

Faculté de santé publique

**Socio-cultural determinants and
barriers to providing effective mental
health services to the Filipino
community in Belgium**

Submitted by:
Sarah Cordero

Master's thesis adviser(s):
Nataly Filion

Academic year 2019-2020
Master's in public health sciences, final specialization

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... Papa, makakatapos na guihaon ako. Salamat han ngatanan, ginhihigugma ko ikaw.

Plagiarism

I declare on my honor that this thesis has been written by me, without having requested unlawful exterior help, that it is not a resumption of work presented in another institution for evaluation, and that it has never been published, in whole or in part.

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Table of Contents

Chapter 1: Mental health in the Philippines	1
1.1 Introduction	1
1.2 Historical background of psychiatry and mental health in the Philippines.....	4
1.3 Legal context: Mental health act of 2017	6
1.4 Influence of social media on promoting mental health and its effects on the emancipation of the youth	7
Chapter 2: Filipino immigration	8
2.1 The Filipino community in Belgium.....	8
Chapter 3: Conceptual framework	10
3.1 Social determinants and barriers in seeking out mental health support	11
3.1.1 The perception of mental health by the Filipino community	12
3.1.2 The external barriers and socio-cultural determinants in seeking out mental health support	13
3.1.3 The internal barriers and socio-cultural determinants in seeking out mental health support	20
3.2 Chapter's conclusion	21
Chapter 4: Definition of the problem.....	22
Chapter 5: Methods and materials.....	24
5.1 Study design	24
5.2 Data Collection.....	25
5.3 Data analysis	26
5.4 Participants.....	26
Chapter 6: Results.....	29
6.1 Categorization of results.....	29
6.1.1 Perception of mental health	31
6.1.2 External factors and socio-cultural determinants in seeking out MH support	36

6.1.3 Internal factors and socio-cultural determinants in seeking out MH support....	45
Chapter 7: Discussion	52
7.1 Summary of main findings in relation to theoretical literature	52
7.2 Limits and strengths	58
7.3 Perspectives	60
Chapter 8: Conclusion.....	61
9. References.....	62
10. Annexes	69
10.1 Annex 1: Interview guide.....	69
10.2 Annex 2: Research open invitation for participants	72
10.3 Annex 3: Interview Consent Form	73
10.4 Annex 4: Thematic social map.....	76
10.5 Annex 5: Social media posts promoting MH awareness in the Philippines	79

List of figures and tables

Figure 1. Map of the Philippines (Regional Profile Department of Health Region 8, n.d.)	2
Figure 2. Conceptual framework	10
Figure 3. CSDH conceptual framework (Solar & Irwin, 2010, p.6)	11
Table 1. Demography of Filipinos in Belgium. (Embassy of the Philippines, personal communication, 2020)	9
Table 2. Characteristics of the participants	28
Table 3. Distribution of qualitative data in units of analysis	30
Table 4. Perception of MH: a psychological and emotional process	31
Table 5. Perception of MH: a cognitive definition	31
Table 6. Perception of MH: a neurological disorder	31
Table 7. Perception of MH: trivialization of mental illness	32
Table 8. Perception of MH professionals: trained and qualified	32
Table 9. Perception of MH professionals: only severe cases need professional care	33
Table 10. Perception of MH professionals: lack of “emotional connection” with MH professionals	33
Table 11. Folk conceptualization of MH: examples	33
Table 12. Folk conceptualization of MH: role of elders in spreading MH beliefs	34
Table 13. Folk conceptualization of MH: food and drugs	35
Table 14. Mental health in contrast to physical health: MH = PH	35
Table 15. Mental health in contrast to physical health: MH > PH	36
Table 16. Mental health in contrast to physical health: MH < PH	36
Table 17. Public policies: accessibility to MH care	37
Table 18. Public policies: language barrier	37
Table 19. Culture/societal values: Religious beliefs - importance of religious figures	38
Table 20. Culture/societal values: Religious beliefs - Role of priests	39
Table 21. Culture/societal values: Religious beliefs - prayer as a coping mechanism	39
Table 22. Culture/societal values: Religious beliefs - link between MH and religious beliefs	39

Table 23. Culture/societal values: Save face culture and stigmatization of MH - taboos and trivialization of MH	40
Table 24. Culture/societal values: Save face culture and stigmatization of MH - mockery of mental illness	40
Table 25. Culture/societal values: Save face culture and stigmatization of MH - mental illness = outcast	41
Table 26. Culture/societal values: Save face culture and stigmatization of MH - negative portrayal of professional care	41
Table 27. Psycho-social circumstances: Role of family reputation	42
Table 28. Psycho-social circumstances: Role of family reputation - extended family	43
Table 29. Psycho-social circumstances: Care chain	43
Table 30. Psycho-social circumstances: Giving back culture	44
Table 31. Psycho-social circumstances: Resilience of Filipinos	45
Table 32. Behavioral factors: Acculturation process - Difficulties of adaptation	46
Table 33. Behavioral factors: Acculturation process and likeliness to seek MH care	47
Table 34. Behavioral factors: Coping mechanism and likeliness to seek out MH care - 1st group: Sought professional help or willing to seek help as a first recourse	48
Table 35. Behavioral factors: Coping mechanism and likeliness to seek out MH care - 2nd group: Willing to seek professional help as a last recourse	48
Table 36. Behavioral factors: Coping mechanism and likeliness to seek out MH care - 3rd group: Against seeking MH support	49
Table 37. Socio-economic position: Influence of education and immigration on the perception of MH	49
Table 38. Social capital: Preference for lay network	50
Table 39. Social capital: Preference for lay network - advice for other Filipino immigrants	51

List of abbreviations

<i>CSDH:</i> <i>Commission on Social Determinants of Health</i>
<i>DOH:</i> <i>Department of Health</i>
<i>HSB:</i> <i>Help-Seeking Behavior</i>
<i>MH:</i> <i>Mental Health</i>
<i>MI:</i> <i>Mental Illness</i>
<i>NMH:</i> <i>National Mental Hospital</i>
<i>OFW:</i> <i>Overseas Filipino Worker</i>
<i>PH:</i> <i>Physical Health</i>
<i>PMHA:</i> <i>Philippine Mental Health Association</i>
<i>PMHP:</i> <i>People with Mental Health Problems</i>
<i>POEA:</i> <i>Philippine Overseas Employment Administration</i>
<i>PPA:</i> <i>Philippine Psychiatric Association</i>
<i>PSA:</i> <i>Philippines Statistics Authority</i>
<i>WHO:</i> <i>World Health Organization</i>

Chapter 1: Mental health in the Philippines

1.1 Introduction

What is mental health and why is it important? Answering these questions is essential to understanding the focus of this paper. The WHO constitution defines health in general as “*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.*” (WHO, 2001b). This definition implies that mental health is more than just the absence of mental illness. To be more specific, “*Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community.*” (WHO, 2001a). Mental health is progressively being recognized as an integral and fundamental component of health in our society. However, this progress is very uneven; the perception of mental health varies immensely from one country to another. This variation is reflected in the political and societal reactions of nations to the growing recognition of mental health. How has this change been addressed within the political and societal context of the Philippines?

The Philippines is an archipelago located in Southeast Asia consisting of over 7,000 islands. It is a unitary presidential constitutional republic and has a population of over 100 million (“Philippine Statistics Authority,” 2015) of which 2.3 million are Overseas Filipino Workers (OFW) (PSA, 2018). This makes it the 12th most populated country in the world with a population comprised of 91.3% Christians, 5.5% Muslims and 3.2% belonging to other religious groups (Philippine Statistical Yearbook, 2015). Because of its unique status in Asia as a Christian-majority country, the Philippines is subject to significant religious influence, despite the separation of church and state.

Mental health in the Philippines is, unfortunately, not the priority for the Philippine government. Only 5% of the total health budget is allocated to the mental health department, most of which is spent on mental hospitals (WHO, 2006). Community-based care is not promoted, especially in rural areas. According to the WHO-AIMS Report on the Mental Health System in The Philippines, the National Capital Region benefits from easier access to mental health facilities than any of the other 16 regions. In comparison, rural zones and regions furthest from the capital suffer from limited access to these same facilities.(WHO, 2006).

Beyond the fact that the existing infrastructures are insufficient, there is also a significant scarcity in mental health specialists. The country counts 0.52 psychiatrists (Isaac et

al., 2018), 0.07 psychologists and 0.049 mental health nurses per 100 000 inhabitants (WHO, 2014). This severe shortage of mental health professionals is further underscored when compared to the recommended WHO global target of 10 psychiatrists per 100 000 inhabitants (Lally, Tully, & Samaniego, 2019).

The day-to-day reality of life in the Philippines reflects the consequences of these statistics. As a Filipino-Belgian, the researcher lived the first 16 years of her life in a town called Tacloban located 580 km southeast of Manila. With a population of over 200,000, Tacloban is considered as the regional center of Eastern Visayas. As a teenager, she was surprised to hear that only one psychologist was available in the whole region.

Figure 1. Map of the Philippines (Regional Profile | Department of Health Region 8, n.d.)



Unfortunately, data concerning the prevalence of mental health diseases in the country is scarce. However, some figures were gathered by Philippine Statistics Authority as cited by Lally et al.:

“For example, 14% of a population of 1.4 million Filipinos with disabilities were identified to have a mental disorder (Philippines Statistics Authority, 2010). The National Statistics Office identified that mental illness is the third most prevalent form of morbidity, however the finding that only 88 cases of mental health problems were reported for every 100 000 of the population (DOH, 2005) is likely an underestimate of the true extent of these issues.”(Lally et al., 2019, p.2).

Indeed, the numbers presented most likely do not represent the reality of the situation in the Philippines. Many cases go undiagnosed or unrecognized as a direct result of the aforementioned shortage of mental health facilities and professionals.

This led the researcher to question how Filipinos who live abroad seek out help in countries where mental health care is more accessible. What factors might inhibit Filipinos

living overseas from seeking professional mental health support? Does cultural or religious upbringing play a role in their choice to seek psychological support within the context of secular countries such as Belgium which provide easy access to mental health care?

These queries brought to light the following research question: ***What social determinants and barriers prevent the Filipino community in Belgium from seeking out mental health support?***

There are currently no studies concerning the mental health help-seeking behavior (HSB) of Filipino-Belgians. Most of the existing literature concerning the mental health HSB of Filipinos comes from America. These studies focus either exclusively on Filipino-Americans or on various Asian American populations as a group. There is a lack of data concerning the indigenous population itself (Tuliao, 2014). Studies concerning Filipino Americans indicate a general reluctance to seek professional mental help. Currently, these studies identify higher income, health insurance and acculturation to the American way of life as factors which increase the likelihood of seeking mental health support. Conversely, factors which negatively impact the probability of seeking mental health support include the preference for lay networks such as friends, family and folk healers, folk conceptualization of mental illness, stigma and the need to “save face”, emotional restraint and the desire to preserve family honor and hierarchy. (David, 2010).

In order to answer the research question, published literature relating to the issue will be analyzed and a qualitative study will be carried out by conducting semi-directive interviews with members of the Filipino community in Belgium. A comparison between the effect of identified barriers and social determinants on the mental health HSB of Filipinos in existing literature and the information gathered from Filipino-Belgians during the data collection of the study will be made during the analysis.

However, before elaborating on the methods and analysis of this research, a brief historical background of Psychiatry in the Philippines, the current legal context concerning mental health and the shift in perception of mental health among Filipino youth will be presented. Secondly, a short presentation on the Filipino Community in Belgium and the context of immigration will be given. Finally, a description of the conceptual framework on which the analysis and results of the data gathered in the study are based on, will be provided.

1.2 Historical background of psychiatry and mental health in the Philippines

This section is written based on the *“The Evolution of Psychiatry and Mental Health in the Philippines”* of Samaniego (2017). According to the author, the history of mental health in the Philippines can be divided into five eras: The pre-Spanish era, the Spanish era, the American regime, the Japanese occupation and the era of American liberation.

During the pre-Spanish era, there was little documentation regarding mental health and how it was addressed by the community. Any psychiatric disorder was viewed as originating from natural or supernatural causes.

After 333 years of Spanish colonization (1521-1898), the Spaniards introduced and established Christianity in the country. Psychological defects were now being linked to religious factors such as being possessed by the devil or having displeased God. Subsequently, individuals experiencing hallucinations, hysteria or other similar symptoms would be sent to churches for purification and exorcism. On the other hand, some cases were believed to be caused by supernatural forces, such as *mangkukulam* (loosely translated as witches) punishing those who had offended them by inducing mental illness through the use of dark magic. In the hope that they would regain their health,

“(...) they were brought to folk healers or herbolarios who would subject them to physical and psychological distress in an attempt to chase off their mental illness. As an example, an individual would be wrapped in a mat and subsequently flagellated with a dried tail of a stinger fish or a bamboo stick. (...) Curiously, the distressing experience would often be beneficial, especially in purported cases of hysteria.” (Samaniego, 2017, p.103).

The Hospicio de San Jose was the first institution in the country to provide care for the mentally ill in the beginning of the 19th Century, although the scope of their work was very limited. During the American regime (1898-1946), psychiatric disorders became more widely recognized as medical disabilities. San Lazaro Hospital was the first to launch a department specifically for the mentally ill in 1904. However, it wasn't until 1928 that the first psychiatric hospital “Insular Psychopathic Hospital” was officially opened to the public. In light of the increasing demand, Filipino doctors were sent to the US on scholarships to study psychiatry in order to then return to their country to practice. Physicians would follow worldwide trends and practices of somatic therapies (fever therapy, hypoglycemic comas, lobotomies, electroshocks,

etc.) Psychotherapeutic strategies were very rare at the time. However, some occupational and recreational therapies were starting to emerge.

World War II marked the beginning of the Japanese occupation (1941-1945). The evolution of the Filipino psychiatry department was stunted by the war. Most of the patients had to return to their family homes as hospitals were taken over by Japanese soldiers and used for supply storage.

Progress in the discipline of psychiatry resumed during the era of liberation. The adverse effects of the War on the population's mental health motivated local authorities to start rehabilitating psychiatric facilities. The Insular Psychopathic Hospital was renamed National Mental Hospital (NMH) in 1946 and received financial aid from its benefactors. In addition, the University of the Philippines College of Medicine officially established psychiatry as a fully-fledged subject in 1945, which marked the beginning of its scholastic development. Other universities in the country followed suit. Moreover, the Philippine Mental Health Association (PMHA) and the Philippine Psychiatric Association (PPA) were also founded during these times.

In the following decades, psychiatry evolved in congruence with the rest of the world, in favor of a more psychopharmacological approach. Antidepressants, tranquilizers and sedatives were being shipped from the West to treat patients. However, it should be pointed out that in the 70's and 80's a growing disinterest emerged in the discipline of psychiatry. The Filipino people grew apathetic towards issues of mental health. The local authorities neglected issues concerning mental health and did not provide sufficient financial aid to uphold its progress. Several attempts were made to revive the department in the late 80's. The Department of Health (DOH) launched a Project Team on Mental Health. One of their goals was to propose two mental health bills that would create a national coordinating body for psychiatry and promote community-based mental health care. Unfortunately, the bills and following attempts did not push through. It wasn't until the Mental health act of 2017 that a change became perceptible. Before the introduction of this act, the Philippines was one of the only countries in the world with no existing mental health legislation (Samaniego, 2017).

1.3 Legal context: Mental health act of 2017

The Senate Bill No. 1354 or the Philippine Health Act of 2017 was an attempt of the Philippine government to address the issue of the unavailability of mental health care in the country. The Senate website defines this act as follows:

“An act establishing a national mental health policy for the purpose of enhancing the delivery of integrated mental health services, promoting and protecting persons utilizing psychiatric, neurologic and psychosocial health services, appropriating funds therefor and for other purposes. The scope: National. Legislative status: approved by the president of the Philippines (6/20/2018).” (“17th Congress - Senate Bill No. 1354 - Senate of the Philippines,” 2017).

The bill boasts of a very promising plan centered around the following four objectives:

- *To strengthen effective leadership and governance for mental health by, among others, formulating, developing, and implementing national policies, strategies, programs, and regulations relating to mental health;*
- *To develop and establish a comprehensive, integrated, effective, and efficient national mental health care system responsive to the psychiatric, neurologic, and psychosocial needs of the Filipino people;*
- *To protect the rights and freedoms of persons with psychiatric, neurologic, and psychosocial health needs; and*
- *To strengthen information systems, evidence, and research for mental health*

(“17th Congress - Senate Bill No. 1354 - Senate of the Philippines,” 2017)

This bill constituted an important step forward in the development of the country's mental health care system. In hopes of obtaining substantial funding, the DOH has been pushing to make mental health a main concern. A national suicide prevention line “Hopeline” has already been created as well as the signing of an administrative order establishing *barangays* (the smallest administrative division in the Philippines) as the entities responsible for the implementation of mental health provisions within their own communities. Additionally, the bill proposed an increase in the budget for mental health programs. (Samaniego, 2017). The objective of this policy is to neutralize the stigma and simplistic view of mental illness within Filipino society. Nevertheless, some worry that problems will arise during the implementation of the bill. As frequently observed in the Philippines, promising laws are written but seldom implemented correctly for various reasons (Business Mirror, 2019). Also, De Los Santos & Jakubec, (2018) remark that the Mental Health Act lacks details concerning the educational strategies to diminish stereotypes and stigma, as well as educational structures to raise mental health awareness to the public.

