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Cultural correlates of depression among Turkish immigrant and German women:
Implications for psychotherapeutic practice with Turkish immigrants

vorgelegt von
Nazlı Balkır

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Dekan: Prof. Dr. Klaus Fiedler
Berater: Prof. Dr. Sven Barnow

Erklärung

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ii. List of publications

The current dissertation is based on the following publications, which are referred to by their Roman Numerals in the Appendix.

I. Balkir, N.*, Arens, E.A.*, Wolff, C., Barnow, S. (in review). Der Zusammenhang zwischen Selbstkonzept und psychischer Belastung bei türkischen und deutschen Frauen mit Depression: Implikationen für die psychotherapeutische Arbeit mit türkischen Migranten. *Psychiatrische Praxis*.

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II. Balkir, N., Arens, E.A., Barnow, S. (2012). Exploring the relevance of autonomy and relatedness for mental health in healthy and depressed women from two different cultures: When does culture matter? *International Journal of Social Psychiatry*. Retrieved from <http://isp.sagepub.com/content/early/2012/04/16/0020764012441428>,

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III. Arens, E.A., Balkir, N., Barnow, S. (in review). Ethnic variations in emotion regulation: Do cultural differences end where psychopathology begins? *Journal of Cross-Cultural Psychology*.

IV. Balkir, N. (in press). Mental illness models and help seeking behaviors among Turkish immigrant patients in Europe. In Barnow, S., Balkir, N. (Eds.). *Cultural Variations in Psychopathology: From Research to Practice*. Göttingen: Hogrefe Publications.

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iii. Summary

Over the last decades, Germany has become an immigration country hosting 7.3 millions international immigrants – people who left their homes for a better quality of life (German Federal Statistics Office, 2008). Yet, a large literature suggests that migration and acculturation stress have negative effects on mental health and are associated with a higher risk for common mental disorders, such as depression and anxiety (e.g. Bhugra, 2003). As representatives of the largest immigrant group in Germany, Turkish immigrants likewise exhibit higher prevalence of depression and anxiety disorders than the background population (e.g. Tydecks, Temur-Erman, Schouler-Ocak & Fydrich, 2009). However, it was also well demonstrated that this particular patient group is more likely to terminate the treatment prematurely and displays lower rates of treatment compliance compared to native patients (e.g. Calliess, et al., 2007). This reluctance for service utilization might be partially due to the fact that people from non-Western ethno-cultural backgrounds (e.g. Turkey) often have a different perception and comprehension of mental health and illness, which can be divergent from those found in Western societies (e.g. Germany). Such a mismatch often results in a detrimental discrepancy between the needs and expectations of immigrant patients and clinicians, which attenuate the communication and effectiveness of treatment and lead to unexplained high drop out rates (White & Marsella, 1982). In order to provide a continued provision of culture sensitive, high-quality, evidence-based mental health care, the advancement of researches exploring such sociocultural differences between the patients' and the clinicians' notions of mental health must occur.

In response to these problems, this dissertation aims to explore the interplay between culture and mental processes that associate with the etiology, maintenance and management of depression among Turkish immigrant and German women. This is to inform clinicians concerning culture specific correlates of depression among Turkish patients so as to enable them to present interventions that fit the needs and expectations of this particular patient group. To this aim, at the first instance, a conceptual framework was provided for a brief examination of depression in

cultural contexts. Subsequently, the section on the psychological consequences of culture sets the stage for the discussion of the ways in which cultural differences can be organized into tangible and measurable patterns and how these patterns interact with psychological processes and thus mental health.

There is some evidence that cultural orientations have implications for psychological processes, such as self-concepts, sources of motivation, emotional expression and attribution styles (e.g. Oyserman, Coon & Kemmelmeier, 2002). Correspondingly, a large body of clinical research demonstrates that these psychological processes are also associated with depressive experience and present important targets of psychotherapeutic interventions. Taking this into account, the next four sections question the impact of culture on such psychological processes (e.g. self, motivation, emotion, attribution/reasoning) as well as on the ways in which they are related to the experience and management of depression. To this end, existing empirical evidence and the studies of our research team were brought together.

Accordingly, the following section on the self and culture aims to explore whether the relationship between different aspects of the self and depressive experience vary as a function of cultural orientation. Given that the association between psychopathology and different aspects of the self might vary as a function of culture, these variations might lead to differences in what people are motivated to achieve for maintaining self-worth, and thus mental health. Hence, the next section on autonomy and relatedness in cultural context deals with whether culture influences the sources of motivation and their relation to depressive experience.

Further, it is well established that cultures have different norms and expectations for emotional experience and expressions and vary in their expectations for regulating and expressing emotions. Given that emotion regulation is seen as a transdiagnostic approach to the etiology and maintenance of depression, the next section on culture and emotion regulation deals with how cultural factors affect emotion regulation strategies and how these strategies are associated with psychopathology. Finally, cultural modes also have implications for the individuals' attribution

style and causal reasoning. Therefore, the following section additionally examines how culture influences the problem of conceptualization (e.g. perceived causes of depression), which might also lead to cultural differences in the management of depression (e.g. treatment preferences).

So far, our results and conclusions points to some cultural similarities as well as variations between Turkish and German depressive patients concerning self-construals, sources of motivation and the patterns of emotion regulation strategies and how they are related to psychopathology. Furthermore, it was demonstrated that the ways in which Turkish patients conceptualize and manage depression differ to some extent from German patients. These findings have important clinical implications for the psychotherapy practice with Turkish patients. Our results and conclusions postulate that there is a need to extend mainstream Western psychotherapy approaches with culturally congruent interventions in order to meet the specific needs and expectations of immigrant patient groups, so as to acquire positive treatment outcomes. Thus, Turkish patients who have difficulties in initiating and maintaining contact with mental health providers may be more likely to remain in treatment if they encounter these culturally congruent aspects of the care process. Therefore, the last section is an effort to unpack the relevance of empirical findings for clinical practice and to propose culture sensitive therapeutic interventions, which may produce better treatment outcomes for Turkish patients.

1. Introduction

1.1. The problem

Today, the demographic profile of Germany's population is considerably more heterogeneous than it has ever been before. The increased inflow of immigrants has been stated as a key force in this contemporary demographic diversity in Germany, involving 7.32 million people (nearly 9% of the population), who are foreign or from foreign parentage (Carta, Bernal, Hardoy & Haro-Abad, 2005; German Federal Statistics Office, 2008). This proportion has been stated as the fourth highest in Europe (Eurostat, 2011). Numbering nearly three million, Turkish immigrants form the largest immigrant group (German Federal Statistics Office, 2008).

Migration is known to have significant effects on mental health. It is well established that migration and its related acculturation stress are associated with higher risks for mental disorders, such as anxiety and depression (e.g. Bhugra, 2003). This might be especially true for Turkish immigrants, as they are the largest but also one of the least integrated groups in Germany (Berlin Population Report, 2009). The strong clash of values confronts them with a particular high risk of social isolation and psychological distress compared to immigrants from other parts of Europe and background population (Bengi-Aslan, Verhulst & Crijnen, 2002, Levecque, Lodewyckx & Vranken, 2007). For instance, a recent study conducted in Germany indicated that Turkish patients in General Practice showed an increased number of psychological symptoms and a higher rate of mental disorders compared to German patients. Most prevalent were anxiety and depressive disorders. Notably, the study also indicated higher rates of depressive disorders among Turkish women immigrants (55 %) compared to their male counterparts (35 %) (Tydecks et al., 2009). This increased incidence of depression in women immigrants can be attributed to gender differences in biological and/or psychosocial functioning (Bengi-Aslan et al., 2002). Likewise, another epidemiological study conducted in Germany has demonstrated that affective disorders are the second most common diagnosis after schizophrenia / delusional disorders among Turkish immigrants (Koch, Hartkamp, Siefen & Schouler-Ocak, 2008). Despite the higher prevalence rates

of mental disorders, depression in particular, recent studies provide evidence that patients from this particular group are less likely to seek professional care, exhibit higher rates of drop out and lower rates of compliance to treatment compared to native German patients (Calliess, et al., 2007; Haasen, Lambert, Yagdiran & Krausz, 1997; Mösko, Schneider, Koch & Schulz, 2008).

In order to minimize the disability, meeting the deficits of treatment gap (i.e. the absolute difference between the prevalence of the disorder and the treated proportion of the individuals) is essential (Kohn, Saxena, Levav & Saraceno, 2004). However, the treatment process with minority patient groups brings additional difficulties for clinicians compared to the treatment of patients from the background population, particularly when the patient and the clinician are from different ethnic or cultural backgrounds. Patients from non-Western cultural backgrounds (e.g. Turkey) often have different notions and correlates of what is considered mentally ill/dysfunctional or healthy/functional, as defined by their own social and cultural context, which can be different from those found in Western societies (e.g. Germany) (Draguns, 1994; Mente, 1995; Sato, 2001).

As might have been expected, culture is not only a characteristic of the patients. The notions concerning mental health held by clinicians are also a function of their own ethno-cultural background and professional training (Kirmayer, 2001; Kleinman, 1978). Such cultural differences often result in a detrimental discrepancy between problem conceptualization, needs and expectations of patients and of clinicians. This generally attenuates communication and effectiveness of treatment, and therefore leads to unexplained high drop out rates (White & Marsella, 1982). In support of this, empirical evidence suggests that patients are most satisfied and adhere to treatment, when their treatment provider recognizes and shares their problem conceptualization and presents interventions that fit their needs and expectations (Good & Delvecchio-Good, 1980; Kleinman, 1978; Lin & Lin 1978).

In order to prevent poorer health results for minority patients, the exploration of such sociocultural differences between patient and clinician must occur. Hence, the role of culture in the development, maintenance and management of mental disorders should be recognized as an

important step in improving mental health care for culturally diverse (Turkish) minority patients.

1.2. The aim of the current dissertation

In response to these problems, the current dissertation aims to explore the interplay between culture and mental processes that associate with the etiology, maintenance and management of depression among Turkish immigrant and German women. Its general goal is to address the relevance of such cultural variables for psychotherapeutic practice with Turkish minority patients suffering from depression. But before anything else, a conceptual framework for the examination of depression in cultural context, which guided the current dissertation, will be provided in the next section.

2. Conceptual framework: Etic vs. Emic approach

Depressive disorders are among the most prevalent diseases occurring worldwide (Chisholm, Sanderson, Ayuso-Mateos & Saxena, 2004). Depressive disorder or experience is viewed as a product of the interaction between biological, psychological and social factors (see Garcia-Toro & Aguirre, 2007 for a comprehensive review). From this perspective, depression is basically a result of neurochemical or hormonal imbalance (e.g. Rose, 2004), certain styles of thinking (e.g. Beck, 1983, 1987) and negative life events (e.g. Teicher & Jacobs, 1966). The view that numerous factors interact to produce depression dates back to the influential work of Engel who put forward the Biopsychosocial Model of Disease in 1977. However, the extent of the influence of cultural factors on depressive disorders has attracted an increasing interest of researchers in the field of cross-cultural psychiatry/psychology and anthropology during the past few decades. The main debate in the field of cross-cultural psychiatry/psychology took place between the advocates of two different epistemological approaches to depression: biological universalism and cultural relativism, both of which are based on the theoretical rationales of the etic and emic approaches respectively (Kleinman, 1988; Fabrega, 1989; Thakker & Ward, 1998).

The etic approach assumes that mental disorders are similar and valid around the world, regardless of culture as conceptualized by biomedically based psychiatry. On the other side, the

emic approach advocates that Western psychiatric categories cannot be applied across cultures and acknowledges the profound effect of culture on the experience, expression, diagnosis and management of mental disorders as conceptualized by medical anthropology (Littlewood, 1990; Bhugra & Mastrogianni, 2004; Patel, 2001). In order to overcome the limitations of both of these approaches, this dissertation attempts to integrate the concepts and methods (quantitative and qualitative measurements) of both approaches, which is, as Patel (2001) suggests, required for psychiatric/psychological research to be “culturally and biologically correct”. Nevertheless, it remains an empirical fact that culture is a key variable in the cross-cultural psychiatric/psychological research conducted, especially with patients originating from non-western, non-industrialized societies.

3. Cultural orientations and their implications for mental health

So what exactly is culture? There are probably as many definitions of culture as there are studies in its field. In the current dissertation, the term refers to a shared, learned, symbolic system of values, beliefs and attitudes that shapes and influences perception and behavior (Marsella & Sartorius, 1985; Bhugra & Mastrogianni, 2004). Although culture is an abstract term and covers a broad field, it was widely agreed that it is learned and shared, dynamic and ever-changing (Kirmayer, 2001).

One of the most popular dimensions for comparing and contrasting cultural orientations is that of individualism-collectivism as proposed by Hofstede (1980). Although the basic principles of these dimensions have helped to explain differences among cultures, the assumption, that people in the same culture are largely homogeneous, has been widely criticized (Singelis, Triandis, Bhawuk & Gelfand, 1995). Still, Hofstede’s model was important because it organized cultural differences into tangible and measurable patterns, which promoted the understanding of how culture relates to psychological processes in a systematic manner (Oyserman et al., 2002).

Collectivism and individualism can be conceptualized as world-views that determine beliefs, attitudes, norms, roles, values, and behaviors in different cultures (Triandis, 1989, 1995).

These dimensions basically refer to how people define themselves and their relationships with others. On the individualist side we find societies (e.g. Germany (Hofstede, 1995; Schwarz, 1990)), in which the individuals view themselves as independent of one another. Likewise, according to Hofstede's definition (1980), individualism reflects a focus on rights above duties, a concern for oneself and one's immediate family, an emphasis on personal autonomy, self-fulfillment and personal accomplishments. On the other side, the main characteristic of collectivism is the conjecture that people are integrated into cohesive in-groups, often extended families, which provide affinity in exchange for unquestioned loyalty (Triandis, 1995). Similarly, Schwartz (1990) defines collectivist societies (e.g. Turkey (Hofstede, 1995; Schwarz, 1990)) as communal societies characterized by mutual obligations and expectations based on ascribed positions in the social hierarchy.

Given these definitions, presumable consequences of individualism and collectivism for psychology, such as self-concept, sources of motivation, emotional expression and attribution style are easily noticed (Oyserman et al., 2002). Moreover, these consequences of culture for psychology can provide a basis for cultural variations in the mental processes that associate with the etiology, maintenance and management of depression, particularly among Turkish immigrant and German native patients.

First, concerning self-concept, both cultural dimensions value personal traits that reflect their predominant goals and thereby assign different components of the self as central aspects of identity (e.g. independence vs. interdependence) (Guisinger & Blatt, 1994, Markus & Kitayama, 1991, 2003; Smith, 1994). Therefore, members of individualistic and collectivistic societies may differ in personality (selfhood) characteristics, which they need to maintain for a positive view of the self. Consequently, the relationship between different aspects of the self and depressive experience may vary as a function of cultural orientation. Second, this can also lead to cultural variations in what people are motivated to achieve (e.g. sense of autonomy vs. relatedness) in order to maintain self worth and thus mental health (Kagitcibasi, 2005; Sato, 2001). It can

therefore be expected, that culture may influence the sources of motivation and their relation to depressive experience. Third, individualism implies that attainment of personal goals and open emotional expression are important sources of well-being and life satisfaction (Oyserman et al., 2002; Trommsdorff & Rothbaum, 2008). In contrast, in collectivism, the carrying out of social roles and obligations and the avoidance of failures in these domains are seen as important sources of life-satisfaction. So, norms and values constrain open and direct expression of personal feelings in order to ensure in-group harmony (Kim, 1994; Kwan, Bond & Singelis, 1998; Markus & Kitayama, 1991). Accordingly, it might be that the frequency of the use of expressive suppression (i.e. one of the strategies to regulate emotions) and its implications for depressive experience can vary as a function of cultural orientation. Finally, in individualistic cultures, attribution style and causal reasoning are generally directed toward the person rather than the situation or social context. In collectivistic cultures, social context, situational restraints and social roles are prevalent in causal reasoning (Choi, Nisbett & Norenzayan, 1999; Miller, 1984; Morris & Peng, 1994; Newman, 1993). Correspondingly, it is presumable that culture powerfully influences problem conceptualization (e.g. perceived causes of depression), which can also lead to cultural differences in the management of depression (e.g. treatment preferences).

Are these theoretically derived implications of culture for depressive experience verified in empirical literature? Empirical findings together with the studies of our research team included in the current dissertation will be presented within the next sections in order to answer this question. Finally, implications of the empirical findings for psychotherapy practice with culturally diverse (Turkish) minority patients will be briefly discussed in the last section.

3.1. The self as a cultural product: Implications for depression

Several studies have demonstrated that a major cultural influence on depressive experience is the concept of self or personhood as shaped by a particular cultural orientation (Bebbington, 1993; Jenkins, Kleinman & Good, 1990; Kleinman & Good, 1985). The self has been conceptualized within a social-cognitive framework as a manifold, dynamic system of

constructs—a constellation of cognitive schemas (Kihlstrom & Cantor, 1984; Salovey & Rodin, 1985; Segal, 1988). According to Beck’s seminal cognitive theory (1983, 1987), depression is caused by negative depressogenic cognitive schemata that predispose an individual to become depressed when stressful events or losses occur. These depressogenic cognitive schemata involve a negative outlook on the self, the future and the world. As defined by theory and numerous researches on depression, self-view plays a crucial role in the development and maintenance of depression. However, it has been widely acknowledged by cross-cultural researchers, that the nature of the self is culturally constructed (Derlega, Cukur, Kuang & Forsyth, 2002; Lam & Zane, 2004; Morling & Fiske, 1999; Kitayama, Markus, Matsumoto & Norasakkunkit, 1997). The underlying notion of cross-cultural perspective suggested in this section is, that components of self-system from which people derive their feelings of self-worth, self-esteem, that is to say, a positive view of their selves, vary as a function of cultural context (Markus & Kitayama, 1994).

In Germany “*Jeder ist sich selbst der Nächste*” (everyone takes care of himself). In Turkey “*Sürüden ayrılanı kurt kapar*” (stragglers are headed for trouble). Such culture specific proverbs reflect different notions with regard to views of self in relation to others. The German example sustains an individualistic model of a person as endorsed by the theories of personality and social psychology in the West (Cross, Gore & Morris, 2003; Markus & Kitayama, 1991). This model of the person shapes an individual’s self-view, resulting in the development of an independent self-construal (Markus & Kitayama, 1991). As can be seen in the Turkish example, the individualistic, independent model of the self fails to describe the self-concepts of all people. Cross-cultural research has revealed that members of many collectivistic cultures, such as Turkey, see the person as part of the social network, rather than as a unique individual. Therefore, members of such societies tend to construct an interdependent self-construal (Markus & Kitayama, 1991).

Given that long-standing Western/individualistic assumptions of the nature of the self does not apply to all cultures and that the conceptualization of the self has been shown to vary across

cultures, cross-cultural researchers have begun to examine the prevailing assumptions concerning the sources of mental well-being. Markus & Kitayama (1991, 1994; Kitayama & Markus, 2000) argued that the positive view of the self, which people need to maintain in order to derive feelings of self-worth, differs according to their self-construals. Individuals holding an independent self-construal sustain a positive view of themselves when they are in control, assert themselves and achieve success. For individuals with interdependent self-construals, maintaining a positive self-view requires fulfilling social obligations and maintaining harmony with the group to gain social acceptance (Sato, 2001). In support of this argument, Christopher and colleagues (2010) have revealed that a highly interdependent self-construal is related to lower psychological distress in Asian-American university students, whereas in European-Americans a positive correlation was yielded. Independent self-construal was, however, found to be negatively correlated with psychological distress irrespective of cultural orientation (Christopher, D'Souza, Peraza & Dhaliwal, 2010; Kleinknecht, Dinnel, Kleinknecht & Hiruma, 1997). One explanation could be that these findings primarily come from studies that examined people with a bicultural identity, such as immigrants from collectivist cultures residing in individualistic societies (Yamada & Singelis, 1999). Given that culture is a non-static and ever-changing construct, for these people, in spite of their collectivist background, an independent self might serve as a functional way to fit in the Western context.

A cross-cultural evaluation of self-construals in Turkish immigrant and German depressive patients may provide an important contribution to the understanding of cultural variations in the relationship between self and depression. Possible cultural variations may have important implications for the content and design of culturally sensitive prevention and intervention techniques in clinical practice. To this aim, a recently submitted study (see Appendix I) by our research team has investigated cultural differences in the patterns of interdependent/independent self-construals and their relation to psychopathology in a sample of Turkish immigrant and German depressive women. To the best of our knowledge, this is the first study examining this

relationship in a clinical sample. Our results indicated that Turkish patients scored significantly higher in interdependence. However, both groups exhibited similar levels of independence. Accordingly, there were no significant cultural differences in the associations between independence and psychopathology (i.e. overall psychopathological complaints, depressivity, negative affect). In both groups of patients, the association between psychopathology and an independent self-construal tended to be negative. Given that Turkish patients residing in Turkey were not included as a third comparison group, it is not, however, possible to make clear assumptions whether this negative association between independence and psychopathology exists universally or results from Turkish immigrant patients' bicultural identity. Furthermore, there is also some evidence that cultural variations diminish in the presence of psychopathology (Marsella, 1980). The positive impact of independence in Turkish patients might be due to their severe psychopathology as well. Although the aforementioned studies (Christopher et al., 2010; Kleinknecht et al., 1997) yielded a negative association between independence and mental distress among healthy immigrants, one should keep in mind that these specific studies drew samples from young, highly educated and privileged university students, who are presumed to be more integrated in the "popular" culture. Therefore, questions concerning the generalizability of the findings for poorly educated, less integrated immigrants, as is the case with Turkish immigrants in Germany, remain to be explored. The fact that the study did not include healthy samples prevents us to make clear assumptions. Therefore, the next two studies presented in this dissertation (Appendix II, III) also included healthy Turkish immigrant and German women for further exploration.

Be that as it may, a higher level of interdependence was associated with lower levels of psychopathology for Turkish patients, whereas the reverse was true for German patients in our first study. A similar pattern was also evident in the study by Caldwell-Harris and Ayçiçeği (2006). By comparing a Turkish and an American student sample, the authors investigated cultural variations in the relationship between psychopathology and an allocentric (i.e. tradition, conformity and sociability oriented persons) or idiocentric personality style (i.e. competence,

hedonism and autonomy-oriented people). Similar to the interdependent self-concept in our study, allocentric style was related to a better mental well-being in the Turkish sample but found to be a risk factor for the American sample. These results provide evidence that the relationship between the interdependent view of the self and depression is moderated by the participant's ethno-cultural background (Draguns, 1990, Kagitcibasi, 1990; Sato, 2001).

In summary, cultural background determines the components of self-system from which people acquire their mental health to some extent. So far, these different components were clustered into two main groups (such as independent vs. interdependent self-construals) by Markus and her colleagues. Similar attempts were made in the past in order to cluster culturally endorsed components of self-system (e.g. Bakan, 1966; Chodorow, 1989; Mills & Clark, 1982). What is relatively recent is the integration of motivational and cognitive approaches involved to make this differentiation. Accordingly, two different self-systems have emerged as a result of this integration, namely, autonomy and relatedness.

3.2. Autonomy and relatedness in cultural context: Implications for depression

Autonomy refers to "self-rule", a sense of agency and control (Ryan and Connell, 1989). Relatedness, on the other hand, is characterized by the emotional and personal bonds between individuals. It has been theorized that individuals are motivated to achieve some sense of autonomy and relatedness (Sato, 2001). In other words, these terms may also be conceptualized as those components of the self-system that motivate individuals to satisfy their needs for autonomy and relatedness. Likewise, Ryan and Deci (Deci & Ryan, 1980, 1991; Ryan & Deci, 2000) proposed autonomy and relatedness as basic psychological needs, while satisfaction of each is assumed to represent the underlying motivational mechanism that energizes and directs people's behavior (Deci & Ryan, 2000). The need for autonomy promotes people to strive for being agents of their own life, having the capacity to make informed, uncoerced decisions (Vansteerkiste, 2004). The need for relatedness is the urge to interact, to be connected, and the experience of caring for others and be cared for by others (Baumeister & Leary, 1995).

