
  - Personal History
  - Personal Model/Narrative
  - Manifestation of Distress: Interaction with Communication
  - Acuteness of distress

- Own Solutions
Appendix III: Filter model Goldberg and Huxley

Filter Model
Based on Goldberg and Huxley (1980), De Jong (1996) and Sels and Boo (2003)
Appendix IV: Ethnicity and Health: Stronks’ conceptual model

Conceptual model which integrates possible explanations for the relation between ethnicity and health. (Stronks et al. 1999)
Appendix V: Interview guide

Introduction to the interviews
a. Explanation and introduction to the interview (for example, referral to this informant by ...., duration, no right or wrong)
b. Two goals of the research:
   - Study of the ideas, wishes, needs and explanations people have for psychosocial distress. What do they think when some disturbing feelings or experiences cross their path, what do they do, where are they looking for consolation and support?
   - Goal of empowerment: together with Cape Verdeans finding out what has to be done so people are better equipped to deal with mental health care and in what way, where and how mental health care should change.
c. Informed consent/information sheet/recording
d. Report available
e. Feedback session at the end
f. Make sure the informant is at ease.

Interview guide for core informant:
1. Introduction, tell something about yourself? Learning to know each other better. Origin on Cape Verde.
3. What kind of concepts do people use to explain what happened?
4. Is this understanding and wording different than the explanations they encounter in The Netherlands? Alienating?
5. What did you do? Who took the initiative? Who decided?
   Where did you go for consolation, advice, togetherness, support?
   Family; church; healers/Cabo Verde; others?
   Who were most important?
6. Were there different opinions/views? What was your point of view?
   What did it render?
7. Were there conflicting opinions: established points of view opposing things that had to be reinvented? How did that work? How do you feel about it?
   (With whom should I talk? Consent!? How to contact them?)
8. Why did it happen to you, who is to blame or what is to blame?
9. Context: personal history/circumstances, family/work/neighborhood. How does the subject relate these factors to personal situation?
10. What should change? Relation with Dutch society, living conditions, mental health care? Cabo Verde?
11. Demographic data: age, sex, profession/work, education, migration history (dates), family conditions.

Closing interview, repeating main things that are said, appointments made. Follow up?