1.4 Influence of social media on promoting mental health and its effects on the emancipation of the youth

Although scientific literature to back up this hypothesis hasn't been found, it is worth mentioning that the current advances in technology are beginning to change the societal perception of mental health. This is especially true for younger members of the population. These advances are paving the way for virtual interactions through social media, facilitating the globalization of ideas. Information concerning mental health awareness spreads more rapidly, especially through platforms like Facebook or Instagram where official parties can publish informative posts. The youth are the main target audience, as the great majority of them use social media and are therefore more likely to interact with and share informative posts. One example of an official informative web page is Mental Health PH, which "*envision[s] a mentally healthy community and aims to promote and protect mental health using social media and digital technologies.*" ("#MentalHealthPH," n.d.). Their awareness and advocacy posts are shared extensively and can therefore reach a wide audience. A compilation of anonymous Facebook posts published by the researcher's acquaintances in the Philippines relating to MH can be found in Annex 5 as an example of this emancipation of the youth and how MH awareness is slowly changing in the country.

Chapter 2: Filipino immigration

The Philippine Overseas Employment Administration estimates that there are 10.24 million Filipinos living abroad as permanent, temporary or irregular migrants (Commission on Filipinos Overseas, 2013). The main destinations for migration are the Kingdom of Saudi Arabia, The United Arab Emirates, Singapore, Qatar, Hong Kong, Kuwait, Taiwan, Malaysia, Bahrain, and Canada (POEA, 2014). This migration phenomenon can be explained by the abundant demand for labor overseas and the unfortunate lack of employment opportunities in the Philippines. Furthermore, there are over 2.3 million deployed Overseas Filipino Workers (OFWs) (PSA, 2018), often considered as *Mga Bagong Bayani* or modern-day heroes since they are the prime breadwinners of many families as well as economic boosters of their home country. Remittance from overseas earning is a major source of national revenue. NGO's estimate 20 billion dollars of remittance each year which makes OFWs the unofficial first source of "exportation" coming from the Philippines.

2.1 The Filipino community in Belgium

The Commission on Filipinos Overseas (2013) estimates over 12,000 Filipinos residing in Belgium. However, the Philippine embassy in Brussels communicated that, as of January 2020, there is a total of 5,584 Filipinos living in Belgium as permanent, irregular or undocumented migrants. The consular section of the embassy mentioned that they estimated undocumented migrants to make up approximately 40% of this figure (c.f. Table 1. *Demography of Filipinos in Belgium*)

The numbers clearly illustrate a gender imbalance in the migrant population in Belgium. There are over 4,000 women compared to 1,354 Filipino men living in Belgium (Embassy of the Philippines, personal communication, 2020). Migration from the Philippines, particularly of women, is at times a family strategy for economic gain. Studies show that there is a high frequency of transnational relationships between Filipinas and foreign husbands, including Belgians (Bulloch & Fabinyi, 2009). Between 1999 and 2012, a total of 2,228 Filipinas left their country to reunite with their Belgian fiancés or husbands (Fresnoza-Flot, 2018).

Moreover, the data shows that the majority are either residing in Flanders (n: 3,196) or in Brussels (n: 1,633) rather than in Wallonia (n: 755). Since English is one of the national languages of the Philippines, this disparity can be explained by Filipinos' general affinity for Dutch rather than French since it is a Germanic language similar to English whereas French originates from Latin.

Table 1. Demography of Filipinos in Belgium. (Embassy of the Philippines, personal communication, 2020)

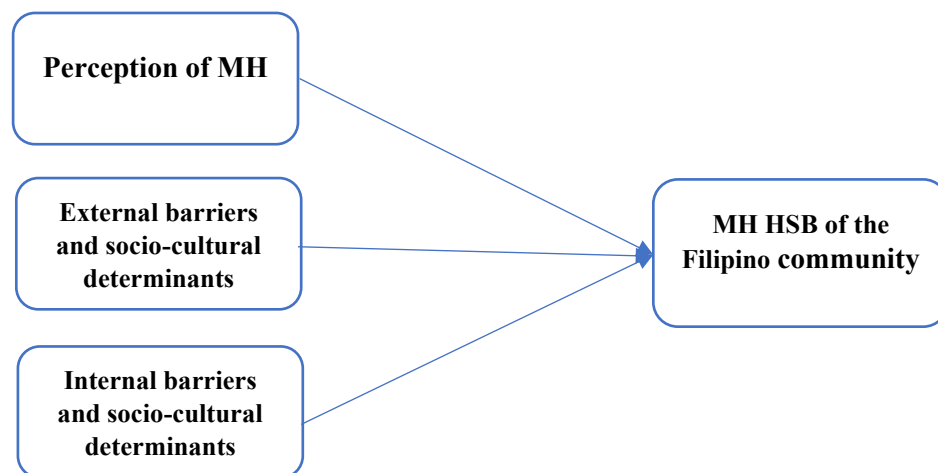
MAJOR CITY	Permanent Migrants			Irregular / Undocumented Migrants			Total		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Antwerp	143	670	814	57	268	325	200	939	1139
Belgian Luxembourg	2	16	18	0	6	6	2	22	24
Brussels	432	732	1166	173	294	467	605	1028	1633
East Flanders	119	506	625	48	202	250	167	708	875
Flemish Brabant	143	330	473	57	132	189	200	462	662
Hainaut	17	72	89	7	29	36	24	101	125
Limburg	21	201	222	8	80	88	29	281	310
Liège	23	72	95	23	29	52	46	101	147
Namur	13	34	47	5	14	19	18	48	66
Walloon Brabant	9	52	61	4	21	25	13	73	86
West Flanders	36	336	372	14	134	148	50	470	520
TOTAL	958	3021	3982	396	1209	1605	1354	4233	5584

According to the Belgian embassy, most of Filipino immigrants residing in Belgium engage in these lines of work : Bartenders; Butlers; Waiters; Children's escort service; Drivers; Electrical repair; Gardeners; House cleaners; House sitters/home managers; Hotel housekeeping staff/porters; Part-time workers engaged in laundering and ironing (...) Baby sitters; Caterers; Elderly care service providers; Entertainers (Antwerp area); Nannies; Domestic helpers/general utility personnel working with Diplomatic Missions and households professionals in private firms, e.g., abstractors, data encoders (a small number though) (Embassy of The Philippines, n.d.). However, there are also a notable number of Filipino students undertaking master's degrees in Flemish universities which offer courses in English.

Chapter 3: Conceptual framework

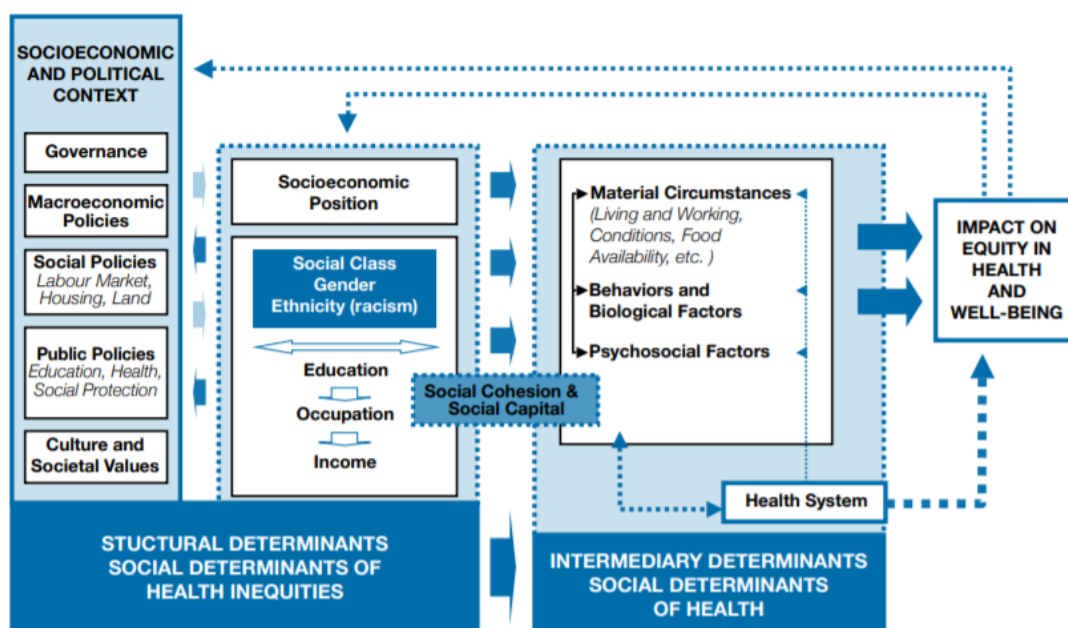
In order to illustrate what the researcher expects to find through her study, she has drafted a conceptual framework that includes three main independent variables : **the perception of mental health (MH)** by the Filipino community; the **external barriers and socio-cultural determinants** in seeking out mental health support; the **internal barriers and socio-cultural determinants** in seeking out mental health support. The dependent variable affected would be the **mental health help-seeking behavior (HSB) of the Filipino community in Belgium**. These variables gathered during the review of literature will be compared to the data collected throughout the study.

Figure 2. Conceptual framework © Cordero



The basis of the framework was inspired by the Commission on Social Determinants of Health (CSDH) of the World Health Organization. The figure below illustrates the relationship between different social determinants of health and their impact on equity in health and well-being. There are two main components: (1) the structural/social determinants of health inequities which are comprised of a variety of factors such as governance, macroeconomic policies, social policies, public policies, culture and societal values, socioeconomic position (social class, gender, ethnicity, education, occupation, income); (2) the intermediary/social determinants of health which are comprised of material circumstances, behaviors, biological and psychosocial factors. (Solar & Irwin, 2010)

Figure 3. CSDH conceptual framework (Solar & Irwin, 2010, p.6)



These different factors and how they affect an individual's equity in health and well-being have been considered. The researcher will be focusing more on their impact on the mental health HSB of the Filipino community in Belgium. Relevant factors are categorized as external or internal barriers and socio-cultural determinants in seeking out mental health care. These factors will be developed in the next section and will be related back to the literature review.

3.1 Social determinants and barriers in seeking out mental health support

The scientific literature found pertaining the topic predominantly originates from English speaking authors coming from America or Australia. Some studies are specific to Filipino immigrants and some authors put them in the same boat as Asian immigrants in general. Each notion elaborated will stipulate if the behavior is specific to Filipino immigrants or generally considered as an Asian immigrant one.

The first step in this study is to identify potential social perceptions that Filipinos living in Belgium have of mental health. What does mental illness represent for them? The researcher hasn't found any data concerning the perception of the Filipino community in Belgium so the consequent sub-chapters will be based on studies concerning the mental health seeking behavior of Filipino immigrants from other countries.

3.1.1 The perception of mental health by the Filipino community

Studies demonstrate how some Filipinos make a distinction between their perception of “soft” mental illnesses such as depression and anxiety compared to more “severe” diseases of a more psychotic nature. For example, findings show that Filipina immigrants in Australia consider depression nonexistent in the Philippines. They think that the “emotional problems” such as unhappiness they encounter in Australia are simply due to the lack of family support. Filipinos generally cope with emotional distress by sharing their burden with a confidant. If no such support is available, they bottle up their feelings, pray or distract themselves instead of dealing and sharing their emotional problems with an exterior party (Thompson, Manderson, Woelz-Stirling, Cahill, & Kelaher, 2002). Moreover, other findings reveal that some Asian Americans consider destructive behaviors such as hysteria, hallucinations, and mental dissociation as the only valid reason to seek out professional care (Leong & Lau, 2001).

Furthermore, other findings show that the perception Filipinos have of mental health professionals is different to that of westerners. Leong & Lau (2001) describe the concept of mind-body holism as one cognitive barrier to help-seeking for many Asian-American groups. No clear distinction is made between psychological and physical illnesses and so they are more likely to believe that mental disorder is due to organic factors. As opposed to European-Americans who consult a general practitioner for physical problems and a mental health professional for psychological problems, Asian-American patients rely solely on medical doctors to cure them for both. They tend to somatise emotional distress. To complement western medicine, they rely on healers and herbalists if they need further help for emotional difficulties. Tuliao (2014) specifies that *“Philippine folk conceptualizations of illnesses do not differentiate between physical and mental disorders (...) Lay conceptualizations of physical and psychological disorders have implications for help seeking for psychological disorders, at least on the issue of the preference for indigenous and folk healers.”* (p.127).

Moreover, a study on Filipina immigrants in Australia elaborated findings where a distinction is made between “emotional” problems and “mental” problems. On the one hand, emotional problems were described as “everyday problems”. These problems were perceived to be “trapped inside the body” and could be liberated through tears, prayer or physical extraction such as cleaning the house. These were considered as “natural” remedies as opposed to “unnatural” methods like seeking professional help. Talking to family and friends was considered the best approach to emotional problems. However, for immigrants who left most

of their social network in the Philippines, sharing their problems with others could be detrimental because of the tendency to gossip within the Filipino-Australian community. Therefore, individuals are expected to take responsibility and deal with their problems alone. On the other hand, mental problems were believed to be caused by the individual's attributes and actions such as his or her isolation and "softness" of character (Thompson et al., 2002).

Lastly, another Filipino lay conceptualization mentioned by Tuliao (2014) is one where mental illness is considered as an evil act or as the result of engaging in such an act. Substance abuse disorders portrayed in local tabloids and newspaper articles were linked to deviant behaviors (criminality, murder, rape) and only a few were associated with being mentally sick. However, those associated with mental illness were depicted in a negative light. The media's portrayal of mental illness was extremely narrow; it was limited to representations of suicide, self-mutilation, hallucinations and delusions. This skewed perception of psychological problems creates stigma for those who are struggling with the illness.

HSB has a close relationship with the perception of mental illness. The value an individual ascribes to mental health care will determine the likelihood of said individual resorting to mental health support. In this study, the researcher will identify how mental health is perceived by the Filipino Community in Belgium and compare it to the findings of the literature review.

3.1.2 The external barriers and socio-cultural determinants in seeking out mental health support

Some barriers and socio-cultural determinants in seeking out mental health care come from external factors. (1) **Public policies** concerning the health system of Belgium, (2) **culture and societal values** and (3) **psycho-social circumstances** are some external factors that affect the Filipino community's HSB. Each point will be developed in this section.

First, (1) **public policies** concerning the health system of Belgium have an influence on the accessibility to mental health care. According to Hermans et al. (2012), over 10% of Belgium's gross domestic product (GDP) is spent on healthcare but only around 6% of this total budget is dedicated to mental health. Although Belgian healthcare has a good reputation when it comes to accessibility, its organization remains complex because of the unique state

structure comprising different regions, communities and languages, which has led to several constitutional reforms throughout the years. Belgium's psychiatric sector is mostly hospital centered.

Recent mental health reforms seek to create a more community-based approach. The most recent one, Reform 107, seeks to achieve these goals:

"(...) (i) 'deinstitutionalisation', (ii) 'inclusion', (iii) 'de-categorisation', (iv) 'intensification' of treatment in hospitals, and (v) 'consolidation'. 'Deinstitutionalisation' is referred to as the implementation of community-based care delivery and the avoidance, as far as possible, of hospital treatment. 'Inclusion' refers to the social rehabilitation and recovery of psychiatric users. 'De-categorization' is defined as the implementation of collaborating procedures to supply integrated care across the different welfare sectors. 'Intensification' refers to shortening hospital stays, as well as reserving them for the most acute care. Finally, 'consolidation' means securing funding for previous pilot care projects and incorporating these into the new policy. These pilot projects were mostly new community-based, specialized services."(Nicaise, Dubois, & Lorant, 2014, p.122)

However, Nicaise et al. (2014) argue that these goals were difficult to attain because the reform and its mechanisms were not detailed enough. They identified 3 major threats to the reform. *"These were: issues concerning the relationship between network structure and purpose, the continued influence of hospitals despite the goal of deinstitutionalisation, and the heterogeneity in the actual implementation of the new policy."*(Nicaise et al., 2014, P.120). This reform is still an on-going process but hopefully it will create a network in psychiatric care that's more compatible to the needs of the population and will be more accessible on a community-level. Even though Belgians generally obtain quality healthcare, the 2019 performance report of the Belgian Health Care Knowledge Centre (KCE) states that the percentage of Belgian households delaying their recourse to healthcare for financial reasons is higher than the European average. This phenomenon has been observed in a variety of medical domains, including dental health, surgery, ophthalmology (prescription glasses or lenses) and mental health (Devos et al., 2019). Indeed, contrary to psychiatric consultations given by doctors with an INAMI number, psychological consultations are not covered by the basic mandatory social security. The reimbursement of psychological consultations depends on the Belgian mutual health insurance with which one is associated. Some health insurance funds do offer to cover a portion of the costs, under the condition that you meet the criteria of eligibility (Commission des Psychologues, 2020).

Given the circumstances surrounding mental health care in Belgium, the socio-economic status of Filipino immigrants should be taken into consideration when analyzing their HSB. The most common lines of work for Filipino immigrants previously listed by the Philippine Embassy indicate that they do not benefit from a high social standing. Paying for mental health care may not be their priority. It is worth noting that most Filipinos living abroad usually shoulder educational, medical or living expenses of family members living in the Philippines. Their earnings are typically subdivided and are not meant to care only for their personal needs. They tend to suffer from ‘self-sacrificial lamb syndrome’; they take pride in the role of modern-day hero, uplifting their families from poverty despite the negative consequences on their personal financial comfort and well-being (Basa, Harcourt, & Zarro, 2011).

Moreover, Belgian health care services are not always translated into English. Indeed, the language used in mental health care is a social determinant that is also worth noting when analyzing the Filipino immigrant HSB. English is one of the official languages of the Philippines. English proficiency remains an asset for Filipinos compared to other immigrants who only know their mother tongue. Although this is already a big advantage for communicating in the international arena, not all mental health professionals speak fluent English and so communication will not always be ideal. A study on Filipino Americans and the relationship between language and HSB states that Filipino immigrants who spoke the language of the host country were more likely to seek out MH care and more aware of various sources of professional support (Gong, Gage, & Tacata, 2003). In a Belgian setting, insufficient mastery of Dutch or French may prevent the Filipino community from properly expressing their needs and from seeking professional help. This could also hinder their awareness of the existing mental health services provided by the social security system which are mainly offered in Dutch or French.