The role of autonomy and relatedness has also been a topic of debate in etiological studies of depression. As supported by some empirical evidence, a well-known explanation for depression and its etiology suggests that a diminished sense of personal control (autonomy) and a lack of social support (relatedness) are two important pathways to disorder (Ryan, Deci, Grolnick & La Guardia, 2006; Beck, 1987; Ross & Mirowsky, 1989; Kasser & Ryan, 1993). In fact, there is also some evidence that the degree of autonomy and relatedness required for optimal functioning may vary as a function of cultural context (Cross, Gore & Morris, 2003; Iyengar & DeVoe, 2003; Markus & Kitayama, 1991; Oishi, Diener, Lucas, & Suh, 1999; Rudy & Grusec, 2001; Sato, 2001). Correspondingly, Kagitcibasi (1990) stated that in Western psychology, the development of a strong sense of autonomy is referred to as a prerequisite for healthy personality and moral and cognitive development. Therefore, more emphasis is given to the development and maintenance of autonomy rather than relatedness. In contrast, collectivistic cultural orientations place greater emphasis on relatedness (rather than autonomy). This might be due to the fact that strivings for autonomy may conflict with the social values of a collectivistic culture (e.g. development and maintenance of social bonds and group harmony) (Schwartz & Bardi, 2001; Singh, 2010).

In support of these assumptions, a recent study documented that Turkish immigrant parents in Germany tend to focus more on family interdependence and less on the promotion of autonomy in long-term socialization goals for their children than German mothers (Durgel, Leyendecker, Yagmurlu & Harwood, 2009). Moreover, another study demonstrated that autonomy significantly and positively correlated with life-satisfaction in many highly individualistic societies such as Germany, whereas it was not related to life satisfaction in most collectivistic countries, including Turkey. Also, relationship-orientation was not associated with measures of life satisfaction in individualistic nations, including Germany (Oishi et al., 1999). However, despite the centrality of autonomy and relatedness satisfaction for depression, to the best of our knowledge, no study has been conducted providing direct empirical evidence for this

association in healthy and depressed individuals from different cultures. Given that the self is seen as an independent, autonomous and differentiated entity in Western societies, psychiatric problems are usually conceptualized as deficits in intrapsychic structures (Douki, Zineb, Nacef & Halbreich, 2007). Accordingly, an emphasis on autonomy and de-emphasis of relatedness are also evident in contemporary Western psychotherapy approaches (e.g. Cognitive Behavioral Therapy) (see Coyne & Gotlib, 1983 for a similar criticism). Therefore, we postulate that the identification of possible cultural variations in the sources of motivation and its mental health outcomes has important implications for therapeutic interventions for Turkish immigrant patients.

In order to address this issue, our research group examined the relationship between autonomy/relatedness satisfaction and psychopathology in a sample of healthy and depressed first generation Turkish immigrant women residing in Germany and their natural-born German counterparts (see Appendix II). Our findings indicated that healthy German women benefited only from autonomy satisfaction, whereas relatedness and psychopathology were not related at all. In contrast, only relatedness satisfaction was associated with lower levels of psychopathology, but not autonomy, in healthy Turkish women. These results are in line with several studies (Durgel et al., 2009; Citlak, Leyendecker, Schoelmerich & Harwood, 2008; Kagitcibasi, 1990; Phaet & Claeys, 1993). However, they also contradict some investigations demonstrating a positive association between autonomy, independence and mental health in individuals who stem from collectivistic cultures (e.g. Christopgh et al., 2010; Chirkov, Ryan, Kim & Kaplan, 2003; Vansteenkiste, Zhou, Lens & Soenens 2005; Sheikholeslami & Arab-Moghaddam, 2010). This might be due to the fact that these specific studies drew samples from young, highly educated and privileged university students, who are more integrated into the “popular” culture in comparison and are therefore not very convenient for representing their culture as a whole. To the best of our knowledge, our study is the first to investigate the role of

autonomy and relatedness satisfaction in mental health for women from different cultures with low-middle socio-economic and educational backgrounds.

The cultural pattern mentioned above was, however, partially replicated in the depressed samples. Here, similar to healthy controls, the experience of relatedness was negatively associated with psychopathology only in Turkish, but not in German patients. Nevertheless, experience of autonomy was negatively associated with psychopathology in both groups. Why did Turkish women diagnosed with depression benefit from the experience of autonomy, while their healthy counterparts did not? Several explanations might stem from the clinical profile of our sample of Turkish depressive women suffering from moderate to severe depression and exhibiting very low levels of autonomy. First, a sense of controlling one's own life might reduce depression, as it might encourage problem solving and promote autonomy regarding stressor-related decisions. Second, there is some evidence that cultural variations in psychological processes decrease as psychopathology becomes more severe (Draguns & Tanaka-Matsumi, 2003). Since our patients were diagnosed mostly with moderate to severe depression, a different picture can be drawn regarding outpatient groups diagnosed with milder forms of depression. Therefore, further studies should examine cultural differences in mental health outcomes of autonomy in milder forms of depression also.

So far, our results indicated the ways in which individuals attain and maintain mental health through different construals of the self (independent vs. interdependent) and that different motivational goals sought (autonomy vs. relatedness) vary, to some extent, as a function of culture. Furthermore, there is also some evidence that cultural orientations toward independence/autonomy and interdependence/relatedness have different norms and expectations for emotional experience and expressions and vary in their expectations for regulating and expressing emotions (Ekman, 1972).

3.3. Cultural correlates of emotion regulation: Implications for depression

Emotion regulation is a transdiagnostic approach to the etiology and maintenance of

depression (Fairholme, Boisseau, Ellard, Ehrenreich & Barlow, 2009). Accordingly, this section is concerned with how cultural factors affect emotion regulation strategies, and how these strategies are associated with psychopathology. In this dissertation, emotion regulation “refers to the process by which individuals influence which emotions they have, when they have them and how they experience and express these emotions” (Gross, 1998, p. 275). Although there are several strategies to examine, this section will focus on two different strategies: Cognitive reappraisal (i.e. reframing emotion-eliciting events so as to change the emotional impact) and expressive suppression (i.e. masking signs of inner emotional states). This focus is due to the fact that cognitive reappraisal and expressive suppression target the main objectives of emotion regulation, which are emotional experience and expression (Gross, Richards & John, 2006).

The use and mental health outcomes of these emotion regulation strategies, expressive suppression in particular, are presumed to be determined by cultural value orientations concerning self, interpersonal relationships and emotions (Haga, Kraft & Corby, 2009; Matsumoto et al., 2008a, 2008b; Trommsdorff & Rothbaum, 2008). For instance, in a recent cross-cultural study conducted in 23 countries (Matsumoto et al., 2008b), individualism, egalitarianism and autonomy have been shown to be associated with more frequent use of reappraisal and less suppression due to the fact that some cultures encourage assertiveness and free and open emotional expression. On the other hand, collectivism, hierarchy, and relatedness are shown to be positively associated with the use of suppression due to the fact that some cultures discourage assertiveness and encourage self-regulation in order to maintain social order and harmony (Matsumoto, 2007). These results are also supported by evidence from facial expression literature (e.g. Ekman & Friesen, 1975; Matsumoto, Takeuchi, Andayani, Kouznetsova & Krupp, 1998), illustrating that individuals with collectivistic backgrounds tend to control (e.g. mask or neutralize) the display of their feelings more than do samples from individualistic societies. It is well established and in line with these arguments that the consequences of emotional suppression for mental health are also culture dependent. For instance, in studies conducted with samples from Western individualistic cultures

(e.g. Euro-American or European) cognitive reappraisal was shown to be related to better mental health, whereas the reverse was true for expressive suppression (Amstader, 2008; Gross & John, 2003; Greenberg & Stone, 1992; Janof-Bulman, 1992), which is more likely to be employed by depressed individuals (Gross & John, 2003). In contrast, it has been revealed that in collectivistic cultures emotional suppression was used more frequently (Gross & John, 2003) and was related to lower levels of negative emotion and better mental health (Butler, Lee & Gross, 2007, 2009; Consedine, Magai & Horton, 2005) than in individualistic cultures.

The positive mental health outcomes of emotional suppression in collectivistic cultures have been shown to be due to a flexible use of suppression together with other emotion regulation strategies, such as cognitive reappraisal (Matsumoto et al., 2001, Matsumoto et al., 2003, Matsumoto, LeRoux, Bernhard & Gray, 2004). For instance, Matsumoto and colleagues (2008) have shown that in collectivistic cultures, which value relatedness and hierarchy, suppression and reappraisal were positively correlated, whereas in individualistic cultures, valuing autonomy and egalitarianism, suppression and reappraisal tended to be negatively correlated. Moreover, the authors postulated that the initial use of suppression followed by a switch to cognitive reappraisal in collectivistic cultures allows individuals to select the socially proper emotion to express. In this way, they maintain social order and may thus benefit more from the use of expressive suppression. This flexible use of suppression and reappraisal might be especially crucial for immigrants, due to the fact that these individuals need to adopt different cultural norms of emotional expression. In support of this, immigrants who have an extended repertoire of emotional regulation strategies were shown to be less depressive and better integrated (Eng, Kuiken, Temme & Sharma, 2005; Matsumoto, Hirayama & LeRoux, 2006). Given that depression is characterized by a restricted repertoire of emotion regulation strategies (e.g. rigid and exclusive use of suppression), the following question arises: Can expressive suppression also have positive mental health outcomes in immigrants with clinical depression, who are assumed to use suppression more rigidly? Unfortunately, current literature lacks empirical evidence addressing this question. To this aim, a

recent study (see Appendix III) conducted by our research team investigated the frequency of expressive suppression and cognitive reappraisal, and the resulting implications for psychopathology among healthy and depressed Turkish immigrant and German women. Accordingly, our main focus was to explore whether consequences of expressive suppression for mental health are moderated by cultural origin, and whether this cultural moderation of expressive suppression is also evident in clinical samples of patients with clinical depression.

Our results indicated that expressive suppression was associated with lower levels of psychopathology in healthy Turkish, but not in healthy German women. Furthermore, Turkish women reported equal use of suppression and reappraisal. However, reappraisal was the predominant strategy among German women. It was illustrated that the positive mental health outcomes of expressive suppression in Turkish women could be attributed to their more flexible use of emotion regulation strategies (i.e. additional use of cognitive reappraisal). These results are in line with several cross-cultural studies indicating that, in contrast with people with individualistic cultural values, individuals from collectivistic cultures are characterized by a more flexible use of emotion regulation strategies, which enables them to switch between the expression and suppression of emotions (Bonanno, 2005; Bonanno, Papa, Lalande, Westphal & Coifman, 2004). However, cultural differences in mental health outcomes of suppression were absent in depressed samples. Both groups, depressed Turkish and depressed German women, exhibited a rigid use of expressive suppression (without reappraisal) and suppression was positively associated with psychopathology in both groups. Our results are in line with other research, showing that depression is not related to specific emotion regulation strategies (e.g. frequent use of expressive suppression), but that it is rather associated with an inflexible use of specific strategies (e.g. rigid use of suppression) and the disability to adjust emotional responses to changing situations (Joorman & D'Avanzato, 2010). Therefore, it can be concluded, especially for Turkish depressed patients, that what relates to a poor mental health is not the presence of suppression, but rather the absence of cognitive reappraisal. These results have important

implications for mainstream Western psychotherapeutic interventions, which are usually designed to encourage an open expression of emotion in patients, (e.g. open expression of emotions in interpersonal conflicts), although this kind of directness may not be socially acceptable in a collectivist (e.g. Turkish) cultural context.

Furthermore, cultural variations regarding norms related to emotional expression have potential influence on the experience and expression of forms of dysphoria (i.e. an emotional state marked by anxiety, depression, and restlessness), such as depression. It has been shown that individuals from cultural orientations, which restrain open emotional expression, are often condemned when expressing emotional problems; their problems are not viewed as appropriate issues to be brought to mental health care. Instead, they are rather viewed as problems which are to be brought to the attention of a family member, an elder or someone who is familiar with the network of social ties (Kirmayer, Robin, Dworkind & Yaffe, 1993). Thus, it is presumable that cultural norms for emotion regulation (expression vs. suppression) might have further implications for help-seeking behavior, which is an emerging topic subjected to cultural psychology due to low rate utilization of mental health care services by minority patients.

3.4. Cultural variations in causal attributions for depression: Implications for depressive experience and treatment preferences

As is the case with most ethnic minority groups, several studies have reported low service utilization and premature treatment termination among Turkish immigrant patients. However, it is still not sufficiently understood why many Turkish immigrants are reluctant to use the mental health care system (Calliess et al., 2007; Haasen et al., 1997; Mösko et al., 2008).

The Explanatory model perspective (Kleinman, 1978) has directed attention to eliciting the cognitive aspects of patients' conceptualization of their illness in order to unravel the correlates of their choices for treatment and responses to clinical interventions. The Explanatory model concerns the patient's understanding of the cause, severity, and prognosis of an illness (i.e. what is the cause? how serious is it?); the expected treatment (i.e. what can be done? who can heal it?);

and how the illness affects his or her life. In essence, it is the conceptualization of the problem and its solution for the patient, which is, to a large extent, culturally determined (Patel, Musara, Butau, Maramba & Fuyane, 1995; Shankar, Saravanan & Jacob, 2006; Kleinman, 1988.). Such model might be a useful tool to gain insights into cultural differences in conceptual models and management of depression so as to scrutinize ethnic disparities in utilization of mental health services.

Causal attributions (i.e. attributions that patients make concerning the causes of their health problems) are suggested to present a pivotal cognitive process in the construction of the explanatory model of illness (Kirmayer, Young & Robbins 1994). Recall that theoretical literature associates individualism with person-focused and decontextualized causal reasoning and collectivism with contextualized and situated reasoning (Choi et al., 1999; Miller, 1984; Morris & Peng, 1994; Newman, 1993). Correspondingly, several psychiatric/psychological and anthropological studies have reported cultural variations in causal attributions about mental distress (see Marsella & White, 1982 for review). For instance, among Europeans, the causes of mental illness is more likely to be located within the individual, whereas many non-western and minority cultures with a collectivistic background cite social relationships as causal (Landrine & Klonoff, 1992; Marsella & White, 1982). In support of this argument, some studies conducted with Turkish psychiatric outpatients in Turkey (Karanci, 1986, 1993) have reported that these patients mainly attribute the cause of their disorder to interpersonal conflicts, conflicts with the current family, conflicts with the family of origin, marital problems, personal characteristics, blame on others, problems at work, fate and bad luck. Among all, conflicts with the current family were reported most frequently. In contrast, Townsend (1975) demonstrated in a cross-cultural study that German patients regarded mental illness as biologically determined, whereas American patients believed that mental illness is a behavioral phenomenon.

Notably, the given literature also suggest that the patients' beliefs regarding what caused their illness have an impact on the decision whether or not to seek medical care, on their adherence to

treatment and their adjustment to prognosis (Hall & Tucker, 1985; Sensky, 1997). For instance, Foulks, Persons and Merkel (1986) have demonstrated that patients who endorse medical beliefs about the causes of their illness are more likely to seek help from medical sources and exhibit higher levels of compliance than the patients who hold non-medical beliefs.

Given that most of the Turkish immigrants in Germany came from (more) traditional rural areas of Turkey, were poorly integrated and had a strong commitment to the extended family and social milieu (Al-Issa & Tousignant, 1997), one can argue that the reluctance to seek professional help, premature treatment termination and low treatment adherence can be attributed to such cultural variations in conceptualizations of mental illness. Although there is considerable evidence demonstrating culturally diverse attributions among Turkish patients regarding cause of illness, the link to their choice for treatment providers was poorly investigated.

To address this issue our research team aimed to explore the ethnic differences in causal attributions on major depression and whether ethnicity or discrepant causal attributions are most relevant for treatment preferences (see Appendix IV). To this aim, Turkish immigrant and German depressive patients were interviewed with a semi-structured interview protocol for their beliefs concerning the factors responsible for their health problems (causal attributions) and the appropriate source for help. A qualitative content analysis procedure was employed through focus group discussions to classify the data into a number of categories that represent themes and patterns of patients' causal attributions and treatment preferences. This method was used to interpret the subjective data in a scientific manner. Causal attributions involved three main domains composed of social (interpersonal vs. non-interpersonal) psychological (personality, psychological trauma etc.) and biological (genetic/neurological, biomedical attributions) factors. No group difference was observed in adopting social factors as causes. However, compared to Turkish patients, Germans were far more likely to name psychological and bio-medical factors responsible for their health conditions. Concerning treatment, compared to Turkish patients, Germans were again far more likely to recommend professional treatment (e.g. psychotherapy,

medication, psycho-education, alternative therapies like relaxation or ergo) as the most valuable tool for recovery. On the other hand, compared to Germans, Turkish patients were more likely to recommend non-professional help sources (e.g. social support, self initiation).

Further, it has been shown that causal attributions (attribution to psychological and biological factors) mediate the relationship between ethnicity and preference of professional treatment resources. That is to say, the difference between Turkish and German depressive patients concerning the preference for seeking professional help could be explained by the differences in their attributions concerning the causes of depression (predominance of psychological and biological attributions in German patients).

Our findings clearly document the differences between popular Turkish and German lay conceptualizations concerning the causes and management of depression. In accordance with the view of Western medicine and according to most of the German patients, depression was regarded as a disease resulting from malfunctioning in biological and/or psychological processes and a breakdown in the social realm, which requires professional treatment. In contrast, Turkish patients usually conceptualized depressive experience as social/life problems or emotional reactions to situations resulting mainly from familial or social conflicts and did not have an inkling of the biopsychological facts. Thus, the Turkish patient group rarely considered professional treatment (e.g. psychotherapy, psychotropic drugs, psycho-education) as a valuable tool for recovery. Instead, the source for recovery was seen in the regaining of social harmony within the family and social environment. Not surprisingly, it has been reported that Turkish immigrant women in Amsterdam consulted social work facilities and women crisis intervention centers nearly 1.5 times more than mental health care services (Ten Have & Bijl, 1999). As Kirmayer and Sartorius also noted (2007), these results suggest that those patients are not only seeking mitigation of symptoms but also individually and socially meaningful explanations and psychosocial treatments for their illness.

4. Implications of the findings for psychotherapeutic practice with Turkish immigrant patients

So far, our results revealed some cultural similarities as well as variations between Turkish and German depressive patients concerning self-construals, sources of motivation (i.e. satisfaction of autonomy and relatedness) and the patterns of emotion regulation strategies and how they are related to psychopathology. Furthermore, it was established that the ways in which Turkish patients conceptualize and manage depression differ, to some extent, from German patients. These findings have important implications for psychotherapeutic work with Turkish immigrant patients.

First, similar to German patients, Turkish patients also benefited from the sense of an independent self and autonomy. Interdependence was associated with lower levels of psychopathology in Turkish patients, whereas the reverse was true for German patients. Furthermore, as expected, relatedness satisfaction was related to lower levels of psychopathology in Turkish patients, while no such correlation was observed in German patients. Our findings clearly present the significance of collectivistic values, such as social solidarity, collectivity and embeddedness for the mental health of Turkish patients. This directs attention to the fact that the individualistic approach of Western psychotherapy should be extended with collectivist principles when working with Turkish immigrants. More specifically, given that the self is deemed as an independent, autonomous and differentiated entity in Western societies, psychiatric problems are usually conceptualized as deficits in intra-psychic structures (Douki, et al., 2007). Consequently, conventional Western therapies (e.g. cognitive behavioral therapy) are often aimed to address the autonomy and intrapersonal development of the patient (e.g. promotion of self-efficacy, self-acceptance, self-management, etc.) (Dwairy & Van Sickle, 1996). However, it was established that Turkish patients also benefit from an interdependent self and a sense of relatedness. Therefore, the processing of interpersonal issues seems to be functional and necessary for this group (Dwairy, 1997; Dwairy & Van Sickle, 1996; Rezapour & Zapp, 2011). It seems crucial to address person-society conflicts in addition to intra-psychic conflicts so as to meet the needs of

this particular clientele and therefore acquire positive treatment outcomes. Additionally, although independence and autonomy were positively related to psychopathology in Turkish patients, one should consider that traditionally minded healthy Turkish women from rural backgrounds with low levels of education do not precisely benefit from a differentiated and autonomous self when it comes to mental health. Compared to people stemming from individualistic and Western societies, most traditional non-Westerners are more dependent on their families and autonomy or self-actualization is rarely accepted (Dwairy, 1997). Likewise, Fisek (1998) points out that Western therapists usually overlook the cohesive family structure of Turkish patients, which leaves very little room for the individuation of the person. Therefore, it is important to note that promotion of independence and autonomy without any consideration of its social counteractions might lead to conflictual family or social environments, with which these patients might be unable to cope (Dwairy, 1997).

A similar conclusion can be derived from our finding that yields a positive relationship between suppression and psychopathology in Turkish women. Traditional Western therapy approaches maintain the assumption that suppression of negative emotions is generally harmful and that open expression is the more adaptive strategy (Greenberg & Safran, 1989). Therefore, psychotherapeutic interventions are usually designed to encourage patients to openly express emotion in their everyday lives. However, one should keep in mind that expressive suppression can be functional for Turkish patients for maintaining their interpersonal relationships, as it was the case with healthy Turkish women. Moreover, it was indicated that the aforementioned positive consequences of expressive suppression in Turkish women were due to their additional use of cognitive reappraisal. This finding can lead to the conclusion that what relates to a poor mental health is not the presence of suppression *per se*, but rather the absence of cognitive reappraisal or the rigid and exclusive use of suppression. Hence, rather than discouraging suppression, promoting a more flexible use of emotion regulation strategies (e.g. additional use of cognitive reappraisal) in psychotherapy seems more fitting to the needs of this patient group. The therapists

should be aware that Turkish patients might benefit from expressive suppression to avoid social or familial conflicts; which are frequently reported as causes of their mental distress.

As already mentioned, most Turkish patients conceptualize depression as a social problem or an emotional reaction to situations resulting from a disruption in social/familial relationships. Unlike their German counterparts, they did not have an inkling of biopsychological causes. Therefore, instead of professional treatment, these patients' suggestions for management and health seeking emphasized self-management and social support. This highlights the importance of psychosocial treatment for this particular clientele. As noted before, without ameliorating familial or social conflicts, working mainly on personal conflicts or using medication alone would probably fail to achieve desired treatment outcomes. Accordingly, given these patients' group and family orientations, acknowledgement and inclusion of family members in the psychotherapy process (e.g. assessment and therapeutic goals/decisions) might bring better outcomes. For instance, there is some evidence that such biopsychosocial holistic approaches work quite successfully with patients from collectivistic non-western cultures (e.g. Egypt) (Okasha, 1993). A similar recommendation also came from some practitioners working with Turkish patients in Germany. Erim and Mustard (2002) highlighted the importance of extending classical Western individualistic treatment approaches with collectivist principles. This could be, for instance, on the one hand working with interpersonal conflicts and the involvement of family members in the therapy; on the other hand, encouraging patients' individuation and social relationships (e.g. through participation in regular activities in clubs or language courses) to promote their integration and, hence, their mental health.

5. Conclusions

Despite higher prevalence rates of mental disorders among Turkish patients, literature points to low service utilization and treatment adherence among this particular group. Consequently, there is an increasing need for continued provision of culture sensitive, high-quality, evidence-based mental health care. A major solution to enhance the quality of mental health care is the

advancement of researches on all aspects of the interplay between culture and mental health, including epidemiology, assessment, diagnosis, course, outcome treatment and prevention of psychopathology as well as appropriateness of the workforce and health services (Kirmayer, Rousseau, Corin & Groleau, 2008). To this aim, the current dissertation attempted to address both cultural differences and similarities regarding the psychological processes underlying mental health in healthy and depressed Turkish and German women. This was to inform clinicians concerning culture specific correlates of psychopathology so as to enable them to present interventions that fit the needs and expectations of this particular patient group. Thus, Turkish patients who have difficulties in initiating and maintaining contact with mental health providers may be more likely to stay in treatment if they encounter these culturally congruent aspects of the care process.

6. References

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7. Appendix

7.1. Appendix I

Title: Der Zusammenhang zwischen Selbstkonzept und psychischer Belastung bei türkischen und deutschen Frauen mit Depression:
Implikationen für die psychotherapeutische Arbeit mit türkischen Migranten

Autoren: Nazli Balkir*, Elisabeth A. Arens*, Carolin Wolff, Sven Barnow

*geteilte Erstautorenschaft

Institut: Abteilung für Klinische Psychologie und Psychotherapie, Psychologisches Institut, Universität Heidelberg

Zusammenfassung

Anliegen Die Untersuchung kultureller Unterschiede im Zusammenhang zwischen Selbstkonzept und psychischer Belastung.

Methode Insgesamt wurden 56 türkische und deutsche stationäre Patientinnen mit Depression untersucht.

