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pp. S1-S81

Migration and Mental Health

- S1 Editorial
A. Heinz, U. Kluge
- S4 The willingness to participate in health research studies of individuals with Turkish migration backgrounds: barriers and resources
D. Dingoyan, H. Schulz, M. Mösko
- S10 Socio-economic status and emotional distress of female Turkish immigrants and native German women living in Berlin
MC. Aichberger, Z. Bromand, A. Heredia Montesinos, S. Temur-Erman, A. Mundt, A. Heinz, MA. Rapp, M. Schouler-Ocak
- S17 Mental health of Turkish women in Germany: resilience and risk factors
Z. Bromand, S. Temur-Erman, R. Yesil, A. Heredia Montesinos, MC. Aichberger, D. Kleiber, M. Schouler-Ocak, A. Heinz, MC. Kastrup, MA. Rapp
- S22 The influence of stigma on depression, overall psychological distress, and somatization among female Turkish migrants
A. Heredia Montesinos, MA. Rapp, S. Temur-Erman, A. Heinz, U. Hegerl, M. Schouler-Ocak
- S27 Translation and adaptation of the Zung Self-Rating Depression Scale for application in the bilingual Azerbaijani population
F. Mammadova, M. Sultanov, A. Hajiyeva, M. Aichberger, A. Heinz
- S32 Construction and interpretation of self-related function and dysfunction in Intercultural Psychiatry
A. Heinz, F. Birmphohl, M. Frank
- S44 Explanatory models and concepts of West African Malian patients with psychotic symptoms
F. Napo, A. Heinz, A. Auckenthaler
- S50 How to express mental health problems: Turkish immigrants in Berlin compared to native Germans in Berlin and Turks in Istanbul
A. Vardar, U. Kluge, S. Penka
- S56 Health services and the treatment of immigrants: data on service use, interpreting services and immigrant staff members in services across Europe
U. Kluge, M. Bogic, W. Devillé, T. Greacen, M. Davvrin, S. Dias, A. Gaddini, NK. Jensen, E. Ioannidi-Kapolou, R. Mertaniemi, R. Puipcinós i Riera, S. Sandhu, A. Sarvary, JFF. Soares, M. Stankunas, C. Straßmayr, M. Welbel, A. Heinz, S. Priebe
- S63 The concept of "intercultural opening": development of an assessment tool for the appraisal of its current implementation in the mental health care system
S. Penka, U. Kluge, A. Vardar, T. Borde, D. Ingleby
- S70 Cross-cultural training in mental health care – challenges and experiences from Sweden and Germany
S. Bäärnhielm, M. Mösko
- S76 Teaching psychiatry and establishing psychosocial services – lessons from Afghanistan
I. Missmahl, U. Kluge, Z. Bromand, A. Heinz
- S81 Epilogue
A. Kleinman

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CONTENTS

Abstracted in: BIOSIS/Biological Abstracts, Current Contents/Clinical Medicine and Social & Behavioural Sciences, EMBASE/Excerpta Medica, MEDLINE/Index Medicus, PASCAL/INIST-CNRS, Psychological Abstracts, PsycINFO, PsyLIT, Research Alert, SciSearch

Migration and Mental Health

Editorial

<i>A. Heinz, U. Kluge</i>	S1
The willingness to participate in health research studies of individuals with Turkish migration backgrounds: barriers and resources	
<i>D. Dingoyan, H. Schulz, M. Mösko</i>	S4
Socio-economic status and emotional distress of female Turkish immigrants and native German women living in Berlin	
<i>MC. Aichberger, Z. Bromand, A. Heredia Montesinos, S. Temur-Erman, A. Mundt, A. Heinz, MA. Rapp, M. Schouler-Ocak</i>	S10
Mental health of Turkish women in Germany: resilience and risk factors	
<i>Z. Bromand, S. Temur-Erman, R. Yesil, A. Heredia Montesinos, MC. Aichberger, D. Kleiber, M. Schouler-Ocak, A. Heinz, MC. Kastrup, MA. Rapp</i>	S17
The influence of stigma on depression, overall psychological distress, and somatization among female Turkish migrants	
<i>A. Heredia Montesinos, MA. Rapp, S. Temur-Erman, A. Heinz, U. Hegerl, M. Schouler-Ocak</i>	S22
Translation and adaptation of the Zung Self-Rating Depression Scale for application in the bilingual Azerbaijani population	
<i>F. Mammadova, M. Sultanov, A. Hajiyeva, M. Aichberger, A. Heinz</i>	S27
Construction and interpretation of self-related function and dysfunction in Intercultural Psychiatry	
<i>A. Heinz, F. BERPohl, M. Frank</i>	S32
Explanatory models and concepts of West African Malian patients with psychotic symptoms	
<i>F. Napo, A. Heinz, A. Auckenthaler</i>	S44
How to express mental health problems: Turkish immigrants in Berlin compared to native Germans in Berlin and Turks in Istanbul	
<i>A. Vardar, U. Kluge, S. Penka</i>	S50

Health services and the treatment of immigrants: data on service use, interpreting services and immigrant staff members in services across Europe <i>U. Kluge, M. Bogic, W. Devillé, T. Greacen, M. Davurin, S. Dias, A. Gaddini, NK. Jensen, E. Ioannidi-Kapolou, R. Mertaniemi, R. Puipcinós i Riera, S. Sandhu, A. Sarvary, JFF. Soares, M. Stankunas, C. Straßmayr, M. Welbel, A. Heinz, S. Priebe</i>	S56
The concept of “intercultural opening”: development of an assessment tool for the appraisal of its current implementation in the mental health care system <i>S. Penka, U. Kluge, A. Vardar, T. Borde, D. Ingleby</i>	S63
Cross-cultural training in mental health care – challenges and experiences from Sweden and Germany <i>S. Bäärnhelm, M. Mösko</i>	S70
Teaching psychiatry and establishing psychosocial services – lessons from Afghanistan <i>I. Missmahl, U. Kluge, Z. Bromand, A. Heinz</i>	S76
Epilogue <i>A. Kleinman</i>	S81

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Editorial

Mental health in different groups of migrants and ethnic minority within Europe and beyond: Regional and cross- national challenges and approaches in research, practice and training

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Mental health and migration are two issues of increasing importance for health care systems and services regarding prevention, promotion and the quality of delivery of care. Immigration and emigration are as old as mankind, however, new forms of mobility [5,10], the effects and consequences of war and demographic changes (to name just a few) created a new quality of migration in recent years that affects European health care systems and services. A great variety of lifestyles, everyday realities and diverse cultural repertoires are interwoven and compete with each other. Migratory milieus and cross-cultural relationships create new spaces, in which individuals from different cultural backgrounds experience diversity and develop their identity and their conception of the self and their environment. The so called globalisation creates new challenges and demands and promotes new competences [24] – also in the health sector [20].

The number of migrants in the world has more than doubled since 1975, with most migrants living in Europe (56 million), Asia (50 million) and Northern America (41 millions) [8].

In Europe, approximately 27% of the population between 18 and 65 years of age are affected by at least one mental disorder, and roughly a quarter of these individuals are in treatment [23]. Mental disorders belong to the group of diseases with the highest proportion of “Disability Adjusted Life Years” (DAYLs), as demonstrated by the Global Burden of Disease Study conducted by the WHO [25]. The economic burden caused by mental diseases

is the highest compared with other diseases [3]. Nevertheless, migrants and people suffering from mental health problems are among those subjects who experience the strongest barriers to access the health care systems in Europe [7] and the opening of mental health care institutions to migrants remains a widely neglected topic.

Barriers preventing migrants to access the health care system are often attributed to cultural differences and misunderstandings. However, “culture” is a multifaceted term that is often (mis-)used as a putative politically correct expression of “ethnic differences”, thus reifying social differences and neglecting discrimination. Misinterpretation of social differences as cultural can therefore result in inappropriate *culturalisation* and lead to new stigmatisation and exclusion. On the other hand, clinical practice is often characterized by a lack of basic provisions to cope with cultural and social diversity, as indicated e.g. by the failure to provide translators in clinical settings. Therefore, we would like to emphasize that our use of the term “culture” does not refer to a homogenous, “ethnic” category but rather to diverse aspects of a web of meanings that embeds people in various contexts [9]. Individuals develop as well as participate in diverse systems that order the available knowledge and actions with meaning. Culture is thus constituted by actions in the social and physical world and can be named as just one aspect of differentiation besides historical, social and economical features.

Reflection on culture includes a reflection on European prejudices and implicit assumptions about mental health and its impairment. Therefore, our articles address the historical and cultural roots of basic clinical and psychological concepts of the body, soul, emotions and self. We also discuss explanatory models of diseases and their context-specific expressions, e.g. the individual adoption of global discourses of disease in locally specific ways [13,21].

In 2008 we had the chance to publish a first supplement on the topic "Transcultural Psychiatry in Europe" in the *European Psychiatry* [22] and discussed epidemiological data regarding mental disorders in migrants, barriers in communication, limited access to treatment and attempts to improve the situation by competence trainings. In the meantime, several lines of funding (European Commission, the German BMBF, VW-Foundation) provided resources to deepen those approaches and findings, particularly with respect to major migrant communities in different parts of Europe.

In the first part of the supplement, social and individual factors determining mental health of migrants in Europe are addressed with a special focus on gender aspects and stress factors resulting from social exclusion. Today, epidemiological studies of mental health in migrants are often limited by the low response rate of contacted individuals in the chosen sample. Therefore Demet Dingoyan and colleagues [6] conducted focus groups to assess resources and barriers in the attendance at scientific studies. Marion Aichberger and colleagues [1] examined the impact of socioeconomic factors on emotional distress in women with and without Turkish migratory background living in Germany. Zohra Bromand and co-workers [4] describe risk and resilience factors contributing to mental distress and highlight the advantages and challenges of close family ties for female migrants. The effects of social stigma on the manifestation of affective disorders and somatization in women with migratory background are reported by Amanda Heredia and others [12], who challenge the hypothesis that somatization rather than depressive symptoms are displayed in women with a Mediterranean background.

Diagnostic instruments for the assessment of mental disorders in migrants and problems of classification are discussed in the second part of the supplement. Fidan Mammadova [16] present a cultural and lingual adaptation of standardised depression ratings in Azerbaijan and discuss differences between Russian and Azerbaijani speaking women. Andreas Heinz and colleagues [11] describe historical and intercultural differences in the construction of the self, address (post-)colonial distortions of the respective concepts and describe their relevance for the diagnosis of mental disorders. Fatima Napo and co-workers [18] assess whether key diagnostic symptoms of schizophrenia can be found among patients suffering from acute psychoses in Mali and among West- African migrants in Europe. Finally, Azra Vardar and colleagues [26] describe differences and similarities in explanatory models of mental disorders depending with respect to diverse factors such as education, gender and migratory background.

In the third section of this supplement, studies address challenges for the health care system when it is geared towards the needs of migrants in Europe. Ulrike Kluge and colleagues [15] describe diverse health care systems in Europe and focus on

service use, diversity of staff members in health care services and the provision of translators. Simone Penka and co-workers [19] introduce an assessment tool that measures the degree of "intercultural openness" of community mental health services. Sofie Bäärnhielm and Mike Mösko [2] give an overview over cross- cultural training programmes and discuss the advantages and limitations of such interventions. Inge Missmahl and colleagues [17] describe basic diagnostic tools for the assessment of mental disorders and their implementation in training programs for medical practitioners, students and psychosocial counsellors based on experiences in Afghanistan.

Finally, Arthur Kleinman [14] discusses challenges and perspectives for the organisation of mental health care systems oriented towards the diverse needs of patients in a globalized world.

Altogether, the studies presented in this supplement illustrate the diverse approaches required in research, practice and training to improve the promotion, access, delivery and quality of health services for migrants and ethnic minorities. As discussed in the articles of this supplement, a wider view on cultural, social, gender and age differences is necessary to meet the needs of the respective groups. Human diversity clearly transcends cultural differences and requires flexible responses to different needs. To address these diverse settings and experiences, the integration of quantitative and qualitative research is warranted to promote comprehensive approaches in the area of mental health. Besides increased epidemiological research, studies on the improvement of communication in the respective settings and a fight against discrimination within the health care system are important tasks for a health care system that is geared towards inclusion of patients, relatives and professionals with diverse backgrounds and experiences.

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None.

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The willingness to participate in health research studies of individuals with Turkish migration backgrounds: barriers and resources

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ABSTRACT

Keywords:
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Background.- Lower participation rates of ethnic minorities in health research studies and potential participation barriers are commonly reported.

Methods.- Four semi-structured focus groups of individuals with Turkish migration backgrounds living in Germany were conducted to identify potential participation barriers. Documented statements and superscripted presentation cards by the participants were evaluated with a qualitative content analysis.

Results: The following eight potential reasons for the lower participation rates were identified: role of women, lack of knowledge, lack of interest, German-Turkish interactions, mistrust, anxiety, data privacy protection and benefits of the study. Additionally, the following recruitment strategies to enhance participation rates were found: public relations, especially word-of-mouth promotion and contacting Turkish key figures, (non-) tangible incentives and trust building through transparent communication of the project and its conditions.

Discussion: The findings provide a wide range of potential participation barriers and implications that should be considered to enhance the participation rates of minority populations.

Conclusion: The willingness to participate in health research studies can be increased through particular efforts, which should be tailored to the recruitment of the underrepresented target population.

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1. Introduction

Multiple health research studies, especially in the context of cancer-related research in the US, have reported the lower participation rates of underrepresented populations, such as the elderly, women, residents of rural areas, individuals of low socioeconomic status and ethnic minority groups [10,13,19,20]. In the context of European migration health research, lower participation rates have been found among individuals with migration backgrounds [1,7,16]. Additionally, in a pre-test study of the German National Health Survey for Children and Adolescents, considerable differences in response rates were

identified across different migration groups. The analyses have indicated that individuals with Turkish migration backgrounds participate significantly less than, for example, individuals with Polish migration backgrounds [17,24]. Several barriers have been reported as possible reasons for the reduced participation of underrepresented populations in health research studies, such as fear (e.g. of negative consequences or of being misused as guinea pigs), lack of information, mistrust (e.g., of scientific institutions and their members, of government) and concerns caused by negative experiences with health research studies [4,5,25]. Significant limitations have also been observed in the planning process of research studies, such as the failure to determine adequate goals to successfully recruit ethnic minority groups [2,8,21]. Moreover, research staff may also hold negative views and stigmatisations of ethnic minority groups, and thus, underestimate the willingness and ability of ethnic minority groups to participate in research

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studies [8,6,27]. Commonly suggested methods of building trust through repeated interactions with the target minority population [11,19,25] include involving key persons of the targeted underrepresented community from areas of religion, politics and the healthcare system [2,3,26], utilizing media (e.g., radio and newspaper) and cultural centres [2,9,14], hiring research staff of the targeted population and intercultural education of the field team [2,11,26], providing tangible and non-tangible incentives (e.g., money, bus and taxi tokens, gift certificates for food, movies or videos) [15,26] and disclosing the benefits and risks of study participation [4,11,26]. The present paper provides information about attitudes towards health research studies and potential participation barriers as well as adequate solutions for the successful recruitment of individuals with Turkish migration backgrounds into health research studies.