Second, (2) **culture and societal values** or collectivist beliefs of Filipinos immigrants play a role in their HSB. In order to understand Filipinos' attitude towards mental illness, we will need to explore the religious context of Filipino culture and the traditional beliefs that this entails. The fact that the Philippines is a predominantly Christian country means that the Church and its teachings have a significant influence on the behavior of the population. The Philippines claim to have a secular state, but the heavy influence of the Church is still reflected in the existing laws of the country. Divorce, abortion and same sex marriage for example, are to this day, illegal (The Economist, 2020). Ruiz Austria (2004) explains:

“Conservative church interests dominate state policy (...) Religious fundamentalists, at one and the same time, argue for religious accommodation of their views by the state on the grounds of religious freedom but refuse to entertain, let alone accommodate, a plurality of views (...) The government still excludes single and unmarried women and adolescents from family planning services, hospitals still require husband consent for sterilization procedures (even in the absence of a law requiring it), and condoms have no place in a government sex education module on HIV/AIDS.”(p.96)

The legal sector is heavily influenced by religious views; however, the behavior of the community is even more affected.

As a matter of fact, divine intervention is still commonly used by the local population to explain certain phenomena. For example, Tanaka, Tuliao, Tanaka, Yamashita, & Matsuo, (2018) explain that many Filipinos believe that all life events are predetermined by God. This is used as a coping mechanism in order to justify mental illness or any of its potential consequences. They deem that being sick is “fate” and remain hopeful because God will help them if they remain faithful. In certain situations, this resilience can help stave off despair. Nonetheless, ascribing the consequences of mental illness to the will of God can negatively affect the probability of seeking professional help.

Additionally, a parallel can be established between the belief that life events are predetermined by God and *attribution theory* (Weiner, 1979) in education. In an educational context, attribution theory studies the factors to which students attribute their successes and failures. Students can attribute failure to external factors which are outside of their control and therefore unchangeable (e.g. the difficulty of a test), or they can attribute failure to internal factors which are within their control, such as their level of effort, determination and use of learning strategies (Weiner, 1979). In a psychological context, the tendency in the Filipino community to attribute failure (or success) to the external factor of “God's will” means that individuals have no control over negative aspect of their lives (e.g. mental illness). Therefore, what would be the point in seeking out mental health support? This perceived absence of control over mental health dismisses the benefits of MH care in the minds of many Filipinos.

Filipinos and Asians in general tend to seek help from their lay network such as friends and family, folk healers and religious leaders rather than from professionals (Tuliao & Velasquez, 2014). Religious leaders are particularly important since they represent the word of God in a Christian-majority country. In times of personal troubles, individuals often turn to their local priest for support. This behavior is so prevalent in part because of the inaccessibility to mental health care.

Superstitious beliefs in the country also affect the social representation of mental illness. For example, individuals experiencing frequent visual and auditory hallucinations are labeled as *baliw* (crazy) and thought to be possessed by a spirit rather than suffering from a psychological disorder (Gingrich, 2006). Tan (2008) adds that Filipinos tend to explain mental illness by spirit possession or the wrath of offended deities. Dark magic and spells cast by *Mangkukulam* (loosely translated as witches) were believed to be the cause of mental illness and so *Herbolarios* (folk healers) used rituals to cast the bad spirits away (Samaniego, 2017). The cause attributed to mental illness ultimately impacts the kind of help Filipinos will seek.

Likewise, the desire to save face is prevalent in many Asian cultures, specifically in Chinese influenced regions such as the Philippines. The Merriam-Webster dictionary defines (the act of) saving face as follows: “*to avoid having other people lose respect for oneself*” (Merriam Webster Dictionary, 2020). Multiple studies have shown links between Filipino's high concern for saving face and their mental health HSB. “*There is a cultural drive to ‘save face’ when there is a threat to or loss of one’s social position, and as such Filipinos may have difficulty in admitting to mental health problems or seeking help.*” (Lally et al., 2019). Tuazon, Gonzalez, Gutierrez, & Nelson, (2019) further explain that Filipino Americans rarely resort to the use of mental health services for fear of humiliation or loss of respect in the community. Other traditional concepts such as “ (...) “*hiya*” (*devastating shame*), “*amorpropio*” (*sensitivity to criticism*), and “*pakikisama*” (*conceding to the wishes of the collective*)” (Sanchez & Gaw, 2007) contribute to the social pressure and stigmatization that Filipinos feel when they are confronted with psychological problems. Although stigmatization of mental illness is not unique to Filipinos, Tuliao (2014) further develops the concept of “*hiya*” and loss of face which are culture-specific values:

“Stigmatization of the mentally ill is a dilemma found in several cultures that serve as barriers in seeking psychological treatment. The way culture shapes attitudes and behaviours towards the mentally ill (public stigma) gets internalized, which subsequently results in low self-efficacy, shame, and reluctance to seek treatment. Hiya and loss of face are cultural values that aim to preserve one’s integrity and to avoid real or imagined social transgressions. Hiya and loss of face, therefore, can hypothetically further compound reluctance to seek psychological help especially when the culture deems mental illness as an aberration.” (Tuliao, 2014, p. 132)

Mental illness is considered taboo and is usually a topic that is avoided within the familial setting. There is *hiya* in having emotional distress and it is frowned upon. This

eventually pushes the patient to keep to themselves and suppress their symptoms (Tuliao, 2014).

Currently, these collectivist beliefs apply to mostly Filipinos living in the countryside, Filipinos with low economic status and Filipino men, but not necessarily everyone. Professor Orban of *l'Université de Namur*, who conducted 62 scientific missions in the Philippines, and local NGOs note a positive development in the mindset of the younger generation, Filipinos living in big cities and the emerging middle class who appear to be distancing themselves from the culture and societal values presented above.

Third, (3) **Psycho-social circumstances** include psychosocial stressors, stressful living circumstances and relationships, social support and coping styles (or the lack thereof) (Solar & Irwin, 2010). This external factor includes the prominent position of family reputation, the characterization of “resilience” among Filipinos and the concept of global care chain also have an impact on their HSB.

Undeniably, family reputation has a very important place in Philippine society. Tanake et al. (2018), explain that,

“Community health volunteers and health workers observed that families of people with mental health problems (PMHP) and people in the local community do not provide appropriate support for PMHP because they perceive mental affliction as a family problem and indicative of so-called “bad blood”. The belief that mental health problems can be transmitted among relatives pushed families of PMHP to deny the existence of mental health issues and people in the community to distance themselves from PMHP.” (Tanaka et al., 2018, p.5)

They elaborated by stating that PMHP of marrying age are further stigmatized because potential in-laws are worried that their grandchildren might inherit the same problems. As a result, denial becomes the coping mechanism in order to save the family reputation.

Additionally, when Filipinos are going through a hard time in their lives due to grief, shock or trauma, they are advised to “offer their problems to the Lord” and to keep going (Tanaka et al., 2018). The resilient mentality of the population can also be observed whenever a typhoon, an earthquake or other natural calamities strikes the country (Adviento & de Guzman, 2015). There is an average of 20 tropical cyclones that enter the country each year (PAGASA, 2019). The Filipino people's faith helps them overcome loss and socio-economic instability triggered by natural calamities. However, this resilience also masks all the unresolved psychological problems and passive suffering that Filipinos experience (Jalandoni, 2015). Jalandoni (2015) criticizes *Filipino fortitude* (the virtue of courage) and in particular,

resilience, which may not always mean what they seem to mean. The author questions “*why is resilience and quiet endurance of suffering so exalted and who profits from the silent suffering of so many people?*” (Jalandoni, 2015, p.9). The issue of Filipino resilience will be raised during the data collection of this research to evaluate its impact on the HSB of members of the Filipino community in Belgium.

While a number of Asian countries export care labor, the Philippines is the most established one and prides itself for introducing a policy of labor export in 1974. This type of state regulation emphasizes the development of global care chains (Yeates, 2004). A global care chain can be illustrated this way:

“An older daughter from a poor family in a third world country cares for her siblings (the first link in the chain) while her mother works as a nanny caring for the children of a nanny migrating to a first world country (the second link) who, in turn, cares for the child of a family in a rich country (the final link). Each kind of chain expresses an invisible human ecology of care, one care worker depending on another and so on. A global care chain might start in a poor country and end in a rich one, or it might link rural and urban areas within the same poor country.”(Hochschild, 2001)

Filipina immigrants who work as domestic helpers or nannies and leave behind their own families tend to be the most affected by this care chain. In this kind of situation, due to the absence of their own children, they give a lot of love and attention to the children they care for. This gives them an advantage in the labor arena since they withhold a reputation of being “loving”, in addition to being proficient in English. Nonetheless, the psychological impact of this care chain on these women is considerable. For example, they suffer from having to raise their children from a distance (Hochschild, 2001). Despite the circumstances, they are characterized as having a resilient mentality that helps them overcome their situation. It would be worth noting what the members of the Filipino community in Belgium think of this care chain and if they mention it as something that impacts their mental health. If it does, would they seek out mental health care to tackle its consequences?

Although the emotional support of relatives and friends can be beneficial to the individual’s well-being, Thompson et al. (2002) argue that it can also be a stress factor for Filipino immigrants whose social network is primarily in the Philippines. In most cases, when a Filipino migrates, the expectation is that money will be sent back to the migrant's family in the Philippines. This obligation not only strains the financial stability of the individual but can also potentially sever ties with family back home if it is not fulfilled. The loss of social network negatively affects the mental health of the individual.

3.1.3 The internal barriers and socio-cultural determinants in seeking out mental health support

Internal factors can have an equally important influence on an individual's decision to seek mental health care. These internal factors include **(1) Behavioral and biological factors, (2) Education level and (3) Social capital**. Each point will be developed in this section.

First, **(1) Behavioral and biological factors** such as acculturation process, age and gender can all have a significant impact on HSB. Leong & Lau (2001) mention the impact of acculturation in the HSB of Asian-Americans and its utmost importance. Positive attitudes to help-seeking are typically found in highly acculturated individuals.

“(...) individuals who simultaneously retain their native cultural identity and also move to join with the dominant society tend to have more favorable attitudes toward help-seeking. These findings suggest that the barriers to help-seeking (...) may be more salient for individuals at lower levels of acculturation, and for individuals with a separationist or marginalist mode of acculturation.” (Leong & Lau, 2001, p.203).

It would be interesting to determine if Filipino immigrants in Belgium are highly acculturated individuals and determine what impact this has on their help seeking behavior.

Moreover, age can be a barrier to seeking out mental health support. In chapter 1.4, the researcher mentioned the involvement of Filipino youth in the ongoing movement to raise mental health awareness within their communities. Indeed, the younger generation are more open to the concept of globalization and its effects on promoting awareness. The informative facet of social media and the influence of “millennials” are helping to diminish the stigma surrounding mental illness that exists in Filipino culture. First-generation Filipino immigrants in Belgium are less likely to participate in this movement because they are not as engaged and aware as the youth.

It is worth mentioning that the impact of gender on HSB remains ambiguous. In Tuliao's (2014) review of literature on mental health help seeking among Filipinos, he found contradictory stances on the impact of gender on HSB. On the one hand, several studies concluded that gender has no effect on the probability of seeking mental health support. Both genders are reluctant to utilize mental health care. On the other hand, some findings indicate that men are less likely to seek professional care. As there is a gender imbalance (Embassy of the Philippines, personal communication, 2020) within the Filipino Community in Belgium,

this will inevitably be reflected in the results of the investigation. The implications of this gender imbalance will therefore be considered throughout the examination of the data collected.

Second, (2) **the educational level** of the individual must be taken into consideration when analyzing HSB. Hourani & Khlat's 1986 study found a correlation between the level of education and the broadening of the definition of mental health, the perception of symptoms, and health seeking behavior. It could be a potential social determinant in the HSB of Filipino immigrants in Belgium and will be kept in mind during the analysis of the interviews.

Finally, (3) **the social capital** of the individual and **social cohesion** in the form of a strong sense of family and social cohesiveness in the society has an effect on HSB of Filipinos. Gong et al., (2003) suggests that the most frequently used source of care for Filipino Americans is the lay system which consists of friends and family as opposed to medical professionals and folk healers. Tuliao & Velasquez (2014) further explain that the extended family, that includes grandparents, aunts, uncles and cousins, play a big role in times of difficulties. PMHP rely heavily on this support group and see their social circle as the only necessary source of emotional support. This attitude further intensifies their reticence to seek professional mental care (Thompson et al., 2002).

3.2 Chapter's conclusion

The various aforementioned factors can either have positive or negative effects on the HSB of Filipino immigrants. *A better acculturation process, higher education and being part of the younger generation* are factors which increase the likelihood of seeking mental health support. On the contrary, factors which negatively impact the probability of seeking mental health support include *the preference for lay networks, folk conceptualization of mental illness, religious beliefs, language barrier, stigma and loss of face and the desire to preserve family reputation*.

The different external and internal factors will make up the framework of analysis for the data collected during the interviews of members of the Filipino community in Belgium. The factors mentioned previously do not claim to be exhaustive. New factors may emerge during the interviews and will be included in the subsequent inductive thematic analysis.

Chapter 4: Definition of the problem

The existing literature on the perception of mental illness in the Philippines revealed the country's poor track record in providing psychiatric care to its population (WHO, 2006). Due to the historical, political, religious and social context of the Philippines, mental health awareness has not been a priority for the government. Fortunately, the introduction of the Mental Health Act of 2017 and the rise of globalization and social media have contributed to a profound shift in Filipinos' perception of mental illness. However, substantial change has yet to be implemented on a local scale (De Los Santos & Jakubec, 2018). Access to professional mental health services remains limited, and is reserved for those of significant financial means (Isaac et al., 2018). After so many years of neglect, the Filipino department for mental health is still in desperate need of reform.

The Filipino youth are the drivers of the aforesaid change in perception of mental illness. They are helping to normalize HSB within the Filipino community by breaking down stereotypes and stigma. Personally, the researcher has been seeing more and more Facebook and Instagram posts about mental health awareness shared by her Filipino family and friends. What intrigued her was how these posts were perceived by the older generation. Will the new movement affect their prejudice towards mental diseases? Will they recognize and accept the existence of mental illness within their community? If the opportunity arises for them to seek help for themselves or for a family member, will they seize it? The answers to these queries remain purely hypothetical in a setting where access to mental health care is limited. For this study, the researcher chose to interview Filipino immigrants in Belgium, as they benefit from easier access to mental health care compared to the Philippines.

According to the Belgian Health Care Knowledge Centre (KCE) report, mental health services such as psychiatric home care, *Initiatives d'Habitation Protégée* (IHP), *Maisons de soins psychiatriques* (MSP), private psychiatry clinics, psychiatric hospitals etc. are in abundance throughout the country. The report mentions that Belgium has 1.37 psychiatric beds per 1000 inhabitants which makes it the country with the second highest ratio of psychiatric beds within the OECD. With the 107 Reform project, the country expects to reduce the number of hospital beds and shift to a more community level mental health care and improve the psychiatric care network (Mistiaen, Cornelis, Detollenaere, Devriese, & Ricour, 2019).

Moreover, the mental health of these immigrants should be addressed properly. The process of immigration is very challenging and can cause a lot of stress and anxiety. Factors such as culture shock, the difficult adaptation process and the language barrier can put a strain on mental health. Thompson et al.'s findings on the social and cultural context of mental health of Filipinas living in Australia state that:

“'Mental' problems are highly stigmatized, in comparison to 'emotional' problems that are believed to result largely from the absence of close family ties. The loss of these ties and the transition from a collectivist to individualist society are key themes related to emotional distress in Filipinas.” (Thompson et al., 2002, p.681)

This should be kept in mind when investigating whether Filipino immigrants who are away from their family and experience mental health problems will avail themselves of the services offered by the Belgian health system. What representations of mental illness do they have within their society? What are the key barriers preventing them from seeking mental health care? Does their historical, political, religious and social background affect their help-seeking behavior? Ultimately, this thought process led to a research question: ***Do the aforementioned socio-cultural determinants and barriers and/or other factors prevent members of the Filipino community in Belgium from seeking out mental health support?***

Chapter 5: Methods and materials

5.1 Study design

This study was conducted using a qualitative research method. This method was chosen due to its compatibility with the research question and with the expected results of the study. The researcher hasn't found any substantial scientific research specifically concerning the mental health HSB of the Filipino community in Belgium. Therefore, this study is a first in its field. However, she was able to gather information pertinent to the research question through a literature review. Keywords used for the review of literature were Filipino; Filipino-Belgians; Mental health; Help-seeking behavior; Barriers; Social determinants.

Data was obtained from a variety of sources including research engines such as PubMed, ScienceDirect, Scopus and Google Scholar. Rogene Ramos, a psychologist who graduated from the University of The Philippines shared several articles that were included as references in this study. Additionally, the embassy of the Philippines in Brussels provided the researcher with relevant statistical data through digital correspondence. Furthermore, social media pages pertaining to mental health awareness in the Philippines were also consulted. The researcher also had the chance to meet Françoise Orban-Ferauge, professor emeritus of l'Université de Namur (UNamur) who carried out 62 scientific missions in the Philippines and shared her take on Filipino culture.

The qualitative data was gathered through semi-directive interviews that lasted on average thirty minutes to an hour. The semi-directive method allows the participant to speak freely within a framework predefined by the researcher. An interview guide was prepared with open-ended questions to help direct the course of the interviews (Annex 1). Additionally, the participants were asked to sign an interview consent form and were recorded for transcription purposes (Annex 2). However, due to the SARS-CoV-2 pandemic and the subsequent community quarantine established by the federal government of Belgium, half of the interviews were done through video calls instead of face-to-face dialogue. Oral consent was given instead of the signed interview consent form. The interview guide was tested on one of the researcher's Filipino acquaintances before conducting the interviews with the participants. Throughout the interview process, additional questions were added due to emerging factors such as "the giving back culture of Filipinos". The full transcripts of the interviews were sent to the participants

for their review. The anonymity of the participants was guaranteed before the start of each interview.