Ergebnisse Bei türkischen Frauen war ein interdependentes Selbstkonzept mit einer niedrigeren, bei deutschen Frauen mit einer höheren psychischen Belastung assoziiert.

Schlussfolgerung In der psychotherapeutischen Arbeit mit türkischen Migranten spielen kulturell bedingte Unterschiede im Selbstkonzept eine wichtige Rolle für die Ableitung von Therapiezielen und Interventionen.

Schlüsselwörter

Selbstkonzept · Interdependenz · Independenz · türkische Migranten · Depression

The Link between Self-construal and mental distress in Turkish Migrants and German Women with Depression:

Implications for the psychotherapeutic work with Turkish Immigrants

Abstract

Objective The current study aims to analyze cultural differences in the patterns of self-construals (interdependent vs. independent) and their relation to mental distress in a sample of depressed Turkish migrants and German women.

Methods A total number of 56 in-patients with a diagnosis of major depression were compared in terms of self-construals and their relations to different aspects of mental distress.

Results Turkish patients exhibited a stronger interdependent self-construal compared to Germans, whereas no group differences were observed with respect to independence. While for Turkish patients a higher level of interdependence was associated with lower levels of mental distress, the reverse was true for German patients. However, there were no significant ethnic differences in the associations between independence and mental distress.

Conclusions The current study provides evidence that the relation between self-construal and mental distress is moderated by patient's cultural background. The findings have implications for integrating self-construals into psychotherapy practice with culturally diverse populations, in order to adjust therapy goals and intervention techniques.

Keywords

self-construal · interdependence · independence · Turkish immigrants · depression

Konsequenzen für Klinik und Praxis

- Bei türkischen Patienten ist ein interdependentes Selbstkonzept stärker ausgeprägt und im Gegensatz zu deutschen Patienten mit einer geringeren psychischen Belastung assoziiert.
- Es wird empfohlen, vor der Therapieplanung das Selbstkonzept der Patienten in der Anamnese zu erfassen.
- Für eine kultursensitive Versorgung von türkischen Migranten, sollten Interventionen zur Stärkung des independenten Selbstkonzepts (z.B. Selbstwirksamkeit) um Interventionen zur Stärkung des interdependenten Selbstkonzepts (z.B. systemischer Ansatz, kohäsive Familienstruktur als Ressource) ergänzt werden.

Einleitung

Laut aktuellem Mikrozensus 2010 leben in Deutschland insgesamt 15,7 Millionen Menschen mit Migrationshintergrund. Sie bilden damit einen Anteil von 19,3% an der Gesamtbevölkerung, wobei die Gruppe der Menschen mit türkischem Migrationshintergrund mit 2,5 Millionen die größte ethnische Minderheit in Deutschland darstellt [1]. Eine zunehmende Anzahl an Studien deuten auf eine erhöhte psychosoziale Belastung bei in Deutschland lebenden Menschen mit Migrationshintergrund hin [2-4]. Dabei zeigen epidemiologische Studien eine erhöhte Prävalenz psychischer Störungen insbesondere in der Gruppe türkischstämmiger Migranten, vor allem im Bereich affektiver und somatoformer Störungen [5-8]. Trotz der erhöhten psychischen Belastung ist die Inanspruchnahme psychotherapeutischer Versorgungsangebote von Migranten in Deutschland verhältnismäßig gering und die Einstellung gegenüber Psychotherapie vergleichsweise negativ [9-10]. Mösko und Kollegen (2008) untersuchten bei Patienten mit verschiedenen psychischen Störungen den Genesungsverlauf nach einem stationären Aufenthalt und fanden schlechtere Behandlungsergebnisse bei türkischen im Vergleich zu deutschen Patienten [11]. Insbesondere in den Bereichen allgemeine psychische Belastung, Depressivität und positive Erlebnisfähigkeit zeigte sich bei der türkischen Patientengruppe keine Verbesserung. Als mögliche Gründe für den schlechteren Behandlungserfolg vermuten die Autoren, dass bestehende westliche psychotherapeutische Behandlungsangebote keine kultursensitiven Interventionen beinhalten und sich nicht flexibel an unterschiedlichen soziokulturellen Ausrichtungen der Patienten orientieren, wie bspw. Soziokulturell geprägte Selbst- und Krankheitskonzepte, sowie kulturell bedingte Unterschiede in Ausdruck und Regulation von Emotionen. Im Einklang mit dieser Annahme zeigte sich in einer Studie von Arens et al. (im Druck), dass die Unterdrückung des emotionalen Ausdrucks mit einem geringeren psychischen Wohlbefinden bei deutschen, nicht aber bei türkischen Frauen einherging [12]. Ähnliche Befunde gingen aus einer Studie von Balkir und Mitarbeitern (im Druck) hervor, die türkische und deutsche Frauen hinsichtlich psychologischer Grundbedürfnisse verglichen [13]. Es konnte gezeigt werden, dass Autonomie-

Erleben ein signifikanter Prädiktor für die psychische Gesundheit bei deutschen Frauen war. Bei türkischen Frauen erwies sich hingegen das Erleben von Verbundenheit als wichtigster Faktor psychischen Wohlbefindens.

Solche kulturellen Unterschiede im emotionalen Ausdrucksverhalten sowie hinsichtlich grundlegender Bedürfnisse bzgl. Autonomie und Verbundenheit in sozialen Beziehungen liefern Hinweise darauf dass sich Patienten mit Migrationshintergrund womöglich in wesentlichen Aspekten ihres Selbstkonzepts von deutschen Patienten unterscheiden. In der Tat konnten kulturelle Unterschiede bzgl. des Selbstkonzepts in einer Reihe von Studien gezeigt werden [14,15,16]. So findet sich bei Personen aus individualistischen Kulturen (z.B. Westeuropa, Deutschland, USA) [17], ein vorwiegend independentes Selbstkonzept, welches durch ein hohes Maß an Eigenverantwortlichkeit, Selbstverwirklichung und Autonomie gekennzeichnet ist [14,16,18]. Im Gegensatz dazu findet sich bei Personen aus kollektivistisch geprägten Gesellschaften (z.B. Asien, Mittlerer Osten z.B. Türkei) häufig ein interdependentes Selbstkonzept [17,19], welches durch ein hohes Maß an Gruppenzugehörigkeiten, Konformität und Anpassung der eigenen Bedürfnisse an die Erwartungen der Bezugsgruppe gekennzeichnet ist. [14,18]. Es hat sich gezeigt dass solche unterschiedlichen Konzepte der eigenen Persönlichkeit und sozialen Umwelt einen wesentlichen Einfluss darauf haben ob ein Verhalten/Erleben als funktional oder dysfunktional erscheint [16]. So mögen symbiotische Familienstrukturen und soziale Abhängigkeiten in der einen Kultur als normal erscheinen während dies in einem anderen kulturellen Kontext als dysfunktional und pathogen erscheint.

Christopher et al. [20] zeigten, dass ein interdependentes Selbstkonzept in einer asiatischen Stichprobe negativ mit der allgemeinen psychischen Belastung korreliert, nicht jedoch in einer US-amerikanischen Stichprobe. Hinsichtlich eines independenten Selbstkonzepts zeigt sich jedoch kulturübergreifend ein negativer Zusammenhang zu psychischer Belastung [20,21]. Eine Erklärung hierfür könnte sein, dass solche Befunde v.a. aus Studien stammen die Personen mit einer bikulturellen Identität untersucht haben, z.B. Migranten die aus einer kollektivistischen

Kultur in eine individualistisch geprägte Gesellschaft auswandern und in der Regel hohe Ausprägungen beider Selbstkonzepte aufweisen [22]. Für diese Personen gilt ein independentes Selbstkonzept trotz ihres kollektivistischen Hintergrunds als funktional, um sich in dem westlichen Kontext zurechtzufinden. Entsprechend zeigt sich in einem Großteil der Studien, die US-asiatische Stichproben (Personen die in Asien geboren und in die USA migriert sind) untersuchten ein positiver Zusammenhang zwischen independentem Selbstkonzept und psychischer Gesundheit [23-27].

Die Untersuchung des Selbstkonzepts bei türkischen Immigrantinnen im Vergleich zu deutschen Patienten leistet demnach einen wichtigen Beitrag um die Entstehung psychischer Krankheiten bei Menschen mit Migrationshintergrund besser zu verstehen. Mögliche kulturelle Unterschiede liefern wichtige Implikationen für den Inhalt und die Gestaltung kultursensitiver Präventions- und Versorgungsangebote. Anknüpfend an die Studie von Mösko und Kollegen (2008) waren vor allem die Variablen Depressivität, allgemeine psychische Belastung sowie positive und negative Affektivität von Interesse [11]. Soweit den Autoren bekannt ist, existiert derzeit keine Publikation, die diesen Zusammenhang an einer klinischen Stichprobe untersucht hat.

Folgende Hypothesen werden untersucht: 1) Im Vergleich zu deutschen weisen türkische Patientinnen ein höher ausgeprägtes interdependentes Selbstkonzept auf. 2) In Bezug auf das independente Selbstkonzept besteht kein Unterschied. 3) In der türkischen Stichprobe geht ein ausgeprägtes interdependentes Selbstkonzept mit einer niedrigeren psychischen Belastung einher (niedrigere allgemeine psychische Belastung, Depressivität und negative Affektivität sowie eine erhöhte positive Affektivität). In der deutschen Stichprobe werden gegenteilige Zusammenhänge erwartet. 4) In beiden Stichproben geht ein ausgeprägtes independentes Selbstkonzept mit einer niedrigeren psychischen Belastung einher.

Methoden

Stichprobe

Es wurden 56 klinisch depressive Patientinnen untersucht, die sich zum Zeitraum der Erhebung in stationärer Behandlung befanden. Die Gesamtstichprobe setzte sich zusammen aus 29 türkischen Patientinnen ($M = 43,26$ Jahre; $SD = 1,91$) sowie 27 deutschen Patientinnen ($M = 44,48$ Jahre; $SD = 1,84$). Alle Patientinnen wiesen die Primärdiagnose einer Major Depression auf. Zu den Ausschlusskriterien zählten komorbide Persönlichkeitsstörungen, bipolare Störungen, Psychosen oder Alkohol- bzw. Substanzmissbrauch. Die Gruppe der türkischen Patientinnen umfasste ausschließlich Migrantinnen der ersten Generation, die nach ihrem elften Lebensjahr nach Deutschland ausgewandert sind. Die durchschnittliche Aufenthaltsdauer in Deutschland betrug ca. 25 Jahre ($M = 25,07$ Jahre; $SD = 8,04$).

Die Rekrutierung der Studienteilnehmerinnen erfolgte im Zeitraum von 2009 bis 2010 in einer psychiatrischen und zwei psychosomatischen Kliniken im Kreis Heidelberg, Mannheim und Ludwigshafen. Mit Patientinnen die sich zur Studienteilnahme bereit erklärten wurde das Strukturierte Klinische Interview nach DSM-IV für Achse I und Achse II- Störungen durchgeführt (SKID I, II) [28]. Die Interviews wurden von türkisch- oder deutschsprachigen Diplompsychologinnen in der jeweiligen Muttersprache der Patientin durchgeführt. Bei Einschluss in die Studie wurde den Patientinnen eine Fragebogenbatterie sowie eine Einverständniserklärung vorgelegt. Die Fragebögen standen den Patientinnen sowohl in türkischer als auch in deutscher Sprache zur Verfügung. Alle Teilnehmerinnen wurden am Ende der Studie mit 50 Euro entlohnt.

Erhebungsinstrumente

Psychische Belastung und Depressivität: Zur Erfassung der subjektiv empfundenen Belastung durch körperliche und psychische Symptome innerhalb der vergangenen sieben Tage wurde die Symptom Checklist-90-R (SCL-90-R) [29] eingesetzt. Diese erfasst die Bereiche Somatisierung, Zwanghaftigkeit, Unsicherheit im Sozialkontakt, Depressivität, Ängstlichkeit, Aggressivität/ Feindseligkeit, Phobische Angst, Paranoides Denken und

Psychotizismus, die durch jeweils zehn Symptome beschrieben werden. Die Schwere der Symptomatik wird auf einer fünfstufigen Likert-Skala von 0 für „Überhaupt nicht“ bis 4 für „Sehr stark“ bewertet. Die allgemeine psychische Belastung kann durch einen globalen Kennwert bestimmt werden (GSI; Gesamt-Schwere-Index). Für die vorliegende Studie wurde sowohl der Gesamtwert als auch der Depressivitätswert bestimmt. Die SCL-90-R existiert in türkischer [30] und in deutscher Sprache [31] mit jeweils sehr guter bis guter interner Konsistenz für den Gesamt-Schwere-Index (türkische Version $\alpha = 0,98$; deutsche Version $\alpha = 0,87$).

Affektivität: Zur Erfassung der Affektivität wurde die von Watson et al. [32] entwickelte Positive and Negative Affect Schedule (PANAS) verwendet. Die Skala beinhaltet insgesamt 20 Adjektive, von denen jeweils zehn eher positive (z.B. „begeistert“ oder „angeregt“) (PA-Skala) und zehn eher negative Empfindungen (z.B. „bedrückt“ oder „beschämt“) (NA-Skala) beschreiben. Auf einer fünfstufigen Likert-Skala von 1 für „Überhaupt nicht“ bis 5 für „Sehr oft“ wird bewertet, wie oft positive bzw. negative Emotionen in den vergangenen vier Wochen erlebt wurden. Sowohl die deutsche [33] als auch die türkische Adaptation der PANAS [34] weisen hohe interne Konsistenzen auf (deutsche Version: $\alpha = 0,85$ für PA, $\alpha = 0,86$ für NA; türkische Version: $\alpha = 0,83$ für PA, $\alpha = 0,86$ für NA).

Selbstkonzept: Zur Erfassung des Selbstkonzepts wurde die Self-Construal Scale (SCS) nach Singelis [17,35] eingesetzt. Diese beinhaltet insgesamt 30 Aussagen, von denen jeweils 15 Items ein unabhängiges Selbstkonzept, z.B. „Ich mache mein eigenes Ding, egal was andere darüber denken“, oder ein interdependentes Selbstkonzept abbilden, z.B. „Ich habe das Gefühl, dass meine Beziehungen wichtiger sind als das, was ich selber erreicht habe“. Alle Aussagen sind auf einer siebenstufigen Likert-Skala von 0 für „Stimme überhaupt nicht zu“ bis 7 für „Stimme völlig zu“ einzuschätzen. Es existieren Übersetzungen der SCS ins Deutsche [36] und ins Türkische [37] mit jeweils befriedigender interner

Konsistenz für beide Subskalen (deutsche Version: $\alpha = 0,71$ für Independenz, $\alpha = 0,68$ für Interdependenz; türkische Version: $\alpha = 0,69$ für Independenz, $\alpha = 0,65$ für Interdependenz).

Ergebnisse

Soziodemographische Merkmale, psychische Belastung und Selbstkonzepte bei türkischen und deutschen Patientinnen

Tab. 1 zeigt den Vergleich der türkischen und deutschen Stichprobe hinsichtlich soziodemographischer Merkmale, Psychopathologie und der Ausprägung des independenten und interdependenten Selbstkonzepts. Es zeigten sich keine signifikanten Altersunterschiede, jedoch hinsichtlich des erreichten Bildungsabschlusses und des Familienstatus. Im Vergleich zu deutschen, waren türkische Frauen häufiger verheiratet und schlechter ausgebildet. Aufgrund dieser Unterschiede wurde bei allen statistischen Analysen für die Variablen Bildungsgrad und Familienstatus kontrolliert. Beide Gruppen zeigten ein vergleichbares Ausmaß an Depressivität und negativen Affektivität. Türkische Patientinnen wiesen eine signifikant höhere allgemeine psychische Belastung sowie ein höheres Ausmaß positiver Affektivität auf. Des weiteren zeigten sich in der türkischen Stichprobe signifikant höhere Ausprägungen des interdependenten Selbstkonzepts im Vergleich zur deutschen Stichprobe. Keine signifikanten Unterschiede wurden hinsichtlich der Ausprägungen des independenten Selbstkonzepts gefunden.

---Tab. 1---

Zusammenhang zwischen Selbstkonzept und Psychopathologie bei türkischen und deutschen depressiven Patientinnen

Zur Überprüfung der Annahme dass der Zusammenhang zwischen einem interdependenten Selbstkonzept und psychischer Belastung von dem kulturellen Hintergrund der Patientinnen moderiert wird, wurde eine 2x2 multivariate Kovarianzanalyse (MANCOVA) gerechnet. Als abhängige Variablen gingen Depressivität, allgemeine psychische Belastung, sowie positive und negative Affektivität ein, als unabhängige Faktoren der kulturelle Hintergrund, sowie niedrige ($\leq 25.$ Perzentil) vs. hohe Ausprägungen ($\geq 75.$ Perzentil) des independenten/interdependenten

Selbstkonzepts. Als Kontrollvariablen gingen der Bildungsstand und der Familienstatus der Patientinnen ein. Es zeigte sich ein signifikanter Haupteffekt des kulturellen Hintergrunds auf allgemeine psychische Belastung ($F(1,22)=4,89$, $p < 0,05$). Keine Effekte wurden hinsichtlich des interdependenten Selbstkonzeptes gefunden (allgemeine psychische Belastung $F(1,22) = 1,20$, ns; Depressivität $F(1,22) = 2,09$, ns; negative Affektivität $F(1,22) = 0,04$ ns; positive Affektivität $F(1,22) = 0,09$, ns). Es zeigte sich eine signifikante Interaktion zwischen dem kulturellen Hintergrund der Patientinnen und der Ausprägung ihres interdependenten Selbstkonzeptes. Während bei den türkischen Patientinnen ein ausgeprägtes interdependentes Selbstkonzept mit einer geringeren allgemeinen psychischen Belastung ($F(1,22) = 6,08$, $p < 0,05$, **Abbildung 1a**), einer geringeren Depressivität ($F(1,22) = 7,59$, $p < 0,05$, **Abbildung 1b**) und einem geringeren Ausmaß an negativer Affektivität ($F(1,22) = 5,21$, $p < 0,05$, **Abbildung 1c**) einherging, zeigten sich gegenteilige Zusammenhänge bei den deutschen Patientinnen. Für positive Affektivität wurde kein signifikanter Interaktionseffekt gefunden ($F(1,22) = 1,03$, ns).

--- **Abbildung 1a, 1b, 1c**---

Laut der vierten Hypothese war zu erwarten, dass über beide Gruppen hinweg ein hoch ausgeprägtes independentes Selbstkonzept mit einem höheren psychischen Wohlbefinden einhergeht. Diese Hypothese wurde ebenfalls mit einer 2x2 multivariaten Kovarianzanalyse (MANCOVA) überprüft. Die Analyse zeigte einen signifikanten Haupteffekt des independenten Selbstkonzepts auf negative Affektivität ($F(1,23) = 8,10$, $p < 0,01$). Hinsichtlich allgemeiner psychischer Belastung ($F(1,23) = 3,18$, $p = 0,08$) und Depressivität ($F(1,23) = 3,20$, $p = 0,09$) zeigten sich marginal signifikante Effekte. Kein Effekt zeigte sich hinsichtlich positiver Affektivität ($F(1,23) = 0,02$, ns). Es zeigten sich keine signifikanten Interaktionseffekte zwischen dem kulturellen Hintergrund der Patientinnen und ihren Ausprägungen des independenten Selbstkonzepts.

Diskussion

Die vorliegende Studie zeigt, dass sich das Selbstkonzept türkischer und deutscher depressiver Patientinnen voneinander unterscheiden. Das stärker ausgeprägte interdependente Selbstkonzept in der türkischen Stichprobe deckt sich mit zahlreichen Befunden, nach denen die türkische Kultur als vorwiegend kollektivistisch charakterisiert wird [19, 38-40] und die eigene Person vorwiegend über Konformität und Gruppenzugehörigkeiten definiert wird. [14,26]. Wie erwartet wiesen beide Gruppen vergleichbare Ausprägungen hinsichtlich des independenten Selbstkonzeptes auf. Vor dem Hintergrund, dass die türkischen Patientinnen im Durchschnitt bereits mehr als die Hälfte ihres Lebens in Deutschland verbracht haben, deutet dies auf die Entwicklung einer bikulturellen Identität hin [41]. Im Einklang mit anderen Studien [20,21] zeigte sich außerdem ein negativer Zusammenhang zwischen einem independenten Selbstkonzept und psychischer Belastung in beiden Gruppen. Allerdings zeigten sich wie erwartet kulturelle Unterschiede im Zusammenhang zwischen einem interdependenten Selbstkonzept und psychischer Belastung. Während türkische Patientinnen mit einem hoch ausgeprägten interdependenten Selbstkonzept eine geringere allgemeine psychische Belastung, Depressivität und negative Affektivität aufwiesen, zeigte sich bei den deutschen Patientinnen gegenteilige Zusammenhänge. Ein ähnliches Bild zeigte sich auch in der Studie von Caldwell-Harris und Ayçiçeği (2006). Im Vergleich einer türkischen und einer US-amerikanischen Studentens Stichprobe untersuchten die Autoren den Zusammenhang zwischen Psychopathologie und einem allozentrischen (d.h. vorwiegend in Richtung Tradition, Konformität und Soziabilität orientierte Personen) beziehungsweise idiozentrischen Persönlichkeitsstil (d.h. vorwiegend in Richtung Kompetenz, Hedonismus und Eigenständigkeit orientierte Personen) [42]. Ähnlich zum interdependenten Selbstkonzept in der vorliegenden Studie erwies sich Allozentrismus als gesündester Persönlichkeitsstil in der türkischen, jedoch als Risikofaktor in der amerikanischen Stichprobe. Die Ergebnisse stützen die Annahme, dass der Zusammenhang zwischen

interdependentem Selbstkonzept und psychischer Belastung moderiert wird von der kulturellen Werteorientierung (kollektivistisch/individualistisch) [16,43-45].

Implikationen für Psychopathologie und Psychotherapie

Die vorliegenden Befunde liefern Hinweise, dass bestehende Therapiekonzepte nicht ohne Modifikation in der Behandlung von Migranten eingesetzt werden sollten. Während gängige westliche Therapieansätze (z.B. Kognitive Verhaltenstherapie) häufig darauf ausgerichtet sind die *intrapersonelle* Entwicklung der Patienten zu stärken (z.B. Förderung von Autonomie, Selbstwirksamkeit, Selbstakzeptanz, Selbst-Management etc.), mag für Patienten aus dem kollektivistischen Kulturkreis vor allem auch die Bearbeitung *interpersoneller* Themen funktional sein [46,47]. Fisek (1998) warnt davor, dass nach einer westlichen Sichtweise von einheimischen Therapeuten manchmal vermutet werden könne, dass die kohäsive Familienstruktur türkischer Patienten keinen Raum für die Individuation des Einzelnen lasse und somit die Persönlichkeitsentwicklung zu kurz komme [48]. Es dürfe jedoch nicht übersehen werden, dass in solch kohäsiven Familienstrukturen die Klarheit der sozialen Rolle die Grundlage für eine eigenständige Persönlichkeitsentwicklung sei. Demnach sind die Stärkung des Familiensystems durch Einbezug von Familienmitgliedern in die Therapie, Interventionen zur Konfliktvermeidung mögliche wichtige Bausteine für die Therapie mit Migranten. Allerdings zeigte sich auch in dieser Studie, dass türkische Frauen, die mehr als die Hälfte ihres Lebens in Deutschland verbracht haben, ein bikulturelles Selbstkonzept aufweisen und demnach neben sozialer Bezogenheit auch autonome, von sozialen Strukturen unabhängige Entwicklungsziele verfolgen dürften. Vor diesem Hintergrund schlagen einige Autoren [40] vor, klassische westlich-individualistische Behandlungsansätze um kollektivistische Prinzipien zu erweitern. So könnten zum einen soziale Strukturen und Konflikte sowie der Einbezug von Familienangehörigen in die Therapie berücksichtigt werden. Zum anderen sollte vor allem auch im Hinblick auf die Integration der Patienten deren Individuation gefördert werden und die Erschließung abgegrenzter sozialer Beziehungen angestrebt werden (z.B. durch die Teilnahme an regelmäßigen Aktivitäten in

Vereinen oder Sprachkursen). In jedem Fall empfiehlt es sich vor der Therapieplanung das Selbstkonzept der Patienten in der Anamnese zu erfassen (z.B. Selbstkonstruktionskala) um Therapieziele und Interventionen in Anpassung zu gestalten. Neben gezielter Diagnostik und Interventionstechniken dürfte aber vor allem auch eine therapeutische Haltung entscheidend sein, die von einer wohlwollenden Neugier gekennzeichnet sind – auch gegenüber Wertesystemen, die unseren eigenen zunächst fremd sind [49].