2. Subjects and methods

2.1. Recruitment and conduction

From March to June 2010, a total of four semi-structured focus groups were conducted with adults with Turkish migration backgrounds who resided in Hamburg. The participants were recruited by the research staff using invitations printed in German and Turkish that were entitled "Your opinion is important to us!" and included a brief explanation of the focus groups. The aim was to include eight individuals per focus group [12] between the ages of 18 and 65 years. As a result of last-minute cancellations and attendance without prior notification, the number of participants varied between 7 and 12 individuals. The majority of the participants were accompanied by friends or relatives. The mean duration of the meetings was 100 minutes, and a compensation of 10 € was offered to each participant. The focus groups were held in Turkish by a female bilingual psychologist who was assisted by a female bilingual student.

Prior to the focus groups, four experts (two with Turkish migration backgrounds and two with broad experiences in field research) were consulted to evaluate key aspects when conducting focus groups with individuals with Turkish migration backgrounds. The experts indicated that this type of investigation could be an unfamiliar situation for the majority of the target group and may lead to uncertainties or inhibitions in open discussion. Furthermore, the experts recommended not video or tape recording the participants for the same reasons. To initiate communication between the participants, they were asked to discuss the first two questions in pairs of two and noted their ideas on coloured presentation cards. Subsequently, the cards were attached to a pin board, and the topics were discussed as a group. Additionally, written notes of the discussion were kept (protocols).

The procedure of the focus groups was semi-structured and included a question guideline. Initially, the participants were asked for their language preferences (German or Turkish) and were informed that their attendance was voluntary. After an introduction of the attendees and a brief presentation of the background and aim of the research study, the participants were asked the following questions:

- Perceived barriers: What do you think are reasons for less willingness of individuals with Turkish migration backgrounds to participate in research studies? With this question, an example was given that referred to enrolment challenges of women with Turkish migration backgrounds in a current survey¹.
- Recommendations: How can individuals with Turkish migration backgrounds be motivated to participate in future research studies?
- Contacting: Can direct personal contact (such as home visits) increase the willingness to participate in research studies?
- Tangible incentive: What amount of money do you consider as appropriate for a three-hour interview?
- Key figures: Can well-known public figures increase the participation of individuals with migration backgrounds in research studies?

Furthermore, two questionnaires were completed. One questionnaire asked for socio-demographic data, and the second questionnaire surveyed the popularity of key figures with Turkish migration backgrounds (on a scale from 0=unpopular to 10=popular). At the end of the meetings, feedback was given by each participant. Because of the different group sizes and the limited time frame, the questions concerning the perceived barriers and the contacting were excluded from two different focus groups.

2.2. Content analysis

The qualitative content analysis of the superscripted presentation cards and documented statements was based on the method of Mayring [18]. The protocols and transcriptions of the presentation cards were translated into German by the bilingual psychologist who moderated the focus groups. In the first stage of the analysis, all statements were paraphrased by one person. In a further stage, two raters independently grouped content coherent statements to inductively form appropriate categories. Typical example sentences and commonly used terms (keywords) were extracted and defined for each category. In the case of inter-rater divergence, the categories were discussed by both raters and coding rules were specified. Subsequently, all categories were revised and compared to the original non-paraphrased statements. Finally, the statements were counted within each category to indicate commonly mentioned topics among all focus groups.

3. Results

3.1. Sample characteristics

A total of 37 individuals with Turkish migration backgrounds and a mean age of 44 years participated in the focus groups. Although it was intended to recruit an equal number of men and women in the focus groups, more women (78%) than men (22%) participated. Twelve participants born in Turkey did not answer the question about their year of migration, without indication of reasons. Further information concerning the sample's characteristics is illustrated in table 1.

¹ personal note from Marion Aichberger (2011)

3.2. Perceived barriers

The participants mentioned a number of reasons for the lower participation rates of individuals with Turkish migration backgrounds in research studies. The content analysis indicated eight distinct categories (Table 2). The first category refers to the traditional role of women that is culturally determined by the Turkish community. The participants stated that women are controlled and oppressed by male family members (father, husband) and have little opportunity to make individual decisions. Therefore, women would need to exhibit courage to participate

in research studies. This type of self-confidence is often lacking, as many Turkish women perceive themselves as subordinated and helpless without their husbands at their sides. Furthermore, the participants expressed that most Turkish women do not have the time or interest to participate in research studies because of their family responsibilities (child care, household, jobs) (e.g., "Turkish women carry a heavy burden on their shoulders and typically do not have time to deal with such interviews."). A *lack of knowledge* (category 2) and a *lack of interest* (category 3) were further reported reasons. Lack of knowledge was mainly attributed to low education and knowledge levels as well as a

Table 1
Socio-demographic characteristics of focus group participants with Turkish migration backgrounds.

characteristics	N	labels	results	percentage
age	37	range	16-62	
		mean age	44	
gender	37	female	29	78%
		male	8	22%
country of birth	37	Turkey	31	84%
		Germany	6	16%
nationality	37	Turkey	12	32%
		Germany	25	68%
year of migration	37	1969 - 1981	8	42%
		1982 - 1994	7	37%
		1995 - 2008	4	21%
first language	37	Turkish	33	89%
		German	1	3%
		both	3	8%
highest 37 any school graduation	37	any school graduation	1	3%
		primary school (5 years)	10	27%
		secondary school (Haupt- or Volksschule)	6	16%
		secondary school (Realschule)	6	16%
		grammar school (Gymnasium)	10	27%
		other	4	11%

Table 2
Stated reasons for the lower willingness of individuals with Turkish migration backgrounds to participate in health research studies.

categories	key words	examples	number of statements
1 role of woman	oppression patriarchiat lack of self-confidence	"Many women are controlled by their husbands and are put under pressure, it takes a lot of courage to participate in such a survey."	17
2 lack of knowledge	ignorance lack of education unawareness	"Unfortunately, education does not have a great meaning for Turks and they do not take it seriously."	15
3 lack of interest	disinterest passivity lack of openness	"The Turks remain indifferent towards such projects."	15
4 German-Turkish interactions	cultural differences lack of communication lack of empathy	"We stand outside social life, we lack the interaction with the Germans."	14
5 mistrust	distrust scepticism trust problem	"Distrust if a letter is delivered from an unknown location. Distrust of the German population."	13
6 anxiety	fear concerns doubts	"Fear of to get ripped off and not get out of it anymore."	10
7 data privacy protection	data abuse problems through signature state control	"Does the German government want to monitor us? There is the fear that our profits will be taken out of our hands."	9
8 benefits of the study	study aim benefits personal advantages	"Many are wondering what benefit the participation has for them, and what will come of it at the end?"	9

lack of desire to obtain an education and to increase their general knowledge. Other categories include *mistrust* (category 5), *anxiety* (category 6) and concerns about *data privacy protection* (category 7). The terms mistrust, anxiety and lack of interest were often used in the form of general catchwords (e.g., "People are mistrusted, fearful or disinterested."). Mistrust and anxiety were mentioned particularly in connection with the receipt of a cover letter from an unknown location. In such cases, beyond mistrust and scepticism, fear would arise about the potential negative consequences of signing a document (e.g., "I would ask myself: Do we have any drawbacks? Will our financial liberties become restricted through this?"). Moreover, participants expressed specific concerns about data privacy protection, such as doubts about the secrecy of personal data (data abuse) and concerns that the German government was spying on people with Turkish migration backgrounds or of the Muslim faith. *German-Turkish interactions* (category 4) was another topic mentioned by the participants. In this context, cultural differences and communication deficits between the German and Turkish community were expressed. These deficits were partially associated with a lack of empathy (e.g., "Germans cannot evaluate how Turks think.") or a sense of indifference (e.g., "The Turks feel the indifference and lack of interest of the Germans and are tired of this.") of the German community towards individuals with Turkish migration backgrounds.

3.3. Recommendations

The following categories were identified as reported motivating factors to enhance participation rates in future research projects (Table 3): Public relations, trust building, incentives, interview conditions and relevance of study. Concerning *public relations* (category 1), word-of-mouth was considered particularly effective for successfully enrolling individuals with Turkish migration backgrounds in research studies (e.g., "Recommendations from friends and word-of-mouth advertisements would motivate."). Furthermore, participants recommended

increasing the awareness of health research studies through cultural associations, mosques, religious representatives and doctors with Turkish migration backgrounds. As an optional addition to word-of-mouth promotion, the appropriation of classical media (e.g., radio, television, newspapers, posters, flyers, brochures) was also mentioned. Participants further emphasised the need to *build up trust* (category 2: "To gain our trust is a first and important step.") through transparent communication of study objectives and conditions. Therefore, the credibility and reliability of research institutions and their staff were mentioned as important components. The members of the study group should be selected correctly to be accepted by the Turkish residents of Hamburg. A further category is represented by incentives (category 3). Tangible (money, gifts) and non-tangible incentives, such as caring for the participants' children for the duration of the interview or offering food and drinks, were suggested. Concerning *interview conditions* (category 4), there were a number of indications. Specifically, the interviews should be as short as possible and should be conducted by individuals with Turkish migration backgrounds in a friendly atmosphere. Moreover, it was stated that the survey should not include personal questions, especially concerning sexual issues, which might otherwise anger the respondents. *Relevance* of the study (category 5) is closely related to the first category of public relations and the explanation of personal and social benefits of participation in health research studies. The participants recommended highlighting the health benefits for the respondent or the family.

3.4. Contacting

A positive association between home visits and the willingness to participate was denied by the majority of the participants. They reported a fear of attack and being robbed if they allowed the alleged interviewer to enter their home. Only two participants stated that they would invite the interviewer into their home without hesitation if the interviewer identified

Table 3
Stated motivation aspects to increase the participation of individuals with Turkish migration backgrounds in health research studies.

categories	key words	examples	number of statements
1 public relations	word-of-mouth	through Turkish social networks and popular persons: associations, mosques (Hocas), Turkish physicians, various events (such as leisure, family and women's meetings etc.)	43
	classical media	through Turkish media: radio, newspapers, television, billboards, brochures, internet	25
2 trust building	transparency	transparent communication of the study objective credibility of the researchers seriousness of the research institution	23
3 incentives	tangible incentives	money gifts	11
	non-tangible incentives	childcare food drink	11
4 interview conditions	objectives contents time factors	interviewers with Turkish migration backgrounds no personal questions (e.g. concerning sexuality) short interview duration	21
5 relevance of study	explanation of benefits	importance of the research study aim of the survey: health benefits important contribution by participating	12

him/herself. Moreover, all of the focus groups mentioned that women with Turkish migration backgrounds are not allowed to invite a male interviewer into their home without the presence of a male family member. Such an invitation could lead to conflicts with the social environment of the women, such as defamations. It was also repeatedly stated that the interviewer should be able to speak the Turkish language.

3.5. Tangible incentives

For a three-hour interview, the overall mean tangible incentive was 29 € (range: 20–45; n=36). One participant refused to specify an amount (“To me, it is more important if I will be helped at that moment. So, I will not name a sum.”)

3.6. Key figures

Thirty-six participants stated that well-known public figures would positively affect participation in research studies. Only one participant expressed that there would not be a relation between participation willingness and well-known figures. On the basis of the questionnaire concerning the relevance of key figures, public figures from various social areas were identified. Table 4 shows the top ten named figures and their degree of popularity. An internationally known film director and a local hairdresser with Turkish migration backgrounds were most frequently mentioned.

4. Discussion

Regarding the sample characteristics (e.g., age, country of birth, nationality, year of migration, school and professional qualification), with the exception of gender, the sample composition is diverse and widely ranged (Table 1). As all participant statements were included in the content analysis, it can be assumed that the results of the focus groups are not distorted fundamentally by the smaller number of male participants. An exception is the category “role of women”, which will be

discussed later. Moreover, it is not clear whether the low level of male participants is due to a generally lower willingness of men with Turkish migration backgrounds to participate in health research studies, or whether other factors (e.g. time-related or personal reasons, various factors influencing the recruitment process) may have played a role. Overall, the enrolment of participants with Turkish migration backgrounds into the focus groups was associated with several challenges. For the majority of invitees, the issue of “to know each other” was a motivating factor for their participation. Being accompanied by friends or relatives was the most often expressed condition for attendance. Furthermore, the feedback indicated that many participants had concerns about the research staff’s expectations of them and whether they would be able to meet them. In this context, some participants also reported concerns of being examined and providing incorrect answers. For these reasons, it seems adequate not to have audio and video taped the participants, so as not to excite their fears of being controlled or examined. These factors and the need to be accompanied by a trusted person may also be related to previously mentioned reasons for lower participation rates (perceived barriers), such as anxiety, mistrust and negative experiences in the interactions with the majority population. Considering the findings of the perceived barriers, it is striking that most of the documented statements were related to the first category, which refers to the traditional *role of women*. This result was not merely due to the large number of female participants. The women became increasingly conversational with each other, which led to more differentiated statements. Therefore, care should be taken in drawing conclusions that could result in unfounded generalisations or the stigmatisation of women and men with Turkish migration backgrounds.

The results provide a wide range of potential participation barriers that should be considered in the process of study planning. Of note, some of the stated reasons for the lower participation rates were also reported in other studies, such as *lack of knowledge, anxiety* and *mistrust* of scientific institutions and the government. An extreme example of negative experiences with health research studies is the Tuskegee Syphilis Study. Many authors point out that this study became a symbol of research subject abuse of African Americans. It is discussed that these experiences affect the willingness to participate in health research studies until today [4,5,25]. The present study did not demonstrate such a clear association between a specific traumatic event and the willingness to participate. However, focus group participants mentioned negative experiences with governmental institutions (such as national authorities) as possible reasons for mistrust of health research studies. Thus, trust building through diverse resources is a key aspect that has been indicated in the literature [11,19,25] and by focus group participants (recommendations). When the participants were asked to name motivating factors for participation in future research, word-of-mouth promotion of the research project and the involvement of well-known key figures were mentioned as trust building methods. The importance of key figures and the social networking of the Turkish community should be considered to be a relevant resource to build trust and to enhance participation rates in health research studies [2,3,26]. As also mentioned in the focus groups, the transparent communication of the study objectives, interview conditions and relevance of

Table 4
Top ten frequently mentioned key figures and their degree of popularity on a 0–10 scale.

well known key figures	gender	n	popularity $\bar{\sigma}$
1 Turkish businessman	male	30	8
2 Turkish film director	male	27	7
3 Turkish physician	male	23	7
4 Turkish federal politician	male	22	7
5 German mayor	male	22	7
6 Turkish local politician	female	20	7
7 Turkish hairdresser	male	20	4
8 Turkish local politician	male	19	6
9 Turkish sportsman	male	15	8
10 Turkish tv presenter	male	15	7

the study should be emphasised [4,11,26]. Furthermore, culture and gender-specific aspects of the interview conditions (e.g., female interviewer for home visits) should be considered in the face of possibly far-reaching consequences on women with Turkish migration backgrounds (e.g., problems with the husband, defamation). Concerning the meaning of incentives, tangible and non-tangible incentives were considered additional motivating factors, and the mentioned mean value (29 €) for a three-hour interview was moderate. Interestingly, language difficulties were not mentioned as a main reason for lower participation rates. This aspect was discussed at a later stage during the focus group meetings (contacting). In this context, the participants mentioned that it would be helpful if the interviewer spoke Turkish. Therefore, it can be assumed that language barriers are of relevance with regard to recruitment processes and interviews [28,23,22]. Furthermore, it was striking that many participants requested help when completing the questionnaires, although most of them were able to write their ideas on presentation cards. This could be also due to their unfamiliarity with investigations.