A qualitative method of data collection was selected in this study as it facilitates the identification of emerging and recurring themes in the answers provided by the participants. A qualitative research answers the following questions: “What? How? Why?”. It allows the development of conceptual definitions, typologies, classifications... but above all to understand human experiences. The goal of this research is not to test hypotheses or quantify the extent of the problem but to illustrate the perception of MH by members of the Filipino community in Belgium. By choosing this type of methodology, the subjectivity of the participants is brought forward and contributes to the value of the results.

5.2 Data Collection

The research was carried out with a diverse group of first-generation Filipino immigrants living in Belgium. They were contacted through various platforms via an open invitation:

- Through a private Facebook group used exclusively by Filipino immigrants or Filipino-Belgians : Filipino Community In Belgium (“Filipino Community In Belgium,” n.d.)
- Through “snowball sampling”, a procedure where one participant leads to another potential participant.
- Through family connections of the researcher

Convenience sampling was used to recruit a community-based sample. The researcher used the following criteria to narrow down potential participants:

- 18 years of age or older
- A first-generation Filipino immigrant
- Must have grown up in the Philippines
- Must have a legal status in the country as a regular immigrant
- Must have lived in Belgium for a minimum of 2 years
- English-speaking

These factors of eligibility were selected in order to establish a group of participants possessing a Filipino cultural background.

5.3 Data analysis

The data was transcribed after each interview along with memos describing non-verbal reactions of the participants and the researcher's thoughts throughout the process. The data collected during the interviews was subjected to an inductive thematic analysis. A categorization approach was implemented throughout the analysis, which enabled the researcher to establish a thematic social map of the data (Annex 4). This thematic social map helped categorize the data collected during the interviews into central themes. The central themes of the thematic social map were subsequently divided into sub-themes. This system of thematic grouping highlights the recurrence of certain themes within the collected data and helps to illustrate the relationship between different themes (Paillé & Mucchielli, 2015).

The first step of the analysis was to compare the transcripts of the interviews using RQDA, a computer assisted qualitative data analysis software. Through a comprehensive review of the data, the researcher was able to gain an overview of the answers provided by the participants. This allowed her to then identify the recurring ideas or concepts into which the data would be coded. Following the organization of data into codes, categories and central themes, an analysis was conducted in order to establish links between various themes and to eliminate irrelevant data. This process of data categorization and analysis informed the creation of the thematic social map. Finally, the researcher attempted to answer the research question of this study by analyzing the data of the thematic social map. In order to do so, she focused on the central themes which were most relevant to the study.

5.4 Participants

The selection process of participants for this study was subject to much change. The researcher was initially interested in interviewing Filipinos suffering from mental disorders who could provide firsthand accounts of their experiences in seeking out mental health support. However, she decided against this approach for several reasons. Firstly, the selection process of the participants would have been complex, as all the interviewees would have had to be psychiatric patients. This would have required authorizations from the ethics committee of the institution to conduct the interviews. Additionally, finding psychiatric patients willing and stable enough to share their experiences with mental illness would have been challenging. Furthermore, the aim of this paper is to identify key barriers to mental health HSB. Data

gathered exclusively from participants who already benefit from mental health support would therefore have been irrelevant.

For these reasons, she chose to shift the focus of the study to Filipino immigrants living in Belgium who are not undergoing official psychological care recognized by the Belgian health system. The main objectives of this study are to determine what perception the Filipino community has of mental illness and to identify the barriers that prevent members of this community from seeking mental health support. The questions the researcher prepared for her interview guide (Annex 1) are centered around hypothetical situations relating to mental illness. Participants were asked to react to the hypothetical situations in order to evaluate their mental health HSB. For example, participants were asked whether they would seek the assistance of a psychologist if a loved one was showing signs of depression.

Potential participants were selected based on the inclusion criteria established previously. Initially, around 10 to 15 participants were expected for the study. However, for this kind of qualitative research, a principle of data saturation was used which means that at a given point, there is thematic redundancy or there are no new emerging data identified. The final sample included N=10 participants of which 2 were men and 8 were women. The relationship between gender and HSB will not be taken into account in this research due to the limited number of participants and the gender imbalance in the sample. The average age of the participants is 47 years old with the youngest being 39 years old and the oldest being 68 years old. The research sample is a highly educated one in terms of academic degrees. All the participants have at least a bachelor's degree except for one who completed secondary education with a secretarial certificate. All the participants are currently working though most of the occupations do not correspond to their educational level. For example, four participants obtained a Bachelor of Science in education from the Philippines but none of them were able to practice in Belgium since most Filipino diplomas are not recognized by the authorities. All but one, who is a Protestant, declared themselves as Catholics. The most common purpose of immigration is marriage with a Belgian. All except one are married /widowed with children. Nearly all of the participants live either in the capital or in the Flemish region. Three out of ten participants have benefited from MH care services in the past. Details of the characteristics of the participant are detailed on the table below (Table 2).

Table 2. Characteristics of the participants

Participant	Gender	Age	Place of residence	Religious affiliation	Education	Occupation	Language learnt in Belgium	Purpose of immigration	Number of years in Belgium	Family situation	Availed MH care services in the past
P1	M	39	Brussels	Catholic	MA Communications	Project manager	French (basic)	Erasmus scholarship + work	2	Single	Yes
P2	F	33	Alsemberg	Catholic	PhD student in Public Health	Project manager	French (basic)	Marriage w/ Belgian	6	Married (pregnant w/ 1 st child)	Yes
P3	F	41	Brussels	Catholic	BS in Law	Secretary	French (fluent)	Parents migrated for work	30	Married, 2 children	Yes
P4	F	44	Heusden-Zolder	Catholic	BS in Education	Life coach	Dutch (basic)	Marriage w/ Belgian	20	Widow, 1 child	No
P5	F	43	Antwerp	Catholic	BS in Education	Nail technician	Dutch (fluent)	Marriage w/ Belgian	19	Married, 1 child	No
P6	F	48	Jette	Catholic	BS in Nursing	Staff at the embassy of Malta	French (basic)	Looking for better economic opportunities	19	Married, 1 child	No
P7	F	63	Leuven	Protestant	BS in Education	Waitress	Dutch (basic)	Marriage w/ Belgian	26	Widow, 2 children	No
P8	F	42	Leuven	Catholic	HS graduate + 1-year junior secretarial course	Kitchen help/cleaner at a nursing home	Dutch (basic)	Marriage w/ Belgian	8	Married, 4 children	No
P9	M	55	Brussels	Catholic	BS in Education	Staff at the embassy of Malta	French (basic)	Looking for better economic opportunities	28	Married, 3 children	No
P10	F	68	Braine-l'Alleud	Catholic	BS in Nursing	Caregiver	French (fluent)	Family reunification + work	40	Married, 3 children	No

N.B.: **HS**= High School; **BS** = Bachelor of Science; **MA** = Master's; **PhD** = doctorate

Chapter 6: Results

6.1 Categorization of results

After the analysis, three central themes were identified: the perception of MH; external factors and socio-cultural determinants in seeking out MH support; internal factors and socio-cultural determinants in seeking out MH support. These themes are in line with the conceptual framework elaborated in chapter 3. Nevertheless, the details of the codes were derived from the responses of the participants. Cross reading the interviews allowed the classification of the units of analysis. They are listed in a table distinguishing the themes, their definitions as well as the sub-categories and the codes used to classify the data collected. The summary of the table is presented below to allow readers to have an overall picture of what emerged from the interviews. The details of each unit of analysis will be presented subsequently.

Table 3. *Distribution of qualitative data in units of analysis*

Themes	Definition of theme	Categories	Codes
The perception of MH	This refers to how members of the Filipino community in Belgium perceive mental health and the importance they give to it.	Perception of MH	
		Perception of MH care professionals	
		Folk conceptualizations	
		MH vs physical health	
External factors and socio-cultural determinants in seeking out MH support	The external factors and socio-cultural determinants are elements that influence the HSB of members of the Filipino community in Belgium from the outside. These factors are part of the political, cultural, and social environment of the participants. It explores how the environment affects the HSB of the participants.	Public policies	Accessibility to MH care
			The language barrier
		Culture/societal values	Religious beliefs
			The “save face” culture and stigmatization of MH
		Psychosocial circumstances	The role of family reputation
			The care chain
			The “giving back” culture
			The resilience of Filipinos
Internal factors and socio-cultural determinants in seeking out MH support	The internal factors and socio-cultural determinants are elements that influence the HSB of members of the Filipino community in Belgium from the inside. These factors include the personal characteristics of the participants such as their socio-economic position and social capital. This theme also studies the acculturation process the participants undertook when immigrating; their coping mechanism in response to emotional distress; and examines their likeliness to seek out MH care.	Behavioral factors	Acculturation process
			Coping mechanism and likeliness to seek out MH care
		Socio-economic position	Influence of education in the perception of MH
		Social capital	Preference for lay network

In order to respect the anonymity of the participants, the annotations “P1 to 10” in the consecutive sections will be used as reference. P1 being the first person interviewed, P2 the second person interviewed and so forth. R refers to the researcher.

6.1.1 Perception of mental health

a) Perception of MH

The perception of MH by the participants varied from one person to the other. While some perceived MH as a psychological and emotional process,

Table 4. Perception of MH: a psychological and emotional process

<i>“Mental health is more or less about how we are going to act psychologically, socially and emotionally to everyone. Mental health for me is [not the absence of] problems, everyone has problems, but [it is] how we can tackle all these problems [...] but I think you just need to [...] develop this awareness [of mental MH].” [P9]¹</i>
<i>“Mental health is very important. You should keep a good mental health all the time but for some people, it’s very difficult for them to know how to do that. [...] it’s also a process. There are different insights or ways to deal with mental health. I have noticed some [people have] poor mental health because of their experiences, the conditioning, their limiting beliefs and their environment.” [P4]</i>

others viewed it from a cognitive standpoint, relating MH to an idea of 'mental alertness', evoking the importance of mental stimulation to stave off stagnation and linking MH (Table 5) to neurological disorders such as dementia and autism (Table 6).

Table 5. Perception of MH: a cognitive definition

<i>“I: I think mental health is that you shouldn't stop learning. I am a teacher so for me I always want to learn [...] I read and watch tutorial videos. I'm always busy with my hands so for me, mental health is that you should use what you know. [...] You should be always ready to learn and be curious. [...] It is also important to manage my mental health. What I'm trying to say is that there are days where I just sit at home but I still can do things like, I can maybe watch a tutorial on something or do some crocheting etc. You also have to focus so you have to be mentally alert.” [P5]</i>

Table 6. Perception of MH: a neurological disorder

<i>“For me, mental health is the way you think. It's also autism” [P8]</i>
<i>“Probably because I didn't really encounter mental health problems, so I never really thought about it. Is it important? I don't know. Here in Belgium we talk about dementia a lot. They say we should always continue learning and reading and challenge your brain with puzzles because if you stop learning, your mental health will decrease.” [P5]</i>

¹ Some of the verbatim of this research paper have been modified with the intention of bringing more clarity or context to the participant’s phrases but does not alter the intended original message.

Furthermore, two participants identified severe cases as the only recognized form of mental illness in Filipino culture. In contrast, “softer” cases tend to be trivialized.

Table 7. Perception of MH: trivialization of mental illness

<i>“[...] but it's really this definition or interpretation of mental health that is more to the extreme. Anything in between, they would just call it “going through a breakdown or depression”. Depression is more related to the “lack of faith”. Comparing depression and for example schizophrenia, one is just you are overreacting, and the latter is mental health “crazy” for them. [P2]</i>
<i>“For example, if I’m having this mental health issue, society would just say “I know you're just depressed, go out and have fun”. I think the society tends to diminish the fact that someone has a mental issue.” [P3]</i>

b) Perception of MH care professionals

Mental health care professionals are generally perceived by the participants as trained professionals who provide adequate care to those who are in need. Their skills are valued in dealing with mental illness.

Table 8. Perception of MH professionals: trained and qualified

<i>“[T]hey [mental health professionals] know how to talk to you they know how to help you navigate through your feelings and decide on the things that are good for you. Rather than talking to people who would just downplay your problem.” [P1]</i>
<i>“In my opinion, it’s necessary to go ask for help. Professionals aren’t called professionals for nothing. I mean they all make studies to be a psychologist or psychiatrists, they are qualified.” [P3]</i>
<i>“When you meet a psychiatrist or psychologist, I think it's more for mental health. [...] It's more like when you talk to people you don't know, like strangers, you would open up more about stuff about yourself, rather than talking to your friends or family. You would think that, since you won't see that psychiatrist anymore in the future, he wouldn't judge you because he doesn't know you.” [P5]</i>
<i>“They're good because they are the ones who are helping people who are depressed [...]. Yeah, because if somebody needs help with their mental capacity or mental abilities, if they don't want to live anymore because of depression because of burnout or stress, of course they need a psychiatrist.” [P8]</i>
<i>“I would think their role is to guide people... like I said, there are lots of people who cannot manage to handle their own problems especially mentally, psychologically. Some are really disturbed and don't know what to do. So, we need people to guide them, instruct them and advise them on what to do. [...] I think we need Mental health professionals.” [P9]</i>

However, only those identified as suffering from "severe cases" are perceived to be eligible for mental health care. Professional care is deemed unnecessary in cases of "simple" emotional distress. This point is further developed in **6.1.2.3.b the stigmatization of MH (table 26)**.

Table 9. Perception of MH professionals: only severe cases need professional care

<i>"[...] psychiatrists would be meant for those who are completely identified or diagnosed mentally disabled or mentally incapacitated but it's not just for normal persons who are studying/working and just suffering from ups and downs in his or her life."</i> [P2]
<i>"Normally mental health is about a person who [...] is sick and stays at mental facilities and they are there because of the sickness."</i> [P6]

One participant noted the lack of "emotional connection" between MH professionals and their patients. She says that for Filipinos who are quite emotional, western psychiatrists are too "cold" in their interactions and this consequently discourages future consultations.

Table 10. Perception of MH professionals: lack of "emotional connection" with MH professionals

<i>"I know some Filipino friends of mine who see psychologists [here in Belgium]. [...] It depends because, when you meet these professionals, the connection must be there. Some professionals, they're just doing their job according to books, according to studies, but they don't have that in the heart. If you're a doctor, you should have your spirituality a little bit. [...] your energy has to be connected with the professionals. The initial trust should be there before you can open up. Sometimes the professionals just say, "Ok, here is the prescription, you can go now. One of my friends, she said that she didn't take the medication yet [...] the other one stopped [going to the psychiatrist]."</i> [P4]
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c) Folk conceptualization of MH

Almost all of the participants were able to give examples of folk conceptualization concerning MH in the Philippines. Although they believed them when they were children, they are not affected by those perceptions today.

Table 11. Folk conceptualization of MH: examples

<i>"Oh yeah, I was totally told that they're "crazy" people because they're possessed. We shouldn't touch them because they have a demon inside and that they might come into our body."</i> [P3]
<i>"If someone is having mental problems, people would say that maybe he is influenced by bad spirits. Like they are harming him. [P4]</i>

*“My friends here in Belgium who are Filipinos, I try to see them once every 2 weeks. And some of them say “Oh, she’s so sick. She just came back from the Philippines. She was probably **“Kinulam” [bewitched].**”* [P5]

*“Before, if I saw someone having hallucinations or something like that, the first thing I will think is that there is a **spirit who sinanib** [possessed that person].”* [P6]

*“Yes, there are a lot of superstitious beliefs in the Philippines, **but I was against all that.** I only believe in ghosts but not spirits ha-ha. I’ve heard a lot of people saying that there is this **bad spirit** that made a person crazy. Especially in our place, there were lots of beliefs about that, but we don’t know if it’s true or not. They also talk about **Mangkukulams.**”* [P9]

*“I think in high school if suddenly someone would collapse or would have an epileptic shock with convulsions we would say that it’s probably because he or she is **possessed by a demon** [...] Another example is that when there’s a tree behind a classroom it was probably causing the demise of the sick person because of the **“Kapre”** [tree giant] living there.”* [P2]

The older generation was identified as responsible for circulating these superstitious beliefs, especially to children.

Table 12. Folk conceptualization of MH: role of elders in spreading MH beliefs

*“There were the **Mangkukulams** and people would get sick because of them but I don’t believe in those [laughs] [...] [It’s] more of the **old people** [who propagate these beliefs]. To frighten the young ones. They tell them “Don’t go there because there’s a Mangkukulam”. [P10]*

*“(…) yeah, it’s more the **adults** that instill that thought. As a child you believe them. But yeah, basically they call them [homeless people] crazy. [P2]*

“R: Would you say that your family in the Philippines still have these beliefs?

*P4: Yes, especially the elders or even the kids who will hear from **the elders** because they don’t know better. It’s very difficult for me to go there, telling them this and that. It’s impossible for them to hear even if I share my opinion.”* [P4]

Moreover, misconceptions concerning the consumption of food and illegal drugs and their impact on MH were also mentioned several times.