Einschränkungen

Die Ergebnisse der vorliegenden Studie basieren auf einer verhältnismäßig kleinen Stichprobe. Als Folge dessen wurden möglicherweise schwache Zusammenhänge aufgrund der geringen Teststärke übersehen. Weitere Studien sind notwendig, die die vorliegenden Befunde mit größeren Stichproben replizieren. Des Weiteren ist zu beachten, dass ausschließlich Frauen untersucht wurden. Da davon auszugehen ist, dass Selbstkonzepte Geschlechtsunterschiede aufweisen [50], können die Ergebnisse nicht auf männliche depressive Patienten generalisiert werden. Auch hier sind weitere Untersuchungen wünschenswert, die potentielle geschlechtsspezifische kulturelle Effekte nachweisen.

In der vorliegenden Studie wurden vorwiegend Selbstbeurteilungsinstrumente verwendet. Kitayama [51] wies in diesem Zusammenhang auf die Schwierigkeiten in der Erfassung von Selbstkonzepten über Selbstauskünfte hin, da es sich nicht um deklaratives Wissen handelt. Eine mögliche Alternative wäre eine Erfassung des Selbstkonzepts mittels impliziter Messverfahren, um auch kulturell bedingte Antworttendenzen zu kontrollieren.

Schließlich muss beachtet werden, dass wir in der vorliegenden Studie türkische Immigrantinnen untersucht haben, die ca. die Hälfte ihres Lebens in Deutschland verbracht haben. Insofern ist unklar, ob es sich bei den in beiden Stichproben gefundenen positiven Assoziationen eines independenten Selbstkonzepts um ein kulturübergreifendes Phänomen handelt. Bei den türkischen Frauen könnte es sich auch um die Folge ihres Akkulturationsprozesses und der Entwicklung einer bikulturellen Identität handeln. Zukünftige Untersuchungen mit türkischen

Patienten die in der Türkei leben, können weiteren Aufschluss geben über kulturspezifische und kulturübergreifende Aspekte des Selbstkonzepts und dem Zusammenhang zu psychischer Belastung.

Keine Interessenkonflikte

Die vorliegenden Forschungsprojekt wurde im Rahmen des interdisziplinären Exzellenzclusters “Asia and Europe in a global context”, gefördert durch die DFG, an der Universität Heidelberg durchgeführt.

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Anhänge

Tabelle 1 Soziodemographische Merkmale, Psychopathologie und Selbstkonstruktionen der türkischen verglichen mit der deutschen Stichprobe

	Türkischstämmige Patientinnen (n=29)	Deutsche Patientinnen (n=27)	Türkischstämmige vs. deutsche Patientinnen	
			F/ χ^2	p
Alter (M/SD)	44,5 (1,84)	43,3 (1,91)	0,24	n.s.
Bildung (%)			21,29	p < 0,001
Keinen Abschluss	6,9	0		
Hauptschule/ Volksschule	69,0	18,5		
Realschule / Mittlere Reife	24,1	51,9		
Fachhochschule	0	22,2		
Abitur/ Deutsche Hochschulreife	0	7,4		
Familienstatus (%)			9,91	p < 0,01
ledig	3,4	33,3		
verheiratet/ zusammenlebend	65,5	33,3		
geschieden/ getrennt lebend	31,0	33,3		
verwitwet	0	0		
Psychopathologie (M/SD)				
SCL-90-R Gesamtwert	2,0 (0,70)	1,3 (0,49)	17,76 a	p < 0,0001
SCL-90-R Depressivitätsskala	2,4 (0,82)	1,9 (0,73)	3,92a	n.s.
PANAS- NA Skala	3,4 (0,92)	3,5 (0,74)	0,02a	n.s.
PANAS-PA Skala	2,8 (0,55)	2,4 (0,61)	4,75a	p < 0,05
Selbstkonstruktionen (M/SD)				
Interdependente Selbstkonstruktion	4,91 (0,89)	4,60 (0,96)	4,55b	p < 0,05
Independente Selbstkonstruktion	4,19 (0,93)	4,26 (0,90)	0,15b	n.s.

a Multivariate Statistik (Wilks' Lambda) $\lambda = 0,559$, F 9,663, p < 0,0001

b Multivariate Statistik (Wilks' Lambda) $\lambda = 0,913$, F 2,425, p = 0,099

Abbildung 1a Zusammenhang zwischen interdependentem Selbstkonzept und allgemeiner psychische Belastung bei türkischen (N=29) und deutschen (N=27) Patientinnen

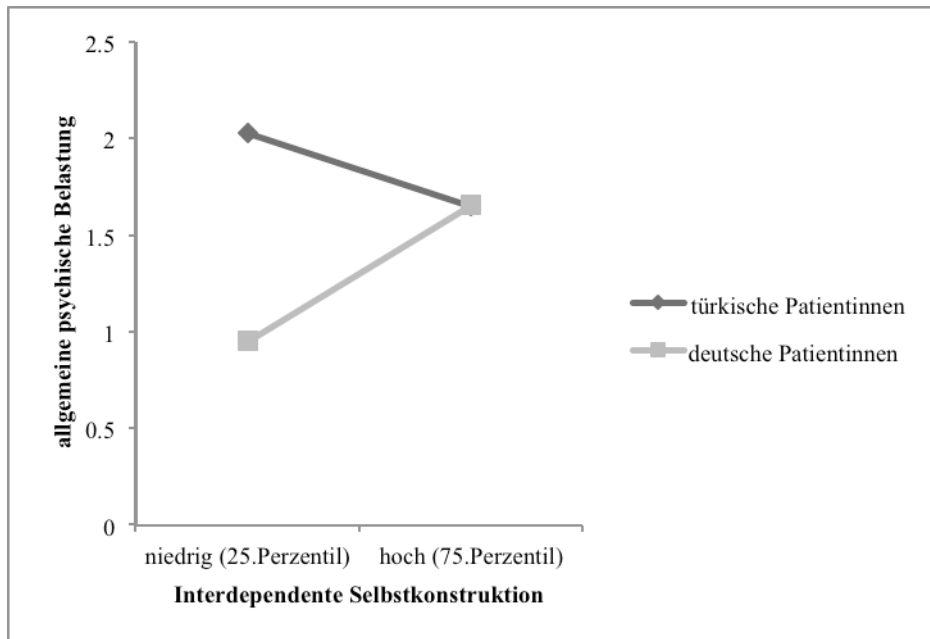


Abbildung 1b Zusammenhang zwischen interdependentem Selbstkonzept und Depressivität bei türkischen (N=29) und deutschen (N=27) Patientinnen

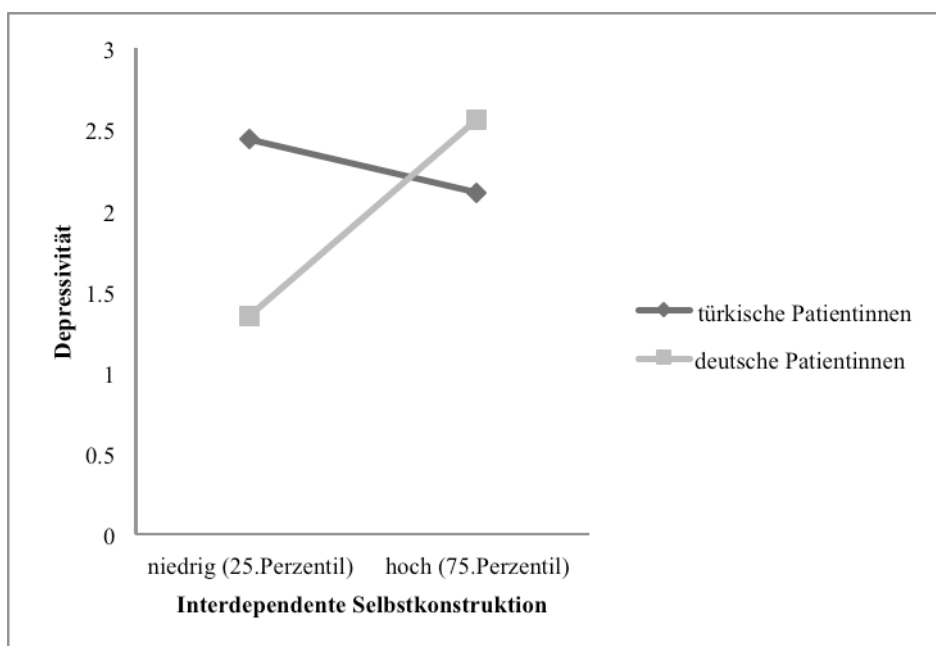
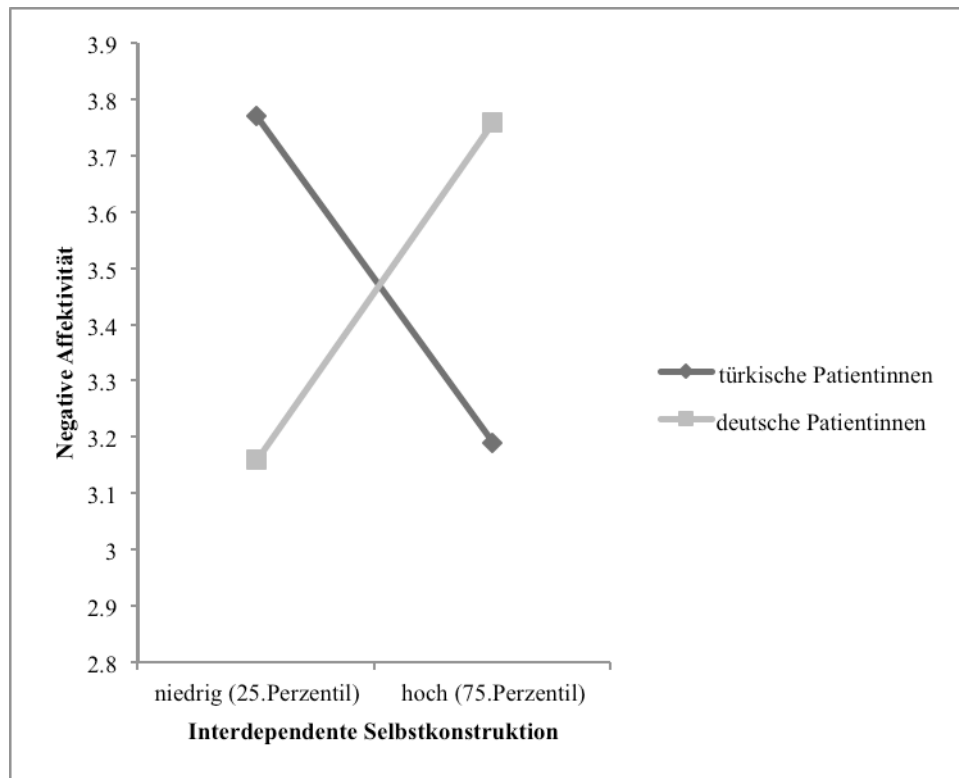


Abbildung 1c Zusammenhang zwischen interdependentem Selbstkonzept und negativer Affektivität bei türkischen (N=29) und deutschen (N=27) Patientinnen



7.2. Appendix II

Title: Exploring the relevance of autonomy and relatedness for mental health in healthy and depressed women from two different cultures: When does culture matter?

Authors: Nazli Balkir, Elisabeth A. Arens, Sven Barnow

Abstract

Background: It is well-known that the absence of both autonomy and social support (relatedness) are two important etiologic pathways to major depressive disorder (MDD). However, cross-cultural researchers state that the implications of autonomy and relatedness for mental health vary across cultures.

Aim: To test these assumptions, the current study investigated the relevance of autonomy and relatedness for mental health in healthy and depressed women from two different cultures (Germans and Turkish immigrants in Germany).

Methods: A total number of 108 women were evaluated for their levels of autonomy/relatedness satisfaction, for overall psychopathological complaints including depression, for affectivity and for perceived loneliness through self-report measures.

Results: Among healthy groups, relatedness satisfaction predicted a better mental health in Turkish women, whereas in German women, autonomy satisfaction was the better mental health predictor. Within depressed groups however, cultural differences in mental health outcomes regarding autonomy were no longer evident. Autonomy was associated with higher levels of mental health in Turkish as well as in German patients.

Conclusions: Our findings indicate that the relation between autonomy and mental health is culture-specific in healthy women, but disappears in depressed women. These findings are discussed with consideration of clinical implications and an outlook regarding further research.

Key words: *culture, women, autonomy, relatedness, depression, mental health*

Introduction

Depressive disorders are among the most prevalent diseases occurring worldwide (Chisholm *et al.*, 2004). Many researchers have suggested that the etiology, exacerbation and maintenance of depressive disorders are strongly affected by socio-cultural factors (e.g. Bebbington, 1993; Kirmayer 2001; Kirmayer 2008; Kirmayer & Looper 2006; Manson, 1995; Marsella *et al.*, 1985; Okello & Musisi, 2006). Nevertheless, although current conceptualizations of depression recognize culturally diverse manifestations, little is known about cultural variations in psychosocial factors associated with the development and maintenance of these disorders (Vandervoort & Skorikov, 2002). Such knowledge would contribute to a better understanding of the risk and protective factors of depressive disorders. It may also offer new avenues for prevention and treatment among rapidly growing minority groups.

A well-known explanation for MDD and its etiology suggests two distinct pathways to the disorder. The first concerns a diminished sense of personal control (autonomy) and the second concerns a lack of social support (relatedness) (Ryan *et al.*, 2006; Beck, 1987; Ross & Mirowsky, 1989). Several studies have documented, that the satisfaction of the need for autonomy and relatedness respectively predict peoples' emotional well-being in daily life (e.g. Reis *et al.*, 2000; Sheldon & Elliot, 1999), effective modulation of emotions and adequate self-regulation (Ryan *et al.*, 1996) and lower levels of depression (Kasser & Ryan, 1993). However, there are some limitations to these studies, as they leave much room for confounding variables. It seems crucial, that the aforementioned studies investigated highly educated, middle-class individuals (e.g. university students) from highly individualistic nations such as USA. This questions the generalizability of the findings when it comes to diverse socio-cultural contexts.

In fact, there is some evidence that the degree of autonomy and relatedness required to maintain optimal functioning is mediated by cultural orientations (Cross *et al.*, 2003; Iyengar & DeVoe, 2003; Markus & Kitayama, 1991; Oishi *et al.*, 1999; Rudy & Grusec, 2001; Sato, 2001). For example, it has been suggested that individualistic cultural orientations (i.e. cultures in

which people tend to view themselves as individuals and emphasize their own needs (Triandis, 1995)), e.g. USA, UK, and Germany (Hofstede, 1997), give greater importance to autonomy than to relatedness (Guisinger & Blatt, 1994, Markus & Kitayama, 2003; Kagitcibasi, 2005; Sato, 2001; Smith, 1994). In contrast, collectivistic cultural orientations (i.e. cultures in which people tend to view themselves as members of groups and consider the needs of the group to be more important than the needs of individuals (Triandis, 1995)), e.g. Turkey, Arab and Asian countries (Hofstede, 1997), might place greater emphasis on relatedness (rather than autonomy). This might be because strivings for autonomy conflict with the social values of a collectivistic culture (e.g. development and maintenance of social bonds and group harmony) (Schwartz & Bardi, 2001; Singh, 2010).

In line with these assumptions, a recent study documented that Turkish immigrant parents in Germany tend to focus more on family interdependence and less on the promotion of autonomy in long-term socialization goals for their children than German mothers (Durgel *et al.*, 2009). Moreover, another study demonstrated that autonomy significantly and positively correlated with life-satisfaction in many of the highly individualistic nations such as Germany, whereas it was not related to life satisfaction in most of the collectivistic countries including Turkey. On the other hand, relationship-orientation was not associated with measures of life satisfaction in individualistic nations, including Germany (Oishi *et al.*, 1999). However, despite the cultural variations in the role of autonomy and relatedness satisfaction regarding mental health, to the best of our knowledge, no study has been conducted providing direct empirical evidence for this association in healthy and depressed individuals from different cultures.

In order to address this issue, the current study examined the relationship between autonomy/relatedness satisfaction and mental health outcomes in a sample of healthy and depressed women from two different cultures: First generation Turkish immigrant women residing in Germany and their natural-born German counterparts. Turkish immigrants were chosen due to the fact that they constitute a good example for a collectivistic culture (Hofstede,

1997) and because they are the largest (32% of all foreigners) (German Federal Office for Statistics, 2008), yet the least integrated (Berlin Institute for Population and Development, 2009) immigrant group in Germany. Due to this large gap between host culture and culture of origin they run a high risk to be affected by social isolation and psychological distress (Bhugra, 2003). This results in higher prevalence rates of depression compared to the native population (Van der Wurff *et al.*, 2004; Levecque, *et al.*, 2007). This might be especially true for female immigrants who are at higher risk for depression than male immigrants (Bengi-Arslan *et al.*, 2002). However, despite the higher prevalence rates of mental disorders, it has been constantly reported that Turkish immigrants are less likely to seek professional care, exhibit higher rates of drop out and lower rates of compliance towards treatment compared to the native population (Calliess *et al.*, 2007; Haasen *et al.*, 1997). In order to compensate the existing treatment gap, a more nuanced understanding of the cultural construction of psychopathology in the Turkish immigrant community is needed.

Thus, we tested the following hypotheses: 1) In healthy German women, autonomy satisfaction would be positively associated with mental health (i.e. lower negative affectivity, higher positive affectivity, fewer feelings of loneliness, fewer psychopathological complaints and depressive symptoms. In healthy Turkish women, satisfaction of relatedness would be positively related to mental health. 2) Given that the lack of both autonomy and relatedness are suggested to be central for the development and the maintenance of MDD, we also tested these relationships within depressive woman from both cultures.

Method

Participants

A total of 108 women took part in this study constituting of 4 group samples; first generation immigrant Turkish women diagnosed with MDD (n=29, mean age=43.3, sd=1.91), first generation immigrant Turkish women with no history or current diagnosis of psychiatric disorders (n=28, mean age=43.6, sd=1.87), German women diagnosed with MDD (n=27, mean

age=44.5, sd=1.84), German women with no history or current diagnosis of psychiatric disorders (n=26, mean age=43.9, sd=1.95). Participants were recruited from Germany (Heidelberg, Mannheim, Ludwigshafen) within (the period) 2009-2010 as part of a broader cross-sectional study concerning depression among divergent populations in Germany. Since the German Federal Statistical Office (2008) declared that the overall education level of Turkish immigrant women residing in Germany was confirmed as the lowest in comparison to women from other immigrant groups and native German population, we especially excluded university students or women with a higher education degree. This was to avoid any sampling bias and to optimize the generalizability of our findings. Ethnic origin was assessed by the country of birth of the respondent (Turkey or Germany). Further, only Turkish women who immigrated to Germany after the age of eleven were considered as first generation immigrants and included into the current analyses. For establishing patient groups, participants were recruited from inpatient units. Patients were included if they currently met the DSM-IV criteria for MDD as primary diagnosis and were excluded if they had a current diagnosis or history of bipolar disorder, alcohol or substance abuse and/or personality disorders. The preference of inpatient units answered to the fact that it is relatively rare for Turkish patients in Germany to seek help from general outpatient clinics due to cultural and linguistic barriers (Balkir, in press; Haasen *et al.*, 1997). Consequently, they usually delay the decision to seek professional assistance until problems have gotten severe, and finally receive treatment in inpatient units that have been specifically developed for immigrants so as to provide service and treatment in a patients' native language.

Procedure

All interviews and questionnaires were administered in the participants' native language by native speaker psychologists (Turkish or German). At the end of the investigation, written declaration of consent was provided from each participant and all subjects were paid 50 Euro for their participation.

The recruitment of healthy Turkish and German women was implemented through newspaper advertisements and flyers distributed throughout the local community (e.g. marketplaces) and associations (e.g. local community clubs of Turkish immigrant groups). The initial screening was implemented through a brief telephone interview. During the interview, a brief description of the study was provided and it was confirmed, that participants had no university degree and no history of psychiatric treatment. Potentially suitable respondents were then invited to the university outpatient clinic for a diagnostic interview for mental disorders (administered by clinicians) in order to ensure that they have no history or current diagnosis of psychiatric disorders. The Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) (First, Spitzer, Gibbon, & Williams, 1997) and the Structured Clinical Interview for DSM-IV Axis II Disorders (SCID-II) (First, Spitzer, Gibbon, Williams & Benjamin, 1997) were used. Applicants were included in the current research, if they had no current diagnosis and no history of an Axis-I or Axis-II disorder. Following the final selection, a packet containing a set of self-report questionnaires, a declaration of consent form and a stamped self-addressed envelope was provided to the participants to be sent back via mail within 10 days.

German and Turkish depressives were recruited from the inpatient ward of one psychiatric and two psychosomatic hospitals. Members of our research team made announcements (of the study) at the beginning of patients' therapy sessions. After the session, appointments with voluntary patients were arranged for the implementation of the diagnostic interviews. During the interview, clinicians from our research team administered SCID-I and II to confirm the suitability of the applicants. Applicants were included, if they currently met the DSM-IV criteria for MDD as primary diagnosis without any comorbidity of bipolar disorder, alcohol or substance abuse and/or personality disorders. Finally, following the interview, a packet including a set of self-report questionnaires and a declaration of consent form was provided to the participants to be handed in within 10 days.

Instruments

Psychopathological complaints: The severity of psychopathological complaints was assessed by the Symptom Checklist-90-R (SCL-90-R; Derogatis, 1983). The 90 self-rated items constitute eight different symptom scales measuring depression, somatization, phobic anxiety, obsessive-compulsive, anxiety, hostility, interpersonal sensitivity, paranoid ideation and psychoticism. Global Severity Index (GSI) is designed to measure overall psychopathology on the basis of eight symptom scales. Participants rate how much they experienced each item in the past 4 weeks on a 5-point Likert scale. For the current study, GSI and a depression subscale were used to measure overall psychopathological complaints and the severity of depressive symptoms respectively. Internal consistency of the SCL-90 R is good for both Turkish ($\alpha=0.98$; Dag, 1991) and German ($\alpha=0.87$; Franke, 2002) versions.

Affectivity: Affectivity was indicated with the Positive Affect Negative Affect Schedule (PANAS; Watson *et al.*, 1988). PANAS consists of 10 positive (e.g. enthusiastic) and 10 negative (e.g. scared) mood items. Participants were asked to rate how much they experienced each mood state in the past 4 weeks using a 5-point Likert scale ranging from 1 (not at all) to 5 (extremely). Internal reliability of PANAS is good with $\alpha=0.85$ for (the) positive affect and $\alpha=0.85$ for (the) negative affect in the German version (Krohne *et al.*, 1996); $\alpha=0.86$ for (the) positive affect and $\alpha=0.83$ for (the) negative affect in the Turkish version (Gençöz, 2000).

Loneliness: Perceived loneliness in everyday life was assessed with the UCLA Loneliness Scale (Russell *et al.*, 1980). The scale consists of 9 positive (accompanied) and 11 negative (lonely) items. The participants rate each item on a 4-point Likert scale ranging from 1 (never) to 4 (always). Higher scores reflect greater loneliness. The internal consistency of UCLA is good for both Turkish ($\alpha=0.96$; Demir, 1989) and German ($\alpha=0.88$; Stephan & Fäth, 1989) versions.

Basic Psychological Need Satisfaction: The satisfaction of basic psychological need for autonomy (e.g. I generally feel free to express my ideas and opinions) and for relatedness (e.g. I get along with people I come into contact with) was assessed by using the autonomy and relatedness subscales of Basic Psychological Need Satisfaction Scale-general version (Ilardi *et al.*, 1993). The scale contains 21 items constituting three subscales, which measures three basic psychological needs: autonomy, competence and relatedness. The items were rated on a 7-point Likert scale ranging from 1 (completely disagree) to 7 (completely agree). Higher scores reflect greater satisfaction. The original English version of the questionnaire was translated into participants' native languages (Turkish and German) for the current study. Translation-back translation method (Hambleton, 1994) was implemented by English, German and Turkish native speakers. The problems that appeared in the translation process were discussed in the presence of one of the authors until a solution was agreed upon. Internal reliabilities of Turkish ($\alpha=0.69$, $\alpha =0.81$, $\alpha =0.86$ for autonomy, relatedness and overall scores respectively) and German ($\alpha=0.60$, $\alpha=0.72$, $\alpha=0.83$ for autonomy, relatedness and overall scores respectively) versions were found acceptable and similar with the coefficient alphas of the original version ($\alpha=0.61$, $\alpha=0.79$, $\alpha=0.87$ for autonomy, relatedness and overall scores respectively).