5. Conclusion

The findings on the perception of the focus groups about how health research is perceived by individuals with Turkish migration backgrounds and the implications for successful recruitment offer considerable recommendations for enhancing participation rates in further research. Feelings of mistrust and anxiety were embedded in negative experiences with German public authorities and interactions with Germans in daily life. Against this background, it is difficult but necessary for the research staff to build trust. In addition to a field team that should include members of the target population, further relevant steps for a successful recruitment should make use of public promotions (especially word-of-mouth) and of key figures in the Turkish community with the priority of a transparent communication regarding the study project and its conditions. The willingness to participate should be supported by translated information and evaluation materials, considerations of culture and gender-specific aspects of the interview situation and the implementation of (non-) tangible incentives.

Conflict of interest statement

The authors declare that there is no conflict of interests.

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Socio-economic status and emotional distress of female Turkish immigrants and native German women living in Berlin

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ABSTRACT

Keywords:

Female Turkish immigrants
 Socioeconomic status
 Poverty risk
 Unemployment
 Emotional distress

Background. Many immigrants face more economic strains and hardship than non-immigrants. Income inequality and an increasing social gap between immigrants and non-immigrants in Europe warrant further studies on the impact of socioeconomic factors on health in immigrant groups. The purpose of this study was to examine the association of socioeconomic status (SES) and emotional distress in women of Turkish descent and in women of German descent.

Methods and Subjects. A total of 405 women of German or Turkish descent residing in Berlin were interviewed. Emotional distress was assessed by the General Health Questionnaire-28 (GHQ-28), and SES was examined by level of education, employment status, and income. The associations of emotional distress and SES were estimated in multivariate linear regression analyses.

Results. Unemployment was associated with increased levels of emotional distress in all women, with the highest level of distress in the group of unemployed Turkish women. The overall SES level was related to a greater level of emotional distress in Turkish women, but not in German women (-3.2, 95%CI -5.9 – -.5; p=.020 vs. -.8, 95%CI -2.7 – 1.2; p=.431). Further stratified analyses by relationship status revealed that the association of SES and emotional distress only remained significant among single women.

Conclusion. The impact of socioeconomic hardship appears to be complicated by social roles and expectations related to these. Further in-depth study of the complex nature of the interaction of social roles and socioeconomic position in female Turkish immigrants in Germany is needed to better understand differing risk patterns for emotional distress.

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1. Introduction

Income inequality and a continuously increasing gap between social groups in Europe [51] is not only challenging social politics, but also poses a challenge for effective public

health efforts. Increased vulnerability for mental health problems among people who live in poverty [11], or have less access to social resources [44] has been reported since early in the last century [1,41]. Alongside more 'traditional' risk groups such as single parents and the unemployed [38,46], immigrants have been a societal group at particular risk for lower socio-economic status (SES) [49,58]. Some epidemiological studies examining mental health in immigrant and ethnic minority groups suggest an increased risk for psychotic disorders in specific immigrants groups such as Caribbean immigrants in the UK [14,17]. Less

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clear is the picture regarding depressive disorders. Current evidence points to an increased [3,7,10,43] as well as decreased risk [31,59,61,67]. The risk patterns vary according to the examined ethnic group as well as the country of residence [9,12].

It is important to stress at the outset that immigrants are not one homogeneous population, but constitute a great variety of sub-groups, whose social realities will be determined by factors such as the pre-migration history, levels of education, motives for migration, and the extent to which they can acculturate in the new society. Given the diversity of socio-cultural realities social predictors of mental disorders are likely to vary at least to some extent between regions and cultures [57,61], and may even differ between subsequent generations of immigrants [34]. The process of migration itself demands adjustments when settling in a new societal and cultural environment, which can create additional stress [64]. Culture and language related barriers [6,50], as well as societal and structural characteristics of the country of settlement such as attitude towards immigrants [8] or immigration regulations [56], may cause many immigrants to live in segregated areas with a higher ethnic density and less favourable social environment. Racism, ethnic discrimination [49], the process of acculturation or acculturative stress [65], more exposure to stressful life events [48], and lower levels of SES [2,40] have been proposed as possible predictors for mental disorders in immigrants.

As mentioned above, no generalizations can be made about risks for mental disorders, in particular affective disorders, in immigrant groups. To explain this great variability SES factors have frequently been cited as possible mediators or moderators for increased as well as decreased risk [27]. The erosive effect of low levels of SES may particularly impact the association of ethnicity and emotional distress [60,62]. Furthermore, it may be more difficult for immigrants, especially those with lower levels of education and professional training, to receive well-paid jobs. Despite high levels of education, immigrants may have difficulties to get access to jobs in their original field of training [20]. Considering the social hardship and inequalities faced by some immigrant populations [45], a link between risk for mental disorders in immigrants and SES appears plausible. While some studies suggest that SES does not reliably account for differences in mental health status between immigrants and native residents [16,30], several other studies do indeed suggest that differences in mental health between immigrants and native residents are mainly accounted for by SES [29,57,60,62]. It could be hypothesized that not only does the prevalence of mental disorders vary according to SES in immigrants, but also the degree of the association between level of distress and SES. Yet, studies examining this relationship in Europe are scarce [47], and this hypothesis warrants further research.

In Germany the risk for socioeconomic hardship strongly varies by ethnic group and between different regions of the country. While immigrants may be more affluent in the more prosperous regions of Germany making ends meet may be difficult for immigrants in the North-Eastern parts of Germany, where overall poverty and unemployment rates are high [24,25]. Berlin, being the largest urban centre in Germany, has one of the highest poverty levels (19.0% in 2009) [23] of Germany. According to the Berlin social atlas from 2008 [55], non-German citizens were at higher risk to live in poverty than German citizens (25.7% vs. 10.6% in

German citizens). This pattern is exemplified by the situation of Turkish immigrants, who constitute the largest immigrant group in Berlin, and have continuously faced socioeconomic hardship and social exclusion [42].

In this study of female Turkish immigrants and native German women living in Berlin, Germany, the following hypotheses were tested: 1) The level of emotional distress is greater in women with lower levels of SES, and 2) the extent of the relationship of SES and emotional distress is greater in Turkish immigrant women than native German women.

2. Subjects and methods

2.1. Sample

The sample derives from a survey that was conducted in Berlin, Germany from January 2010 to June 2011. The sampling consisted of a random sampling step and snowball sampling. This approach was chosen since low participation rates were anticipated for female Turkish immigrants. First a random sample of 80,000 women aged 18–75 years residing in Berlin at the time of the study was drawn from the population registry of Berlin in three age strata (18–34 years, 35–54 years and 55–75 years). Then an algorithm based on name [18,37] was used to identify female Turkish immigrants and native German women from the population registry (*Meldebehörde*). For the native German group, a random sample of N=8,000 was drawn, which was randomly subdivided into waves. Of these finally only N=1,866 were contacted as part of the random sampling step. No further random sample was drawn from the women of Turkish origin, since only 3,884 were identified in the first step. Turkish women were oversampled since lower participation rates had been anticipated. Initially only N=136 (7.3%) native German women and N=63 (1.6%) female Turkish immigrants from the random sample who were contacted agreed to participate in the study. To increase participation snowball sampling was used in the next step. Here individuals with specific characteristics, e.g. membership to a specific group, are asked to provide contacts of other members of their group [39]. In this study all women willing to participate in the study were asked to provide contact details of other women they knew and who were interested in participating in the study. Via snowballing N=64 native German women and N=142 women of Turkish origin, respectively were recruited. The final sample comprised N=205 female Turkish immigrants and N=200 native German women. Recruitment and interviews were stopped at a predetermined date before the intervention phase of the study started. Interviews were conducted at respondents' home and in some cases at the study centre on campus by female interviewers. Turkish respondents had the option to choose Turkish or German as the interview language and were interviewed by bilingual interviewers. All scales and questionnaires were provided in Turkish and German. Non-responders with whom contact was established were asked to complete a short questionnaire. Additionally, all non-responders were asked to provide reasons for non-participation. A detailed non-responder analysis of the Turkish sample has been published elsewhere [13]. The study was approved by the Ethics Committee of the Charité – University Medicine Berlin (EA1/177/08).

2.2. Measures

2.2.1. Emotional distress

Emotional distress was assessed using the General Health Questionnaire (GHQ-28) [32,33]. The GHQ-28 has been used in different migrant populations in Germany [28,66] as well as cross-nationally [54] to screen for minor mental disorders and emotional distress. The GHQ-28 score ranges from 0 to 84, with a higher score indicating higher levels of emotional distress. It contains 4 subscales for physical symptoms, anxiety/insomnia, social dysfunction and severe depression. The answers were coded on a 4-point Likert scale (0-1-2-3) and a sum score was calculated based on answers to individual items.

2.3. Migration status

The aim was to recruit women born in Turkey or whose parents' country of birth was Turkey. Despite acknowledging the difficulties of such a broad definition of origin, which neglects the diversity of female Turkish immigrants living in Germany, this definition was chosen to permit comparisons to official statistical figures. According to the Federal Statistical Office Germany "Persons with a "migration background" are defined (...) as: all immigrants migrating to the present territory of the Federal Republic of Germany after 1949, as well as all foreigners born in Germany and all born as Germans in Germany with at least one immigrant parent or one foreign parent born in Germany"[21].

2.4. Socioeconomic status

As indicators for SES, current employment status, educational attainment, and poverty risk were used. Employment status was questioned in detail and later categorised as employed, unemployed, retired/being a homemaker or currently in training, and being disabled/in early retirement or disability retirement. For linear regression analysis employment status was further dichotomised in unemployed vs. all other categories. Educational attainment was constructed from school-leaving degree and highest achieved secondary training degree, and categorised according to the International Standard Classification of Education (ISCED) [63]. Educational attainment was then categorized in primary level of education, secondary level of education and tertiary level of education. Level of income was calculated according to OSCE categories for Germany. Self-reported net household income per month in € was adjusted for persons per household with a weight of 1 in single households, plus a weight of 0.5 for any additional person aged 14 years or older and an additional weight of 0.3 for every person aged 13 years or younger living in the household [22]. To examine the specific effects of living below at-risk-of-poverty threshold, adjusted per-capita net income per month was further dichotomized in below at-risk-of-poverty threshold (according to at-risk-of-poverty threshold for 2009): <742 € and above: ≥742 € [23]. Besides the individual contribution of employment status, educational attainment, and poverty risk, an aggregated variable for SES was constructed from employment status (unemployed=0 vs. the

rest=1), educational level (primary=0, secondary=1 and tertiary education=2) and poverty risk (below=0 vs. above risk level=1). A lower value of the composite variable for SES corresponded to a lower overall SES level (range: 0 – 4).

2.5. Covariates

As additional covariates age and relationship status were included as well-known risk factors for depressive symptoms [4,35]. Age, measured in years, was assessed as a continuous variable based on date of interview and reported date of birth. Relationship status was categorised as being married or in a relationship vs. being single.

2.6. Statistical analysis

In order to test for significant associations in categorical data, χ^2 -tests were performed. For continuous data independent student-t tests and univariate ANOVA were performed. For the total sample and the subsamples (by migration status) linear regression models were calculated. As covariates employment status, educational attainment, poverty risk, age, and relationship status were included in linear regression analyses. All analyses were conducted using STATA statistical software version 10.1.

3. Results

3.1. Population characteristics

A total of N=405 women participated in the study. The mean age was 40.7 (SD=14.5) years, and 20.5% (N=83) were living alone. The level of unemployment was approximately the same in both groups with a total of 9.9% (N=39) who were currently unemployed ($X^2(1, N=405)=0.57, p=.447$). Significantly more German women had reached ISCED level of 5 or higher ($X^2(1, N=405)=5.42, p=.020$). More Turkish than German women were at risk for poverty ($X^2(1, N=355)=6.15, p=.013$). The majority of participants lived in districts of a lower overall social index, such as Neukölln (18.6%, N=75) and Mitte (15.8%, N=64). While the majority of female Turkish immigrants resided in the districts Neukölln (25.5%; N=52), Mitte (22.1%; N=45), and Friedrichshain-Kreuzberg (12.8%; N=26), which are areas with a high fraction of Turkish immigrants. The districts Steglitz-Zehlendorf (14.5%; N=29) and Tempelhof-Köpenick (12.5%; N=25) ranked highest in the native German group, though followed by Neukölln (11.5%; N=23). Native German participants were less clustered in specific districts. The sociodemographic characteristics of the sample by migration status are presented in table 1 (Table 1).

3.2. SES and emotional distress

Unemployment did impact on emotional distress levels (M=60.6, SD=17.7 vs. 51.3, SD=13.8; $t(377)=-3.82; p=0.0002$). In the group of unemployed Turkish immigrant women the distress level was particularly high with M=62.9, SD=21.0 (vs. M=53.0,

SD=15.9; $t(183) = -2.575$; $p = .011$). Also, the negative impact of unemployment was particularly high in Turkish women living at risk for poverty ($M = 72.1$, $SD = 22.6$); although small subsample size ($N = 8$) did not allow for further analysis. In the German group the effect of unemployment on the level of distress was lower, but still significantly higher than for all other employment groups ($M = 57.6$, $SD = 12.5$ vs. $M = 49.6$, $SD = 11.3$; $t(192) = -2.76$; $p = .006$), but no difference was found for the poverty risk group. In the total sample no difference was found between educational groups (high level: $M = 50.4$, $SD = 13.1$, medium level: $M = 52.0$, $SD = 13.9$, low level: $M = 55.1$, $SD = 17.9$; $F(2, 369) = 2.23$; $p = .109$). In additional analyses of interactions between SES indicators the level of education was found to be negatively associated with employment in German women (-1.6 , $p = .026$), but not in Turkish women ($.09$, $p = .214$). In the Turkish group poverty risk was correlated with level of education (-1.9 ; $p = .012$), but not in the German group ($-.07$, $p = .319$). Overall, mean level of emotional distress was slightly, but not significantly higher

in the poverty risk group ($M = 53.2$, $SD = 15.1$ vs. 51.1 , $SD = 13.5$; $t(332) = -1.39$; $p = .166$). Though, the mean GHQ-28 scores were significantly higher in the Turkish group at poverty risk compared to the German group ($M = 55.9$, $SD = 16.8$ vs. $M = 50.4$, $SD = 14.4$; $t(162) = -2.32$; $p = .0214$).

Multivariate analyses were conducted to examine the combined contribution of all SES variables. Linear regression analyses were conducted for the total sample and stratified by migration background. Table 2 presents results from linear regression analyses by migration background (Table 2).