Table 13. Folk conceptualization of MH: food and drugs

<i>“No, I don't really have [superstitious] beliefs like that. I believe that maybe because out of hunger, or if he's not eating well or on time, or that he's using illegal drugs, his mind was destroyed by those. [...] when it comes to the use of illegal drugs, that really makes you "kaput" (crazy).” [P8]</i>
<i>“It's the same with kids, if ever you haven't eaten yet, you're hungry and then suddenly someone with a baby comes to your home... You say “Oh, he's such a cute baby”, if the baby starts crying, the person will say “It's your fault [the baby is in emotional distress] because you said something without eating.” [P5]</i>
<i>“[...] if suddenly someone would collapse or would have an epileptic shock with convulsions, we would say that it's probably because [...] he/she probably missed three meals that day.” [P2]</i>
<i>“R: Do you link drugs to mental illness?</i> <i>P10: I think yes, because drugs can do many things to a person who takes them. When you are a drug addict, your mental health is affected also. You cannot think wisely, you cannot think good.” [P10]</i>

d) Mental health in contrast to physical health

Three participants perceived physical health to be of equal importance to mental health.

Table 14. Mental health in contrast to physical health: MH = PH

<i>“For me it's the same, it should be. You also have to be physically fit. Because if you have a good mental health, your whole body will also be healthy.” [P6]</i>
<i>“I guess mental health is important but at the same time physical health is still important because how can you deal with mental problems if you are physically ill.” [P8]</i>
<i>“It's the same, because if you don't have a good physical condition then you can't have a good mental health also huh. Vice-versa. If you don't have good mental health, you are not physically fit also.” [P10]</i>

Conversely, two of them gave MH greater importance than physical health.

Table 15. Mental health in contrast to physical health: MH > PH

*“I would put it **higher, priority wise**. So, if you have a good mental health your physical health will follow.” [P4]*

*“For me, mental health is a bit higher than physical health. Because, let me give you my own experience. When I have problems at work, I'm really more tired coming back home than physical tiredness. Even if I have mental tiredness and then go to sleep, I wake up and I still have it with me. While physical tiredness once I have the rest, I sleep, it's gone. **I think mental situations are really heavier than physical ones**. once you are mentally disturbed it's hard to take it away.” [P9]*

Only one participant mentioned that in her family, physical health is greatly prioritized. But her perception changed after immigrating.

Table 16. Mental health in contrast to physical health: MH < PH

“Before living abroad, there was much more focus on physical health. My family is very conscious about their diet, so early on we tried to stick to a healthy type of diet. I grew up in a household where you couldn't easily find Coca-Cola in the fridge.” [P2]

6.1.2 External factors and socio-cultural determinants in seeking out MH support

6.1.2.1 Public policies

This category refers to how existing public policies affect the availability of mental health care in Belgium for Filipino immigrants. The first and second codes describe how the accessibility to the services provided by the Belgian social welfare and language influence the help-seeking behavior for MH care of members of the Filipino community.

a) Accessibility to MH care

The participants gave a unanimous answer when it came to accessibility of mental health care. All of them affirmed that they benefit from insurance coverage that includes the cost of potential mental health care services.

Table 17. Public policies: accessibility to MH care

<i>"It's [benefits, including mental health assistance] provided for free by the company. I think that also helped because of course if something is for free then it's easier." [P1]</i>
<i>"In Belgium, I haven't really gone to a psychologist, but I think it's easier because I know friends who can easily consult with a life coach or a professional coach for those who are going through burnout." [P2]</i>
<i>"I had, like, tips from friends, like, "you should see this person or that person" but here in Belgium it's super easy you can go to any professional with just a phone call or via the internet." [P3]</i>
<i>"I don't think it would be difficult because we have insurance here in Belgium, we have Partena. So, for me it's easy to go to the doctor. You don't have to worry for the payment and everything because you have insurance." [P6]</i>
<i>"We haven't tried it, but I think for the moment, with our family doctor, he can always recommend somebody [MH care professional] so it's not really that hard. We have insurance." [P9]</i>
<i>"R: Would it be a problem for you financially to seek out mental health support? P8: No, because here I have 3 insurances. It's not a problem." [P8]</i>

b) Language barrier

As illustrated in table 2, six out of ten participants studied French when they arrived in Belgium and the rest studied Dutch. Although the average number of years that the participants spent in Belgium is just shy of 20 years, only three were able to affirm their fluency in the language learnt. It is worth noting that half of participants use English to communicate in their workplace. However, when asked if the language could be a barrier in seeking out mental health care, those residing in Brussels or around the capital stated that their mastery of English was sufficient to enable communication with available English-speaking professionals.

Table 18. Public policies: language barrier

<i>"Our company has this global hotline where you can request for local support from a professional. They try to identify professionals based on your needs, so I mentioned there that I needed someone who speaks English. They were able to provide [support], and they took a week to get someone." [P1]</i>
<i>"Nowadays, I think, I mean if you speak at least English or one European language [...] In the hospitals they have a list of doctors on their website so you can see if they speak French, English, Portuguese, Spanish or Italian so you have a lot of choice. But definitely yes, 20 to 30 years ago it would've been a problem. Brussels changed so much." [P3]</i>

“Normally if I will make an appointment I will ask if she [the professional] can speak English. It’s the best if they can speak English because you can tell them what you want. It’s easier for me.” [P6]

“Almost all doctors [in Brussels] speak English so, there's no problem.” [P9]

In contrast, the participant who previously mentioned the lack of “connection” between MH care professionals and Filipino patients stated that language is a potential barrier.

6.1.2.2 Culture/societal values

This category is divided into two codes. The first code focuses on the impact of religious beliefs on the perception of MH and how it influences the way participants deal with their emotional distress. The second portrays the stigma that surrounds mental illness in Filipino culture which results in the desire to save face to protect one’s honor.

a) Religious beliefs

Participants consistently mentioned the importance of religious figures in Filipino culture, especially priests because they act as God’s messengers. Priests along with family and friends were mentioned several times by participants as someone they would reach out to in times of emotional distress (cf. 6.1.3.3 *Social capital - preference for lay network*). Yet, some participants are skeptical of sharing their problems with priests who are not qualified to deal with mental issues. However, a MH professional with a religious background is much appreciated.

Table 19. Culture/societal values: Religious beliefs - importance of religious figures

*“I studied in a Catholic school in my primary years and I think during that time, I remember my Christian living teacher always saying, “**oh if you have any problems you can approach the priests**” I’ve never done it of course [...] **I don't think priests and nuns were really trained professionally to deal with mental health problems** except for those who were employed in psychiatric hospitals owned by a certain congregation.” [P1]*

*“I never confided to a priest. [...] I had trust issues. If I would confide to someone, I would prefer to my sister, also friends. Priests were definitely present though. Maybe not for me but for my family, yes. [...] they had a **huge influence**. [...] [He’s] someone **who's talking in behalf of God** or something like that.” [...]*

*I have a son who obviously is having teenage issues [...] So, we go to these sessions where we go to **a psychiatrist who's a religious figure**. [...] And we are perfectly happy with that because he speaks English. I recommend him to some of my Filipino acquaintances living in Belgium [...], they tend to go to him because he would say good stuff as a Catholic to you. My friends would say “**Wow he's a doctor who is also catholic**, so we should definitely go to him.”” [P3]*

Priests are also called upon to perform exorcisms on individuals considered to be "possessed" in the Philippines.

Table 20. Culture/societal values: Religious beliefs - Role of priests

*"[In my local community in the Philippines] **they [priests] were linked to someone who is possessed.** That person would be taken to the church and the **priest would exorcise him/her** and shower him with holy water and other specific procedures that they would do in the church."* [P2]

Religion plays a great role in how the Filipino community deals with emotional distress. Prayer was mentioned numerous times as a coping mechanism.

Table 21. Culture/societal values: Religious beliefs - prayer as a coping mechanism

*[...] I did not focus on mental health because **if you have a problem you pray.**"* [P2]

*"They [Filipinos] have this tendency to not to ask for help, you know. "I can do this on my own. **I pray to God** and we have family and friends". [...] In Belgium, if you have a problem, a friend will say "Go see a shrink, go see someone". Filipinos they would be more like "**Oh I will pray for you,** will take care of you and make you food and cook for you and make you fat". It's cultural. I don't even know if they would think of psychologists or professional care."* [P3]

*"[...] if you are a catholic and you believe in God, or if you're from whatever religion, whatever you believe, **it really helps your mental health** if [you get] sick and [are] **always praying,** [to] ask [God] for guidance on what to do..."* [P6]

Participants indicated mixed feelings regarding the link between MH and religious beliefs. On the one hand, a participant blamed faith for masking MH problems because traumatic events and difficult circumstances are seen as the result of 'God's will', which leads to emotional distress being dismissed or swept under the rug. On the other hand, others see faith as having a positive impact on MH. They describe how God "lifts up" a distressed person with love and gives positive vibes in their life.

Table 22. Culture/societal values: Religious beliefs - link between MH and religious beliefs

*"I also saw that in my family. We never really talked about it [mental health] or see that as a problem that can be solved. Especially if you come from a religious family, **everything is kind of "God's will"**. [...]. My family thinks that [...] whenever there is a problem, whatever you go through in life, like if you fail an exam or a class, they were always saying "it's God's will" or "When a door closes, another one opens". So, growing up, you always think that it's ok, that you just have to **accept that you failed and forget about it** because **God planned it.** So, there's nothing to be done cause **it's not under your control** and you never really realize what made you fail or know what you could have changed."* [P2]

"I think someone [a Filipino] who would be depressed [...], they would confide themselves to priests or to a religious person. They would have this "pray over" thing. So, I guess they [religious persons] have an influence and I think that sometimes it's really good. In any case, the priest or the Catholic Community is lifting them up with love. Filipinos, they are very sensitive to that. God loves you and you're lifted up with the love and there's this big sense of community which I think is a lot different from Belgium." [P3]

"R: Do you think that your faith impacts your mental health beliefs?"

P8: Yes, because it's giving me more motivation, giving me more positive thinking that God is helping me. I cannot see God, but I believe in him." [P8]

b) Save face culture and stigmatization of MH

Participants affirmed that MH issues were considered taboo in the Filipino community. If one dared to talk about emotional distress, it was trivialized, and the person was made to count their "blessings" instead of complaining.

Table 23. Culture/societal values: Save face culture and stigmatization of MH - taboos and trivialization of MH

"Nobody would speak about it [MH] at home." [P2]

*"As far as I know, culturally, growing up, it was never discussed. [...] whenever you are struggling with something, you feel sad, the perception of others is that, ok you really have to deal with it, you **must never discuss it**. I have tried to discuss this with my family and they always say "you know what, you're lucky to have opportunities, compared to other people in the Philippines..." those words just do not help."* [P1]

Participants also acknowledged the pervasiveness of mockery and shaming of individuals with mental illness in the Philippines. For the reader's information, Mandaluyong city is notorious for having one of the first psychiatric hospitals in the country. There is a lot of stigma surrounding the residents of the city.

Table 24. Culture/societal values: Save face culture and stigmatization of MH - mockery of mental illness

*"Sometimes whenever you say something about what you are feeling it's either friends would **make fun of it, they joke around** or it's just their way of trying to appease you, but it doesn't help. They try **to play it down** or they try to make fun of it to make me feel better."*

*[...]when I was a child, I would have this perception [that] whenever you talked to someone in your family or your playmate, **they always have jokes or make fun of people who go to mental institutions**. For example, if you live in Mandaluyong, people always make fun of you by saying "**Oh, you're from Mandaluyong so you might be crazy**". [...] So, there is still a need to eradicate the stigma and not use mental health to ridicule someone."* [P1]

*"Yes, people tell me I'm crazy. They say, "**Oh you're from Mandaluyong, are you from the inside [of the asylum] or outside?**". Yeah, it's always the same "joke"."* [P3]

The participants also mentioned that the stigma surrounding mental illness in Filipino culture is still very strong. Individuals suffering from mental illness were either branded as outcasts, avoided like the plague, or directly labeled as violent and dangerous.

Table 25. Culture/societal values: Save face culture and stigmatization of MH - mental illness = outcast

<i>“Oh, it was everyone [who thought like that]. I mean if you had mental issues, you are just like an outcast and that's it.” [P3]</i>
<i>“[...]if I come across someone [who seemed “crazy”] on the street , maybe I would tell my daughter, “We have to go to the other side of the street, or we should go further.” you never know what he's thinking. I would probably react like that.” [P5]</i>
<i>“I saw a person who was buang/baliw [crazy]. [...] he was mentally disturbed. He was very dangerous to the people. I heard that they sent him to a psychiatric hospital. I was very sad for him [...] But he was too dangerous. When you talked to him, he attacks you suddenly with knives. He was very violent [...].” [P7]</i>

This stigmatization of mental illness leads to a negative portrayal of professional care. Treatment is reserved for severe cases. Therefore, participants expressed that people experiencing emotional distress will not resort to professional care for fear of judgment and shame.

Table 26. Culture/societal values: Save face culture and stigmatization of MH - negative portrayal of professional care

<i>“While growing up, I think that there was a stigma about mental health professionals, psychologists and psychiatrists. If you're talking to a psychiatrist, then you are already “crazy”.” [P1]</i>
<i>“The first step is to accept and recognize that they have a problem. Most of them [Filipinos] have too much pride and they don't want to accept it. For them it's shameful. [...] I guess it's the most difficult step, because the moment they say that they will go seek help, they usually think that “Oh I'm crazy, and my reputation would be ruined”. They have to know when they need professional help, because a lot of them are in denial.” [P4]</i>
<i>“So, I think she [Filipino friend in Belgium] was afraid to tell us when she was going through it [postpartum depression], but she was actually crying every night when she just got the baby. Probably she was not so open about it because she was worried, we would judge her or something like that or we wouldn't believe her.” [P5]</i>
<i>“[...] when a person thinks that he has a mental illness, they don't mention symptoms etc. No, they think that, especially if you are in the community, in your barangay, Once you go to a psychologist, even if it's only because you are stressed, people will think that you are baliw [crazy]. That's what they say so the person won't go directly to a psychologist because they are scared to be judged. Instead, they go to the priest and they tell him their problems.” [P6]</i>
<i>“Sometimes if you want to help them [Filipino friends in Belgium] and tell them to go to a psychiatrist, it's only good if they are already looking for help or if they think that seeing a psychiatrist is a good thing for them. But sometimes, it's like you're judging them. They think</i>

about it negatively. They say "Why are you suggesting that to me? I'm not kurong-kurong [crazy]. Is it your duty to tell me that? Mind your own business". [P8]

*"Sometimes, the perception of other Filipinos is that **when you go to psychiatrist, you're already crazy**. That's the perception so they are ashamed to go because they don't want the community to tell them that they have mental problems." [P9]*

6.1.2.3 Psycho-social circumstances

This category focuses on psychosocial stressors, stressful living circumstances and relationships (such as the role of **family reputation, the care chain and the "giving back" culture**) and coping styles (**the resilience of Filipinos**) affecting the MH and HSB of the participants.

a) Role of family reputation

Four participants stated that fear of dishonoring the family name would not prevent them from acknowledging and openly discussing the existence of mental illness within their families. However, this only applied to severe cases of mental illness that would require psychiatric care in an institution.

One participant cited the "bad blood" belief (that marrying into a family with a history of mental illness brings bad luck and ensures any descendants will inherit said mental illness) held by some members of the Filipino community but stated that it did not personally affect him.

Table 27. Psycho-social circumstances: Role of family reputation

*"It's okay to talk about it because if he [a member of the family] needs help, **we can seek help from psychiatry and have him admitted at the hospital**. **Why will you hide** if he/she has a problem mentally? It's for his own good." [P10]*

*"For me? No. **I need to tell them the truth that he's in a facility**, he's sick so he needs to go there. At least after a few months he can come back healthy. **Why should I hide?**" [P6]*

*"I think they [my family] **would place that [mentally ill] family member straight away to a mental institution** [...] **though it's not a good thing to say**, they would place that person in an institution because they would be scared that He/She would hurt someone. [...] he's getting the help he needs. **I don't think that they would say, like, "Oh, we should hide him"**." [P5]*

"R: If ever you or a family member has symptoms of mental illness, would it be a problem for your family reputation?"

P9: I don't think so because my wife's aunt, [...] has this mental problem. She is just like lost all the time. She doesn't know what she's doing but [...] **it did not bother us.** [...] other people would say that **when you have this kind of problem in your family then you might inherit it.** Some other people may not even let you marry a member of the family because they're scared that they will inherit the disease." [P9]

Nonetheless, two participants argued that when it came to mental problems, their extended families were less open-minded and so they tended to avoid discussing the issue.

Table 28. *Psycho-social circumstances: Role of family reputation - extended family*

"Not everyone has an open mind about it [mental illness] so I have a feeling that when you tell this to people who are not part of your close-knit family **they would not understand, and they would judge you.** I mean I talked about it with my siblings who I am close with, **but we do not talk about it with extended family** like our cousins, uncles and people we're not really close to." [P1]

"[They would react] very badly [to mental illness in the family], yes. [...] **[T]he entire clan, they really dislike having any labels of mental health problems** on any member of the family. Though, we do have family, like distant cousins, who had terrible diseases and they had to be taken into an asylum, **but the family doesn't want to talk about it.**" [P2]

b) Care chain

The care chain phenomenon was nearly non-existent in the sample of individuals of this research. The children of the participants are currently residing with them in Belgium or are old enough to have their own families elsewhere. Only two participants recalled leaving their children in the Philippines with nannies when they first immigrated, however, the families were later reunited.

Table 29. *Psycho-social circumstances: Care chain*

"Ah, I had nannies. I had my own 3 helpers at home [Philippines]. They were living in my house in the Philippines. I also had a tutor for my children, I had a nanny, I had a cook, I had one who wash the clothes." [P8]

"Yes, we left behind two children. They were 5 and 1 year and a half year old at that time. It was a very hard decision, leaving them there very small [with nannies] but since we had the chance to come here, we just took the risk. As they say, "to find the greener pasture". [P9]

c) Giving back culture

This code emerged after the interview of participant number 4 [P4] who talked about the psychological impact of the “giving back” culture in the Philippines. She explained how it is part of Filipino culture to send money to the family left behind in the Philippines. She further elaborated that this culture is a “curse” to both the giver and receiver. It creates significant financial pressure and affects the mental health of the giver and generates dependency for the receiver. As a life coach, P4 is in contact with a lot of Filipino immigrants in Belgium who share the same problem surrounding financial and psychological strain due to this “giving back” culture.