Results

Demographics

Table 1 presents the sociodemographic characteristics, means and standard deviations regarding measures of mental health and autonomy/relatedness satisfaction for each group. All four groups did not differ in age. The level of education and family status differed significantly between Turkish and German women within both healthy and patient groups. Therefore, family status and education level were controlled for all intercultural mean comparisons concerning mental health and need satisfaction. Healthy Turkish women reported significantly

lower levels of mental well-being, indicated by psychopathological complaints, depressive symptoms, perceived loneliness and lower levels of positive affectivity compared to healthy German women. Turkish patients reported significantly higher levels of psychopathological complaints and positive affectivity than German patients. All other dependent variables, such as depression levels, perceived loneliness and negative affectivity were comparable between German and Turkish patient groups. Healthy Turkish women reported lower levels of autonomy satisfaction compared to healthy German women ($p < .08$), whereas no cultural difference was observed between Turkish and German women with MDD. The level of relatedness satisfaction did not differ between German and Turkish women regardless of whether or not they were depressed. Turkish patients reported significantly lower levels of need satisfaction compared to healthy Turkish women ($F(1,55) = 7.71, p < .01$ for autonomy, $F(1,55) = 4.60, p < .05$ for relatedness). Similarly, German patients reported significantly lower levels of need satisfaction compared to healthy German women ($F(1,52) = 23.22, p < .0001$ for autonomy, $F(1,52) = 9.58, p < .01$ for relatedness).

--- TABLE 1 about here ---

In order to test the impact of autonomy and relatedness satisfaction on mental health across all four groups, we conducted stepwise regression analyses for each group of samples independently.

Autonomy and relatedness as predictors of mental health in healthy Turkish and German women

Table 2a and 2b present the regression coefficients for autonomy/relatedness satisfaction as predictors of mental health for each culture group (German and Turkish respectively). Our first hypothesis concerning healthy German women assumed that rather than relatedness, autonomy satisfaction would predict a better mental health. To test this hypothesis, we conducted

stepwise regression analyses for German women using psychopathological complaints, depression, perceived loneliness as well as positive and negative affectivity scores as dependent variables. The influence of demographic variables such as family status and education level on mental health was controlled for by entering them as independent variables in the first step. Due to the theoretical and literature-guided assumption postulating autonomy as central to the mental health of German women, the second step involved autonomy satisfaction, while relatedness was entered into the third step of the model. In order to reject the null hypothesis, the sequence of the independent variables seeks to establish whether relatedness satisfaction would explain additional variance in mental health measures after entering autonomy satisfaction as a predictor. Among demographic variables, the education level was not a significant predictor and excluded from the model. Family status was found to be a significant predictor for depression and overall psychopathological complaints. Single German women reported significantly higher levels of depression and psychopathological complaints compared to their married/cohabiting and divorced/separated counterparts. In the second step, autonomy satisfaction significantly predicted a better mental health outcome as expected. Relatedness satisfaction was not a significant predictor for any of the measures of mental health and therefore excluded from the model. Our second hypothesis concerning healthy Turkish women assumed that rather than autonomy, relatedness satisfaction would predict a better mental health outcome. To test our second hypothesis, stepwise regression analyses were employed for the Turkish group using the same measures as dependent and control variables that were used for healthy German women. Reversely, in the Turkish group, due to the theoretical and literature-guided assumption postulating relatedness as central to the mental health of Turkish women, relatedness satisfaction was placed at the subsequent step; the last step involved autonomy satisfaction. Similarly, the sequence of independent variables was aimed to explore whether autonomy would explain additional variance in mental health measures in Turkish women after entering relatedness satisfaction. None of the demographic

variables constituting the initial step were significant, and thus excluded from the model. As expected, relatedness satisfaction significantly predicted a better mental health. Autonomy satisfaction was not a significant predictor for any of the measures of mental health and therefore excluded from the model.

--- TABLE 2 AND 3 about here---

Autonomy and relatedness as predictors of mental health in Turkish and German women with MDD

Table 3a and 3b present the regression coefficients for autonomy/relatedness satisfaction as predictors of mental health for each culture group (German and Turkish respectively). In order to test whether cultural differences found in healthy samples would be absent in both groups of German and Turkish women with MDD, we repeated the same regression analyses with the clinical samples. In the case of German patients, the demographic variables constituting the initial step were not significant and excluded from the model. As expected, satisfaction of autonomy significantly predicted psychopathological complaints, depression and loneliness but not negative and positive affectivity. However, relatedness satisfaction was not a significant predictor for any of those variables and therefore excluded from the model. In our model for the Turkish women with MDD, after controlling for demographic variables, both autonomy and relatedness satisfaction significantly predicted psychopathological complaints, depression and loneliness, whereas negative and positive affectivity were predicted only by autonomy satisfaction.

--- TABLE 4 AND 5 about here---

Figure 1a and 1b were provided in order to present an overview on autonomy/relatedness satisfaction as predictors of mental health e.g. depressive complaints across all four groups of women.

--- FIGURE 1 AND 2 about here---

Discussion

The main question of the current study dealt with the cultural differences in the impact of autonomy and relatedness satisfaction on mental health outcomes. This was investigated both in German and Turkish women with and without MDD. In congruence with our first and second hypotheses, healthy German women benefited only from autonomy satisfaction, whereas in healthy Turkish women only relatedness satisfaction was associated with higher levels of mental well-being.

These results are in line with several studies linking Turkish culture with tightly connected social networks and limited room for personal initiative (Durgel *et al.*, 2009; Citlak *et al.*, 2008; Kagitcibasi, 1990; Phalet & Claeys, 1993). However, our findings also contradict some investigations, which demonstrate a positive association between basic psychological need satisfaction and mental health in non-western cultures high in collectivism (e.g. Chirkov, *et al.*, 2003; Vansteenkiste *et al.*, 2005, 2006; Sheikholeslami & Arab-Moghaddam, 2010). This might be due to the fact, that these specific studies, implying a universality of autonomy-experience in collectivistic cultures, drew samples from young, highly educated and privileged university students. These students inhabit a considerably different socio-cultural environment than the majority of Turkish immigrant women in Germany. To the best of our knowledge, the present study is the first to investigate the role of autonomy and relatedness satisfaction in mental health for women from different cultures with low-middle socio-economic and educational backgrounds.

However, the cultural pattern mentioned above was only partially replicated in the depressed samples. Here, similar to healthy controls, the experience of relatedness was negatively associated with psychopathology only in Turkish, but not in German patients. Nevertheless, experience of autonomy was negatively associated with level of depression, overall psychopathological complaints and perceived loneliness in both groups.

Why did Turkish women diagnosed with MDD benefit from the experience of autonomy, while their healthy counterparts did not? Several explanations might stem from the clinical profile of our sample of Turkish depressive women suffering from moderate to severe depression and exhibiting very low levels of autonomy. First, similar to several other studies (e.g. Karanci, 1993), the majority of these cases reported family and marital conflicts (e.g. intergenerational conflicts with the family, the husband's family or the husband himself due to pressure, domestic violence etc.) as the major source of their health problems (Balkir, in press). In the view of these circumstances, a sense of controlling one's own life might reduce depression, as it might encourage problem solving and promote autonomy regarding stressor-related decisions (e.g. decisions concerned with how to regulate behavior in the context of negative life events, with which the self can no longer identify i.e., leaving home or the husband, withstanding overwhelming social pressures). Here, future studies seem necessary to investigate the mediating role of internalization of cultural norms and social expectations, so as to understand when and under which circumstances an experience of autonomy can be useful. Second, although all of the admissions to psychiatric hospitals were voluntary among our Turkish patients, receiving treatment in an inpatient unit at the time of recruitment might also have an impact on how these patients perceive the importance of autonomy. Third, these results are also in line with studies demonstrating that cultural differences in psychological processes disappear in the presence of psychopathology (Marsella, 1988). For instance, our research team revealed a similar portrait with the same participants, when we compared the frequency of their emotion regulation strategies and their association with different outcomes

of mental health. Although cultural differences existed in the use of emotion regulation strategies and their link to mental health, none of these differences were found between patient samples (Arens *et al.*, in review). Moreover, there is some evidence that cultural variations decrease as psychopathology becomes more severe (Draguns & Tanaka-Matsumi, 2003). Since our patients were diagnosed mostly with moderate to severe depression and receiving treatment in inpatient units, a different portrait can be revealed regarding outpatient groups diagnosed with milder forms of depression. Therefore, further studies should examine cultural differences in mental health outcomes of autonomy in milder forms of MDD also.

Our findings have implications for the psychotherapy process with Turkish depressive women as well. Given that the self is seen as an autonomous and differentiated entity in Western societies; psychiatric problems are usually conceptualized as deficits in intrapsychic structures (Douki, et al., 2007). Consequently, psychotherapeutic interventions are designed to address self-efficacy (i.e., autonomy) (Dwairy & Van Sickle, 1996). Considering the positive impact of relatedness on mental well-being in Turkish women, regardless of health status, it seems crucial to address person-society conflicts in addition to intrapsychic conflicts in the therapy process so as to increase treatment adherence and acquire positive treatment outcomes. Without ameliorating familial or social conflicts, working mainly on personal conflicts or using medication alone would probably fail to achieve desired treatment outcomes. For instance, it has been reported that this biopsychosocial holistic approach worked quite successfully with patients from non-western cultures (e.g. Egypt) (Okasha, 1993). Furthermore, although the contrary has been revealed for Turkish women with MDD, traditionally minded healthy Turkish women from rural backgrounds with low levels of education do not precisely benefit from a differentiated and autonomous self when it comes to mental health. Compared to people living in individualistic and Western societies, most non-westerners are more dependent on their families and autonomy or self-actualization is rarely accepted. Therefore, it is important to note that promotion of autonomy without any consideration of its social counteractions

might lead to conflictual family or social environments, with which these patients might be unable to cope (Dwairy, 1997).

Limitations

The findings of our study are constrained by some limitations. The first is the small sample size of each research group. Therefore, weaker associations between variables might go unnoticed. However, it is noteworthy to remind oneself of the emphasis put on avoiding sampling bias in our case. Unfortunately, our recruitment criteria, especially for Turkish immigrants, such as Turkey as the birthplace, immigration after age of eleven, having no further education etc., were indicative to the disadvantage of reaching a higher number of participants. Second, since our Turkish sample is composed of immigrant women, the current results might reflect a comparison of immigrant versus non-immigrant groups in addition to a cross-cultural comparison. It has been suggested, that immigrating to a new country may strengthen the cultural identity and that culture shock may cause a person to revert to that, which is most familiar (Meaders, 1997). Therefore, our findings concerning Turkish immigrant women might not be representative for native Turkish culture overall. In order to tease out whether group differences are due to culture or in some part due to immigration, future studies should include a third comparison group composed of non-immigrant Turkish women residing in Turkey. Moreover, the current study did not investigate the extend to which the Turkish women sampled have acculturated and adopted some of the cultural norms of their host (German) culture, which might have an influence on the relationship between autonomy/relatedness and mental health. Therefore, future studies are needed in order to shed more light on the within-ethnic groups variability due to an acculturation experience. Furthermore, the gender of our samples prevents us to make any generalizations for Turkish and German male populations. Be that as it may, there are some studies providing evidence for gender differences on the issues of autonomy and relatedness (Kirsh & Kuiper, 2002). Thus, further studies are required so as to demonstrate possible gender differences within Germans

and Turkish immigrants. Finally, we used only one instrument for measuring the levels of satisfaction in autonomy and relatedness. Including other instruments measuring the levels of need for autonomy and relatedness would help to gain a deeper understanding of the relationship between culture and the mental health outcomes of basic psychological needs.

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Attachments

Table 1. Sociodemographic characteristics, mean salience and standard deviations of all samples together with comparative analyses

	Turkish Controls (n=28)	German Controls (n=26)	Turkish Patients (n=29)	German Patients (n=27)	TC vs. GC		TP vs. GP	
					F/ χ^2	p	F/ χ^2	p
Age	43.6(1.87)	43.9(1.95)	44.5(1.84)	43.3(1.91)	0.01	ns	0.24	ns
Education (%)					19.60	<.01	21.29	<.001
No education	7.1	0	6.9	0				
Secondary General School	57.1	7.7	69.0	18.5				
Intermediate Secondary School	17.9	61.5	24.1	51.9				
Upper Secondary School	10.7	23.1	0	22.2				
University of Applied Sciences	7.1	7.7	0	7.4				
Family Status (%)					8.31	<.05	9.91	<.01
Single	0	15.4	3.4	33.3				
Married/cohabiting	75	69.2	65.5	33.3				
Divorced/separated	10.7	15.4	31.0	33.3				
Widowed	14.3	0	0	0				
SCL-90 Total score	1.2(0.54)	0.2(0.30)	2.0(0.73)	1.3(0.55)	45.01 ^a	<.001	12.65 ^b	<.01
SCL-90 Depression score	1.3(0.67)	0.3(0.39)	2.3(0.86)	1.9(0.78)	33.71 ^a	<.001	3.08 ^b	ns
UCLA Loneliness score	2.0(0.56)	1.6(0.41)	2.4(0.65)	2.2(0.44)	8.04 ^a	<.01	0.67 ^b	ns
PANAS- NA Score	2.3(0.83)	2.2(0.65)	3.5(0.92)	3.5(0.74)	0.92 ^a	ns	0.02 ^b	ns
PANAS- PA Score	2.9(0.68)	3.7(.059)	2.8(0.55)	2.4(0.61)	19.08 ^a	<.05	4.96 ^b	<.05
Autonomy satisfaction	4.6(1.02)	5.1(0.82)	3.9(1.22)	4.1(0.89)	3.10 ^a	<.08	0.73 ^b	ns
Relatedness satisfaction	5.6(0.80)	5.6(0.57)	4.9(1.10)	5.1(0.88)	0.10 ^a	ns	0.28 ^b	ns

^a Multivariate Statistic (Wilks' Lambda) $\lambda = 0.360$, F 8.58, p< 0.001

^b Multivariate Statistic (Wilks' Lambda) $\lambda = 0.612$, F 3.80, p< 0.01

Table 2. Variables identified by stepwise regression analyses as predicting different outcomes of mental health in healthy German women (n=26)

Step	Predictors	Psychopathological Complaints			Depression			Perceived Loneliness			Negative Affectivity			Positive Affectivity		
		Block			Block			Block			Block			Block		
		β	R2	Block F	β	R2	Block F	β	R2	Block F	β	R2	Block F	β	R2	Block F
1	Family status	0.69***	0.45	20.08***	0.64***	0.39	15.77**	-	-	-	-0.50*	0.22	7.92*	0.47*	0.19	6.75*
2	Family status	-0.47**	0.61	19.00***	-0.40*	0.59	17.36***	-	0.33	13.03**	-0.32 ns	0.40	9.29***	0.31 ns	0.32	6.91**
	Autonomy satisfaction	-0.46**			0.52**			0.59**			-0.48**			0.43*		

ns. not significant, * p< .05, ** p< .01, ***p< .001

Table 3. Variables identified by stepwise regression analyses as predicting different outcomes of mental health in healthy Turkish women (n=28)

Step	Predictors	Psychopathological Complaints			Depression			Perceived Loneliness			Negative Affectivity			Positive Affectivity		
		Block			Block			Block			Block			Block		
		β	R2	Block F	β	R2	Block F	β	R2	Block F	β	R2	Block F	β	R2	Block F
1	Relatedness satisfaction	0.54**	0.26	10.60**	-0.51**	0.23	8.89**	0.71***	0.48	26.29***	-0.50**	0.22	8.46**	-	-	-

* p< .05, ** p< .01, ***p< .001

Table 4. Variables identified by stepwise regression analyses as predicting different outcomes of mental health in German women with MDD (n=27)

Step	Predictors	Psychopathological Complaints			Depression			Perceived Loneliness			Negative Affectivity			Positive Affectivity		
		Block			Block			Block			Block			Block		
		β	R2	Block F	β	R2	Block F	β	R2	Block F	β	R2	Block F	β	R2	Block F
1	Autonomy satisfaction	-0.45*	0.17	6.16*	-0.55**	0.28	10.54**	0.755**	0.27	8.70**	-	-	-	-	-	-

* p< .05, ** p< .01, ***p< .001

Table 5. Variables identified by stepwise regression analyses as predicting different outcomes of mental health in Turkish women with MDD (n=29)

Step	Predictors	Psychopathological Complaints			Depression			Perceived Loneliness			Negative Affectivity			Positive Affectivity		
		Block			Block			Block			Block			Block		
		β	R2	Block F	β	R2	Block F	β	R2	Block F	β	R2	Block F	β	R2	Block F
1	Relatedness satisfaction	-0.55**	0.28	12.05**	0.53**	0.25	10.33**	0.73***	0.62	23.41***	-	-	-	-	-	-
2	Relatedness satisfaction	-0.39*	0.37	9.24**	-0.32t	0.41	10.89***	0.65***	0.66	19.19***	-	0.39	18.97***	-	0.13	5.05*
	Autonomy satisfaction	-0.37*			0.47**			-0.28*			0.64***			0.40*		

t p= .55, * p< .05, ** p< .01, ***p< .001

Figure 1. Autonomy satisfaction as predictor of depression in healthy Turkish and German women and depressed Turkish and German patients.

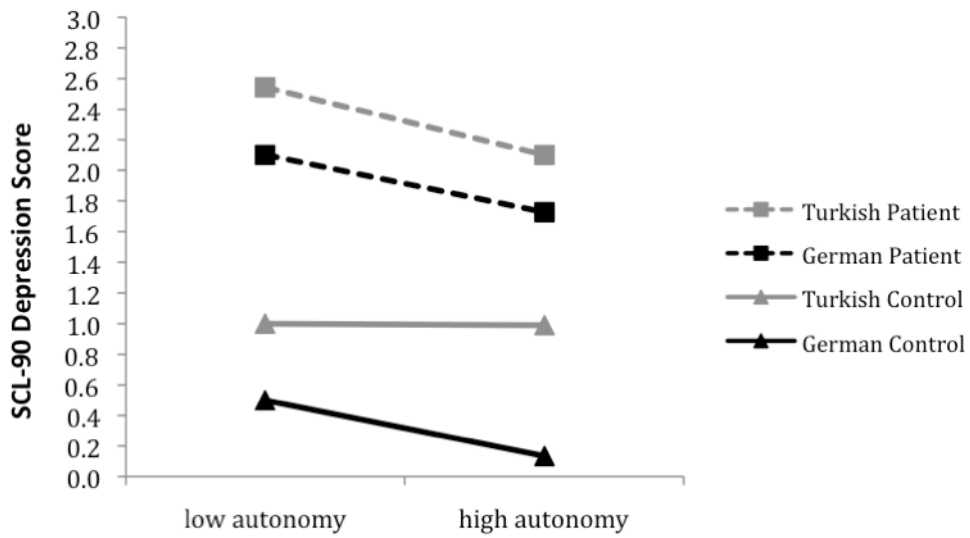
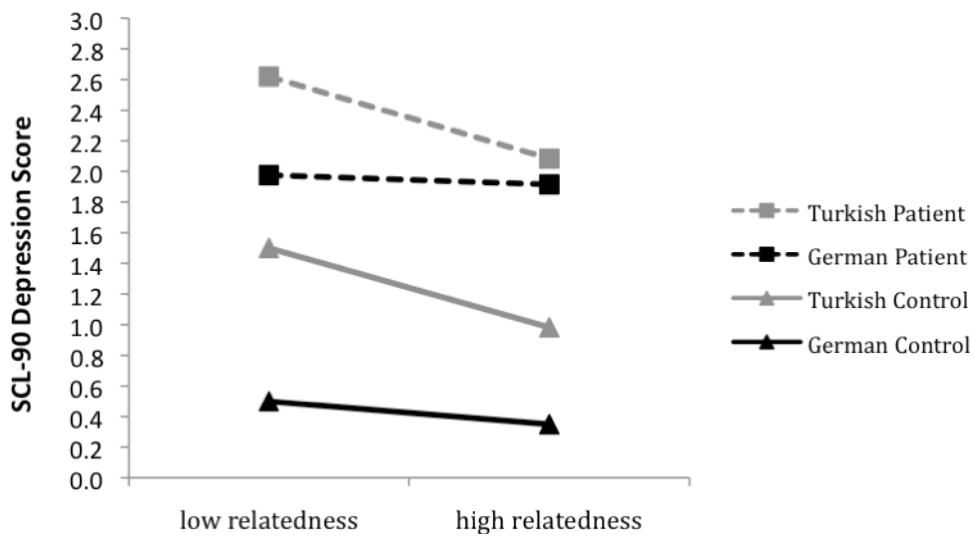


Figure 2. Relatedness satisfaction as predictor of depression in healthy Turkish and German women and depressed Turkish and German patients.



7.3. Appendix III

Title: Ethnic Variation in Emotion Regulation: Do Cultural Differences End Where Psychopathology Begins?

Authors: Elisabeth A. Arens, Nazli Balkir, Sven Barnow

Abstract

Emotion regulation (ER) via cognitive reappraisal has been shown to be superior to the use of expressive suppression regarding several aspects of mental well-being. However, a cultural perspective suggests, that the consequences of emotional suppression may be moderated by cultural values. In order to examine whether this also applies to clinical samples, we investigated healthy and depressed German women and healthy and depressed Turkish immigrants living in Germany. Groups were compared in terms of frequency of ER strategies (cognitive reappraisal and expressive suppression) and with which different aspects of mental well-being the same are associated. Healthy Turkish immigrants exhibited a greater ER balance (frequent use of suppression plus frequent use of reappraisal), which was associated with more positive outcomes of expressive suppression in Turkish than in German women. None of these differences were found in patient samples, both of which showed a greater use of emotional suppression than cognitive reappraisal. Results suggest that the cultural moderation of the link between emotional suppression and well-being is associated with a greater ER balance in healthy Turkish individuals. Depressed Turkish patients may not profit from suppression due to their more rigid use of it.

Ethnic Variation in Emotion Regulation: Do Cultural Differences End

Where Psychopathology Begins?

Contemporary research has demonstrated that patterns of emotion regulation (ER), i.e., the conscious or unconscious attempts people make to modify their emotional responses (Barnow, *in press*; Gross & Thompson, 2007), serve crucial functions for individuals' well-being and health (Gross & Thompson, 2007). It has been shown that *response-focused* ER strategies (i.e., inhibiting ongoing emotions *after* they have been generated) are less effective than *antecedent-focused* ER strategies (i.e., alteration of the emotional response *before* it arises) (Gross, 2002; Gross & John, 2003; John & Gross, 2004). Thus, expressive suppression, a response focused strategy, has been repeatedly linked to poor physical (Kune, Kune, Watson, & Bahnson, 1991), social (Butler et al., 2003), affective (Gross & Levenson, 1997; Stepper & Strack, 1993) and cognitive (Richards & Gross, 2000) conditions, whereas the reverse has been true for the antecedent-focused strategy cognitive reappraisal (i.e., the reframing or re(-)contextualization of a negative stimulus in less emotional terms).

However, these studies have been based on data from samples of predominately highly educated Europeans/European Americans (e.g., samples of European/American students); a fact that questions the ethnic generalizability of these findings (Butler, Lee, & Gross, 2007; Consedine, Magai, & Bonanno, 2002; Consedine, Magai, & Horton, 2005). Indeed, there is recent evidence, that frequency and psychological consequences of ER strategies differ in ethnic groups, depending on different cultural values (Barnow, Arens, & Balkir, 2011; Butler et al., 2007; Butler, Lee & Gross, 2009; Chentsova-Dutton, Chu, Tsai, & Rottenberg, 2007; Gross & John, 2003; Miyamoto & Ma, *in press*). For instance, a study of Soto and colleagues has shown that the habitual use of expressive suppression was associated with adverse psychological functioning for European Americans, but not for Chinese participants (Soto, Perez, Kim, Lee, & Minnick, 2011).