In the total sample unemployment ($\beta = 8.7$, $95\%CI = 3.6-13.8$; $p = .001$) and being single ($\beta = 3.5$, $95\%CI = .2-6.9$; $p = .036$) were strongly associated with increased levels of emotional distress. In the stratified analyses it was found that being unemployed ($\beta = 9.6$, $95\%CI = 1.1-17.9$; $p = .026$), and higher age ($\beta = .2$, $95\%CI = .01-.50$; $p = .044$) were associated with emotional distress in the Turkish group. In contrast, neither educational attainment nor poverty risk was associated with level of distress in Turkish

Table 1
Demographic characteristics of the sample.

Variable	Total sample (N=405)	Turkish sub-sample (N=205)	German sub-sample (N=200)	p-values
Age, mean (SD), years	40.7 (14.5)	37.0 (12.8)	44.5 (15.1)	$t(405) = 5.37$; $p = .000$
Married, in a relationship, %	70.6 (286)	65.4 (134)	76.0 (152)	$\chi^2(1, N = 405) = 5.52$; $p = .019$
Living alone, %	20.5 (83)	9.3 (19)	32.0 (64)	$\chi^2(1, N = 405) = 32.10$; $p = .000$
Persons/household, mean (SD)	2.6 (1.9)	3.3 (1.4)	2.0 (1.0)	$t(400) = 10.32$; $p = .000$
Employed	43.2 (170)	32.8 (62)	54.6 (100)	$\chi^2(1, N = 394) = 17.96$; $p = .000$
Unemployed	9.9 (39)	11.1 (22)	8.7 (17)	$\chi^2(1, N = 394) = 0.57$; $p = .447$
Homemaker/in training/retired	41.9 (165)	51.0 (101)	32.6 (64)	$\chi^2(1, N = 394) = 13.64$; $p = .000$
Disabled/early retirement/disability pension	5.1 (20)	5.0 (10)	5.1 (10)	$\chi^2(1, N = 394) = 0.001$; $p = .981$
High education ² , ISCED >=5, %	30.8 (122)	26.0 (51)	35.5 (71)	$\chi^2(1, N = 396) = 5.42$, $p = .020$
Low education, ISCED 0-2, %	18.4 (73)	31.1 (61)	6.0 (12)	$\chi^2(1, N = 396) = 41.55$, $p = .000$
Net household income/month, mean (SD) in €	2007.3 (1653.8)	1958.1 (1454.2)	2052.5 (1820.8)	$t(355) = 0.54$; $p = .588$
At poverty risk, %	49.0 (174)	55.9 (95)	42.7 (79)	$\chi^2(1, N = 355) = 6.15$, $p = .013$
SES, mean (SD)	2.6 (0.9)	2.3 (0.9)	2.8 (0.9)	$t(348) = 4.76$; $p = .000$

Table 2
Results from linear regression analyses with GHQ-28 as the dependent variable.

	Total sample (N=329)			Turkish sub-sample (N=150)			German sub-sample (N=179)		
	β	(95% CI)	p value	β	(95% CI)	p value	β	(95% CI)	p value
Age	.01	-.1-.1	0.886	.2	.01-.5	0.044	-.1	-.2-.04	0.211
In a relationship ¹		1.00			1.00			1.00	
Single	3.5	.2-6.9	0.036	4.9	-.6-10.5	0.082	2.8	-1.3-6.9	0.173
Educational attainment ²	-1.8	-4.1-0.4	0.111	-3.1	-6.6-.5	0.093	1.3	-1.8-4.3	0.416
Unemployed ³	8.7	3.6-13.8	0.001	9.6	1.1-17.9	0.026	8.8	2.8-14.8	0.004
Poverty risk ⁴	1.8	-1.2-4.8	0.245	2.2	-3.2-7.6	0.424	0.1	-3.3-3.6	0.936

¹ Reference category is being in a relationship or married.

² Measured as from low, medium to high educational level according to OSCE criteria.

³ Reference category is all other employment categories.

⁴ Poverty level is defined as weighted net household income per month of ≤ 742 €. Income level was calculated according to OSCE categories for Germany.

immigrant women. In additional univariate linear regression analyses unemployment was found to be associated with higher distress levels ($\beta=9.3$, 95%CI=4.5-14.1; $p=.000$), with poverty risk acting as an effect modifier (poverty risk group: $\beta=14.9$, 95%CI=7.6-22.3; $p=.000$ vs. above poverty risk group: $\beta=3.4$, 95%CI=-3.5-10.4; $p=.328$). Due to the small number of cases per cell, multivariate analysis stratified by migration background and poverty risk could not be performed. In the German group only unemployment showed a significant association with increased emotional distress ($\beta=8.8$, 95%CI=2.8-14.8; $p=.004$).

3.3. Composite SES indicator and emotional distress

Finally, the contribution of the overall SES level (composite SES indicator) was examined in multivariate linear regression analyses. The stratified analyses of the German and Turkish group revealed that the overall SES did contribute to a greater level of emotional distress in the Turkish group, but not in the German group (-3.2, 95%CI -5.9 - -.5; $p=.020$ vs. -.8, 95%CI -2.7 - 1.2; $p=.431$) while controlling for age and relationship status. Relationship status modified the association of SES and emotional distress in the Turkish group. To account for the effect modification of relationship status, a stratified analysis was performed. In the group without a partner the association of SES and emotional distress remained significant (-5.9, 95%CI -10.6 - -1.3; $p=.014$) while controlling for age and living alone and having children, whereas for the ones in a relationship no association of SES and emotional distress (-.7, 95%CI -4.1 - 2.6; $p=.675$) was found anymore. However, age only remained significantly associated to emotional distress in the group in a relationship (.4, 95%CI .1-.6; $p=.013$) (Table 3).

4. Discussion

In this study higher levels of emotional distress were found in unemployed women independent of migration background. This finding demonstrates again the erosive effects of unemployment on mental well-being [15]. In this sample, the proportion living below the at-poverty-risk-threshold (49.0%) was relatively high in comparison to official figures, according to which 35.4% of immigrants and 13.5% of non-immigrants were living below the at-poverty-risk-threshold in Berlin in 2009 [23]. The difference in socioeconomic indicators between native German

and Turkish immigrant women could be explained by the social position of their families. The majority of Turkish immigrants in Germany are so-called former 'Gastarbeiter' (guest workers), who came to Germany in the late 1950s and 1960s [5]. Overall, these families have a lower socioeconomic and educational status, thus, perhaps providing fewer resources for their daughters' educational attainment, and thereby putting them at greater risk for low socioeconomic status than their German counterparts. Levels of distress were exceptionally high in Turkish women at risk for poverty, yet no significant association was found when examined in linear regression analyses. Other than unemployment none of the socioeconomic status indicators anticipated to be associated with emotional distress show a relationship with increased levels of distress independently. The association of unemployment and emotional distress is not unexpected since job loss and unemployment have long been known for being associated with ill health [38,53]. The modifying effect of poverty risk on unemployment solely in the group of Turkish women could suggest that for Turkish immigrant women the impact of unemployment on emotional distress was only exerted when associated with economic strains, whereas in the group of German women unemployment and income were unrelated. This may also be explained by the larger size of Turkish households, which mostly consist of only one or two adults supporting a number of dependents such as children or elderly relatives, which may put these households at greater risk for poverty and might be particularly distressing for unemployed women. Further analysis revealed that only in the German group was unemployment correlated with lower levels of education.

Interestingly, the overall SES was only associated with emotional distress in female Turkish immigrants without a partner. It could be hypothesized that particular difficulties may emerge when immigrant women from more collectivistic and family-oriented cultures (as e.g. Turkish immigrants) try to be economically (and socially) independent [26]. In some cultures women are the ones predominantly conveying and retaining cultural values [52]. Thus, being without a partner and being economically independent may contrast with traditional family values and parents' expectations in more traditional families [19,26]. For example, Hilmann (1999) investigated the female position of Turkish entrepreneurs and dependent workers in Berlin at the end of the 1990s and found that independent of their professional position women were more likely to retain their social roles and family obligations, such

Table 3
Results from linear regression analyses with GHQ-28 as the dependent variable and SES aggregated variable.

	Aggregated SES Turkish group			Aggregated SES German group		
	β	(95% CI)	p value	β	(95% CI)	p value
Age	.2	.04-.4	0.045	-.7	-.1-.03	0.200
In a relationship ¹		1.00			1.00	
Single	5.5	.1-10.9	0.047	3.3	-.7-7.3	0.107
SES aggregate measure ²	-3.2	-5.9- -.5	0.020	-.8	-2.7-1.2	0.431

¹ Reference category is being in a relationship or married.

² Higher score is indicative for higher level of SES, ranges from 0-4. The SES aggregate measure is constructed by ISCED level of education, poverty risk and unemployment.

as caring for children and taking care of the housework [36]. When a woman fails to comply with her expected social role, more may be demanded from her regarding economically supporting herself. Beyond this, additional stress may arise in this situation if she fails to reach her aspired goals – like socioeconomic independence or higher levels of socioeconomic status. Due to the quantitative nature of this study it was not possible to further analyze the specific circumstances of this group of female Turkish immigrants, which calls for further in-depth qualitative study.

Overall, an association of lower SES and emotional distress was found in female Turkish immigrants but not in native German women in this study, although levels of distress were influenced by relationship status. The impact of socioeconomic hardship appears to be complicated by social roles and the expectations related to them. Further qualitative study of this finding is needed to establish an understanding of the complex nature of the interaction of social roles and socioeconomic position in female Turkish immigrants in Germany.

There are a number of limitations to this study. As mentioned above the small number of observations by cell did not allow for an analysis stratified by migration background and poverty risk, thus limiting conclusions about the interacting relationship of the poverty risk and unemployment in female Turkish immigrants. Another limitation was that a subset of the participants was recruited through snowball sampling, which could have led to recruiting more women with bigger social networks. Lastly, the definition of Turkish immigrant status was based on a widely used concept of migration background in Germany to enable comparisons to official data, neglecting the diversity of female Turkish immigrants living in Germany.

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Conflict of interest statement

None.

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Mental health of Turkish women in Germany: resilience and risk factors

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ABSTRACT

Keywords:
 Turkish migrants
 Resilience and risk factors
 Mental health
 Women

Background.- The purpose of the present study was to examine the protective and risk factors of mental distress among Turkish women living in Germany.

Method.- 105 Turkish immigrant women living in Berlin were investigated with measures of extraversion/neuroticism (NEO-FFI), general self-efficacy (GSE), social support (BSSS), social strain (F-SOZU) and mental distress (GHQ-28). Interrelations between psychosocial variables were assessed using simple Pearson correlations.

Results.- In all subjects, social strain (Pearson's $r=0.26^{**}$, $p=0.008$) and neuroticism ($r=0.34^{**}$, $p<0.001$) were positively associated with mental distress. In contrast, perceived self-efficacy ($r=-0.38^{**}$, $p<0.001$) and extraversion ($r=-0.36^{**}$, $p<0.001$) were negatively associated with mental distress.

Conclusion.- Protective factors such as extraversion and self-efficacy seem to have a buffering effect on the process of migration. However, in addition to neuroticism, social strain seems to be positively associated with mental distress.

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1. Introduction

The process of migration is a significant event in the lives of migrants [14]. Migrants leave their home country to inhabit and re-establish themselves in a foreign country. In the migratory process they may be faced with a number of challenges including the need to learn a new language and adopt a new culture. Old coping strategies that were useful in the culture of origin may be ineffective or even counterproductive in new cultures. Hence, migration can be a major life event [29], characterized by adaptation and acculturation processes.

The relationship between migration, stress and psychological strain has been investigated in several studies [6,25]. Several psychiatric disorders consisting of depressive disorders, post-traumatic stress disorder, and somatization disorder appear to

be related to migration [11,24,29,37]. For example, Breslau et al. found increased risk for mood and anxiety disorders among Mexican immigrants to the United States compared with Mexicans who remained in their home country [9]. Koh [32] reported significantly higher rates of somatization among the Korean immigrants than for nonimmigrants. In Germany, also suicide rates and attempted suicide rates especially among young women of Turkish background were found to be higher than for native Germans [22,36]. Family conflicts and cultural differences seem to play a crucial role in the appearance of suicidal behavior and mental health among the female participants [15,36,39].

Migration is a stressful event that can influence psychological and physical health, but does not always lead to mental disorders. Previous studies have mostly focused on the risk factors for developing mental disorders among migrants. But migration can also be a chance for positive development [1]. Whether migration is perceived positively or negatively depends on several factors, including socioeconomic status [47], level of education [17], voluntary decision of migration [23], personality traits (extraversion, neuroticism), social support, and social

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strain. However, to date, there are few studies to identify risk and protective factors in migrant populations in Europe. In the current study, we explored both risk factors (neuroticism, social strain) and protective factors (self-efficacy, extraversion, and social support), associated with mental health status among Turkish women living in Germany.

1.1. Psychological factors in regard to mental disorders

Personality traits [7,46], perceived self-efficacy [43,49], social support, and social stress, especially resulting from violence within the family [4,21,34,38] are psychosocial contributors to the emergence of mental disorders. There has not been a comprehensive study about the relationship between social support, self-efficacy, and personality factors among migrants of Turkish descent.

Research on non-migrant populations points to a significant correlation between personality traits and psychological complaints [13,16]. Personality traits can influence health in various ways, and together with behavior patterns, can either have a health-promoting or health-threatening effect. Several studies reveal a positive correlation between the personality trait, neuroticism, and anxiety and depression [21,34]. Likewise, neuroticism is a risk factor for cultural conflicts. In contrast, extraversion was found to be a major predictor of life satisfaction and less depression [28,41]. The present study focuses on these two dimensions of personality: neuroticism, and extraversion, as previous findings suggest they are the best predictors of psychological functioning.

Self-efficacy is regarded as a central protective factor in dealing with psychological stress [18,48]. Self-efficacy expectation refers to the belief that one can achieve goals with one's own capability despite potential obstacles. Since people with higher self-efficacy expectations are more confident about their own abilities and skills, they can deal with challenges more positively [5], and achieve success more frequently. Schwarzer [43] suggests that subjective behavior patterns are available as resources for various situations, and therefore self-efficacy can be seen as a generalised, temporally steady construct. The self-efficacy expectation has been found to be an indicator for mental health, with low self-efficacy associated with anxiety and depression [26,43]. Therefore, migrants with a higher self-efficacy expectation could possibly, despite strain, integrate better in the host country, and have a lower risk of developing psychological problems.

Social support has been found to be a protective factor in stressful situations [31]. The quality of interpersonal interactions has a crucial role in social support [31] and social support can be defined as general perceived or anticipated support, i.e. the subjective conviction about receiving support from one's social network in case of need [30,45].

Interpersonal interactions can, as well, be experienced as burdening if one feels controlled, constrained, criticised or looked down upon by others [45]. This can lead to conflicts within the family and increase social strain, which may have negative effects on mental health. Therefore we hypothesize a negative effect of social strain on the development of psychological problems amongst migrant women.