Table 30. Psycho-social circumstances: Giving back culture

*“It's the same situation with Filipinos abroad. It's a very delicate matter to mention. **Our culture is to help the families left behind** in the Philippines are you familiar with that? It has a very **serious effect on mental health of Filipinos who are living abroad**. The way we help our parents, our families... that is what I'm trying to talk about or mentor the Filipinos abroad, because it causes a lot of problems: **stress, depression**... [...] I'm not against it, I'm very generous. I gave a lot already. However, the fact that the immigrants are working very hard here and they just give a lot, even sometimes more than they can afford. I am one of the few who actually stopped that because actually it's not helping anymore. I'm trying to talk about it with other Filipinos here. I'm telling them that if you want to help but it's painful in the heart, it's not good anymore. [...]*

*But our Filipino culture is this way. I have to be very careful with what I say because Filipinos would react by saying **“How dare you! You are so bad because you're already abroad and you adapted to this Belgian culture. Where are your Filipino roots? Where is your Filipino “giving back” behavior?”** This has to stop. You can give of course, but only occasionally, if there's an emergency. I'm still ok with that but I know people, maybe you do too, Filipinos who are sending lots of money every month to the Philippines plus giving money for emergencies. So, who's going to help you when you are in an emergency yourself [...]*

For example, if someone in the Philippines is dying and that you're the only family abroad, it feels like it's your responsibility to keep that person alive. Especially if it's your parents, your brothers or sisters. It already happened that I helped a friend. I lent her some money because she couldn't stop herself from giving. [...]

*[Money is always needed] for medical expenses, somebody's getting married, somebody is delivering a baby or somebody's sick. [...] Yeah, I worked very hard for that money. **I had that guilt** and I was telling myself it's not good. I'm the one waking up early every morning [to work], why am I feeling this? There is this voice in my head telling me “if you don't help your parents, they're poor, what kind of daughter are you?” That's what people would say.” [P4]*

d) Resilience of Filipinos

Two of the participants brought up the resilience that characterizes the Filipino people; the extraordinary willpower that allows them to surpass the difficulties that they may encounter in life. They talk about survival and positivity, like looking at the brighter side of events. As a result, Filipinos generally think that they are capable of dealing with their problems on their own. The notion of religion and its positive impact on their mentality also resurfaced when discussing the topic.

Table 31. Psycho-social circumstances: Resilience of Filipinos

*“As a **Filipina**, you have that kind of personality you know, **we survive** anything or any obstacle. [...] I have my mental health under control. It's like, ok whatever comes, **I can handle it.**” [P4]*

*“For me, I always look for the **positive side**. You are the author of your own story. So, the way you think that something will happen, it will really happen if you really focus on it. If you're always negative, of course your life is not good but if you're always positive, your life will be good. It's the way you handle your life. [...] **I have to deal with it** (emotional distress). [...] **Filipinos are optimistic**, and we are strong and tough to tackle all of our problems and we are believers of Christ that's why we are scared of God [god-fearing]. So, it helps our mentality.” [P8]*

6.1.3 Internal factors and socio-cultural determinants in seeking out MH support

6.1.3.1 Behavioral factors

This category emphasizes how the participants experienced their acculturation process and how their immigration in Belgium impacted their MH help-seeking behavior. It also tackles their coping mechanisms in times of emotional distress and likeliness to seek out help from professionals.

a) Acculturation process

Predictably, most of the participants had a hard time adjusting to life in Belgium due to several factors like the language, the weather and the culture shock between a community-centered country like the Philippines in contrast to an individualistic society like Belgium.

Table 32. Behavioral factors: Acculturation process - Difficulties of adaptation

<i>“Maybe because of the culture in the Philippines [...] Asian cultures in general are more of a groupie [group-oriented] kind of people. Here it's more like individual relationships and it's quite hard to [create relationships with others]. [...] in the Philippines it is more of like you have friendships on a personal level. Here there is still some barriers with people showing (sharing) stuff with you. [...] when I moved in here in February 2018, it was raining it was gloomy and everything was so gray [...] for some reason I felt much more depressed – well, not depressed, sorry, I think depressed is a really strong word - but it was more of, like, I felt alone and sad and the weather wasn't helping and so I felt like yeah I have those moments and it was quite a struggle for me.” [P1]</i>
<i>“I was wondering why we left the Philippines for “this”. I mean this weather [...] It was quite tough for me at the beginning because of the language barrier. I had to learn from scratch, and nobody could understand even my English. I felt really handicapped. I think it took me a couple of years before I really started to feel at home here in Brussels.” [P3]</i>
<i>“Life was really tough as a foreigner here, it wasn't easy. [...] It was a huge adjustment period. [...] I arrived here on August 30, but it was already very cold. The first thing that I noticed, coming from the airport to my late husband's place, was the quietness. It was very calm. Nobody was on the streets. That's the first impression that I had because in the Philippines, at any time of the day, the streets are packed. Everybody's moving around, so that was it. For the food it wasn't that bad but for the language, it was really hard. I only had a few words [of Dutch] when I came here.” [P4]</i>
<i>“For me, it was really difficult because I'm living in the suburbs and there is only one bus in the morning and in the afternoon. My husband was a full-time music teacher, so I mostly stayed home. It was very difficult. You know, we come from a very crowded place and suddenly I am isolated. It's as if you're living in the mountains. I can't drive, I can't bike, so I'm really isolated. I was thinking I was [...] living in a monastery. The houses were very far and there were no neighbors, so it was not easy for me.” [P7]</i>
<i>“It was very difficult for me because I wasn't used to [having] no Filipino friends. I didn't have any for the first 2 years but straight away I studied a Dutch course in Leuven and I also followed the integration course. [...] it's for people who came to Belgium from other countries and got married to a Belgian. [I met other Filipinos there]” [P8]</i>
<i>“It was hard because I didn't know how to speak French, but little by little [I learned]. It was very hard to work in the hospital because [I couldn't speak French]. The medication is the same, it's written in English, but the rest... it was very hard to adapt. Little by little I made it.” [P10]</i>

Three participants link acculturation process to the likeliness of seeking out MH care. They argue that Filipino immigrants in Belgium should not limit themselves to Filipino culture but rather should adapt and discover other cultures, be more open-minded and take full advantage at what the Belgian healthcare system can offer. Seeking professional care in Western Europe is less of a taboo ergo better acculturation to Belgian society facilitates access to mental health care for Filipino immigrants.

Table 33. Behavioral factors: Acculturation process and likeliness to seek MH care

<i>“There is this tendency of Filipinos to really try to make the definition of comfort is equal to having everything Filipino around. Talking with Filipino friends, only cooking Filipino food at home... and that to me, it's not bad of course, you shouldn't forget where you came from, and yeah you can continue to practice your culture. But if you decide to live in a new community in a new society, and you live there because economically it's much better, you should take full advantage of it. (...) Yeah, it really helps when you're abroad to talk with non-Filipinos because otherwise you don't really grow as a person. [...] It's not enough to just learn the language, you also have to live a bit like the locals. Or else it's a pity if some don't take advantage of the healthcare system here.” [P2]</i>
<i>“I think they should open up themselves to cultures other than the Filipino one. [...] I think that what would really encourage them to seek out mental health support would be to surround themselves by Belgians or other nationalities and other cultures. Because staying amongst Filipinos, it's not bad, I think it's strengthening them, but it's also a barrier to open themselves up to what is actually the Belgian culture.” [P3]</i>
<i>“Well it was quite hard because of the language [...] There was a little by little adaptation with Belgian culture. When our children were all going to school (in French), we were more and more exposed to the Belgian culture until we wanted to stay more with this Belgian culture rather than the Filipino culture. Sorry to say that but sometimes we need to adapt ourselves in the place we live. [...] I think it's because we totally detached from the Filipino community. If you are with Europeans, if you say that you seek out help from a psychiatrist that's not a problem. They are more open-minded.” [P9]</i>

b) Coping mechanism and likeliness to seek out MH care

Through analysis of the answers provided, three distinct mindsets held by participants towards mental illness were identified. Therefore, the participants were classified into the following three groups. The first group (1) consists of the participants who have previously sought out professional help or who would readily do so. The second group (2) comprises participants who would be willing to seek MH care only as a last resort. The last group (3), consists of only one participant who is against seeking MH for herself and her family. She believes that if her children have emotional problems, talking to her is enough, psychological care is not needed.

Table 34. Behavioral factors: Coping mechanism and likeliness to seek out MH care - 1st group: Sought professional help or willing to seek help as a first recourse

"I needed to identify the problem. This is taking so long already, the feelings that I have, like being lonely, alone, sad, and missing the family and so on. [...] I realized, okay, I really need professional help. [...] I availed of that [professional MH care] and I was able to meet a clinical therapist. [...] I did 5 sessions with her and it was really helpful, and we just talked about the struggles that I had and so on." [P1]
"If I'm talking to my peers abroad, it's normal to speak about mental health. Burnout, depression, is all over my workplace. The first time I realized that it's normal is when I lived in Japan because I was seeking help when I was there. That's when I realized that ok, it's not really something that you should be ashamed of or scared to talk about." [P2]
"I've always had a bit of depression and I'm perfectly aware of that, so I went to a psychiatrist and psychologist to seek help". [P3]
"For me, If I see him [my husband] depressed, more stressed [...] I would think to send him to a psychologist first, to check with him how he could cope with the stress and depression." [P6]

Table 35. Behavioral factors: Coping mechanism and likeliness to seek out MH care - 2nd group: Willing to seek professional help as a last recourse

"Personally, I also experienced that burn out situation, but I was, like thinking, if I can handle it, I'm not going to seek mental health care. For me, the best therapy is self-therapy. So, if you can handle it, yeah [...] Personally, I did not seek professional help but I'm not against it." [P4]
"R: Would it be a problem for you to see a mental health professional? P5: No not at all, and it's probably because I don't get homesick [...]. I would probably first look for a hobby and not go straight or psychologist or psychiatrist. Yeah, I probably would first try to help myself." [P5]
"P8: But if I can't handle it anymore, of course we need rehabilitation [...], psychiatrists or a doctor to help us. R: So, you're saying that when you would really need it, you would go seek professional care? P8: Yes, if it's really needed. If I cannot solve it. But for myself, I won't need it because I'm always positive." [P8]
"Socialization is my way to cope if I have some emotional problems. I just throw a little party, ask my friends to come for a drink, we talk and after that, it will ease me. [...] If the friend is not enough, then I think we need to seek professional advice." [P9]

Table 36. Behavioral factors: Coping mechanism and likeliness to seek out MH care - 3rd group: Against seeking MH support

<i>“R: How likely are you to seek out professional care if you or a member of your family is in need?</i> <i>P7: normally I'm against it.</i> <i>R: Why is that so?</i> <i>P7: Because you know, I observed the daughter of my husband who was difficult to control... nobody believed her when it comes to her problems, nobody listened to her. So, what did I do to my own children? I said, you don't need to cry, you can tell everything to me. You can feel confident about telling me. Don't tell lies, like that if you have a problem don't cry, just tell it to me. So, my children, they are open to say anything that they want. [...]. For me, I don't need to send them to a psychiatrist. If they can talk to me, then it's okay. Instead of talking to a psychiatrist, they can talk to me if they have problems.” [P7]</i>

6.1.3.2 Socio-economic position

Influence of education and immigration on the perception of MH

When the participants were asked to talk about Folk conceptualizations of mental health, most of them had plenty of examples to give. They mentioned *Mangkukulams* (witches) who curse people to make them mentally ill. They also talked about bad spirits who “possess” individuals, causing mental problems (Table 11). Although they believed these conceptualizations as children, their perceptions changed when they went to university or when they were able to go abroad.

Table 37. Socio-economic position: Influence of education and immigration on the perception of MH

<i>“However, after attending the university and working, that perception [Mentally ill = crazy] has changed. [...] I also think that being able to work outside of the Philippines, being exposed to different cultures, studying in different universities, opened my mind.” [P1]</i>
<i>“When I was a child, I guess I was scared, and I believed them [old people], but I realized that all of those were fantasies [the devil possessing people]. In High school, that was the time that I started to distance myself from anything religious. Moving abroad, I could freely practice my non-religious affiliations. Then, it was easier to focus on what was essential and what were the roots of the problem. Moving abroad, I managed to keep a balance with both [MH and physical health]. Well, I don't really know how to deal with mental health per say but at least I acknowledged that it is something that I had to address or that I have to try to address and figure out how to be more of serene mind.” [P2]</i>
<i>“As a kid yes [I believed in those folk conceptualizations of MH], because you just quite tend to believe what the adults would tell you and that's it. But afterwards, growing up in Belgium,</i>

<i>you figure it out. You get to develop this double culture. Then, I got to make my own beliefs. I still embrace my roots of course but it allows you to understand the different cultures.” [P3]</i>
<i>“If someone is having mental problems, people would say that maybe he is influenced by bad spirits. Like they are harming him [...]. I also believed that before, but later, when I came here, I was more open-minded about different things.” [P4]</i>
<i>“Yes, I've learnt a lot about it [MH] with my sister-in-law [who is a Belgian nurse]. She talked about it constantly when she got depressed and she had to go to psychologists. It's more common to hear about it here. It's like a normal thing to do. Probably when I just arrived here and if she told me that, I probably would've said "Is there something wrong with her? Why is she going there?" I've never really encountered something like that in the Philippines so I wouldn't have known how to react.” [P4]</i>
<i>“Well, when we were young, we were scared but when you grow up and you go to school, you learn things, especially science which is totally different from the beliefs. I think education helps you not to believe in those superstitions.” [P9]</i>

6.1.3.3 Social capital

Preference for lay network

Seven participants expressed a preference for their lay network (friends, family and sometimes priests) when dealing with emotional distress.

Table 38. Social capital: Preference for lay network

<i>“So, if you can handle it [emotional distress], [...] I was also at the point where I was thinking, maybe I have to see someone [professional] and talk with them, but I didn't get to that point because I have good friends who I can talk to. It helped a lot.” [P4]</i>
<i>“Most of the time, when I'm emotionally disappointed, [...] it's mostly about of my daughter. [...] Yeah, she's a teenager you know... But I talk to her when I have something [that bother me] [...] I normally talk to my husband when there is something [wrong] because he understands it and he always listens.” [P5]</i>
<i>“Normally if we are depressed or something it's because we have problems with the people in the Philippines. [In order to deal with it] we call our family, we talk, we communicate to them. [I] talk to my sister or father...” [P6]</i>
<i>“For me, I don't need to send them [my sons] to a psychiatrist. If they can talk to me, then it's okay. Instead of talking to a psychiatrist, they can talk to me if they have problems.” [P7]</i>
<i>“I'm a very positive person so, first at home I have to deal with it. I have to solve all the problems at home. I don't need anyone to solve my problems or to solve the problems of my family. Only me and my family members are allowed to solve the problem, not other people.” [P8]</i>

“Socialization is my way to cope if I have some emotional problems. I just throw a little party ask my friends to come for a drink, we talk and after that, it will ease me. [P9]

“Oh, [when I feel emotional distress] I do my work. I talk with my husband, my children [...]

R: What advice would you give to other Filipino immigrants in Belgium who needs to cope with MH issues?

*P10: I can tell them that they can **speak to their family about their problems**. Especially their mother or father. But not to hide because it’s difficult to solve a problem when you are alone. **You can talk to a priest or your best friend**, something like that. I think it’s the right way to solve whatever problem you have.” [P10]*

Participants from the first group (those who had sought professional care in the past) in one of the previous codes “Coping mechanism and likeliness of seeking out MH care” also stated that they would advise other Filipino immigrants in Belgium to also seek professional help should they find themselves in a state of emotional distress. However, even if these participants are personally satisfied by the effectiveness of professional MH care in Belgium, they say that it’s difficult to convince other Filipinos because of the preference for lay networks and the stigma surrounding mental illness.

Table 39. Social capital: Preference for lay network - advice for other Filipino immigrants

“I think I would probably encourage it [MH professional care] because first it's free – well, practically; it's affordable. But, I guess it's just important to have someone to talk to and just to express whatever you can express [...] I think there's just no other way, other than encouraging the person [a Filipino immigrant in Belgium] to talk to **his/her family, friends, the community or the priest**.” [P2]

“I think it's upon the person to acknowledge that they [Filipinos in emotional distress] need go to that professional and ask for help. **It’s not common to Filipinos to do that**. In Belgium for instance, people would just say “I have a mental issue, I have to go see my shrink”. But Filipinos here, they won’t. They have this tendency to not to ask for help [...]. **“I can do this on my own. I pray to God and we have family and friends”** [P3]

Chapter 7: Discussion

7.1 Summary of main findings in relation to theoretical literature

To be able to answer the initial research question: “*Do the aforementioned socio-cultural determinants and barriers and/or other factors prevent members of the Filipino community in Belgium from seeking out mental health support?*”, a summary of the main findings of this research will be presented in relation with pertinent theoretical literature provided in the conceptual framework.

As a reminder, WHO defines mental health as “*a state of well-being in which an individual can realize his or her own potential, cope with the normal stresses of life, work productively and make a contribution to the community.*”(WHO, 2001b). In contrast, mental disorders “*(...) comprise a broad range of problems, with different symptoms. They are generally characterized, however, by some combination of disturbed thoughts, emotions, behaviour and relationships with others. Examples are depression, anxiety, conduct disorders in children, bipolar disorders and schizophrenia. Many of these disorders can be successfully treated.*” (WHO, 2002). The definition of mental health itself and the confusion brought by the term mental illness are the main misunderstandings that the participants portray in this research. Several of the participants appear to hold a misconception about MH, defining it as a neurological disorder such as dementia or autism or equating it to a state of mental alertness (Table 5). Generally, participants utilize the term mental health during the interviews to refer to mental illness.