It has been argued that in Eastern/collectivistic cultures (e.g., Asian countries, Orient,

Turkey), which emphasize interdependence and social cohesion (Hofstede, 2001; Markus & Kitayama, 1991), expressive suppression may be more encouraged than in Western/individualistic cultures, in order to fulfill pro-social goals (e.g., suppression of anger to preserve group harmony) (Hui, Triandis, & Yee, 1991). In contrast, in Western/individualistic cultures (e.g., Great Britain, USA, Germany) expressive suppression may clash with values such as independence and open emotion expression (Hofstede, 2001; Markus & Kitayama, 1991). In such contexts other ER strategies might be preferred, e.g., cognitive reappraisal (Gross & John, 2003; Matsumoto, Yoo, & Nakagawa, 2008). In line with these assumptions, the use of suppression was shown to be applied more frequently in collectivistic cultures (Gross & John, 2003), more automatized (Butler et al., 2007; Soto, Levenson, & Eberling, 2005) and related to lower levels of negative emotion (Butler et al., 2007), less negative social consequences (Butler et al., 2007) and better health (Butler et al., 2009; Consedine et al., 2005) than in individualistic cultures.

There is recent evidence that the positive consequences of expressive suppression in individuals with a collectivistic background may rest on their not using suppression exclusively and rigidly, but rather shifting to other ER strategies (e.g., cognitive reappraisal), whenever suppression would have a negative impact (Butler et al., 2007). Indeed, the ability to flexibly regulate emotions has been associated with reduced levels of distress (Bonanno, 2005; Bonanno, Papa, Lalande, Westphal, & Coifman, 2004). Furthermore, it has been demonstrated that the correlation between expressive suppression and cognitive reappraisal is higher in Eastern than in Western countries (Matsumoto et al., 2008). This indicates, that individuals with collectivistic cultural values may have a more balanced use of both strategies and thus may benefit more from the use of expressive suppression (Butler et al., 2007).

This might be especially true for immigrants who “live at the juncture between two cultures” (LaFromboise, Coleman, & Gerton, 1993, p.395) and thus may need to adopt various forms of emotional expression, in order to flexibly shift between contrasting culture-specific communication styles (i.e., those of their heritage culture and those of the host culture) (Eng,

Kuiken, Temme, & Sharma, 2005). Accordingly, immigrants with a heightened flexibility and an extended repertoire of emotional expressivity/ER were shown to be less depressive and better integrated (Matsumoto, Hirayama, & LeRoux, 2006).

It has been argued that regulating/controlling one's emotions might be important for positive adjustment, since it allows one to not be overly influenced by stress and negative emotions, which are inevitable in the acculturation process. Instead, emotion regulation and control allows one to think clearly and rationally, paving the way for using other psychological skills important for intercultural adjustment, e.g., openness, critical thinking etc.. Thus, functional ER, flexibly applied suppression in particular, might mediate the link between mental health and integration.

It has been demonstrated that many immigrants are poorly integrated and develop mental disorders such as depression or somatoform disorders (Bengi-Arslan, Verhulst, & Crijnen, 2002; Bhugra, 2003). It has been assumed that mental distress and/or psychopathology is associated with the inflexible use of certain ER-strategies. In this case, mental health problems might undermine the flexibility of ER, which in turn might prevent the use of other psychological skills important for intercultural adjustment. Thus, immigrants who develop mental disorders might exhibit dysfunctional ER strategies, i.e., the rigid use of expressive suppression, and no/less use of cognitive reappraisal (Matsumoto et al., 2006; 2008). This raises the question whether the positive consequences of flexibly applied suppression found in healthy integrated immigrants can be generalized to immigrants with mental disorders, who are poorly integrated and may have a more restricted repertoire of ER strategies, i.e., using suppression less flexibly. To the best of our knowledge no study has been published so far, which investigates whether the cultural moderation of expressive suppression is also evident in clinical samples of patients with mental disorders.

In order to address this question, we compared frequency of expressive suppression and cognitive reappraisal and their implications for subjective well-being not only between healthy Turkish immigrants living in Germany and healthy German women, but also between Turkish

migrants with depressive disorders and depressed German patients. Measurement of well-being included positive and negative affectivity, loneliness and dysfunctional attitudes, all of which have been cited as common problems experienced by immigrants (Vedder & Virta, 2005) and hence might be crucial areas impacted by ER.

Turkish immigrants were chosen because Turkish culture has often been described as high in collectivism (Hofstede, 1980; Schwartz, 1994) and they are the largest (Report of German Federal Statistical Office, 2010), yet the least integrated immigrant group in Germany (Berlin Institute for Population and Development, 2009). This puts them at a high risk of reduced quality of life, including physical and psychological disorders (Bongard, Pogge, Arslaner, Rohrman, & Hodapp, 2002), unemployment (Kogan, 2004) and lower education (Söhn & Özcan, 2006). Thus, our study avoids sample bias caused by the selection of primarily highly educated Europeans/European Americans, which might have reduced the validity of previous research findings. Furthermore, we investigated only women because female Turkish immigrants present a high-risk group, with higher rates of negative health outcomes in comparison to male Turkish immigrants (David & Borde, 2000), especially regarding suicidal ideation and depression (Bengi-Arslan et al., 2002).

In this article, we test the hypotheses that (1) healthy Turkish immigrants show a more balanced use of ER strategies than healthy German women, i.e., in addition to frequent use of expressive suppression, they will also report frequent use of cognitive reappraisal. Further, (2) when this greater balance of ER in healthy immigrants is observed, we expect that expressive suppression is associated with better mental well-being, i.e., lower negative affectivity, higher positive affectivity, fewer feelings of loneliness and fewer dysfunctional attitudes when compared to healthy German women. It is further hypothesized that these cultural differences will be absent in the clinical samples, i.e., (3) both Turkish and German depressed patients are expected to use expressive suppression more rigidly (i.e., frequent use of expressive suppression, no or less use of cognitive reappraisal) and thus, (4) suppression is expected to be associated with worse mental

well-being in both groups, i.e., higher negative affectivity, lower positive affectivity, more feelings of loneliness and more dysfunctional attitudes.

Method

Participants

The participants were 108 women: Turkish healthy immigrants with no current diagnosis or history of mental disorder ($n=28$; mean age 43.6, $SD=9.6$) as assessed with the SCID-I Interview (see below; First, Spitzer, Gibbon, Williams, & Benjamin 1997), German healthy women with no current diagnosis or history of mental disorder ($n=26$; mean age 43.8, $SD=11.2$), Turkish patients with a current Major Depressive Disorder (MDD) ($n=29$; mean age 44.4, $SD=8.1$), and German patients with a current MDD ($n=25$; mean age 43.4, $SD=10.7$). Additionally, condition of participation for both Turkish healthy and depressed participants included Turkey as birthplace and immigration to Germany after the age of eleven. This procedure established that both Turkish groups consisted of first generation immigrants and did not differ in their length of residence in Germany ($t(55)=1.81, ns$).

All participants gave written informed consent after the study and its objectives had been explained to them. All participants were paid 50 Euro for their participation. Investigations of both healthy and depressed Turkish participants were conducted by a native-speaking Turkish psychologist to allow flexibility regarding the investigation's language (i.e., availability of German and Turkish versions of questionnaires/interviews). Healthy Turkish and German women were solicited through advertisements in local newspapers and numerous locations in the local community (e.g., supermarkets, cinemas). Participants' responses to a telephone interview provided initial selection information. This phone screening established participants were female, did not have a university degree and never visited a psychotherapist. Potentially suitable participants were then invited to come to the laboratory for a more extensive interview.

During the interview session, trained interviewers administered the Structured Clinical Interviews for the Diagnostic and Statistical Manual for Mental Disorders, 4th edition (DSM-IV; American Psychiatric Association, 1994) for Axis-I and Axis-II disorders (SCID-I and SCID-II; First et al., 1997; First, Spitzer, Gibbon, & Williams, 1997). SCID-I and SCID-II interviews assess DSM-IV current and lifetime diagnoses for anxiety-, mood-, and psychotic-disorders, alcohol and substance abuse, somatoform- and eating-disorders as well as personality disorders. Inter-rater reliability has been shown to be fairly good to excellent for SCID-I, with kappa values ranging from .61 to .83, and excellent for SCID-II, with kappa values ranging from .77 to .94 (Lobbestael, Leurgans, & Arntz, 2010). Participants were included when they did not meet diagnostic criteria for current or history of Axis I or Axis II disorders. Several questionnaires (see below) were then handed out to these participants. They were asked to fill them out at home and send them back via mail.

Data collection of Turkish and German depressed patients was conducted in two psychosomatic clinics and one psychiatric clinic in Southwest Germany. In each clinic, one member of our research team visited group therapy sessions of patients with depressive disorders to introduce the study. Patients who were willing to participate were given several questionnaires (see below) and asked to complete them by the next study session. During the next study session, trained interviewers administered SCID-I and SCID-II interviews. Patients were excluded for a current diagnosis or history of bipolar disorder, alcohol or substance abuse and the presence of personality disorders. Participants were included in the patient samples, if they currently met the DSM-IV criteria for MDD. The Turkish patient sample included individuals with MDD single episode, mild (n=2); single episode, severe (n=1); recurrent, moderate (n=4); recurrent, severe (n=11); and recurrent, severe with psychotic features (n=11). The German patient group consisted of participants with MDD single episode, mild (n=1); single episode, moderate (n=1); single episode, severe (n=3); recurrent, mild (n=1); recurrent, moderate (n=8); recurrent severe (n=10); and recurrent, severe with psychotic features (n=1).

Questionnaires

We used the German (Hautzinger, Bailer, Worall, & Keller, 1994) and Turkish (Hisli, 1989) version of the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock & Erbaugh, 1961) as an additional tool to evaluate depressive symptoms in healthy and depressed participants. The BDI is a 21-item self-rating questionnaire, which asks participants to rate their response to items related to depressive symptoms such as hopelessness, feelings of guilt or fatigue on a scale of 0-3. Scores range from 21 to 63, with higher scores indicating a greater level of depression. Internal consistency reliability for the current samples was found to be excellent for both the Turkish (Cronbach's $\alpha=.93$) and German versions (Cronbach's $\alpha=.95$). The Turkish (Dag, 1991) and German (Franke, 2002) version of The Symptom Checklist-90-R (SCL-90-R, Derogatis, 1994) were used to assess general psychopathological complaints. The SCL-90-R consists of 90 self-rated items regarding recent physical and psychological complaints that are scored on a 5-point scale. On the basis of eight subscales (e.g., anxiety, somatization, depression), a global severity index (GSI) is calculated. Internal consistencies of the SCL-90 R scales were excellent for both the Turkish (GSI Cronbach's $\alpha=.98$) and German samples (GSI Cronbach's $\alpha=.97$).

The presence and intensity of dysfunctional beliefs were assessed with the German (Hautzinger, Luka, & Trautmann, 1985) and Turkish (Sahin & Sahin, 1992) versions of the Dysfunctional Attitude Scale Form A (DAS-A; Weissman & Beck, 1978). The DAS-A consists of 40 items rated on a 1-7 Likert-type scale ranging from "totally disagree" (1) to "totally agree" (7). In the present study, the total score used was generated by summing all 40 item scores. Higher scores indicate more dysfunctional attitudes. In the current study internal consistency reliability was shown to be good in the German (Cronbach's $\alpha=.82$) and Turkish samples (Cronbach's $\alpha=.82$).

Subjective feelings of loneliness were assessed with the German (Lamm & Stephan, 1986) and Turkish version (Demir, 1989) of the Revised University of California Los Angeles (UCLA) Loneliness Scale developed by Russell, Peplau and Cutrona (1980). This self-rating questionnaire

consists of 20 statements related to the experience of loneliness based on satisfaction of interpersonal relationships. Participants rated how often they experience each feeling on a 4-point scale (never, rarely, sometimes, often). Internal consistency of the UCLA was found to be high for the Turkish version (Cronbach's $\alpha = .88$) and satisfactory for the German version (Cronbach's $\alpha = .78$) in the current samples.

In order to measure positive and negative affectivity we administered the German (Krohne, Egloff, Kohlmann, & Tausch, 1996) and Turkish (Gençöz, 2000) version of the Positive and Negative Affect Schedule (PANAS; Watson, Clark, & Tellegen, 1988). The PANAS is a self-rating instrument consisting of 20 adjectives, 10 of which encompass positive affect (e.g., feelings of activation, enthusiasm) and 10 that encompass negative affect (e.g., distress, hostility). Participants were asked how often they have experienced these feelings within the past four weeks. Items were rated on a 5-point scale ranging from 1 (not at all) to 5 (very often). Cronbach's alphas of the PANAS scales were excellent in the German sample (positive affect: $\alpha = .92$; negative affect: $\alpha = .92$) and acceptable to excellent in the Turkish (positive affect: Cronbach's $\alpha = .65$; negative affect: Cronbach's $\alpha = .91$) version.

To assess emotion regulation strategies we used the German (Abler & Kessler, 2009) and Turkish (Yurtsever, 2004) version of the Emotion Regulation Questionnaire (ERQ; Gross & John, 2003). The ERQ is a 10-Item self-report, measuring the habitual use of expressive suppression and cognitive reappraisal as strategies to regulate emotions. Each item is rated on a seven-point Likert scale (1=strongly disagree, 7=strongly agree). The subscale of reappraisal (e.g., I control my emotions by changing the way I think about the situation I'm in) contains six items and the subscale of expressive suppression (e.g., I keep my emotions to myself) consists of four items, with subscales scored as the mean of the items. Internal consistencies (Cronbach's alpha) were good in the German (suppression, Cronbach's $\alpha = .82$; reappraisal, Cronbach's $\alpha = .88$) and acceptable to good in the Turkish version (suppression, Cronbach's $\alpha = .65$; reappraisal, Cronbach's $\alpha = .80$).

Results

Table 1 and Table 2 display socio-demographic and psychopathological complaints of healthy and depressed Turkish and German women as well as comorbid Axis-I disorders of the patient samples. Groups did not differ in age. Healthy Turkish women exhibited a significantly lower level of education than healthy German participants. They further reported a significantly higher level of psychopathological complaints in the SCL-90 and BDI. Poorer education was also found in Turkish patients. Due to education difference between Turkish and German participants in both healthy and depression groups, we controlled for education in all statistical analyses. There was also a higher level of general psychopathology in Turkish than in German depressives. Severity of depression was comparable between both groups, as the mean BDI score and the score on SCL-90 depression subscale did not differ significantly between Turkish and German patients. Comorbidity was also similar, with the exception of a significantly higher level of comorbid obsessive-compulsive disorder in Turkish depressed women.

ER Balance

Healthy Turkish immigrants ($M=3.95$, $SD=1.29$) reported higher levels of suppression than healthy German women ($M=2.77$, $SD=0.83$) ($t(52)=3.98$, $p \leq .001$, $d=1.12$), whereas there were no significant differences in cognitive reappraisal between healthy Turkish ($M=4.07$, $SD=1.18$) and German women ($M=4.66$, $SD=1.41$) ($t(52)=-1.65$, ns). Analyses of depressed patient samples revealed no significant differences, neither in the use of suppression (Turkish patients: $M=4.60$, $SD=1.43$, German patients: $M=4.41$, $SD=1.26$) ($t(52)=.52$, ns) nor in the use of cognitive reappraisal (Turkish patients: $M=3.28$, $SD=1.47$, German patients: $M=3.41$, $SD=1.01$) ($t(52)=-.36$, ns). Comparing both healthy and depressed immigrant groups, healthy Turkish women ($M=4.13$, $SD=1.12$) reported significantly higher levels of cognitive reappraisal than depressed Turkish women ($M=3.23$, $SD=1.42$) ($t(55)=-2.22$, $p \leq .05$, $d=.65$), whereas there were no significant differences in the use of suppression between both groups ($t(55)=1.78$, ns).

We created a balance score in order to test our hypothesis whether there are differences in ER balance between healthy Turkish and German women and whether these differences are absent in the clinical samples. This balance score was calculated by subtracting the mean value of cognitive reappraisal from the mean value of expressive suppression for each subject; thus while higher positive scores represent a favor of suppression over reappraisal (and *vice versa*), values close to zero imply a balanced use of both strategies. Some *t*-tests were conducted to test for significant difference scores in ER strategies and group differences. As can be seen in Figure 1, there was a significant difference in balance of ER strategies between healthy German and Turkish women ($t(52)=4.24, p \leq .001, d=1.22$). German women reported a primary use of cognitive reappraisal, as their negative difference score significantly differed from zero ($t(25)=-6.10, p \leq .001$). Turkish women reported to use both ER strategies to a similar extent, as their difference score did not significantly differ from zero ($t(27)=-.41, ns.$). Comparing the clinical samples, analyses revealed no significant differences between both groups regarding ER balance ($t(52)=-.06, ns.$). Positive difference scores of Turkish ($t(28)=3.64, p \leq .001$) and German ($t(24)=3.24, p \leq .001$) depressed patients differed significantly from zero, indicating a primary use of expressive suppression in both groups.

Associations between ER strategies and mental well-being

In order to test our hypothesis whether associations between expressive suppression and subjective well-being would differ between healthy Turkish and healthy German women, we conducted a Multivariate Analysis of Variance (MANOVA) and tested for interactive effects. Different measures of mental well-being were entered as dependent variables and group (healthy Turkish vs. healthy German women), and expressive suppression (low [$\leq 25^{\text{th}}$ percentile] vs. high [$\geq 75^{\text{th}}$ percentile]) as fixed factors. There was no main effect for suppression ($F(4, 19)=.57, ns.$) but a significant group effect ($F(4, 19)=5.58, p \leq .01, \text{partial } \eta^2=.54$), indicating significant differences between groups in terms of their mental well-being (see Table 3). Healthy Turkish

women reported significantly lower positive affectivity, more dysfunctional attitudes and greater loneliness. On entering education as a covariate, results did not change significantly.

Further, we found a significant interaction between group and expressive suppression ($F(4, 19)=3.99, p \leq .05, \text{partial } \eta^2=.45$). While for German women greater suppression was accompanied by higher negative affectivity ($F(1, 22)=5.30, p \leq .05, \text{partial } \eta^2=.19$) (see Figure 2), greater loneliness ($F(1, 22)=4.97, p \leq .05, \text{partial } \eta^2=.18$) (see Figure 3) and more dysfunctional attitudes ($F(1, 22)=15.60, p \leq .001, \text{partial } \eta^2=.41$) (see Figure 4), the reverse was true for Turkish migrant women. There was no effect for positive affectivity ($F(1, 22)=2.45, ns$). Results remained unchanged when controlling for education. The same analyses were conducted for the clinical samples. There was no group effect ($F(4, 16)=.62, ns$), implying that both patient samples did not differ in terms of their mental well-being (see Table 3). There was also no significant interaction effect ($F(4, 16)=.28, ns$), indicating that expressive suppression has the same negative impact on all mental well-being measures in both groups (see Figures 2, 3 and 4).

Given that our hypotheses suggest that differences in ER balance and suppression-outcomes are associated, we investigated whether our findings were connected in the form of a mediated moderation model. We tested for this by following the three-step procedure for mediated moderation models outlined by Baron & Kenny (1986). This involved the moderation effect of culture, which shows that expressive suppression is associated with differential mental health conditions depending on patient's culture (step1). This has already been demonstrated above. Secondly, the model was used to show that ER balance is different depending on patient's culture (step2), which has also been demonstrated above. In step3, we tested a model containing suppression scores, the interaction term (culture*suppression) and balance scores. This analysis was conducted for each dependent variable that stood out in step 1. Mediated moderation would be suggested if steps 1 and 2 were met, and additionally if in step 3 ER balance predicted measures of mental well-being, while the differential outcomes of suppression, depending on culture, were reduced. Indirect effects were tested for significance using the Sobel-test (Baron &

Kenny, 1986; Preacher & Leonardelli, 2001).

We found evidence for mediated moderation for all variables that stood out in step 1. On entering all predictors, we found an effect of ER balance scores on negative affect ($B=.31$, $\beta=.70$, $p\leq.001$), loneliness ($B=.14$, $\beta=.48$, $p\leq.01$) and dysfunctional attitudes ($B=.15$, $\beta=.35$, $p\leq.05$), whereas the interaction of culture and expressive suppression was no longer a significant predictor of any mental well-being measures. The tests of indirect effects were also significant (negative affect: *Sobel test statistic*=3.11, $p\leq.001$; loneliness: *Sobel test statistic*=3.08, $p\leq.01$; dysfunctional attitudes: *Sobel test statistic*=3.02, $p\leq.01$), suggesting that the associations between suppression and more positive mental well-being in healthy Turkish women can be attributed to their more balanced use of ER strategies.

Discussion

Our findings are in line with several other studies, suggesting cultural differences in ER practices and health outcomes (Consedine et al., 2002; 2005; Gross & John, 2003). More recently, Butler and colleagues (2007) found that among Asian and European Americans, those individuals holding collectivistic values showed less negative consequences of emotional suppression. However, their study focused primarily on *interpersonal* outcomes, such as social withdrawal and responsiveness and placed less emphasis on the effects of suppression on *intrapersonal* functioning. The present study addresses this gap by showing that individuals holding Eastern collectivistic cultural values may benefit from emotional suppression not only at the social level, but also at the individual level in terms of lower negative affectivity, loneliness, and dysfunctional attitudes.

Furthermore, it could be shown that these benefits of emotional suppression in healthy Turkish women can be attributed to their additional use of cognitive reappraisal and hence greater ER balance in comparison to their German counterparts. There is also evidence from other studies, pointing to cultural differences in the flexibility/balance of ER strategies. Intercultural studies

carried out by Bonanno and colleagues (Bonanno, 2005; Bonanno, Papa, Lalande, Nanping, & Noll, 2005) have shown that in contrast to participants with Western individualistic cultural values (e.g., USA), individuals from collectivistic cultures (e.g., China) are characterized by a more balanced repertoire of coping strategies, which enables them to flexibly move between expressing and suppressing emotions. Similarly, Miyamoto and colleagues (Miyamoto & Ma, in press) have shown in several studies, first, that Easterners combine both up- and down regulation strategies in order to experience a balance between positive and negative emotions, and second, that this dialectical regulation is related to a better health profile in Eastern than in Western cultures.

In contrast, we did not find cultural differences in balance and mental health outcomes of ER in the depressed samples. These results are in accordance with previous research, relating psychopathology to a rigid and contextually insensitive application of ER strategies (Mennin, Holaway, Fresco, Moore, & Heimberg, 2007), in particular to the inflexible use of emotional suppression (Aldao & Nolen-Hoeksema, 2010). In their review on ER strategies in depressed individuals, Joormann and D'Avanzato (2010) conclude, that depression may not be so much associated with the use of ER strategies which differ dramatically from strategies used by other people, but rather with an *inflexible use* of specific strategies: the poor fit of the strategy to the situation, and differences in the ability to implement important effective strategies

Furthermore, the present results substantiate earlier studies, demonstrating that cultural differences in emotional processes shrink or disappear when it comes to psychopathology (Schrier et al., 2010). Therefore, it can be assumed that Turkish immigrant patients may benefit from an ER skills training which is commonly applied in Western therapeutic approaches (e.g., Beck, Rush, Shaw, & Emery, 1979). However, there is some evidence that cultural variability decreases as psychological disturbance becomes more severe (Draguns & Tanaka-Matsumi, 2003). Given that patients of our samples can be considered as relatively serious cases, exhibiting moderate-to-severe depressive symptoms, the examination of less disabling forms of psychopathology might have revealed different results.

There is mounting evidence that a flexible use of emotion regulation strategies is an indication of resilience. The ability to balance ER strategies and the use of flexible forms of emotional expression was shown to be related to higher effectiveness in problem solving (Blanchard-Fields, 2007), lower current (Mino & Kanemitsu, 2005) and prospective levels of distress (Bonanno et al., 2004). Additionally, emotional flexibility has been related to higher bicultural competence and better integration of immigrants (Eng et al., 2005; Matsumoto et al., 2006). Accordingly, a balanced use of ER strategies may have prevented healthy Turkish women from the development of mental disorders in contrast to their depressed compatriots. Importantly, both healthy and depressed immigrant groups did *not* differ in frequency of suppression but rather in the additional use of cognitive reappraisal. This may enable healthy Turkish women to flexibly adapt to alternating culture-specific communication requirements and hence achieve a better integration that may buffer deleterious effects of acculturation stress (Crockett et al., 2007).

Several caveats for this study are noteworthy. The major limitation of the present study concerns the relatively small sample sizes of the groups investigated. As a consequence, the risk of type-II error was elevated and some of the associations among variables may have been significant with larger sample sizes. However, it must be noted, that in the current study special emphasis was given to avoiding sampling bias, which has permeated many previous studies on this topic, investigating young, highly educated and privileged college students (Consedine et al., 2002, 2005). Recruitment criteria such as middle adulthood, low to moderate education, and in the case of Turkish immigrants, Turkey as birthplace and immigration after the age of eleven were set at the expense of larger samples sizes.