To our knowledge, there have been no studies to date, which have systematically investigated the relationship between

resilience (self-efficacy, extraversion, social support), risk factors (neuroticism, social strain) and mental health in women with Turkish backgrounds living in Germany. We hypothesize that 1) resilience factors (self-efficacy, extraversion, social support) would be negatively associated with mental distress and 2) risk factors such as neuroticism and social strain would correlate positively with mental distress.

2. Method

2.1. Participants

Participants were recruited through direct contacts with family members, friends, hospital coworkers and women from Turkish community centers in Berlin. A total of 105 Turkish migrant women between 21 and 64 years of age living in Berlin were included.

Mother-tongue Turkish clinical staff conducted interviews with participants to collect sociodemographic data. Participants completed paper pencil self-report psychological questionnaires in the presence of the mother-tongue Turkish clinical coworkers.

2.2. Setting

The data was collected between April and October 2009. All participants answered the questionnaire in a setting of their own choice, at home, in the university clinical hospital, or in Turkish community centers. Written informed consent was obtained from all participants and the study was approved by the ethics committee of Charité University, Berlin, Germany. Respondents took an average of 120 minutes to complete the interview and questionnaires.

2.3. Measures

2.3.1. Socio demographic variables

Data were collected on age, birthplace of the participants, their parents and grandparents, length of stay in Germany, residence status, reasons for migration, language ability, religious background and several indicators of socioeconomic status (SES) including education (i.e. none, elementary school or post-secondary education), total family income, partnership (i.e. single, steady relationship, married or separated), and employment status.

Furthermore, all respondents were asked to report their own and their parents' physical and mental health (e.g. cancer, diabetes, depression, alcohol addiction, and suicidal ideation or suicide attempts) and experience of trauma.

2.3.2. Translation procedures

Several of the instruments (NEO-FFI, Social Strain questionnaire, Acculturation Scale) were first translated from German to Turkish and then translated back. Translated questionnaires

were then scrutinized independently by three highly competent bilingual coworkers (i.e., a psychologist, a social worker, and a graduate student of psychology) and were adjusted in a consensus conference supervised by the principal investigator of the study.

2.3.3. General health (GHQ-28)

The general health questionnaire (GHQ-28) presents a valid and reliable instrument across cultures. It assesses the recent subjective psychological state along four subscales: (a) psychosomatic symptoms, (b) anxiety and insomnia, (c) social dysfunction, and (d) severe depression [20]. Each subscale contains seven items on a four-point Likert scoring system. Total scores for the GHQ in our sample ranged from 0 to 84. The lower the score, the better the psychological well-being of the subjects. The internal reliability of the Turkish version of GHQ-28 was found to be highly reliable (Cronbachs $\alpha = .82 - .93$).

2.3.4. The General Self-Efficacy Scale (GSE)

The GSE is based on Bandura's self-efficacy theory [5]. Self-efficacy is an optimistic self-belief that one can achieve his or her goals or perform a novel or difficult task with his or her own capability despite potential obstacles. The GSE is a 10-item scale with a four-point Likert scale type format ranging from [1] "Not at all true" to [4] "Exactly true" and with a total range from 10 to 41 [27]. The scale is designed for adult populations and is available in 27 languages. The internal reliability of GSE from the 23 nations including Turkey ranged between .76 and .90, with the majority in the high .80s.

2.3.5. Berlin Social Support Scales (BSSS)

The Berlin Social Support Scales (BSSS) is a multi-dimensional self-report inventory [44] designed to measure various dimensions of social support (perceived available support, need for support, support seeking, actually received support, provided support). In the current study, we only used the subjectively perceived social support as a robust trait, which contains 12 items. Responses ranged from 1 (strongly disagree) to 4 (strongly agree). The internal reliability for the original BSSS version is .83 and for the Turkish translated version .91.

2.3.6. Social Strain (F-SOZU)

Social Strain is a subscale of the German Social Support Questionnaire F-SOZU [45]. The 12-item subscale assesses excessive demands, overprotection and rejection. Examples are "I feel rejected by important people" or "I wish others would not interfere too much with my life". The items are rated on a Likert scale from 1 (totally disagree) to 5 (totally agree). The internal reliability for the German Social Support Questionnaire F-SOZU is between .81 and .93 and for the Turkish translated version .89.

2.3.7. NEO-Five Factor Inventory (NEO-FFI)

The NEO Five-Factor inventory (NEO-FFI) is a shortened version of the NEO PI-R designed to measure five stable domains of personality (Neuroticism, Extroversion, Openness, Agreeableness, and Conscientiousness) [12]. In the current study, all subjects completed only two dimensions (extraversion and neuroticism) from a German version of NEO-FFI [8]. High scores on extraversion represent individual differences in the tendency to experience warmth, gregariousness and assertiveness. Neuroticism is characterized by anxiety, hostility and depression. The (NEO-FFI) is a 60-item self-report inventory, which measures on a five-point Likert-scale (from "strong approval" to "strong disapproval"). The measurement was also translated and back-translated into the Turkish language (Neuroticism, Cronbachs $\alpha = .51$ for translated version; Extraversion, Cronbachs $\alpha = .58$ for translated version).

2.4. Data analysis

All the analyses were conducted in SPSS/PC version 18.0. Descriptive statistics of the frequencies and means of the demographic variables of the study were computed. Missing data were replaced by the mean of nearby points. (chi²) tests were performed for categorical data. Interrelations between psychosocial variables were assessed using simple Pearson correlation.

3. Results

3.1. Participant characteristics

A total of 105 respondents with a Turkish background participated in the study. Participants' mean age was 36.01 years (SD 9.11; range 21 to 64 years). Most subjects were married (54.9%), born in Turkey (66.7%) and migrated to Germany for social reasons (family reunion/marriage)(78%). Only 26% of the subjects had a full-time job and more than 72% of them had relatively low household net income with less than 2000 € per month (Table 1).

3.2. Predictors of mental health resilience and vulnerability factors

In all participants, social strain (Pearson's $r=.26^*$, $p<.01$) and neuroticism ($r=.34^{**}$, $p<.001$) were positively associated with mental distress. Perceived self-efficacy ($r= -.38^{**}$, $p<.001$) and extraversion were negatively associated with mental distress ($r= -.36^{**}$, $p<.001$). Contrary to our hypotheses, the relationship between social support and mental distress did not reach statistical significance ($r= -.17$, $p=.08$).

Self-efficacy was strongly positively correlated to social support ($r=.39^{**}$, $p<.001$) and extraversion ($r=.26^*$, $p<.01$), and negatively to neuroticism ($r= -.33^{**}$, $p<.001$) and social strain ($r= -.26^{**}$, $p=.007$). Extraversion was not significantly correlated with social strain ($r= -.27$, $p=.204$) but was positively associated with social support ($r=.31^{**}$, $p<.001$).

Table 1
Socio-demographic characteristics of the respondents.

Characteristic	Total sample	n (%)
<i>Age (years)</i> (mean \pm SD)	36	(9.1)
<i>Birthplace</i>		
Germany	33	(32.4)
Turkey	68	(66.7)
Other	1	(1)
<i>Length of stay in Germany</i> Years (mean \pm SD)	22.6	(11.4)
<i>Marital status</i>		
Single	24	(23.5)
Married	56	(54.9)
Separate/Divorced	18	(17.6)
Widow	1	(1)
Others	3	(2.9)
<i>Migration background</i>		
Family reunion/Marriage	53	(78.0)
Political reasons	2	(2.9)
Economic reasons	8	(11.8)
Study	4	(5.9)
Others	1	(1.5)
<i>Education (years)</i> (mean \pm SD)	9.84	(3.9)
<i>Employment status</i>		
Employed (Full time)	26	(26.0)
Employed (Part time)	27	(27.0)
Unemployed	12	(12.0)
Student	14	(14.0)
Housewife	9	(8.6)
Others	12	(12)
<i>Per capita net income</i>		
0-900 €	23	(30.7)
1000-1900 €	31	(41.3)
2000-2900 €	18	(24.0)
More than 3000 €	3	(4.0)
<i>Persons living at the house</i> (mean \pm SD)	3.2	(1.5)

4. Discussion

Consistent with previous studies on non-migrant populations, we found a negative correlation between hypothesized protective factors (extraversion, social support, and self-efficacy) and mental distress [3,35]. Fulmer et al. [19] postulated that when a person's personality is congruent with the majority culture (person-culture match hypothesis), it has a positive effect on the self-esteem and subjective well-being. These individuals may be more likely to have positive experiences leading to a higher level of self-efficacy and better psychological wellbeing.

Furthermore, Schimmack et al. (2002) found that extraversion and neuroticism were significant predictors of life satisfaction rather in individualistic cultures than in collectivistic cultures [40]. Therefore, individuals with extroverted personalities might be more satisfied in individualistic cultures like Germany [42] and have a better mental health status than introverted individuals.

Neuroticism, as well as social strain, represented risk factors for mental health, and both were related to self-efficacy, suggesting that the ability to master new environments is strongly dependent on both personality traits and perceived social context stressors. Different non-migrant studies have shown a high association between neuroticism and mental distress [10,33].

It has been suggested that social support has a buffering effect on mental health even after a critical event [3]. Although the relationship between social support and mental health was only marginally significant, social support was positively associated with extraversion, suggesting that extroverts among Turkish migrants may have better skills in recruiting social support.

Limitations of our study are the lack of a representative sample, which may bias our results. However, representative sampling of women of Turkish origin in Germany has been proven to be very difficult, with response rates below 5% in several surveys [2]. In these surveys, an applied convenience sample using a snowballing approach yielded one of the largest samples of this population. A further limitation in our study is that we did not assess the effect of relevant factors, such as socioeconomic status or voluntary decision of migration on mental health, resilience or risk factors. Additionally, a cross-sectional study cannot imply causality. Therefore, the specific role of resilience and risk factors should be examined in future longitudinal studies.

5. Conclusion

Migration represents a major challenge but it does not always lead to mental distress. Protective factors such as social support and self-efficacy seem to have a buffering effect in the process of migration. However, neuroticism and social strain seem to be positively associated with mental distress. Further research is needed on how to best provide and increase social support and self-efficacy among Turkish migrants.

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Conflict of interest statement

None.

Authors contributions

Equal contributors.

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The influence of stigma on depression, overall psychological distress, and somatization among female Turkish migrants

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ABSTRACT

Keywords:
 Stigmatization
 Depression
 Somatic symptoms
 Turkish migrants

Background.- Even though some studies suggest that in Mediterranean and non-western cultures more somatic and less psychological symptoms are reported, this so-called 'somatization' hypothesis has been challenged. Reviews show that somatic symptoms are a core component of depressive episodes regardless of cultural background. The expression of symptoms might be related to the psychosocial, social and cultural context surrounding the patient rather than 'ethnicity' or related constructs. Also, stigma associated with mental disorders can affect patients' symptom presentation.

Methods.- The interrelationships of perceived stigmatization (Explanatory Model Interview Catalogue - Stigma Scale), depression (Beck Depression Index II), overall psychological distress (Symptom Checklist-90-R), and somatic symptoms (The screening for SOMATOFORM SYMPTOMS II) was assessed in a sample of female patients with Turkish descent with a diagnosis of depression (N=63).

Results.- Depression, overall psychological distress, and somatic symptoms were positively and significantly related. Stigma was positively related to depression and overall psychological distress. There was no significant relationship between stigma and somatic symptoms, neither among the severely depressed group (N=39), nor among the less depressed group (N=24).

Conclusion.- The positive relationships between stigma, depression, and overall psychological distress indicate that patients who are more depressed and who have higher levels of overall psychological distress experience their condition as more stigmatizing. Since somatic symptoms and stigma were not related (neither positively, nor negatively), it appears that depressive symptoms and other symptoms of psychological distress affect concerns about stigmatizing attitudes in a way that somatic symptoms do not. This result challenges common assumption of the 'somatization' hypothesis, i.e. that depression is 'somatized' because of concern about stigmatizing attitudes.

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1. Introduction

Cultural differences in the presentation of psychological and somatic symptoms in psychiatric disorders have been a topic under research. Even though some studies suggest that in Mediterranean and non-western cultures more somatic and less psychological symptoms are reported [2,4,5,6,7,14,20], this

so-called 'somatization' hypothesis has been challenged in the literature. A study of the World Health Organization (WHO) about somatic symptoms shows that somatic symptoms are a core component of depressive episodes regardless of cultural background [19]. In line with this finding, a review about cultural variations in the clinical presentation of depression shows that, contrary to the claim that Mediterranean and non-Westerners are

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prone to 'somatize' their distress, somatization is ubiquitous, and somatic symptoms serve as cultural idioms of distress in many ethnocultural groups [8]. Although somatic and psychological symptoms appear to coexist and patients are likely to express both, they may express more of one type of symptom, somatic or psychological, over the other [16]. The expression of symptoms may be related to the psychosocial, social and cultural context surrounding the patient [7,9]. There are several possible reasons for expressing somatic over psychological symptoms.

The above mentioned WHO study conducted at 15 primary care centers in 14 countries showed that a somatic presentation was more common at centers where patients lacked an ongoing relationship with a primary care physician than at centers where most patients had a personal physician [19]. Also, the frequency of somatic symptoms of depression may also vary depending on how somatization is defined. For example, definitions for somatization can include the presentation of a specific somatic symptom, the association between depression and medically unexplained symptoms, or a denial of psychological distress and substitution of psychological distress with somatic symptoms [19]. Furthermore, each person has his or her own specific explanatory model that affects the illness expectations [13], which in turn influence the ways that individuals perceive and evaluate the symptoms. Another hypothesis is that individuals who report physical symptoms are generally more likely to be accepted as ill. Therefore, some patients might reject psychological dimensions as a threat to the legitimacy of suffering [11]. Also, there might be secondary gains from expressing somatic symptoms, such as extra care and sympathy from friends, relatives, and doctors [16]. However, professional's prejudices about the frequency of somatization in different cultural or 'ethnic' groups may promote neglect of somatic concerns and contribute to stigmatization of migrants from certain countries.

Stigma related to chronic health conditions such as mental illness is a global phenomenon with a severe impact on the life of affected individuals, their families, and on the effectiveness of prevention and intervention [21]. Stigma associated with mental illness can affect patients' symptom presentation and help-seeking behavior. When mental illness-related stigma within a culture is strong, patients may present their symptoms as more somatic in an effort to avoid stigmatization [6,16,22]. Kirmayer (2006) discussed how mental illness stigma may also play a role in illness denial. A patient's concern about stigmatizing attitudes or experience of discriminatory behavior can influence their expression of symptoms [16].

A mixed methods study of psychiatric patients in South India using the Explanatory Model Interview Catalogue (EMIC) [23] showed that participants with a greater concern about stigma tended to present a more somatic balance of symptoms [16]. In the narrative part of the interview, participants who expressed symptoms somatically emphasized their personal concerns about stigma. For example, one participant voiced a concern about stigma which caused her to keep knowledge of her mental illness a secret in order to arrange her daughter's marriage without problems. This example illustrates how anticipated stigmatization can be associated with a subsequent change in behavior. In another mixed methods study with psychiatric patients from South India using the EMIC, stigmatization was associated with greater prominence of depressive symptoms but lesser prominence of somatic symptoms.