When discussing the perception of MH, a participant explained that in Filipino culture, “soft” mental problems such as mental breakdowns or depression are attributed to a “lack of faith” or perceived as an overreaction. However, individuals suffering from a severe mental illness like schizophrenia are labeled “crazy” (Table 7). This perception was also revealed in the findings of several authors (Leong & Lau, 2001; Thompson et al., 2002). Given that mental illness is linked only to severe cases in which symptoms like delusions and hallucinations may lead to violence, its stigmatization is intensified (Table 25). Tuliao (2014) also highlights this unfavorable depiction of mental illness in Filipino media outlets. Consequently, since only severe cases are seen as worthy of treatment, this leads to a negative portrayal and underutilization of MH care services. Although the participants generally had a favorable

representation of MH care professionals (Table 8), this did not necessarily imply that they would seek help if they were in need. Rather, participants of the second and third group considered professionals only as a last resort or simply unnecessary (Table 35 & 36). Through the accounts of these two groups of participants, shame (“hiya”) and fear of judgement (e.g. being labeled as someone “baliw” (crazy)) emerged as two of the main factors that dissuade members of the Filipino community from seeking professional mental support (Table 9, 26). This “hiya” and desire to save face was widely discussed in several studies (Lally et al., 2019; Sanchez & Gaw, 2007; Tuazon et al., 2019; Tuliao, 2014) referred to in the literature review. Mental illness is therefore considered to be taboo (Tuliao, 2014) and whenever it was brought up during the interviews with participants, it was said to be either trivialized (Table 23) or mocked (Table 24) in Filipino culture.

As discussed in the literature review, various authors (Gingrich, 2006; Samaniego, 2017; Tan, 2008) developed the notion that Filipinos tend to have superstitious beliefs that affect the social representation of mental illness. However, regarding folk conceptualizations of MH, the participants were unanimous in stating that they do not, or no longer, believe in superstitions like “*Mangkukulams*” (witches) or bad spirits possessing “crazy people” (Table 11). They say that these beliefs were mostly propagated by the elderly to threaten children into obedience (Table 12). According to the participants, the main reason for their shift in perception was proper education and openness to other cultures through immigration (Table 37). This correlation between the level of education and the broadening of the definition of mental health, the perception of symptoms, and health seeking behavior can also be found in Hourani & Khlat's (1986) study. This also coincides with the observations made by Professor Orban and members of local NGOs with whom she worked during her 62 scientific missions in the Philippines. They noted a positive development in the mindset of the emerging middle class who appear to be distancing themselves from these collectivist beliefs. That being said, some participants identified previously unmentioned folk conceptualizations such as relating mental illness to the neglect of food consumption or the use of drugs (Table 13). This can be linked to the concept of mind-body holism of Asian-Americans developed by Leong & Lau (2001) which describes the somatization of emotional distress and vice-versa.

In the conceptual framework of this research paper, it was implied that that socio-economic status of Filipino immigrants may affect the accessibility to mental health care in Belgium. When asked about the topic, participants gave a unanimous answer affirming that they benefit from insurances that could cover MH care services should they need them (Table

17). All of the participants are currently employed and gain stable income (Table 2). Therefore, financial accessibility to MH care was not considered a barrier to their HSB. Nonetheless, the “self-sacrificial lamb syndrome” (Basa et al., 2011) resurfaced during the interviews when the 4th participant mentioned the “giving back” culture of Filipino immigrants. However, instead of taking pride in the role of modern-day heroes by uplifting their families from poverty, she emphasized the psychological impact of this culture and the mental strain that it creates, eventually leading to significant stress and depression (Table 30). This can be linked to Thompson et al.'s (2002) conclusions that this obligation of sending money to the family left behind in the Philippines becomes a burden for Filipino immigrants. This duty threatens the financial stability of the giver and can potentially cause Filipino immigrants to lose their social networks back home should they fail in this duty. Subsequently, this affects the MH of the giver.

As previously mentioned in the results of this research (*cf. 6.1.2.1.b Public policies – language barrier*), despite the participants having spent on average 20 years in Belgium, only three of them considered themselves to be fluent in either Dutch or French, Belgium's two most prevalent official languages. However, participants residing in Brussels or around the capital affirmed that language was not a barrier when it came seeking out MH care. English-speaking professionals were deemed widely available in the region. In their study on Filipino Americans, Gong et al. (2003) link language abilities, specifically proficiency in the language of the host country, to the likeliness of seeking out MH help. In Belgium, although English is not an official language, its international recognition as a lingua franca enables widespread access to professional MH help, according to the participants. Nonetheless, one participant stressed that despite the absence of language barrier, there is a lack of emotional connection between western practitioners and Filipino patients which discourages HSB (Table 10).

For a Christian-majority country like the Philippines, it was only natural to discover that nine out of ten participants were Catholics while one identified as Protestant (Table 2). The results of the research revealed the significant impact of religion on Filipinos' perception of MH, coping mechanisms, and psychological mindset. Participants viewed religious figures as important in Filipino culture and emphasized the substantial role of priests acting as God's messenger. The participants were divided when it came to the matter of approaching a priest in times of emotional distress. While some were skeptical of their qualifications in MH care and wouldn't share their emotional problems with them (P1 and P3 in Table 19), others mentioned priests as confidants in times of emotional distress (P10 in Table 38 and P2 in Table

39). The latter confirms Tuliao & Velasquez' (2014) theory that Filipinos and Asians in general tend to seek help from their lay network, including religious leaders, rather than from professionals. P3 stated that Filipinos are more willing to consult MH care professionals from a religious background [Table 19], further underlining the importance Filipinos ascribe to religion.

Moreover, further implications of religious beliefs include coping mechanisms. Prayer and faith were mentioned numerous times by the participants in dealing with emotional distress (Table 21). Although two participants claimed that their faith has a positive effect on their MH which they described as God lifting them up and bringing positivity to their lives, one participant blamed faith for masking MH problems. She explained that adversity is attributed to “God’s will” and ensuing issues related to MH are swept under the rug (Table 22).

*“My family thinks that [...] whenever there is a problem, whatever you go through in life, like if you fail an exam or a class, they were always saying **“it's God's will”** or **“When a door closes, another one opens”**. So, growing up, you always think that it's ok, that **you just have to accept that you failed** and forget about it because **God planned it**. So, **there's nothing to be done cause it's not under your control** and you never really realize **what made you fail or know what you could have changed.**” [P2]*

This verbatim is particularly interesting because it demonstrates Weiner's (1979) *attribution theory* in a psychological context. As stated previously in the conceptual framework of this research, divine intervention is still commonly used by Filipinos to explain certain phenomena. Many Filipinos believe that all life events are predetermined by God and this is used as a coping mechanism in order to deal with mental illness (Tanaka et al., 2018). The tendency in the Filipino community to attribute failure (or success) to the external factor of “God's will” means that individuals have no control over negative aspect of their lives (e.g. mental illness). Therefore, what would be the point in seeking out mental health support? This perceived absence of control over mental health dismisses the benefits of MH care in the minds of many Filipinos.

Because of the negative perception of MI in the Filipino community, the presence of MI can negatively impact a family’s reputation. Four participants declared that fear of harming their family’s reputation would not stop them from acknowledging and openly discussing the existence of mental illness within their families and seeking professional help. However, this only applied to severe cases of mental illness that would require psychiatric care in an institution. One participant raised the issue of “*bad blood*”, previously introduced by Tanaka

et al. (2018), but explained that it did not affect him personally (Table 27). Nonetheless, two participants highlighted the close-mindedness of their extended family, and identified fear of criticism and judgment as a barrier to publicly discussing their mental health issues (Table 28).

The results of this study showed that the phenomenon of the *care chain* (Hochschild, 2001), a concept explained in the literature review, was nearly non-existent in the sample of individuals who participated in this study. On the one hand, none of the participants previously worked or presently work as nannies in Belgium (Table 2). On the other hand, the children of the participants are currently residing with them in Belgium or are old enough to have their own families elsewhere. Only two participants recalled leaving their children in the Philippines with nannies when they first immigrated, however, the families were later reunited (Table 29). In this specific sample of participants, the care chain is irrelevant and so the question concerning its impact on the MH of Filipino immigrants remains unanswered.

During the collection of data, two of the participants characterized the Filipino community as *resilient*. They identified themselves as survivors, optimistic and strong enough to deal with any problems or obstacles in their lives on their own. They affirmed that this mindset helps their MH. The notion of religion and its positive impact on their mentality also resurfaced when discussing the topic (Table 31). This result is consistent with the importance given to religion by other participants (Table 21 & 22). Conversely, Jalandoni (2015) criticizes this concept of *Filipino Fortitude* (the virtue of courage) and in particular the concept of resilience. The author suggests that resilience and quiet suffering may not always benefit the individual and may mask underlying problems. PMHP with this mindset may overlook seeking professional help due to a false sense of strength.

The acculturation process to the Belgian lifestyle proved to be difficult for most of the participants. They identified obstacles such as the unfamiliarity of the language, cold weather and the culture shock between a community-centered country like the Philippines vs. an individualistic society like Belgium (Table 32). Three participants established an association between acculturation and the likeliness of seeking MH care. They suggested that Filipino immigrants should open themselves up to Belgian society and culture and take advantage of what it has to offer, especially when it comes to healthcare. Since seeking professional care in Western Europe is less of a taboo, higher levels of acculturation to Belgian society facilitate access to MH care for Filipino immigrants (Table 33). This matches conclusions drawn by

Leong & Lau (2001) revealing that positive attitudes to help-seeking are typically found in highly acculturated individuals.

Multiple studies have suggested that the most frequently used source of care for Filipino Americans is the lay system which consists of friends and family who play a significant role in times of emotional distress. PMHP rely heavily on this support group and see them as the only necessary source of emotional support (Gong et al., 2003; Tuliao & Velasquez, 2014). Thompson et al. (2002) add that this preference for lay networks decreases their likeliness to seek professional mental care. These findings were reflected in the answers given by the research sample of this study. Seven out of ten participants expressed a preference for their lay network (Table 38). The three remaining participants had already sought MH professional care in the past and gave positive feedback on their experience (Table 34). Only one other participant stated that he/she would be willing to seek professional care as a first recourse in the event of MH difficulties. The four aforementioned participants make up the first group identified in the point **6.1.31.b Coping mechanism and likeliness to seek out MH care**. The second group comprises participants who would be willing to seek MH care only as a last resort (Table 35) and the third group consists of only one participant who is against seeking MH altogether (Table 36). The overall negative portrayal of MH care professionals within the Filipino community affects Filipinos' likeliness of seeking out professional services. The belief that only severe mental illnesses require professional treatment (Table 9 & 26) could explain why the second group would only seek MH care as a last resort. Although participants of the first group gave positive feedback on MH professionals, when asked what advice they would give to other Filipino immigrants in Belgium to encourage professional HSB, they advised using the lay network. They argue that it is difficult to convince other Filipinos to seek professional help because the stigma surrounding mental illness is still very strong and the preference for lay networks is significant (Table 39).

This study has identified several principle factors which prevent members of the Filipino community in Belgium from seeking mental health support. These factors include socio-cultural determinants and barriers such as: *the “soft & severe” perception of MI, the subsequent stigmatization of MH and MH professionals, the concept of “hiya”, the attribution of adversity to the external factor of God’s will, the concept of resilience, the preference for lay networks and lower levels of acculturation*. On the contrary, the factors of *accessibility to MH care in Belgium and language* mentioned in the conceptual framework of this study were not considered as barriers to HSB by the participants. Other factors that emerged from the

results of the study such as the *lack of connection with Western practitioners and Filipino patients* discouraged HSB. Additionally, “*giving back*” culture was perceived to put significant strain on the MH of Filipino immigrants in Belgium but the relationship with HSB is unclear. The results also highlighted *the preference for MH professionals who were also religious leaders*, therefore encouraging a positive HSB.

7.2 Limits and strengths

The limits and strengths of this study make it unique. To the best of the researcher’s knowledge, there is no substantial scientific research specifically concerning the mental health HSB of the Filipino community in Belgium, so this is the first study that tackles this topic with this specific population. Being of Filipino-Belgian descent, growing up in the Philippines and eventually moving to Belgium, the researcher has been exposed to two very contrasting cultures. This personal characteristic of the researcher can both be a limit and a strength for this study. On the one hand, being of the same cultural background as the participants, her past experiences and knowledge about the Filipino people and MH in the Philippines, as well as her access to local resources and information gave her a wider scope of the subject studied. On the other hand, this can also lead to excessive interpretations and potential bias of data collected if the researcher is not aware of the implications of her background on the study. Nevertheless, this bias was acknowledged from the very beginning of the research.

All the participants spoke English as this was part of the criteria to take part in the research. However, the level of language proficiency varied from one person to the other. Aside from a couple of eloquent speakers, the grammar used by the participants was sometimes incomprehensible to a native English speaker. Thankfully, since the researcher spoke both Filipino and English, and was exposed to colloquial terms and expressions used in the Philippines, she was able to grasp the intended meaning of the participants’ comments and convey it accurately in the study. She gave the option to the participants to express themselves in Filipino if ever English was too complicated for a certain question.

In the presentation of results in this study, the verbatim used were slightly modified with the intention of bringing more clarity or context to the participant’s phrases without altering the intended original message. The researcher was careful not to lose any nuance of the data collected by correcting too many of the grammatical mistakes. Interestingly, a link can

be established between the dialectal nature of the participants' speech and the lack of "emotional connection" with Western practitioners pointed out by one of the participants (Table 10). Indeed, even if English is used as the medium of communication, important nuances of a Filipino patient's speech are lost in translation. Perhaps the "emotional connection" that the participant mentioned lies in the cultural aspect of the language and the warmth it exudes. The ability of the researcher to interpret the underlying meaning of non-idiomatic English expressions used by the participants stems from her understanding of the Filipino language. She was able to identify typical Filipino phrases that the participants had translated literally into English and therefore acquired a comprehensive outlook of the information conveyed by the participants.

The conceptual framework, the interview guide and the semi-directed interviews conducted in this research influenced the kind of factors affecting the HSB of the Filipino community in Belgium that were identified and highlighted in the results. This bias in the selection of factors was used to limit the scope of the study in order to focus on the most important elements. As mentioned previously, the factors developed do not claim to be exhaustive.

Due to the SARS-CoV-2 pandemic and the subsequent community quarantine established by the federal government of Belgium, the data collection process was significantly disturbed. Initially, the researcher wanted to interview members of a catholic church in Brussels (*Eglise Sainte-Marie, Mère de Dieu*) as well as its Filipino priest. However, due to the restriction of religious gatherings, the researcher was not able to attend mass and search for potential participants by distributing or posting research open invitation flyers (Annex 2). Travel to other parts of Belgium was also restricted due to the pandemic so half of the interviews were conducted through videocalls which unfortunately diminishes the detection of non-verbal communication which is otherwise apparent in face-to-face dialogue.

7.3 Perspectives

Firstly, the relationship between Filipino resilience and HSB remains a topic of interest for future studies. The concept of resilience, the extraordinary willpower which allows an individual to overcome hardships, could be expanded upon by including other mindsets that contribute to this resilience, such as positivity, optimism, and the importance of community spirit. Does the prevalence of positivity and optimism make negative emotions taboo? Does the importance of demonstrating resilience make it difficult for Filipinos to admit that they are struggling to cope with adversity such as mental health problems? Do the strong community spirit and the trust built within these communities account for the overall preference for lay networks? How do these attitudes contribute to the generalized reticence to seek out MH care? Deeper and further exploration of the effects of resilience on the HSB of Filipinos could provide answers to these queries.

Secondly, to fully understand the dynamic of help-seeking, a new study with a sample consisting only of Filipino immigrants in Belgium who previously sought out MH care would be needed. Positive factors contributing to the HSB of Filipinos could be identified as well as a deeper understanding of the patterns, pathways, and dynamic processes of the individuals' HSB. A quantitative study could also be developed in order to assess the utilization of MH care facilities by the Filipino immigrants in Belgium.

It would also be interesting to analyze the causes of the slow but ongoing change in the societal perception of MH in the Philippines. What societal factors are influencing this awareness of the importance of MH and what could be done to encourage this ongoing momentum towards change? An evaluation of the Mental health act of 2017 would also be necessary to highlight what areas of the bill need improvement. Indeed, raising MH awareness is on its own insufficient for improving MH care in the Philippines if the lack of quality institutions to cater to the psychological needs of the population persists.

Lastly, having identified different barriers and socio-cultural determinants affecting the HSB of the Filipino community, it is only natural to proceed with another study on how to overcome these obstacles in order to improve accessibility to quality professional care. Strategies for promoting MH awareness, diminishing the stigma surrounding mental illness and improving the acculturation process could be examples of approaches in tackling the problem.

Chapter 8: Conclusion

The general objective of this research paper was to explore the perception of MH as well as the potential barriers and socio-cultural determinants that affect the HSB of the Filipino community in Belgium. The qualitative research using semi-directive interviews revealed interesting data shared by the participants who enriched the study with their experiences and opinions on the subject. The main findings showed that several factors such as *the “soft & severe” perception of MI, the subsequent stigmatization of MH and MH professionals, the concept of “hiya”, attribution theory, the concept of resilience, the lack of connection between Western practitioners and Filipino patients, the preference for lay network and low levels of acculturation* prevent, to a certain degree, members of the Filipino community in Belgium from seeking out mental health support.

Being the first of its kind, this study focuses on the MH perception of Filipino immigrants in Belgium and highlights snippets of reality experienced by these people when it comes to mental health. This first exploration of the subject is just a scratch on the surface of the profoundness and implications of the help-seeking behavior of this community. The intricate relationship between the different factors affecting HSB mentioned in this study as well as other unexplored factors reveal the complexity of the process in seeking out professional help for this specific population.