Additionally, it is important to mention that all participants in the present study were female. The generalizability of the present findings to the male population remains to be explored, as there is evidence for gender differences in the associations between ER strategies and mental well-being (Thayer, Rossy, Ruiz-Padial, & Johnsen, 2003).

Another limitation stems from how ER balance was operationalized in the present study.

Instead of calculating balance scores representing (a)symmetry of ER repertoire, we could have directly measured ER flexibility by using specific questionnaires (e.g., Coping Flexibility Questionnaire, CFQ; Cheng, 2001) or situational measurements, e.g., Ecological Momentary Assessment (EMA). Future studies might use more sophisticated measurements that also include ER strategies other than cognitive reappraisal and expressive suppression.

In sum, the present research serves to mitigate the rigid distinction between the culturalist and universalist views on emotional phenomena. On the one hand, current findings demonstrate the importance of going beyond the conception of ER as an individual process and considering ER as a sociocultural phenomenon. On the other hand, the present study points out that the impact of cultural factors on emotional processes is not unlimited, as it shows the absence of cultural differences in frequency and outcomes of ER strategies in clinical samples. Future research is required in order to shed more light on universal and culturally specific features of ER.

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Attachments

Table 1 Demographic characteristics of healthy Turkish (HC Turk, n=28) and healthy German women (HC Ger, n=26) and depressed Turkish (DEP Turk, n=29) and German patients (DEP Ger, n=25)

	HC Turk	HC Ger	DEP Turk	DEP Ger	<i>t</i> -Test /Chi-square test <i>t/p</i> , χ^2/p (effect size)	
					HC Turk vs. HC Ger	DEP Turk vs. DEP Ger
Mean age, yr (SD)	43.6 (9.6)	43.8 (11.2)	44.4 (8.1)	43.4 (10.7)	^a <i>t</i> =0.1/ns	<i>t</i> =0.4/ns
Place of Birth, %						
Turkey	100	0	100	0	^b $\chi^2=48.0/***$	$\chi^2=53.0/***$
Germany	0	100	0	100	(^c $\lambda=.92$)	($\lambda=.95$)
Years in Germany, mean (SD)	20.4 (11.1)	----	25.1 (8.1)	----	----	----
Marital status, %						
Single	0	15.4	3.4	36.0		
Married/Cohabiting	75	69.2	65.5	28.0	$\chi^2=8.3/*$	$\chi^2=11.1/**$
Divorced/Separated	10.7	15.4	31.0	36.0	($\lambda=.12$)	($\lambda=.18$)
Widowed	14.3	0	0	0		
Number of children, mean (SD)	2.3 (1.1)	1.5 (0.9)	2.5 (1.1)	1.2 (1.2)	<i>t</i> =2.7/**	<i>t</i> =3.8/***
					(^d <i>d</i> =.7)	(<i>d</i> =1.1)
Education, %						
No graduation	7.1	0	6.9	0		
High school (8 grades)	57.1	7.7	69.0	16.0		
High school (10 grades)	17.9	61.5	24.1	56.0	$\chi^2=19.6/***$	$\chi^2=21.8/***$
Advanced high school (13 grades)	10.7	23.1	0	20.0	($\lambda=.42$)	($\lambda=.43$)
Technical College	7.1	7.7	0	8.0		

Note: ^a degrees of freedom for all *t*-tests *t* (52); ^b degrees of freedom for all chi-square tests *df*=1; ^c Goodman and Kruskal's lambda as chi-square effect size measure; ^d Cohens's *d* as effect size measure for mean comparisons; (----) not calculated; **p*≤.05, ***p*≤.01, ****p*≤.001; ns, not significant

Table 2 Clinical characteristics of healthy Turkish (HC Turk, n=28) and healthy German women (HC Ger, n=26) and depressed Turkish (DEP Turk, n=29) and depressed German women (DEP Ger, n=25)

	HC Turk	HC Ger	DEP Turk	DEP Ger	<i>t</i> -test/MANOVA/Chi-square test <i>t/p, F/p, χ^2/p (effect size)</i>	
					HC Turk vs. HC Ger	DEP Turk vs. DEP Ger
Psychopathological complaints						
(SCL 90-R), Means (SD)						
Somatization	1.2 (0.7)	0.2 (0.3)	2.3 (0.8)	1.5 (0.7)	^d <i>F</i> =34.1/***(^e <i>d</i> =1.1)	<i>F</i> =14.7/***(<i>d</i> =1.0)
Obsessive-compulsive attitude	1.2 (0.6)	0.2 (0.3)	2.3 (0.8)	1.8 (0.9)	<i>F</i> =40.0/***(<i>d</i> =2.2)	<i>F</i> =5.0/*(<i>d</i> =.5)
Interpersonal sensitivity	0.9 (0.6)	0.2 (0.3)	1.8 (0.7)	1.2 (0.6)	<i>F</i> =26.4/***(<i>d</i> =1.5)	<i>F</i> =9.1/**(<i>d</i> =.9)
Depression	1.1 (0.6)	0.2 (0.3)	2.3 (0.8)	1.9 (0.7)	<i>F</i> =30.1/***(<i>d</i> =2.0)	<i>F</i> =3.1/ns
Anxiety	0.8 (0.6)	0.1 (0.3)	2.0 (0.7)	1.3 (0.8)	<i>F</i> =19.5/***(<i>d</i> =1.5)	<i>F</i> =11.5/***(<i>d</i> =.9)
Hostility	0.8 (0.5)	0.2 (0.4)	1.7 (0.8)	0.7 (0.5)	<i>F</i> =11.6/***(<i>d</i> =1.3)	<i>F</i> =23.3/***(<i>d</i> =1.5)
Phobic anxiety	0.5 (0.5)	0.1 (0.3)	1.5 (0.9)	0.9 (0.8)	<i>F</i> =11.6/***(<i>d</i> =1)	<i>F</i> =5.7/*(<i>d</i> =.7)
Paranoid ideation	0.9 (0.6)	0.2 (0.2)	1.8 (0.8)	0.8 (0.5)	<i>F</i> =25.5/***(<i>d</i> =1.7)	<i>F</i> =26.2/***(<i>d</i> =1.5)
Psychoticism	0.6 (0.4)	0.1 (0.1)	1.4 (0.7)	0.6 (0.3)	<i>F</i> =32.3/***(<i>d</i> =1.6)	<i>F</i> =25.4/***(<i>d</i> =1.6)
Global severity index (GSI)	0.9 (0.5)	0.2 (0.3)	2.0 (0.6)	1.3 (0.4)	<i>F</i> =34.4/***(<i>d</i> =1.7)	<i>F</i> =17.9/***(<i>d</i> =1.4)
Beck Depression Inventory,						
Total scores, Means (SD)	7.0(4.7)	3.7(4.5)	32.4 (12.8)	26.7 (11.2)	^f <i>t</i> =4.3/***(<i>d</i> =.7)	<i>t</i> =1.7/ns
Comorbid Axis I disorders, %						
Anxiety disorders ^a			10.3	16.7		^g $\chi^2=0.4/ns$
OCD ^b	----	----	31.0	4.2	----	$\chi^2=6.1/**(\lambda=.1)$
PTSD			3.4	8.3		$\chi^2=0.5/ns$
Eating disorders ^c			0	8.3		$\chi^2=2.5/ns$

Note: ^aincluding panic disorder with/without agoraphobia, agoraphobia without panic disorder, social phobia and simple phobia; ^bOCD=obsessive compulsive disorder; ^cincluding anorexia nervosa, bulimia nervosa and not otherwise specified eating disorders; ^ddegrees of freedom for all *F*-tests *F*(10, 42); ^eCohens' *d* as effect size measure for mean comparisons; ^fdegrees of freedom for all *t*-tests *t* (52); ^gdegrees of freedom for all chi-square tests *df*=1; ^hGoodman and Kruskal' s lambda as chi-square effect size measure; (----) not calculated; **p*≤.05, ***p*≤.01, ****p*≤.001; ns, not significant

Table 3 Statistical comparisons (multivariate statistics) between healthy Turkish (HC Turk, n=28) and German (HC Ger, n=26) women and depressed Turkish (DEP Turk, n=29) and German (DEP Ger, n=25) patients in different measures of mental well-being

	HC Turk	HC Ger	DEP Turk	DEP Ger	MANOVA, F/p (Cohen's d) ^d	
					HC Turk vs. HC Ger	DEP Turk vs. DEP Ger
^a PANAS Positive Affectivity, Mean (SD)	2.9 (0.6)	3.6 (0.5)	2.7 (0.5)	2.4 (0.5)	^e F=19.1/* (1.2)	F=0.1/ns
PANAS Negative Affectivity, Mean (SD)	2.3 (0.8)	2.1 (0.6)	3.4 (0.9)	3.5 (0.7)	F=0.1/ns	F=0.6/ns
^b UCLA, Loneliness, Mean (SD)	2.0 (0.5)	1.5 (0.3)	2.4 (0.6)	2.2 (0.4)	F=12.5/***(1.2)	F=0.6/ns
^c DAS Dysfunctional Attitudes, Mean (SD)	3.4 (0.6)	2.7 (0.6)	3.9 (0.6)	3.7 (0.8)	F=15.6/***(1.1)	F=1.6/ns

Note: ^aPositive and Negative Affect Schedule (Watson, Clark, & Tellegen, 1988); ^bUCLA-Loneliness Scale (Russel, Peplau, & Ferguson, 1978); ^cDysfunctional Attitude Scale (Weissman & Beck, 1978); ^dCohen's d is standardized difference, obtained by dividing the difference between group means by the pooled within group standard deviation; ^edegrees of freedom for all F-tests F(4, 48); *p≤.05, ***p≤.001; ns, not significant

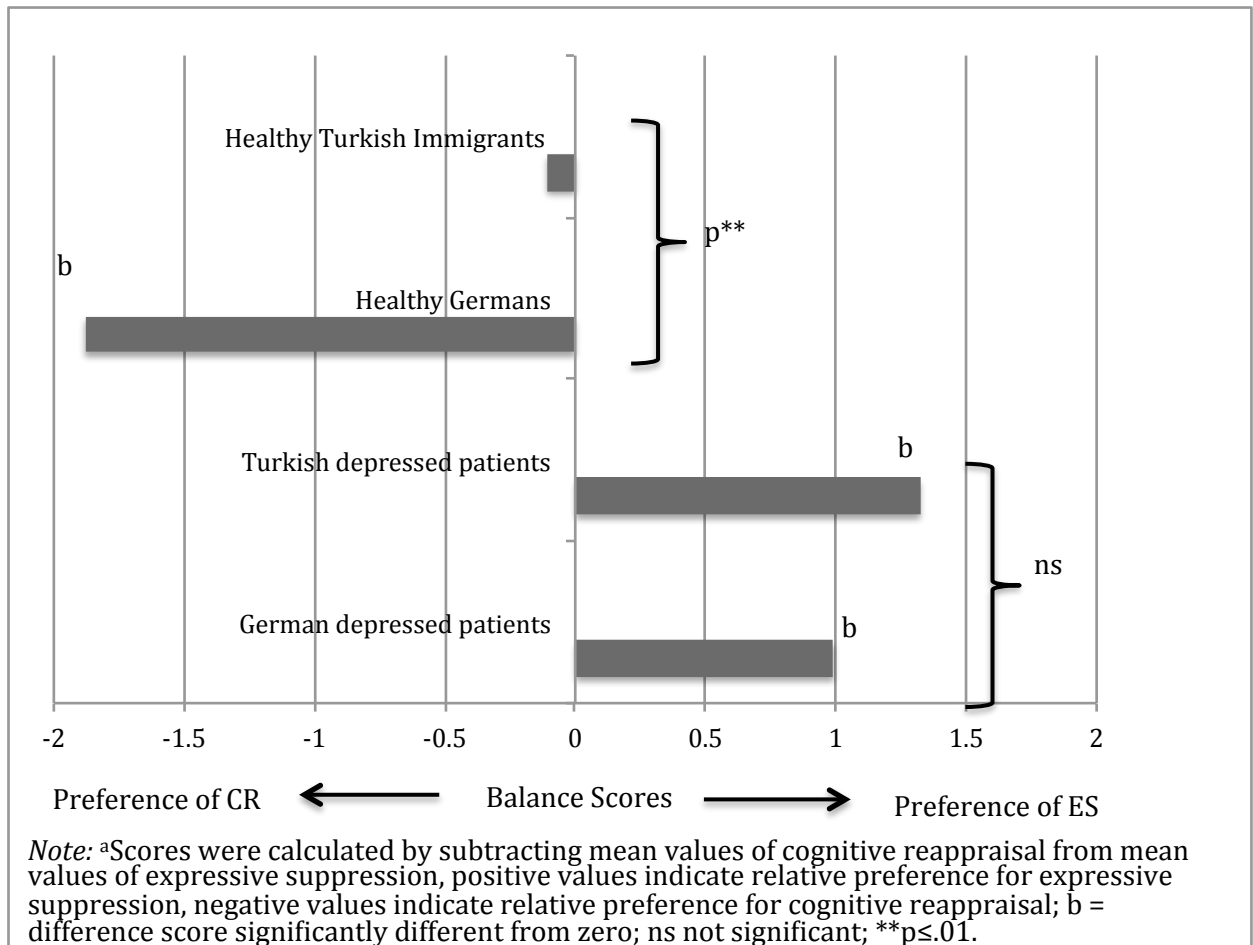


Figure 1 Balance scores^a between expressive suppression (ES) and cognitive reappraisal (CR) in Turkish (n=28) and German healthy controls (n=26) and Turkish (n=29) and German depressed patients (n=25)

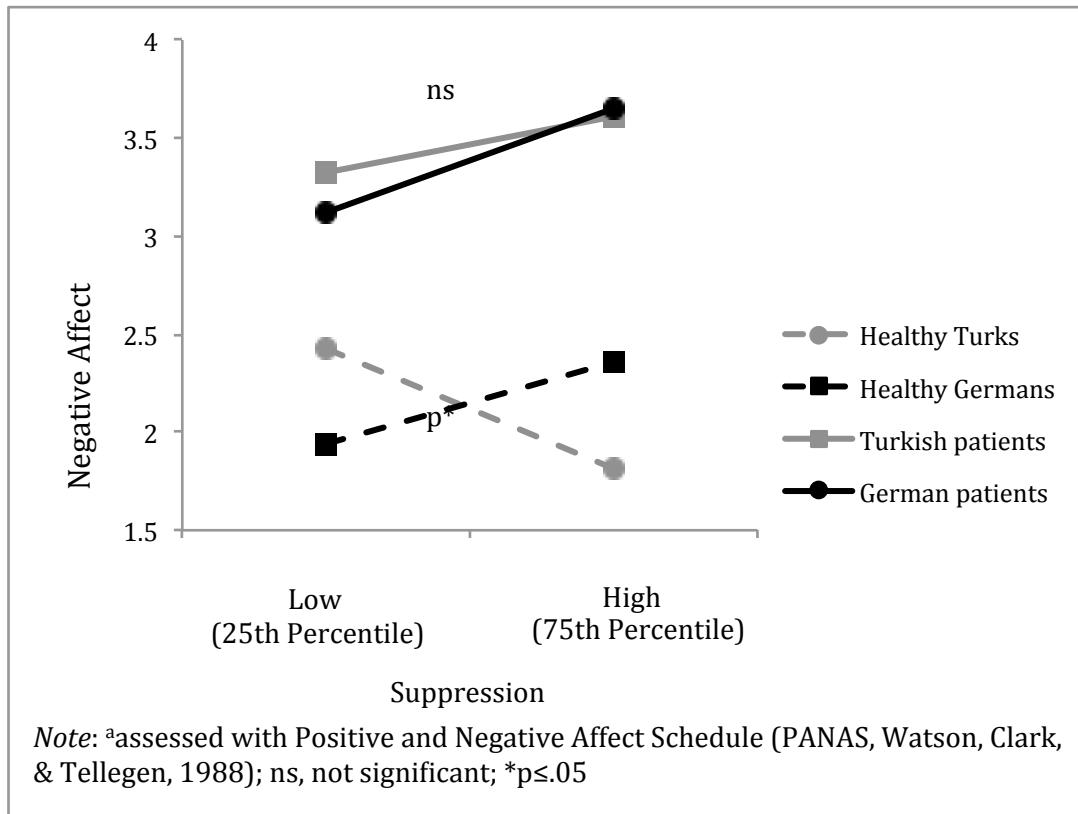


Figure 2 Negative affect^a depending on expressive suppression and culture in healthy Turkish and German women and depressed Turkish and German patients.

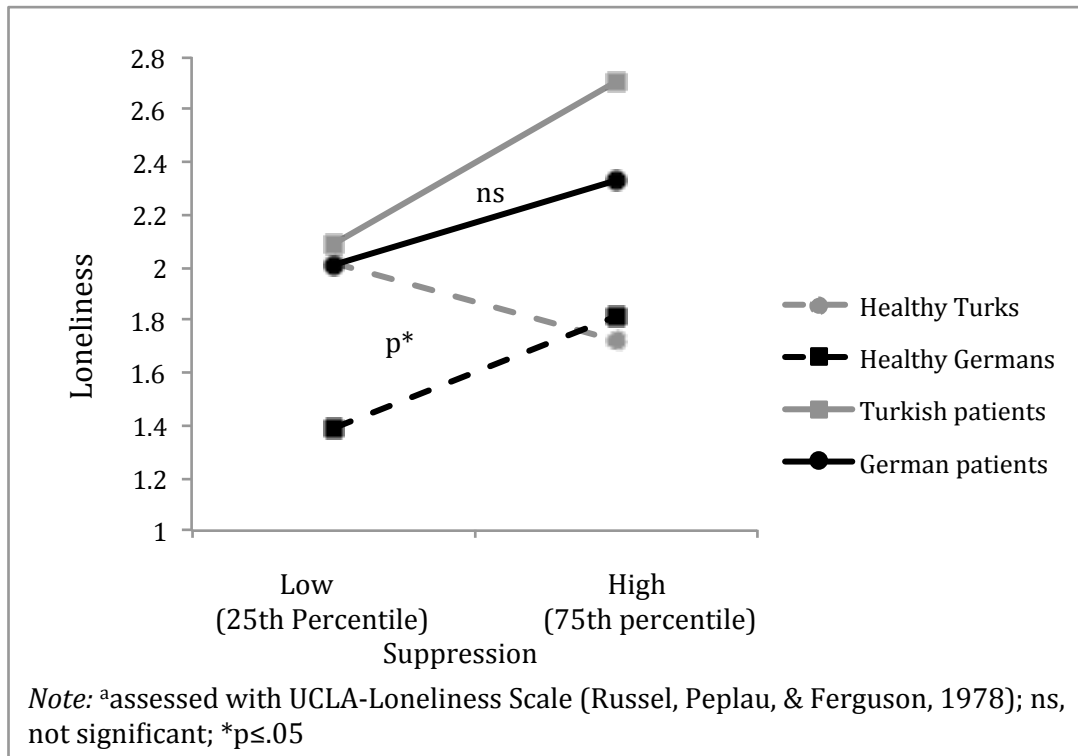


Figure 3 Loneliness^a depending on expressive suppression and culture in healthy Turkish and German women and depressed Turkish and German patients.

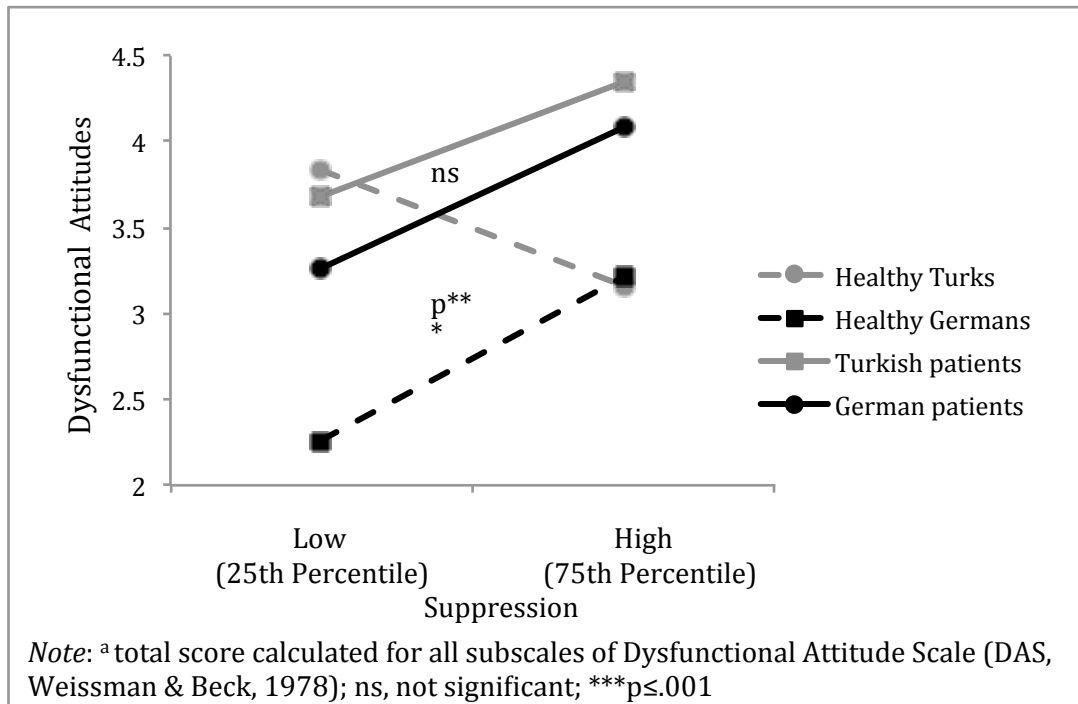


Figure 4 Dysfunctional attitudes^a depending on expressive suppression and culture in healthy Turkish and German women and depressed Turkish and German patients.

7.4. Appendix IV

Title: Mental illness models and help seeking behaviors among Turkish immigrant patients in Europe

Author: Nazli Balkir

Abstract

Although Turkish immigrants in Europe are identified as a vulnerable group with respect to higher prevalence rates of mental disorders, numerous studies constantly report that they fall outside the existing mental health care services. In order to provide insights into the underutilization of mental health care services, premature treatment termination and low treatment adherence among this patient group, an examination of their help seeking behavior is essential. Therefore, the current chapter examines the antecedents of help seeking behavior among Turkish patients suffering from psychiatric disorders considering their social and cultural context. Despite modernizing and acculturative influences, studies have demonstrated that culture is a major determinant of Turkish patients' recognition of symptoms and how these individuals interpret, make sense and react to distress. All of which determine the choice of and adherence to treatment. A better understanding of cultural determinants of help seeking pathways may provide practical solutions for (not only) Turkish immigrant patients' differential utilization of mental health care services and therefore compensate the existing treatment gap. The clinical implications of the findings are discussed.

Keywords: *Turkish, immigrants, somatic, symptoms, causal attribution, help seeking, mental health care*

Introduction

Nowadays, the demographic profile of European population is considerably far from being homogenized. Migration has been stated as a key force in this demographic diversity of European population involving 56 million international immigrants (Carta, Bernal, Hardoy & Haro-Abad, 2005). Numbering nearly 4 million, Turkish immigrants form the largest immigrant group in Western Europe. The largest number of Turkish immigrant workers is to be found in Germany followed by France, Netherlands, Austria, Belgium, Switzerland, United Kingdom, Sweden, Denmark, Italy and Norway (Manco, 2004).