The narratives of these patients revealed that depressive symptoms affect the perceived social status of those who suffer from them in ways that somatic symptoms do not. The social meaning of somatic symptoms was described as less distressing because they closely approximate experiences that everyone has from time to time. Additionally, depressive symptoms may be considered to be private or even socially disadvantageous.

Few studies have investigated the interrelationships of stigma and the severity of psychological and somatic symptoms. In a sample of female patients with Turkish descent with a diagnosis of depression, we analyzed the interrelationship of stigma, depression, overall psychological distress, and somatic symptoms. It was hypothesized that [1] depression, overall psychological distress and somatic symptoms are positively related, [2] stigma is positively related to depression and overall psychological distress. Due to the conflicting results in the literature, no hypothesis was made concerning the relation of stigma and somatic symptoms.

2. Methods

2.1. Participants

Participants were recruited from the psychiatric outpatient clinic at the Psychiatric University Clinic of Charité at St. Hedwig Hospital in Berlin and from four outpatient psychiatric practices. Patients with a diagnosis of depression (F32, F33, and F34) according to ICD-10, and with 11 or more points in the Beck Depression Inventory II at the time of investigation were included in the sample. Patients with co-morbidity of schizophrenia, delusional disorders, personality disorders, dementia, substance abuse and severe somatic disorders were excluded. Participants who migrated from Turkey to Germany as adults or children were defined as patients with Turkish descent. The total sample consisted of 63 female patients with Turkish descent.

2.2. Procedure and Setting

Written informed consent was obtained from all participants. The study was approved by the Ethics Committee of the Charité - University Medicine Berlin (EA1/176/08). The socio-demographic data was collected in face-to-face interviews. Participants could choose if they wanted to be interviewed in German or Turkish. After the face-to-face interview, all participants completed the self-reported psychological questionnaires in the presence of the interviewer. All questionnaires were available in German and in Turkish. Participants could choose to be interviewed at home, at the university clinic, or in a Turkish community center.

2.3. Measures

2.3.1. Socio-demographics

All participants were born in Turkey and most of them migrated to Germany as adults, while a minority migrated as children or during adolescence (11%). The following

socio-demographic data were assessed: age, education level, income, marital status, number of children, region of origin (urban vs. rural), and years in Germany.

2.3.2. Explanatory Model Interview Catalogue (EMIC) Stigma Scale

The Explanatory Model Interview Catalogue (EMIC) [23] is a catalogue of instruments used to study different cultural and epidemiological aspects of a health condition. It has been used to measure attitudes and perceptions regarding a number of health conditions in different cultural settings. For this study only its Stigma Scale was used. The EMIC Stigma Scale covers certain areas of life that may be affected by stigma, namely, concealment, avoidance, pity, shame, being made fun of, respect and marriage (prospects). It is composed of 13 statements which are ranked from 0 to 3 (0=no, 1=not sure, 2=maybe, 3=yes). Since there is no German or Turkish version of the EMIC, the Stigma Scale was translated and translated back into both languages by professional translators.

2.3.3. Beck Depression Inventory II (BDI)

The Beck Depression Inventory II (BDI) is a self-report screening instrument for measuring the severity of depression [1]. The inventory is composed of 21 items relating to depressive symptoms (hopelessness and irritability), cognitions (guilt or feelings of being punished), and physical symptoms (fatigue, weight loss, and lack of interest in sex). Statements are marked which have been true during the past two weeks. Each item consists of 4 statements that range from mild/neutral (mild=0) to severe (severe=3). The severity of depression is divided into four groups: 0–13: minimal depression; 14–19: mild depression; 20–28: moderate depression; and 29–63: severe depression. Higher total scores indicate more severe depressive symptoms.

2.3.4. The Screening for Somatoform Symptoms II (SOMS-II)

The SOMS II [17] is a self-report screening instrument for 53 physical symptoms. It includes all 33 physical complaints of the DSM-IV somatization disorder symptom list, the symptoms of ICD-10 somatization disorder, and the ICD-10 somatoform autonomic dysfunction symptom list. It assesses whether the listed physical symptoms were experienced during the last two years (yes/no).

2.3.5. The Symptom Checklist-90-Revised (SCL-90-R)

The Symptom Checklist-90-Revised (SCL-90-R) is a self-report screening measure of general psychiatric symptomatology with 90 items [3]. It includes subscales measuring somatization, obsessive-compulsive, depression, anxiety, phobic anxiety, hostility, interpersonal sensitivity, paranoid ideation, and psychoticism. The severity of experiences with each symptom over the past week is rated on a 5-point scale ranging from 0 (not at all) to 4 (extremely). The SCL-90-R has three global indices. The

Global Severity Index (GSI) measures the overall psychological distress, the Positive Symptom Distress Index (PSDI) measures the intensity of symptoms, and the Positive Symptom Total (PST) reports the number of self-reported symptoms.

2.4. Data analysis

Statistical analyses were performed with SPSS, Version 19. Pearson's correlations were performed to examine the association between EMIC Stigma Scale, BDI II, SCL-90, and SOMS-II. To explore the influence of severity of depression on the association between stigma and somatic symptoms, the sample was divided into two groups according to the severity of the depression (group 1: BDI>28 vs. group 2: BDI<29). The correlation between stigma and somatic symptoms was assessed for both groups independently.

3. Results

3.1. Socio-demographics

The mean age was 48.42 years (SD 9.1; range: 28–72). All participants were born in Turkey and most of them migrated to Germany as adults, while a minority migrated as children or during adolescence (11%). A detailed description of the socio-demographic characteristics of the sample is displayed in table 1.

Table 1
Characteristics of the sample.

Sample size	63	
Variables	N	%
Education:		
No degree	11	17.5
Primary school	18	28.6
Secondary School	19	30.2
Vocational training	4	6.4
University	9	14.3
Other	2	3.2
Income:		
No own income	9	14.3
Own income	16	25.4
Social benefits	23	36.5
Pension	14	22.2
Other	1	1.6
Marital status:		
Married	18	28.6
Single	11	17.5
Divorced/Widowed	34	53.9
Region of origine: From rural areas (vs. urban)		
Variables:		
Age	M 48.4	SD 9.1
Number of Children	1.96	1.2
Years in Germany	32.4	12.7
EMIC Stigma Scale	19.7	10.1
BDI II	30.7	9.5
SCL-90-R GSI	164.6	62
SCL-90-R PSDI	2.14	0.68
SCL-90-R PST	68.1	15.9
SOMS-II	20.8	9.3

3.2. Interrelations of stigma, depression, overall psychological distress, and somatic symptoms

There were significant correlations between depression and overall psychological distress (Pearson's $r=.718^{**}$, $p<.000$), depression and somatic symptoms ($r=.312^*$, $p<.101$), and overall psychological distress (Global Severity Index) and somatic symptoms ($r=.492^{**}$, $p<.000$). Also, there were positive correlations between stigma and depression ($r=.544^{**}$, $p<.00$), and stigma and overall psychological distress ($r=.374^{**}$, $p<.003$). However, there was no correlation between stigma and somatic symptoms ($r=.082$, $p<.521$). 61.9% ($N=39$) of the sample were severely depressed (group 1), and 39.1% ($N=24$) were minimally, mildly or moderately depressed (group 2). The correlation between stigma and somatic symptoms was neither in group 1 nor group 2 significant (group 1: $r=-.056$, $p<.736$; group 2: $r=.047$, $p<.827$). Correlations are displayed in table 2.

4. Discussion

In our sample of depressed women with Turkish descent the severity of depression, overall psychological distress and somatic symptoms were positively related. The positive relationship between the number of the somatic symptoms and severity of depression indicates that somatic symptoms are an important aspect of depression and that both types of symptoms can be closely associated. This is in line with international studies that describe both psychological and somatic symptoms as core parts of depression [9,18]. Furthermore, the positive relationships between stigma and the severity of depressive symptoms and overall psychological distress illustrates that those patients who are more depressed and who have higher levels of overall psychological distress have significantly more concern about stigmatizing attitudes.

Although somatic and psychological symptoms coexist and are interrelated in this sample, perceived stigmatization

was only associated with depressive symptoms and not with somatic symptoms. It seems that depressive symptoms and general symptoms of psychological distress affect the perceived social status in a way that somatic symptoms do not. In contrast to the two studies of psychiatric patients in South India that reported either a negative or a positive association between stigma and somatic symptoms [15,16], our results did not show any significant relationship between the two variables. Therefore the hypothesis that depression is 'somatized' due to fear of stigmatization was not confirmed in our sample. Whether women do or do not report many somatic symptoms did neither correspond to their experience of stigmatization of their condition nor their concerns about stigmatizing attitudes. The results of this study challenge the widespread assumption of the 'somatization' hypothesis that patients from Mediterranean and non-western countries 'somatize' their emotional distress because psychological symptoms are more stigmatized than somatic symptoms in their cultural context. Of note, there might be other reasons for expressing somatic symptoms than fear of being stigmatized that we did not assess specifically and that could have had an influence on the interrelationship. Examples are a lack of a personal ongoing relationship with a primary care physician, the association between depression and medically unexplained symptoms [19], and gains from expressing somatic symptoms, such as extra care and sympathy [16]. However, since patients in our sample mostly had a long- time treatment history in the medical system, a lack of a personal relationship with a primary care physician was probably not an influencing factor.

Because of the small sample size, our results have to be treated with caution. No generalizations can be made and further investigations are needed to replicate these findings. Also, there was not a comparison with a female German sample or a Turkish male sample so possible differences have to be investigated in future studies.

Altogether, our study did not reveal a significant relationship between perceived stigma and somatic symptoms among women of Turkish descent. Our findings emphasize the need

Table 2
Interrelations of stigma, depression, overall psychological distress, and somatic symptoms.

		Correlations					
		EMIC Stigma Scale	BDI II	SCL-90-R GSI	SCL-90-R PSDI	SCL-90-R PST	SOMS-II
EMIC Stigma Scale	Pearson's correlation	1	.544** ¹	.374**	.363**	.316* ²	.082
	Significance		.000	.003	.004	.013	.521
BDI II	Pearson's correlation	.544**	1	.718**	.686**	.557**	.312*
	Significance	.000		.000	.000	.000	.010
SCL-90-R GSI	Pearson's correlation	.374**	.718**	1	.853**	.841**	.492**
	Significance	.003	.000		.000	.000	.000
SCL-90-R PSDI	Pearson's correlation	.363**	.686**	.853**	1	.492**	.380**
	Significance	.004	.000	.000		.000	.002
SCL-90-R PST	Pearson's correlation	.316*	.557**	.841**	.492**	1	.475**
	Significance	.013	.000	.000	.000		.000
SOMS-II	Pearson's correlation	.082	.312*	.492**	.380**	.475**	1
	Significance	.521	.010	.000	.002	.000	

^{1,2} Note: ** The correlation is significant on a level of 0.001 (two-tailed test),

* The correlation is significant on a level of 0,05 (two-tailed test)

to carefully and individually consider somatic and psychological symptoms in depressed patients regardless of assumed tendencies to 'somatize'. Generalizing assumptions about people from certain cultural backgrounds like the tendency to 'somatize' emotional distress because of fear of being stigmatized, can lead to misunderstandings, misdiagnosis, and finally -again- stigmatization. Also, these dynamics may lead to poor treatment and lack of acceptance of the treatment interventions. Ultimately, individual treatment of the person seeking help regardless of the cultural background and assumptions about culture-specific characteristics is an eminent part of professional attitudes towards all patients.

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Conflict of interest statement

None.

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Translation and adaptation of the Zung Self-Rating Depression Scale for application in the bilingual Azerbaijani population

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ABSTRACT

Keywords:
 Depression
 Scale
 Adaptation
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 Translation

Background.– A self-reported Zung Self-Rating Depression Scale (ZSDS) is recognized as a reliable and valid measure for assessment of depressive symptoms, applicable cross-culturally. The aim of the study was to adapt ZSDS for application in the bilingual Azerbaijani population.

Methods.– ZSDS was translated into Azerbaijani and Russian. Two pilot studies on small samples (n=30 and n=45) were conducted to improve the scale's acceptability. A readability study was conducted on a bigger sample of depressed subjects (n=55) and healthy controls (n=120). Chronbach's alpha for the total scale, item-test correlations, alpha if item deleted, and sensitivity and specificity at various cut-off levels were calculated.

Results.– The drop-out rate was 83.3% at the first pilot study due to problems of comprehension of item 5 and culturally unacceptable wording of item 6. After rewording of the items drop-out reduced to 20%. On the reliability study Chronbach's alpha for the total scale was 0.8727, and item-test correlations for the most individual items were satisfactory. An optimal cut-off point was 45 points with sensitivity=90.91%, specificity=80.83%.

Conclusions.– Adaptation of the Zung Self-Reported Depression Scale improved cultural acceptability of the scale in the context of the Azerbaijani study population.

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1. Introduction

The Zung Self-Rating Depression Scale (ZSDS) [24] is a 20-item self-reported tool, developed to measure depressive symptoms and for depression screening [25,3]. The Scale has been established as a reliable and valid measure in these areas [2,9,18]. Application of the scale increases detection of depression in primary care services, [21] and it is a useful instrument in various clinical settings [11,1,7,15].

From the outset, the ZSDS scale has been shown to be an effective instrument in cross-cultural settings. [24] Yet, such application of self-reported instruments presents additional challenges. The early studies, conducted in five European nations and the United States using five different languages,

established a high correlation between the self-rated ZSDS and physician-administered depression rating scales across the countries. There was, however, a quantitatively significant variance in the mean ZSDS across different populations [22,23]. Furthermore, later research, conducted in three Asian counties and the US (four different languages spoken) also showed that means scores of ZSDS varied significantly across countries [6]. Thus, Zung Self-Rating Depression Scale has been proved to be a reliable self-rated depression tool, applicable cross-culturally. It must, however be adapted and validated in each cultural population context for accurate assessment of depression symptoms severity and application of the scale as a screening instrument.

The aim of the study was to adapt the ZSDS for application to the bilingual Azerbaijani population, also to assess the reliability of the Azerbaijani and Russian translations in this cultural context.

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2. Materials and Methods

2.1. Translation and pilot studies

The original ZSDS was translated from English into Azerbaijani and Russian. The translations were then back-translated into English. The latter were conducted by an independent translator, who was not familiar with the English original. The back-translations were compared with the English ZSDS original by a native English speaker, and were ratified as accurate and valid.

Two pilot studies were conducted to facilitate adaptation of the validated ZSDS translations. The participants were asked to provide comments as necessary. The first pilot study of Azerbaijani and Russian ZSDS versions was conducted among a sample of 30 subjects (21 Azerbaijani-speaking and 9 Russian-speaking). The first pilot showed high drop-out rate, due to skipping of two items within the scale. These items were reworded in Azerbaijani and Russian to improve their acceptability. The reworded items were back translated into English to check similarity in terms of the meaning between the reworded items and the items in the English original. After the rewording the second pilot study was conducted among a sample of 45 subjects (42 Azerbaijani-speaking and 3 Russian-speaking) to check again the acceptability of the scale.