Even if MH care is available in a first-world country like Belgium, different cultures have specific needs and require different approaches in order to obtain quality care. Unfortunately, MH care is not a *“one size fits all”* process. For the Filipino people, socio-cultural background plays a big role in HSB. The specific characteristics of this community should not be overlooked by Belgian healthcare. In fact, *reform 107* aims to establish a community-based approach in MH care. Isn't taking into account the cultural differences in the community one of the core values of community mental health?

This study is the result of a year-long academic requirement in obtaining a master's degree in Public Health. One year is a short lapse of time in tackling a social theme of this nature. Further exploration, as mentioned in the perspectives portion of this paper, could deepen the understanding of the HSB of the Filipino community in Belgium and on how to address the problems that may arise.

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10. Annexes

10.1 Annex 1: Interview guide

Research project title: *Socio-cultural determinants and barriers to providing effective mental health services to the Filipino community in Belgium.*

Research investigator: Sarah Cordero

Introduction

Hello,

Thank you for accepting to participate in this research study and for generously sharing your precious time.

Let me introduce myself, I am a Filipino-Belgian student currently studying my master's in public health at UCLouvain in Brussels. For my masteral thesis, I am conducting a study on the “Socio-cultural determinants and barriers to providing effective mental health services to the Filipino community in Belgium”. The study aims to identify the eventual barriers that the Filipino community may have in seeking mental health care.

Rest assured, the data gathered will be strictly confidential and anonymous. It shall only be used for analysis purposes during the study. Here is an interview consent form that you need to sign before partaking in this study. (*hand out document*)

During the interview, a recorder app on my smartphone will record our conversation. It will only be used for transcript purposes. Feel free to interrupt the recording if you deem the questions to be inappropriate or you wish not to answer. All the information shared today are strictly confidential and anonymous.

Once I am done writing the full transcript of the interview, this will be sent to you for your reviewal. If you have any edits to apply, please contact me through my e-mail address.

Interview proper

Q: Do you have any questions concerning the proceedings of the interview?

Part 1: Introduction + Internal barriers and socio-cultural determinants

Q: Could you tell me a little about yourself?

- Educational background
- Occupation
- Age
- Family situation – social capital
- Religious affiliations
- Gender
- Education
- Origin: are parents both Filipino?

Q: May you briefly talk about your personal history concerning your immigration process?

- Age when the participant left the Philippines
- In what circumstances the participant immigrated / purpose of immigration
- Trajectory of immigration: is Belgium the first country of destination?

Q: How did your acculturation process/adaptation period take place during the first two years of being in Belgium?

Part 2: The perception of MH

Q: How do you perceive mental health?

Q: What is your opinion on mental health professionals such as psychologists or psychiatrists?

Q: How valuable to do you consider mental health?

- In contrast to physical health?

Part 3: External barriers and socio-cultural determinants

Q: Administratively wise, how easy is it for you to access mental health care if ever you or someone you know is in need of help?

Q: In terms of priority in finances, what place does mental health occupy?

Q: How fluent are you in French/Dutch?

- Does the language barrier affect your willingness to seek out mental health care?

Q: What beliefs did you have concerning mental health growing up in the Philippines?

- How do they impact you today?

Q: What role does family reputation have in your life?

- How would you react in a situation where there is mental disease stigma towards you or a member of your family?

Q: What implications do your religious beliefs and religious leaders have on mental health?

Q: In 2017, The Mental Health Act was signed by the president. Have you seen any changes in the perception of Mental Health of your family and friends living in the Philippines?

Q: How does the *utang na loob* (giving back culture) of the Philippines affect your mental health as a Filipino immigrant living in Belgium?

Part 4: The mental health help-seeking behavior

Q: How do you deal with times of emotional distress?

Q: How likely are you going to seek out professional care if you or someone in your family display signs of mental health illness?

Q: What would help you take a step forward in seeking out mental health care if ever you are in need?

Q: Would you like to add anything else about this topic?

That was my last question for this interview. Thank you again for your time and for sharing your views. I will send the full transcript as soon as I am done. It was a pleasure meeting you.

10.2 Annex 2: Research open invitation for participants



Hello, I am a Filipino-Belgian student currently studying my **master's in public health at UCLouvain** in Brussels. For my masteral thesis, I am conducting a study on the **social representations regarding mental health of the Filipino community in Belgium.**

I am inviting all people who match all of the following criteria: **English-speaking individuals who are 18 years of age or older ; a first-generation Filipino immigrant who grew up in the Philippines ; an individual who has a legal status in the country as a regular immigrant and has been living in Belgium for minimum two years.**

It would be a pleasure to meet and interview you concerning my thesis subject on the perception of mental health. The study aims to identify the help-seeking behaviour of the Filipino community towards mental health care. Rest assured, the data gathered will be strictly confidential and anonymous. It shall only be used for analysis purposes during the study.

If you are willing to participate please suggest a day and time that suits you and I'll do my best to be available.

If you have more questions, feel free to contact:

Name of researcher: Sarah Cordero; +32.498.43.00.05; sarah.cordero@student.uclouvain.be

Research supervisor: Nataly Filion; nataly.filion@uclouvain.be

10.3 Annex 3: Interview Consent Form



Interview Consent Form

Research investigator: Sarah Cordero

Research Participants name:

The interview will take 30 minutes to an hour. We don't anticipate that there are any risks associated with your participation, but you have the right to stop the interview or withdraw from the research at any time.

Thank you for agreeing to be interviewed as part of the above research project. Ethical procedures for academic research undertaken from UCLouvain require that interviewees explicitly agree to being interviewed and how the information contained in their interview will be used. This consent form is necessary for us to ensure that you understand the purpose of your involvement and that you agree to the conditions of your participation. Would you therefore read the accompanying information sheet and then sign this form to certify that you approve the following:

- the interview will be recorded, and a transcript will be produced
- you will be sent the transcript and given the opportunity to correct any factual errors
- the transcript of the interview will be analysed by the researcher investigator
- access to the interview transcript will be limited to the researcher investigator and academic colleagues and researchers with whom he might collaborate as part of the research process
- any summary interview content, or direct quotations from the interview, that are made available through academic publication or other academic outlets will be anonymized so that you cannot be identified, and care will be taken to ensure that other information in the interview that could identify yourself is not revealed
- the actual recording will be destroyed
- any variation of the conditions above will only occur with your further explicit approval

Quotation Agreement

I also understand that my words may be quoted directly. With regards to being quoted, please initial next to any of the statements that you agree with:

	I wish to review the notes, transcripts, or other data collected during the research pertaining to my participation.
	I agree to be quoted directly.
	I agree to be quoted directly if my name is not published and a made-up name (pseudonym) is used.
	I agree that the researchers may publish documents that contain quotations by me.

All or part of the content of your interview may be used;

- In academic papers, policy papers or news articles
- On our website and in other media that we may produce such as spoken presentations
- On other feedback events
- In an archive of the project as noted above

By signing this form, I agree that;

1. I am voluntarily taking part in this project. I understand that I don't have to take part, and I can stop the interview at any time;
2. The transcribed interview or extracts from it may be used as described above;
3. I have read the Information sheet;
4. I don't expect to receive any benefit or payment for my participation;
5. I can request a copy of the transcript of my interview and may make edits I feel necessary to ensure the effectiveness of any agreement made about confidentiality;
6. I have been able to ask any questions I might have, and I understand that I am free to contact the researcher with any questions I may have in the future.

Printed Name

Participants Signature

Date

Researchers Signature

Date

Contact Information

This research has been reviewed and approved by the Catholic University of Leuven. If you have any further questions or concerns about this study, please contact:

Name of researcher: Sarah Cordero

Tel: +32498430005

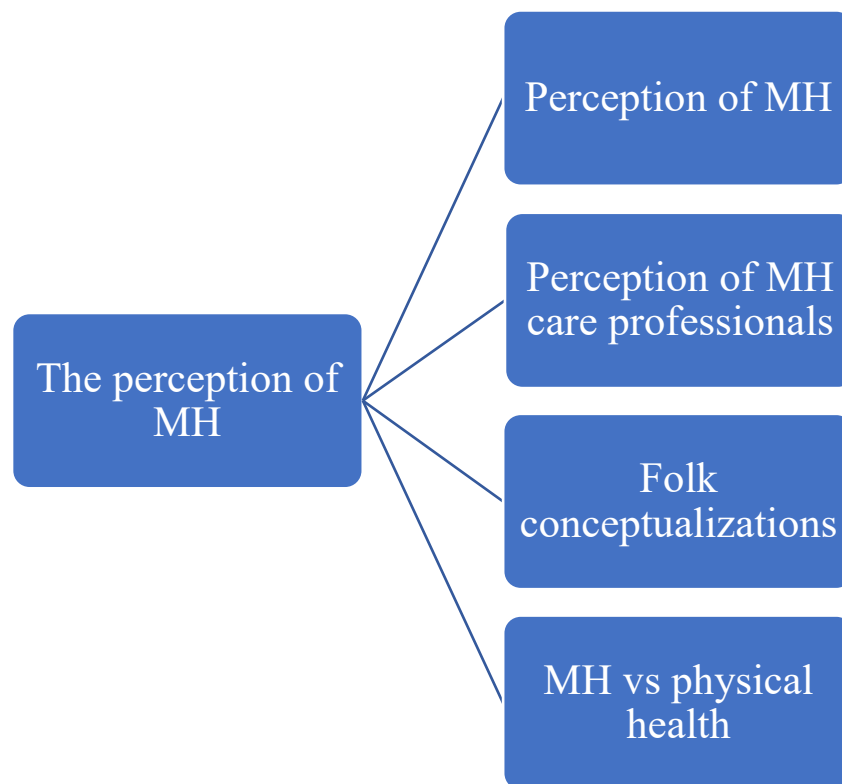
E-mail: sarah.cordero@student.uclouvain.be

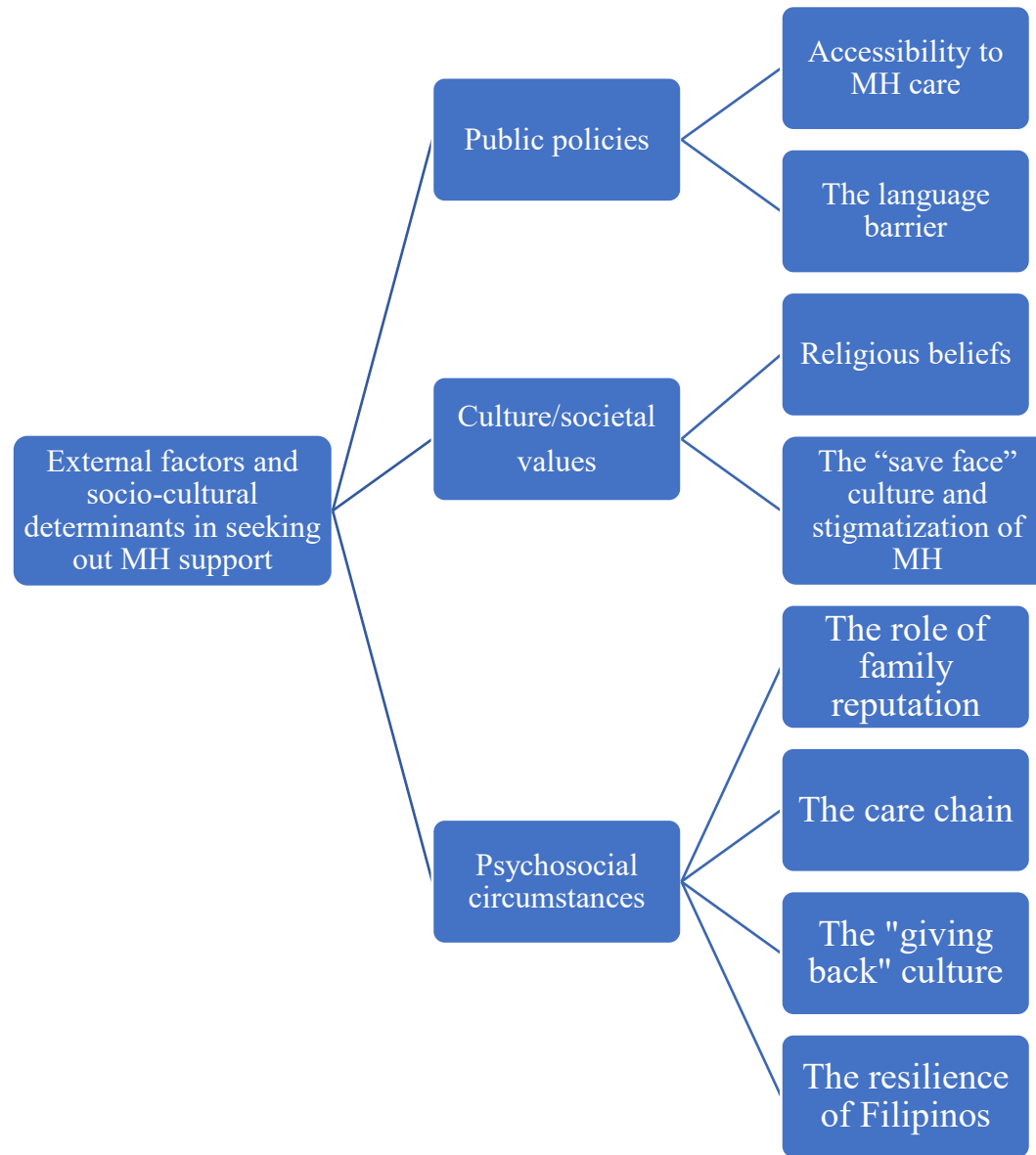
You can also contact the research supervisor: Nataly Filion

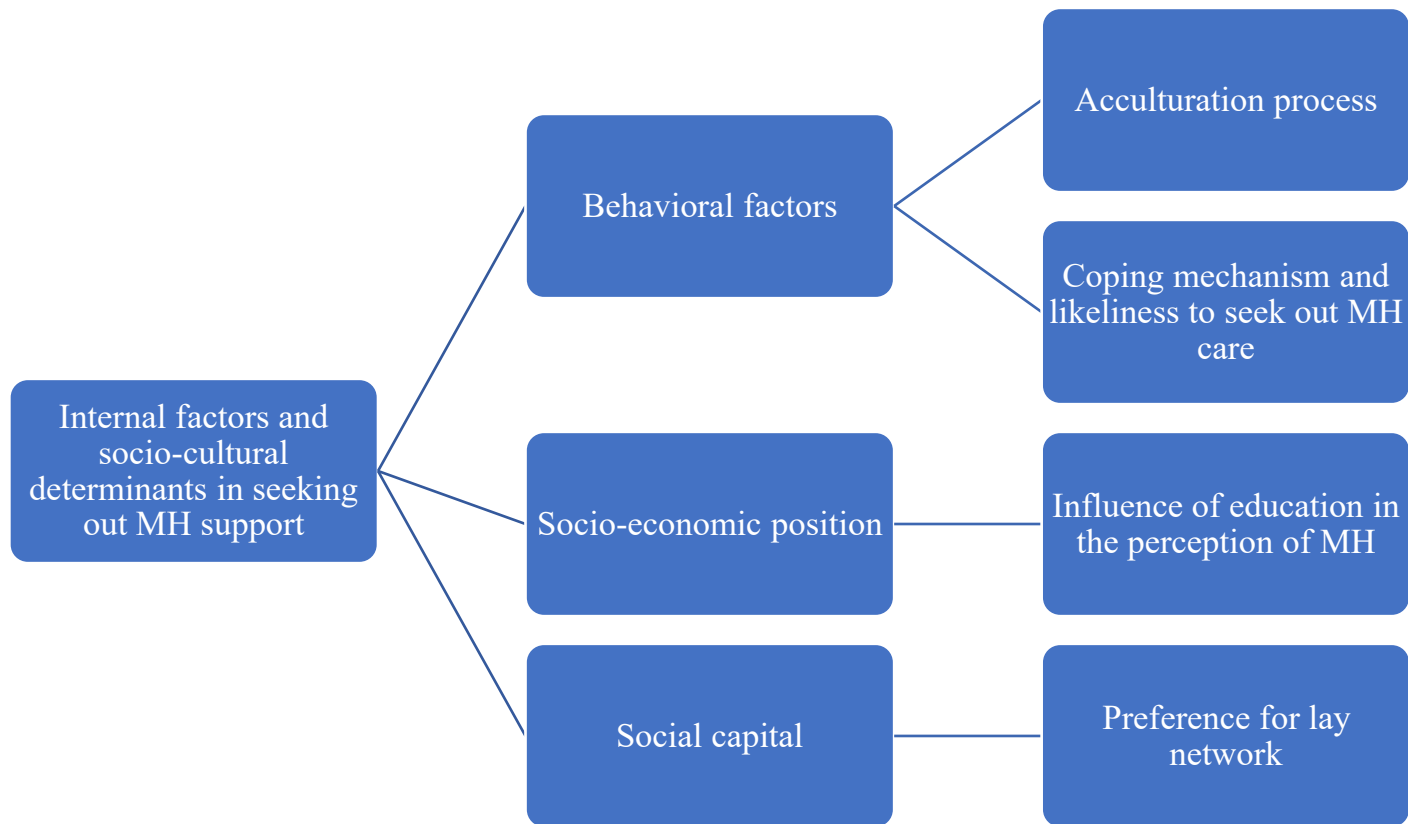
E-mail: nataly.filion@uclouvain.be

(Reference template : (*Interview_Consent_Form.Pdf*, n.d.)

10.4 Annex 4: Thematic social map







10.5 Annex 5: Social media posts promoting MH awareness in the Philippines