Immigrants tend to bring with their own values and practices, which could be very different from those of the host culture, as they immigrate and settle in a new country. The adaptation to their new environment brings along difficulties that immigrants have to cope with when they integrate new styles and norms of interpersonal relationships, social habits and rules, organization of community services, etc. to initiate a new life in a different culture (Rios, 2008). The psychological effect derived from adapting to such a situation, known as acculturative stress, is added to the difficulties that normally characterize immigration (e.g. loss and bereavement). According to a recent report on "State of the Mental Health in Europe" the risk of distress in immigrants against natives were found as 1.0 in Belgium, 1.2 in Netherlands, 1.4 in Spain, 4.3 in Germany and 4.7 in France (The State of the Mental Health in Europe, 2004, cited in Carta et al., 2005). Furthermore, several studies indicated that the immigration and its related acculturation stress are associated with higher risk for mental disorders, such as anxiety and depression (e.g. Bhugra, 2003). This might be especially true for Turkish immigrants, as they are the largest but also one of the lowest integrated group in Europe (e.g. German Federal Office for Statistics, 2008). The strong clash of values places them at particular high risk of social isolation and psychological distress compared to immigrants from other parts of Europe and native population. In support of this, an epidemiological study in Belgium by Levecque, Lodewyckx and Vranken (2007) demonstrated that the immigrants originating from Turkey and Morocco reported

significantly higher levels of depression and anxiety in comparison with other European immigrant groups and Belgian natives. Comparably, a recent study conducted in Germany indicated that Turkish patients in General Practice showed an increased number of psychological symptoms and a higher rate of mental disorders compared to German patients. Notably, the study also indicated higher rates of mental disorders among Turkish women immigrants (55 %) compared to their men counterparts (35 %). Most prevalent were anxiety and depressive disorders (Tydecks, Temur-Erman, Schoular-Ocak & Fydrich, 2009). Likewise, a recent study carried out with a sample of Turkish immigrants in Netherlands, found a prevalence rate of minor psychiatric disorders¹ (33.4% in general, 36.1% in females, 27.9% in males) higher than those normally found in community-based samples. This increased prevalence of depression in women immigrants can be attributed to sex differences in biological and/or psychosocial functioning (Bengi-Aslan, Verhulst & Crijnen, 2002) (see Chapter 1).

In order to minimize the disability, a compensation of the treatment gap (i.e. the absolute difference between the prevalence of the disorder and the treated proportion of the individuals) is essential (Kohn, Saxena, Levav & Saraceno, 2004). However, despite the higher prevalence rates of mental disorders, Turkish immigrants are less likely to seek professional care, exhibit higher rates of drop out and lower rates of compliance to treatment compared to native population. For instance, studies conducted in Germany provide an evidence for lower rates of immigrant admissions to mental health care services compare to native population (Haasen, Lambert, Yagdiran & Krausz, 1997). Moreover, in Turkish patients, it was revealed that linguistic barriers are associated with more frequent involuntary hospital admissions and less frequent release from hospital after regular treatment (Künzler, Garcia-Brand, Schmauss & Messer, 2004). Another study on service utilization in women immigrants in Amsterdam found that Surinamese, Antillean, Turkish and Moroccan women made considerably less use of mental health care services than native born women. It was found out that immigrant women consulted, in stead, social work

¹ Minor psychiatric disorders (MPD) are understood as symptoms such as depression, anxiety, fatigue, irritability, insomnia and memory and concentration deficit (see Harding et al., 1980).

facilities and women crisis intervention centers nearly 1.5 times more often than mental health care services (Ten Have & Bijl, 1999). A similar portrait was revealed in Switzerland. For example, Lay, Lauber and Rossler (2005) demonstrated that Turkish women in-patients had higher rates of compulsory admission, were more unlikely to be readmitted and spent significantly shorter time in hospital compared with Swiss women in-patients. To summarize, these results demonstrate a significant underutilization of mental health services and delayed treatment among (Turkish) immigrants. Thus, a broader understanding of the factors associated with their lower rates of service utilization is necessary.

Numerous studies report service underutilization among Turkish immigrants in Europe, however it is still not sufficiently understood why many Turkish immigrants are reluctant to use the mental health care system, or what do they experience before their encounter and during their exposure. Much of this fault can be imputed to the fact that most research on service use in Turkish immigrants has omitted to consider the social and cultural context in which help seeking is initiated (McKinlay, 1972). It has been demonstrated that people from all cultures seek help for their suffering based on the meaning culture ascribes to the suffering (White & Marsella, 1982). Therefore, a better understanding of cultural determinants of help seeking pathways might provide insights into ethnic group differences in mental health care utilization.

2. Cultural determinants of help seeking behavior

In this chapter, help seeking refers to the attempts to maximize well-being or to ameliorate, minimize illness (Saint Arnault, 2009). A comprehensive understanding of help seeking pathway requires an enlargement of the scope of the research agenda beginning with the time when a problem is first recognized. Once a problem is recognized, labeled and interpreted the decisions regarding seeking help and the selection of help provider take place. A large amount of empirical psychological and anthropological literature clearly documented that cultural models determine the perceptual, explanatory and behavioral options for understanding and responding to illness (e.g. Mechanic, 1973; Fabrega, 1974; Chrisman & Kleinman, 1983). Therefore, culture has an

extensive influence on the entire stages of help seeking pathway, including recognition (i.e. what to attend or ignore?), labeling (i.e. what does it mean?) and interpretation of the problem (i.e. what is the cause? how serious is it?) and therefore the choice of treatment providers (i.e. what can be done, who can heal it?) (e.g. Cauce et al., 2002; Bhui et al., 2003; Briones et al., 1990).

2.1 Recognition and the labeling of the problem: Somatic symptoms in Turkish patients

Kirmayer and Sartorius (2007) pointed out that an analysis of sensation and symptoms are the pivotal units in understanding illness experience. In their comprehensive work, Hinton and Hinton (2002) denoted that cultural models guide processes of sensation amplification, which alter the perception and awareness of arousal sensations. Likewise, Zola (1966, 1973) also provided an empirical evidence that culture has a significant effect on the recognition of symptoms, which, in turn, affecting health communication. Some cultures are suggested to have a deeper awareness for the physiological shifts. Conversely, others are portrayed with less attention to the bodily sensations but have a more extensive emotional awareness (Saint Arnault, 2009). For instance, there is a precise separation between physical and emotional experience in Western European languages. In Turkish language, however, emotional perceptions are figuratively expressed through representations of body sensations (Nickel et al., 2006) (see Chapter 8). Either physical or emotional, the alterations in one's sense of well-being are then said to be cognitively differentiated into the categories of normal or abnormal. Several psychological and anthropological studies documented that culture has a profound impact on categorizations of states as normal or abnormal. At this point, normality is assessed through comparisons with the average health status of one's reference group. If an abnormal physical or emotional condition is prevalent in reference groups, then individuals are less likely to attribute great significance to it. This categorization regarding normality is what Angel and Thoits (1987) called "first-order categorizations". These authors argued that the lack of predictive power of most of the large-scale surveys investigating help seeking behavior among culturally diverse patients is mainly due to the influence of culture on this pre-symptom, which has cumulative effects on the entire help seeking behavior. Nevertheless,

there is a lack of empirical studies about these early stages of the illness modeling process in this particular patient population.

Once the physical or emotional change is noticed and referred as abnormal, second-order categorizations are made in order to determine whether this abnormal state is an indicative of an illness (i.e. symptom). Sequentially, a further evaluation is made according to whether the underlying disorder is physical or psychological in nature (Angel & Thoits, 1987). There is some evidence that the organization of symptoms into consistent categories is considerably influenced by folk knowledge. Members of traditional cultures such as Turkey may differentiate less between psychological and physical symptoms and therefore experience in a holistic fashion. Given the emotions also have physical effect on bodily functions; both physical and emotional symptoms may be viewed as physical disorder. Individuals who hold more “scientific” orientations differentiate between these types of disorder to a greater degree (Angel & Thoits, 1987; Saint Arnault, 2009). The traditional Turkish who experience what modern medicine recognize as depression as physical illness are a prime example. There is considerable evidence demonstrating high prevalence of somatic symptoms among this patient group living in Germany (Diefenbacher & Heim, 1994), in Netherlands (Limburg-Okken 1989) and in Denmark (Mirdal, 1985). Likewise, Schmeling-Kludas, Frfschlin and Boll-Klatt (2003), reported that most prevalent psychiatric disorder diagnosed in this population are some type of somatoform disorder (over 60%), which can be interpreted as related to a culturally-patterned perceptual focus on the body rather than a difference in levels of distress (Nickel et al., 2006). In the light of aforementioned facts, Turkish immigrants from traditional Eastern cultural backgrounds might label such psychological distress as somatic illness and present distress as physical illness in medical settings (Karasz, 2005). Given that this particular population hardly corresponds bodily symptoms to psychoemotional factors, it might be that they rarely view psychiatric treatment as an acceptable or valuable tool for recovery. Thus, help seeking among Turkish immigrants is usually organized around the presentation of bodily complaints rather than explicit mention of emotional disturbance or family conflict and

seek a physical cure in primary care settings. Thus, an overexpression of somatic symptoms should alert physicians to peruse the possible existence of minor psychiatric disorders in order to improve the patient care (Bengi-Arslan et al., 2002).

2.2 Interpretations of Illness: Causal attributions as a cultural product

Further categorizations in the construction of illness meaning involve additional dimensions, such as cause, seriousness, prognosis and responsibility by which the patients make further evaluations about their disorder and thus decide upon an appropriate source for help (Angel & Thoits, 1987). A similar perspective, explanatory model (EM) perspective, coined by medical anthropologist Arthur Kleinman (1978), has also directed attention to eliciting the cognitive aspects of patients' understanding of their illness in order to unravel their help seeking behaviors and responses to clinical interventions.

EM is the patient's understanding of the cause, severity, and prognosis of an illness; the expected treatment; and how the illness affects his or her life (Kleinman, 1980). In essence, it is the meaning of the illness for the patient. It has been stated that patients' explanatory models of illness are, to a large extent, culturally determined. These explanations, in turn, are said to set up expectations that influence the ways that individuals attend to their bodies and the sorts of symptoms they recognize and report to others (Groleau, Young & Kirmayer, 2006) (see Chapter 15).

Causal attributions are suggested to be a pivotal cognitive process in the construction of EM of illness (Kirmayer, Young and Robbins 1994). Given the EMs are said to be coherent with general cultural beliefs about sickness and health care as well as they are historical and sociopolitical constructs, several anthropological studies differentiated between Western and non-Western causal beliefs (i.e. causal attributions) about mental distress (Marsella & White, 1982). It has been stated that social and supernatural etiologies are associated with more traditional societies of non-Western cultures whereas natural or patient-centered explanations of distress are more commonly found in Western industrialized societies (Landrine & Klonoff, 1992). For

instance, among Europeans, the causes of psychological illness is more likely to be located within the individual whereas many non-Western and minority cultures cite supra-individual or social relationships as causal (Marsella & White, 1982). Moreover, with the advantage of a medical and social science history for hundreds of years, medical agenda is commonly adopted by Western societies to understand and interpret the experience of mental illness. Such understanding of psychopathology does not exist in traditional Eastern societies. Furthermore, Littlewood and Lipsedge (1997) underlined the historical importance of religion in such traditional cultures and its significance in the understanding of mental illness. In support of aforementioned arguments, a study conducted in rural areas of Turkey revealed that lay beliefs concerning causes of mental illnesses are strongly religious in nature and involved possession of jinns, spiritual entities whose existence is accepted by Islam, sorcery or evil eye rather than organic causes (Öztürk & Vamik, 1971). Similarly, a study, which was conducted with Turkish immigrants in Australia, revealed two dimensions of causal beliefs distinctly interpretable as natural and supernatural. The findings showed that while beliefs in natural causes (e.g. stress, infections and organ damage) are more common, beliefs in supernatural causes (e.g. fate, sorcery, mysticism -breaking taboos, the disrespect to religious and cultural practices) persist despite modernizing and acculturative influences (Minas, Klimides & Tuncer, 2007). Additionally, in a study of Turkish psychiatric outpatients in Turkey, Karanci (1986) found that these patients mainly attribute the cause of their disorder to interpersonal conflicts, conflicts within the current family, conflicts in the family of origin, fate and marital problems, personal characteristics, blame on others and lack of willpower. In a similar study of Turkish psychiatric outpatients in Turkey, a total of seven different dimensions for causal beliefs were revealed, namely, conflict with the current family and family of origin, personal characteristics and behaviors, problems with work, interpersonal conflicts and bad luck. The highest values were obtained for the conflict with the current family (Karanci, 1993). On the contrary, Townsend (1975) in a cross-cultural study demonstrated that German patients

regarded mental illness as biologically determined whereas American patients believed that mental illness is a behavioral phenomenon.

Notably, the findings also suggest that the patients' beliefs regarding what caused their illness play an important role in the organization of effective healing strategies (Hall & Tucker, 1985). Likewise, it has been suggested that the beliefs that people hold for their illnesses have an impact on the decision to seek medical care, adherence to treatment and adjustment to prognosis (Sensky, 1997). For instance, psychiatric patients who attribute their illnesses to supernatural agents; witchcraft and possession by evil spirits are more likely to seek help for their problems from traditional healers (Razali, Hasanah, Aminah & Subramaniam, 1998). Furthermore, Foulks, Persons and Merkel (1986) demonstrated that patients who endorse more medical beliefs about the causes of their illness are more likely to seek help from medical sources and exhibit higher levels of compliance than the patients who hold more non-medical beliefs.

Given that most of the Turkish immigrants in Europe came from rural areas of Turkey, were relatively low educated people who had a strong commitment to Islamic religious practices and the extended family, and had (and still have) to deal with an urban and individualistic Western society (Al-Issa & Tousignant, 1997), it can be argued that the underutilization of mental health care services, premature treatment termination and low treatment adherence among Turkish immigrant patients might be attributed to such cultural variations in EM of mental illness. Although there is considerable evidence demonstrating culturally diverse causal attributions among Turkish patients, their link to their choice for treatment providers was poorly investigated.

To address this issue our research team aimed to explore the ethnic differences in causal beliefs about major depression and whether ethnicity or discrepant causal beliefs is most relevant for decisions regarding an appropriate source for help (Balkir et al., manuscript in preparation). To this aim, a qualitative study design was used based on an explanatory model of illness. 39 Turkish immigrant and 27 German female depressive inpatients were interviewed with a semi-structured interview protocol for their beliefs concerning the factors responsible for disease (causal beliefs)

and the appropriate source for help. A content analysis procedure was employed through focus group discussions to identify and code specific categories within the data. Causal beliefs involved three main domains composed of social (interpersonal vs. non-interpersonal) psychological (personality, psychological trauma etc.) and biological (genetic/neurological, biomedical attributions) factors. Ethnicity was not a significant predictor for adopting social factors as causes. However, compared to Turkish patients, Germans were more likely to address psychological and bio-medical factors responsible for their health conditions. Concerning treatment, compared to Turkish patients, Germans were far more likely to recommend professional treatment (e.g. psychotherapy, medication, psycho-education, alternative therapies like relaxation or ergo) as the most valuable tool for recovery. On the other hand, compared to Germans, Turkish patients were more likely to recommend non-professional help sources (e.g. social support, self initiation) (Table 1). Further, it has been revealed that causal beliefs (attribution to psychological and biological factors) mediate the relationship between ethnicity and preference of professional treatment resources (Figure 1). These results indicate that the difference between Turkish and German depressive patients concerning the preference for seeking professional help could be explained by the differences in their beliefs concerning the causes of depression (predominance of psychological and biological attributions in German patients).

---Insert Table 1 about here---

---Insert Figure 1 about here---

Our findings clearly document the gap between popular Turkish lay beliefs about the cause of mental distress, which are said to rely mainly on familial or social conflicts and the culture of Western medicine, in which mental distress is mainly seen as a result of malfunctioning in or maladaptation of biological and/or psychological processes in addition to social problems. Thus, the Turkish patient group rarely sees professional treatment (e.g. psychotherapy, psychotropic

drugs, psycho-education) as a valuable tool for recovery. Instead, the source for recovery is seen as regaining social harmony within the family and social environment. A similar empirical evidence for the support of this argument came from a recent comparative study (Calliess et al., 2007). It was illustrated that overall the Turkish population reported a less positive attitude towards psychotherapy in comparison to the German population. The Turkish immigrants with a less traditional cultural background reported a more positive attitude towards psychotherapy when compared to Turkish immigrants of a more Turkish identified traditional cultural background. Not surprisingly, it was also reported that Turkish immigrant women in Amsterdam consulted social work facilities and women crisis intervention centers nearly 1.5 times more than mental health care services (Ten Have & Bijl, 1999). Although religion, prayer and spirituality were shown by previous studies as the key aspects of beliefs about the nature of mental illness and coping styles of the patients in rural areas of Turkey, our research did not reveal any religious aspect of causal beliefs or treatment preferences (Sunter, Guz, Ozkan & Peksen, 2006; Öztürk & Vamik, 1971). As Kirmayer and Sartorius also denoted (2007), the aforementioned results suggest that those patients are not only seeking mitigation of symptoms but also individually and socially meaningful explanations and psychosocial or spiritual treatments for their illness.

Given that the mental illness is perceived to be a result of a disruption in social relationships or in the spiritual realm in most of the Turkish patients, instead of seeking help from mental health professionals, these individuals usually prefer informal solutions for their mental health problems, such as seeking the support of friends or family; implement religious practices such as praying or working out problems on their own and delaying the decision to seek professional assistance until problems have gotten severe. When Turkish patients finally decide to acquire help, they usually prefer contacting non-professional sources such as religious healers (Sunter et al., 2006; Röder, 1988), social work facilities or women crisis intervention centers (Ten Have & Bijl, 1999). Additionally, it is also well documented that even after initial contact with mental health professionals drop out rates and premature treatment termination is also common among those

patients (Haasen et. al., 1998; Künzler et al., 2004). These findings might suggest that patients sought non-professional treatment when they evaluate professional treatment as ineffective. Literature has pointed to the need for culturally competent providers who are able to recognize and share the patient's illness model and present interventions that fit the patient expectations (Good & Delvecchio-Good, 1981; Kleinman, 1978; Lin and Lin 1978; White and Marsella, 1982). It has also been suggested that matching of problem conceptualization between service provider and the client to be crucial in increasing service utilization by the minority clients (Zane, Sue, Castro & George, 1982). Furthermore, empirical evidence suggests that patients are most satisfied when their psychiatrist shares their model of understanding distress and treatment (Callan & Littlewood, 1998). Thus, Turkish patients who have difficulties in initiating and maintaining contact with mental health providers may be more likely to stay in treatment if they encounter these culturally congruent aspects of the care process.

2.3. Social context – Stigma and emotional display rules in Turkish culture

Alternatively, evaluation of illness might be also related to its social significance. For instance, the condemnation of expressing emotional complaints to the people who are not from family or close social environment in Turkish culture may also influence culture specific styles of expressing distress (somatic symptoms). Thus, those patients may decide that seeking help for emotional problems is simply not a socially appropriate behavior. Moreover, the underreporting of psychological symptoms and somatic presentation may also be related to the limited opportunities for the expression of psychosocial distress available to members of traditional collectivistic societies (Arens, Balkir & Barnow, in review). Indeed, in a study conducted with somatizing Turkish inpatients in Germany it has been stated that expressions of their emotional distress were ranging from open use of culturally traditional expressions to complete avoidance in which cross norms contribute to emotional suppression (Nickel et al., 2008). Another study showed that Turkish first generation immigrants in Sweden with somatization avoided discussing illness and healing within the family or social contexts in order to avoid causing concerns (Bäärnhielm and

Ekblad, 2000). On the contrary, so-called “individualistic” and “autonomous” cultures use less often suppression to regulate their emotions because of the higher acceptance of psychological problems in these cultures (Haga, Kraft & Corby, 2009; Butler, Lee & Gross, 2007; Matsumoto, Yoo & Fontaine, 2008, Arens et al., in review). When trust is established with the physician these patients may acknowledge significant psycho-emotional problems such as marital and family problems. (see Figure 2 for an overview on help seeking process).

---Insert Figure 2 about here---

3. Conclusions and clinical implications

Despite modernizing and acculturative influences, studies demonstrated that culture is a major determinant of Turkish patients’ recognition of symptoms and how these individuals evaluate and react to distress. All of which determine the choice of and adherence to treatment. These findings have several implications for clinical practice. First, the overexpression of somatic symptoms in Turkish patients may lead to under-recognition and delayed treatment of psychiatric disorders. Due to several reasons, Turkish patients do not usually report affective symptoms in primary care settings. Therefore, several diagnostic tests and medical treatments are held by physicians to examine those physical complaints (Lipowski, 1990), whereas psychological diagnostic is often neglected. In order to avoid such undesirable situation, asking those patients explicitly possible existence of psychological symptoms might be useful. Moreover, eliciting patients’ mood symptoms with a culture sensitive terminology would help to minimize the social and moral stigma attached to mental disorders (Yeung & Kam, 2005). Second, collectivistic values adopted by those patients also point towards the importance of addressing person-society conflicts in addition to intra-psychic conflicts and involvement of family members within the therapy process in order to increase treatment adherence and acquire positive treatment outcomes. This highlights the importance of psychosocial treatment in Turkish immigrant patients. Without ameliorating personal, familial or social conflicts, using medication alone would probably fail to get desired outcomes from the treatment. Third, it has been shown to be crucial to remain open to multiple

explanatory models including biomedical, psychological, religious and traditional ones to enhance communication with the minority patients (Kirmayer & Robbins, 1996). This may refer to the fact that while clinicians provide psychological treatment, the patients may maintain their beliefs regarding what they believe/practice is also effective for their treatment. That is to say, it may be helpful for keeping these patients in treatment by remaining open not only to alternative explanatory models but also to the use of traditional forms of treatment (De Jong, 1994; Razali et al., 1998) (see Chapter 15). Finally, increasing the communication between primary care settings and mental health care services may facilitate the recognition and treatment of psychiatric disorders especially in culturally diverse patient groups.

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Attachments

Table 1. Causal beliefs and treatment preferences among Turkish immigrant and German patients

	Turkish Patients (n= 39)	German Patients (n= 27)	F/ χ^2	p value
Age (mean)	43.68	43.26	.04	p> .05
Somatic symptoms (mean score)	2.26	1.49	14.28	p< .0001
Causal attributions (%)				
Social	%68.4	%47.8	2.55	p> .05
Interpersonal (Family & marital conflicts)	%63.2	%8.7	17.38	p< .0001
Non-interpersonal (severe working conditions, life burden)	%13.2	%47.8	8.9	p< .001
Psychological	%15.1	%60.9	13.21	p< .0001
Personality	%15.8	%17.4	0.3	p> .05
Psychological trauma	%0	%43.5	19.76	p< .0001
Biological	%21.1	%60.9	9.85	p< .001
Genetic/Neurological	%2.6	%60.9	26.21	p< .0001
Biomedical	%18.4	%26.1	.50	p> .05
Treatment preferences (%)				
Professional	%26.3	%91.3	24.21	p< .0001
Psychotherapy	%13.2	%73.9	22.94	p< .0001
Psycho-education	%2.6	%13	2.54	p> .05
Medicines	%15.8	%43.5	5.68	p< .05
Alternative therapies (relaxation or ergo therapy)	%10.5	%17.4	.59	p> .05
Non-professional	%76.3	%26.1	14.78	p< .0001
Social satisfaction	%64.9	%13	15.39	p< .0001
Self initiation	%29.7	%17.4	1.15	p> .05

Figure 1. Determinants of patients' preference to seek professional help: Ethnicity or discrepant causal beliefs?

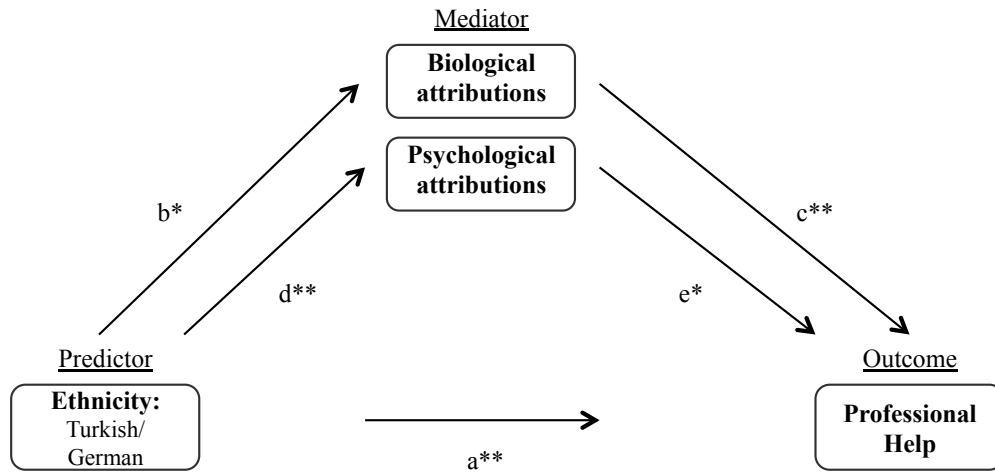


Figure 1: a= ($\beta= 3.61$, $W= 8.45$), $p< .01$; b= ($\beta= 1.99$, $W= 5.12$), $p< .05$; c= ($\beta= 2.94$, $W= 8.52$), $p< .01$; d= ($\beta= 2.04$, $W=7.43$), $p< .01$; e= ($\beta= 2.44$, $W=6.67$), $p< .05$

Figure 2. Determinants of help-seeking