The reworded Azerbaijani and Russian ZSDS versions were chosen for further use in the study.

2.2. Reliability study

The second phase of the study was a reliability study of the ZSDS Azerbaijani and Russian versions and was conducted on a sample of 175 subjects with a mean age of 32.66 SD=11.28 (range 19-64), 58 males (33.14%) and 117 females (66.86%). 104 (59.43%) subjects of the sample were Azerbaijani-speaking and 71 (40.57%) were Russian-speaking. The total sample consisted of 2 sub-samples: depressed patients diagnosed with depression according to ICD-10 criteria [20] (n=55) and healthy control sample (n=120). The depressed patients' sample (15 males and 40 females) had a mean age of 32.74, SD=9.23 (range 18-61). The healthy controls sample (43 males and 77 females) had a mean age of 32.61, SD=9.23 (range 19-64).

The depressed patients were attending Baku the city Psycho-Neurological Dispensary, outpatient department of the Republic Psychiatric Hospital, "Saglam Aile" Private Medical Center and "Fundu" Private Medical Center, Baku, Azerbaijan. The healthy control sample was composed of members of the mentioned medical centers staff, relatives of the patients and the research team members. All sample subjects were tested once by the Azerbaijani or Russian ZSDS versions, according the first language they spoke.

All the obtained data were summarized in a database built on SPSS 16.0 software for Windows, which was used for the later statistical analysis. Chronbach's alpha coefficient for the total scale was calculated to check the reliability of the ZSDS scale adaptations. Item-test correlations and alpha if item deleted were calculated to check performance of the individual items. Sensitivity and specificity of the ZSDS scale at various cut-off levels for the total sample were calculated to choose an optimal cut-off point.

3. Results

The first pilot study revealed a very high drop-out rate of 25 subjects (83.3%) due to skipping of the item 5 (missed out by 8 subjects (26.7%) and item 6 (missed out by 23 subjects (76.7%). The participants, who missed items of the ZSDS scale, were interviewed to provide reasoning for not completing the scale. According to comments and explanations, made by the participants, item 5 (I eat as much as I used to) was missed out due to the difficulty in comprehension of the item's word-for-word translation. Skipping of item 6 (I still enjoy sex) was explained by the fact that it is culturally unacceptable to report about one's sexual activity (or to be sexually active), particularly for local unmarried women (19 out 21 unmarried female participants (90.0%) missed item 6). There was a high overlap between subjects not responding both to items 5 and 6, respectively: 6 out 8 subjects (75%), who missed item 5, missed item 6 as well. Such a high overlap can be explained by a high non-responsiveness to item 6, which covers 76.7% of the total sample in the first pilot study.

Item 5 was reworded and translated (in back translation) as "my appetite is as it used to be". Item 6 was reworded as well, and translated back into English as "my sexual drive (interest) is as it used to be".

In comparison with the first pilot, the second pilot study of the Azerbaijani and Russian ZSDS versions, which was conducted after the rewording of the scale items, revealed a significantly lower drop-out rate of 20.0% (9 subjects) due to miss of item 6. Only 5 out 29 unmarried female participants (17.2%) missed item 6. There was no miss of item 5, as there had been in the first pilot.

The processing of the data from the second phase of the study (reliability study) revealed the following findings: Chronbach's alpha for the total scale was equal to 0.8727, and this value suggests that the scale has a good general internal consistency. However, items of the scale did not perform similarly, in terms of the item-test correlations. The range of item-test correlations is significantly wide with the highest correlation for item 1 (0.71) and the lowest for item 8 (0.24). Sixteen items, if deleted, would decrease the total scale alpha. three items (item 5, item 7, and item 8), if deleted, would increase the total scale alpha, and these three times have low item-test correlations, which are 0.38, 0.29, and 0.24 respectively. Item 6, if deleted, would have no impact on the total scale alpha (Table 1).

Sensitivity and specificity of the scale at various cut-off levels for the total sample were calculated. (Table 2) The results established that an optimal cut-off point can be suggested at ≥ 45 with sensitivity=90.91%, specificity=80.83%. The area under ROC curve for ZSDS scores=0.9440. (Fig. 1)

4. Discussion

Publications on using of the ZSDS in various cultural contexts indicate that, despite being successful, there are difficulties presenting the language adaptation of the scale. Adaptation of the ZSDS for using in a Spanish-speaking population demonstrated the scale's usefulness [4], but presented interpretation difficulties of the scale's Spanish version. The Spanish version was needed to be

Table 1
Correlations between individual items and total scores (N=175).

Item	Item-test correlation	Item-rest correlation	Interim covariance	Alpha if item is deleted
ZSDS 1	.708	.659	.265	.860
ZSDS 2	.439	.362	.282	.870
ZSDS 3	.527	.456	.276	.867
ZSDS 4	.456	.376	.280	.870
ZSDS 5	.382	.293	.285	.873
ZSDS 6	.428	.339	.281	.872
ZSDS 7	.290	.215	.293	.874
ZSDS 8	.239	.165	.296	.875
ZSDS 9	.516	.446	.278	.867
ZSDS 10	.681	.629	.266	.861
ZSDS 11	.694	.642	.266	.861
ZSDS 12	.623	.561	.269	.863
ZSDS 13	.673	.617	.266	.861
ZSDS 14	.662	.599	.264	.862
ZSDS 15	.508	.429	.276	.868
ZSDS 16	.493	.416	.278	.868
ZSDS 17	.639	.578	.268	.863
ZSDS 18	.667	.606	.264	.861
ZSDS 19	.483	.424	.283	.868
ZSDS 20	.655	.591	.264	.862

ZSDS Zung Self-rating Depression Scale

Table 2
Results of sensitivity and specificity analysis.

Cut-off point	Sensitivity	Specificity	Correctly classified	LR+	LR-
≥34	100.00%	35.83%	56.00%	1.558	0.000
≥35	100.00%	40.00%	58.86%	1.667	0.000
≥36	98.18%	44.17%	61.14%	1.758	0.041
≥37	98.18%	51.67%	66.29%	2.031	0.035
≥38	98.18%	55.83%	69.14%	2.223	0.033
≥39	98.18%	60.83%	72.57%	2.507	0.029
≥40	98.18%	65.83%	76.00%	2.874	0.028
≥41	98.18%	68.33%	77.71%	3.101	0.027
≥42	98.18%	71.67%	80.00%	3.465	0.025
≥43	94.55%	75.83%	81.71%	3.912	0.072
≥44	92.73%	77.50%	82.29%	4.121	0.094
≥45	90.91%	80.83%	84.00%	4.743	0.113
≥46	89.09%	85.00%	86.29%	5.939	0.128
≥47	89.09%	86.67%	87.43%	6.682	0.126
≥48	83.64%	90.83%	88.57%	9.124	0.180
≥49	80.00%	92.50%	88.57%	10.667	0.216
≥50	74.55%	93.33%	87.43%	11.18	0.272

Likelihood ratio for a positive test result (LR +), likelihood ratio for a negative test result (LR-).

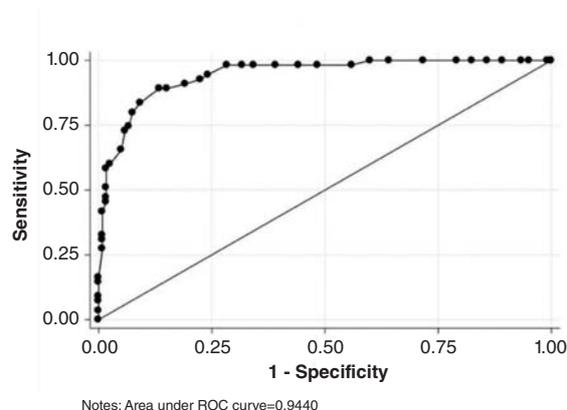


Fig. 1. Roc curve for ZSDS Scores.

developed taking into consideration the particularities of the local population [14]. Application of the scale in the Eskimo community required the scale's items to be modified to fit idioms of the local population [10]. Similar to our study, adaptation of the Arabic ZSDS translation demonstrated difficulties in acceptability of item 6 (I still enjoy sex), which was considered to be unacceptable due to cultural and religious sensitivities [12].

One publication cited a multiple-choice format of the ZSDS as a reason for non-completion [7]. Our study, however suggests that the main reason of non-completion, particularly in cross-cultural application of the scale, is poor acceptability of straightforward use of a Western developed self-reported questionnaire.

Our results suggest that the Russian and Azerbaijani translations are suitable for application in the bilingual Azerbaijani population. We were able to establish an optimal cut-off point of the ZSDS scale for the particular Azerbaijani population context. Identification of an optimal cut-off point for a self-reported tool, used as a screening instrument is a complicated issue: we need a cut-off point with sensitivity as high as possible to provide effective detection of the positive cases, but have to consider that this should not be at the expense of low specificity [5,13,17,19]. The data obtained suggests that application of the adapted version of scale ZSDS at the cut-off point of 45 provides high sensitivity and specificity of the scale as a depression screening tool among the Azerbaijani female population.

The obtained data also provides findings on the performance of separate items of the ZSDS. The context of the item 5 ("my appetite is as it used to be") and items 7 ("I notice that I am losing weight"), which are associated with depression somatic symptoms of marked loss of appetite and weight loss respectively, showed low item-test correlations. Deletion of these items improves the total scale performance. These findings suggest that the above mentioned symptoms are less common among the studied population. Item 8 ("I have trouble with constipation"), which has the lowest item-test correlation, is not associated with any ICD-10 diagnostic criteria of depressive disorder [20]. Deletion of this item also improves the total scale performance. Poor performance of the item 8 may be because its context is not specific to depressive disorder symptoms [16,20].

Despite valuable data having been obtained, interpretation is limited by the relatively small non-representative sample achieved in this study. A wider-ranging study on a large randomized population sample is now being planned for the further validation of the scale to be used as a depression screening instrument in the general Azerbaijani population.

5. Conclusions

Adaptation of the Zung Self-Reported Depression Scale's translations into Azerbaijani and Russian improved cultural acceptability of the scale in the studied Azerbaijani population. The adapted version of the Zung Self-Rating Depression Scale is a reliable instrument for depression screening among the Azerbaijani population. A study using a larger randomized sample is needed for the further validation of the ZSDS to be applied as a depression screening instrument in the general Azerbaijani population.

Conflict of interest statement

None.

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Construction and interpretation of self-related function and dysfunction in Intercultural Psychiatry

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ABSTRACT

Keywords:

Self-concept
Pre-reflective self-awareness
Self-reference
Transcultural psychiatry
Dysfunction of the self

In several psychiatric disorders, key symptoms are associated with aspects of an individual, which are usually referred to as the “self”. For example in schizophrenia, it has been suggested that the activity of the self and the distinction between self and others are impaired. However, such models of the self and its dysfunction have been developed among Western societies and may not easily be transferred into different cultural settings, which can be characterized by alternative concepts of a person's self. This study compares traditional Western concepts of the self and its dysfunction with self-concepts developed in Caribbean, African and South-East-Asian societies.

This review demonstrates that “the self” is a fluid concept. Social function and dysfunction of such a self-concepts depend on a given cultural context. We argue that the cursive concept of the self is culturally constructed around cursive experiences which are shared by all human beings. Such universal experiences may include the prereflective access to individual thoughts and feelings, an automatic knowledge that (at least in non-pathological states) these emotions and cognitions belong to my self. Conscious self-reflection and its narrative articulation, on the other hand, is necessarily imbued with social and cultural norms, images and events, often of conflicting nature.

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1. Introduction

Many psychiatric disorders are characterized by alterations of self-reference and the sense of personal agency. For example, in schizophrenia, patients may report that their thoughts appear to be or feel “alien” and under external control, or that outer forces can block their flow of ideas. In certain states of trance or dissociation, patients can experience obsession by spiritual forces, which may or may not be associated with local religious rituals and belief systems. Classification of such experiences is based on Western concepts of a person, which usually include ideas of individual agency and autonomy. However, can such concepts be transferred to other cultural contexts with alternative ideas about a person's self and its characteristic structure and abilities?

In this essay, we will first describe the historical development of Western concepts of the “self”, emphasizing the diversity of such constructions and discussing some questions and problems that have bothered Western discourses about the self for centuries. We feel that this diversity of Western concepts needs to be considered before otherwise reductionist comparisons between “Western” and non Western concepts of the self and its dysfunction are engendered. This part includes an excursion into related topics discussed within a Buddhist tradition. We describe how conceptualisation of a subject's access to his or her own thoughts shaped concepts of core or “first rank” symptoms in psychotic disorders and discuss whether prereflective self-awareness is a universal human experience that can be altered in psychotic disorders.

We then continue by claiming that modern Western concepts of the self are strongly influenced by psychoanalytical theories, which we compare with self concepts that arose in India and some parts of West Africa and the Carribeans. These examples were selected because they illustrate influences of

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society, history (slavery and colonization) and gender relations on self-concepts. We compare such cultural concepts with respect to three topics: first, the question of dissociation and spirit possession, secondly the question of the embodied self including a discussion of current neurobiological explanations of self-referential processing, and finally with respect to social performances of self-related narratives. We end by suggesting that core aspects of self-related experiences such as prereflective self awareness appear to be a universal human trait, while diverse social and cultural norms interact with and modify narration and performance of self concepts and constructions. Such a cultural variety has to be considered when diagnosing alterations of self-concepts and “ego disorders” in various cultural and social contexts.

2. Classical concepts of the self and the problem of circularity: the “infinite regress” of self-consciousness

While neither history nor culture originated in classical Greece, concepts which have been articulated in this culture coined central aspects of the European tradition. Some of the oldest traditions appear not to distinguish categorically between mind and matter, and pre-Socratic philosophies tried to identify fundamental principles of nature. Such fundamental principles were alternatively identified in the element of water (Thales) or the air or individual breath (Anaximenes). In this context Pythagoras was one of the first to suggest the idea of an eternal soul, which appears to be influenced by East-Asian concepts of reincarnation or soul migration and by the ecstatic cult of Dionysos [43]. Plato also articulated a concept of an immortal soul and distinguished between the deceitful world of the senses and the immortal forms or “ideas”. This concept of ideas was for example developed when asking what it means to be “beautiful” and was aimed at the definition of “the beautiful” itself, and it was suggested that this idea is an object of pure thought and not of the senses [39]. The relation of any concrete object to such an idea was conceptualised as a form of participation.

Aristoteles (1970), on the other hand, did not propose that ideas have an existence which is independent of concrete objects. His key concept is easier to grasp when we acknowledge that the Greek word “eidos” can be translated into Latin as “forma” or “species”, suggesting that ideas represent the form of an object. For example, Aristoteles suggested that the form of a human being would only manifest in matter, namely in the flesh, bones and other parts of a human being; nevertheless, bones and flesh would not be a part of the form or concept of a human being but instead represent the matter, in which the form manifests itself. He went on to suggest that the soul would be the primary form of a living being, and this concept thus acquired a functional meaning [2]. The soul is therefore not perceived as an immortal idea, which somehow resides in a material body, but rather Aristoteles suggested that the soul is the form or function of a definite body, like “being an axe” represents the functional form of this instrument [3]. As form or function of a human being, the soul has three different aspects: the potential of nutrition, which is shared with all living beings such as plants, the potential of sense perception and desire for positive experiences, which is shared with animals, and intellectual insight, the highest

potential of any human being. Aristoteles compared the domination of intellectual insight over desires with the domination, which politicians exert with respect to the people, and suggested that such intellectual capacities are lacking in slaves and are ineffective in women and undeveloped in children [43].

Aristoteles also identified one of the problems characterising several concepts of self-consciousness: the question who or what actually perceives what is represented in the senses. This problem can be illustrated when we reflect on some common concepts of sense perception. For example, when we look at a tree, we are usually aware that the outer object (the “real tree”) may somehow differ from our percept: we perceive only some part of the outer object or the way in which we perceive it may depend as much on the constitution of our senses as on the outer object itself, e.g. the “real tree” reflects light waves, which we perceive as green but which appear indistinguishable from red in case of colour-blindness. Nevertheless, in everyday life, we usually assume that our senses represent a reliable and useful percept of our environment. Hume (1978) called such perceptions “impressions”. When we close our eyes, we can maintain a mental picture of what we have just seen – Hume called this an “idea” and suggested, that, compared to impressions, ideas are less vivid and clear [27]. However, we would like to suggest that a decisive difference between an impression and an idea resides in the malleability of the phenomenon: an idea can be actively modified (for example, we can imagine that the tree stands on its head), while this is not possible with any given perception. So if “we” can modify “ideas”, which are obviously different from impressions, one may ask where such ideas are “perceived” and modified. In everyday life, we may assume that this perception is located somewhere in the mind or brain; however, this explanation only doubles the problem: now we have three trees, a real one (the thing in itself), a perceived one (the impression) and an imagined tree (the idea). Husserl (1962) would probably object to our “common sense” reasoning and point to the fact that there is not “one tree in the mind (brain)” and “the other one outside” but that instead in both situations we are intentionally focussed on the tree, in one case on a tree that we assume to be real and in another case on a tree that we imagine to be an idea [28]. However, this argument may still not help to answer the question who or what actually perceives the ideas or impressions. Is there an independent “ego” in the mind or brain, which “perceives” the impressions or ideas of sense objects? Or are these impressions somehow transparent for consciousness? But what is consciousness? In Aristoteles words: “Inasmuch as we perceive that we see and hear, it must either be by sight or by some other sense that the percipient perceives that he sees. But, it may be urged, the same sense which perceives sight will also perceive the colour which is the object of sight. So that either there will be two senses that perceive the same thing or the one sense, sight, will perceive itself. Further, if the sense concerned with sight were really a distinct sense, either the series would go on to infinity or some one of the series of senses would perceive itself” [3].

Aristoteles did not try to answer the question *who* is the subject of perception and instead focuses on the problem *how* the sense organ can get in contact with the perceived object. Nevertheless, the question who perceives ideas in the mind continues to trouble Western philosophy. If the ideas are impressions of outer objects, is a “self” or “soul” the entity that perceives

these ideas or impressions? And how can you avoid that “the series goes on to infinity”, i.e. an infinite regress, in which the entity that perceives an impression, is itself unconscious and in order to become conscious in turn, becomes again the object of a higher entity which experiences it?

3. Classical theories of self-consciousness: Hume versus Kant

In his “Treatise of human nature”, Hume avoided the infinite regress by suggesting that there is no inner self or entity which perceives an impression. For Hume (1978), there was no identical self but only a stream of ever changing impression: “I can never catch myself at any time without a perception, and never can observe anything but the perception” [27]. He thus suggested that there is no independent observer outside of this “bundle of perceptions”. Hume compared the mind with a theatre scene without spectators. He suggested that different impressions flow into each other without clear boundaries and this may be the reason why we attribute an identity to this ever changing stream and miss the truth – that there is nothing but the perceptions: “Thus we feign the continued existence of the perception of our senses, to remove the interruption; and run into the notion of a soul, and self, and substance, to disguise the variation” [27]. Hume suggested that we feel an association between the different perceptions when our thinking focuses on one after the other. However, since there is no link that can be perceived between the different ideas and impressions, Hume remained a sceptic with respect to personal identity. He criticised that personal identity requires a “unity of consciousness”, a concept which Hume did not accept: “I cannot explain the principles that unite our successive perceptions in our thought or consciousness” [27].

Kant (1966) proposed a different solution of this problem. He suggested that there is a kind of personal ownership of one's own thoughts, which is not reflected in a (separate) perceptive act. Instead, this ownership rather resembles a disposition: “The: I think, must be able/poised to accompany all my ideas... This idea [of a thinking self] in itself is an act of spontaneity, i.e. it can not be understood as belonging to sense perception” [31, §16]. Kant suggested that *my* ideas would not be “*my*” ideas, if they could not stand together in a “common self-consciousness” and thus belong to me. Kant agreed with Hume that the empirical consciousness that accompanies different ideas is in itself dispersed and without a clear relation to the identity of the subject. Nevertheless, Kant assumed that the association between the ideas is created by the subject, who places one idea to the other and who is aware of the “synthesis” of these ideas. The association would not be in the objects itself and cannot be perceived by the senses and thus be transferred into the mind; instead, according to Kant, the association is a capacity of the intellect (*Verstand*), which in itself is nothing but the ability to associate ‘a priori’. In other words, Kant may ask the question: if one of my perceptions is not “my” perception, how could I reflect on it? Ownership of ideas is thus a capacity of the intellect, not a quality to be perceived. For Kant, the identity of consciousness is a necessary precondition for the association of perceptions (a priori), and not, as suggested by Hume, a misconception arising *a posteriori* from the stream of ideas and impressions.

However triumphant Kant may be considered to have been over Hume, he turned out to be unable to deliver a clear analysis of what the structure of selfhood actually consists in and how our mind can come to cognize itself. In the *Critique of Pure Reason* he wrote: ‘Now it is, indeed, very evident that what I must presuppose in order to cognize an object at all, cannot itself be cognized as an object [...]’ [31, A, 402]. In the paralogism chapter of the *Critique* Kant had repeatedly described the difficulty of apperception, of grasping oneself not via objectual representation, but *as such*, roughly as follows: In trying to say who I am, I must self-ascribe some, for example perceptual, properties. As soon as I question about the legitimacy of these attributions, however, it becomes clear that I could only make them if I was previously already familiar with the meanings of ‘I’ or ‘my’. So I feel compelled to choose myself (or the concept ‘I’) as the ‘correlate of my comparisons’, which should resolve for me which property defines me. Yet, in this way I presuppose exactly that which I had laid claim to bring to knowledge [31, A, 366, 345ff]. Elsewhere Kant stresses that ‘I’ is in fact not a concept but rather a perception or even a feeling (e.g. [32], further references and an interpretation of this conflict see [15].

The first to have not only clearly articulated but also proposed a solution to Kant's problem was Johann Gottlieb Fichte in 1797. He first spotted the failure of what henceforth has been called the reflection-model of self-consciousness. This model implies that self-consciousness comes about either through “direct” consciousness of the I as an object (egological version), or through a kind of higher-order consciousness which is directed towards a first order consciousness (non-egological version). In this way consciousness discovers itself in the position of an object. And since, according to this model, all knowledge consists of knowledge of objects (whether of individuals, universals or facts), self-knowledge too is explained as knowledge of a particular type of object.

Let us first consider the egological version of this reflection-theory. According to it the “I” obtains knowledge of itself through reflection – through entering into a reflective relation with itself, and thereby, as it were, “setting its eyes on itself”. However, if it holds that there is knowledge only of phenomena which occupy an object-position in relation to a knower, and if what we are after is the I as a subject, not as an object, then there seems to be no way for the I to have knowledge of itself. In fact, the reflection-theory, as Kant takes it over from Descartes and Leibniz (but also from numerous thinkers of British empiricism, see Frank [15]), must then presuppose the phenomenon whose structure it assumes to explain. It was for this reason that Fichte accused it of ‘sophistry’ in his lectures on the *Wissenschaftslehre nova methodo* [12].

What about the non-egological version of the reflection theory? If self-consciousness only came about through a ‘piling up’ of consciousnesses, where a lower-order consciousness was attested to by a higher-order consciousness, then there would be no self-consciousness at all. This is because for the “top” of the chain of reflected consciousnesses, the same condition would once again apply whereby in order for it to become conscious of itself, it would have to be made into an object by a successive consciousness, which again would be non-self-conscious, and so on *ad infinitum* (see also Sartre [51]). Thus we arrive back at the infinite teatess Aristoteles identified and tried to avoid.

That the model is false suggests that consciousness must be acquainted with itself *immediately*, independently of objectification by a successive consciousness. Fichte expresses this by talking of the complete non-differentiability of subject and object in self-consciousness (compare Sartre [51, p. 382]). In Kantian terminology, such an immediate consciousness is an intuition (*Anschauung*); in contrast to sensory intuition it has no object in space and time.

4. Excursion: an Eastern answer to circularity and some similarities in neurophilosophical approaches

Another answer to the question whether there is an internal spectator of perceptions and ideas who guarantees their unity is given by some forms of Buddhism, particularly Zen-Buddhism. Based on Hinduism, in which the individual soul (Atman) is supposed to participate in the absolute (Brahman), Buddhism focuses on the danger that a human being may confuse her or his individual "concept" of the own soul with the absolute soul itself [43]. This danger may also be reflected in Hume's words: "When I turn my reflection on myself, I never can perceive this self without some one or more perceptions" [27]. To mistake an idea of the own soul with the soul itself would thus be akin to mistaking the slide projected by a projection machine with the projection machine itself. Buddhism tries to avoid this danger by negating the idea of an individual self. According to Allen Watts, a proponent of Zen concepts, it is important to be aware that I am not this body, this perception, these feelings, these thoughts or this consciousness – that the basic reality of anyone's life is not identical with any imaginable object. Instead, the self is basically defined by a categorical difference from any specific concept of consciousness or perception – it has "never been seen", "relates to nothing", and it "neither can be touched nor described" [64]. A helpful metaphor to understand this approach may be the statement that "light cannot shine upon itself".

Comparable concepts have been proposed by Metzinger (2005), a contemporary philosopher. Based on his interpretation of phantom limb perception, Metzinger suggested that our ideas of "ourselves", the so called "phenomenal self – model" are a concept created by the brain, i.e. the result of processing information and input in the central nervous system [42]. Unlike all other perceptions and impressions, the self-model is characterized by continuous sensory and sensitive input from internal organs, body representations and other senses. Further, the brain-created self model, the "virtual self", would be characterized by a reduced representation of processes occurring in the real world. Metzinger emphasizes that our virtual self moving in the perceived "phenomenal world" carries no brain, no motor system and no sensory organs: "Parts of the environment appear directly in its mind, the process of perception is effortless and immediate. Also, we experience body movements as directly initiated. However, we are not aware that our virtual self is a construction of the brain" [42]. Instead, Metzinger suggested that the brain or central nervous system fails to recognize its own self-model as a self-created model on the level of conscious experience. And he warns human beings not to confuse their own picture of themselves with these selves [42]. Buddhism may add that such confusion has adverse consequences beyond theoretical confusion, and that the identification with our own wishes,

abilities and successes will necessarily lead into suffering. Watts (1981) therefore suggested that self-liberation is a continuous process of separating the self from any kind of identification [64].

5. Prereflective self-awareness versus a narrative self concept?

So how is the phenomenal self-model constructed, at least in the Western tradition? Metzinger suggested that three phenomenal qualities characterize the self-model: 1) "Mineness (Meinigkeit)", the sense that for example "my leg" has always belonged to me, 2) "Prereflective Self-awareness", an intimate knowledge of the self that is prereflective and constitutes the experience of myself as an "ego" as a fundamental fact of experience, and 3) "Perspectivity", a kind of central perspective which centres all consciously experienced objects around the acting and experiencing subject. All these characteristic qualities of self-experience can supposedly be altered in mental disorders, e.g. in acute schizophrenia, when consciously experienced thoughts are no longer perceived as my own [42]. Interestingly, this assumption is in contradiction with Kant's hypothesis, that the "I think" can necessarily be placed in front of each of my thoughts without itself being accompanied by an act of sense perception – if Kant is right, then why can a patient suffering from acute psychosis experience a lack of ownership of his own thoughts, e.g. if the thought is experienced as being "projected into the mind" by some foreign force? Does this mean that there is a certain feeling or perception of ownership associated with one's own thoughts that can be lost in psychosis? And if so, how can this ownership of thoughts be understood?

It is often assumed that a person's relationship to his or her own thoughts can be conceptualised in the same way as his or her relationship to intentional objects or objects of perception. For example, if I focus my attention not on the perception of a tree but on myself as I perceive this tree, the resulting shift of attention from the object of attention to "my self" as a perceiving subject is supposed to result in reflective self-consciousness. However, how do I know that it is actually *me* who processes these thoughts or feelings? How is my intimate relationship with myself grounded in this experience? Different hypotheses tried to answer these questions. For example, Mead suggested that this relationship to myself is established by a certain condition of (pre)lingual communication: this hypothesis suggests that whenever I voice an opinion, I react to it in the same way as my partner in communication would do. Therefore, I acquire an excentric perspective, which provides me with a picture or perception of myself and thus endows me with an awareness of my own identity [25]. This hypothesis suggests that I perceive myself like a partner in communication would do, i.e. that the third person perspective is primary and that my first person perspective is derived from it. However, this has been negated by other philosophers; for example Frank [14] pointed to the work of Henrich and suggested that there has to be a primary intimate awareness of my own self, which is prereflective and in itself necessary in order to attribute any object of reflection to myself. Otherwise, how should I know that a certain utterance or thought actually belongs "to me"? Thus, any attempt to perceive self-consciousness ("Ichheit") as arising from reflectivity cannot escape the circularity of the infinite regress. This means that whenever such attempts tried

to describe the phenomenon of self consciousness, they already presupposed a kind of primary awareness or knowledge of myself but wrongly suggested that this self-knowledge is a secondary result of reflexivity. Therefore, the primary relation to myself is no propositional knowledge, i.e. it cannot be compared with factual knowledge given as a narrative self-description, e.g. that "I know that I was born in a certain city". The second "I" in this sentence does not appear to be problematic – I know something about myself, just as I can know something about the weather (for example that "it rains"). The expression "I was born in a certain city" represents propositional knowledge about a fact, in this case resulting from a reflection about myself (my birthplace). But how do I know who this "I" actually refers to? How do I know that I am identical with the first "I", the "I" in the part of the sentence which states that "I know something" (in this case something about myself)? Frank's solution, adopting essentially Fichte's reaction to Kant's circularity problem, is the suggestion that the first "I" in the sentence referred above represents no propositional knowledge, because it does not result from a reflection about any perceivable quality of this ego, which can be discussed in discourse. Instead, my experience of myself is a direct awareness, which precedes any "self-reflective knowledge". Frank went on to suggest that the status of this kind of self-awareness could be called prereflective or non-objectual – as it consists in an acquaintance which comes about without objectifying its content. This idea is illustrated by Hector-Neri Castañeda's argument that "there is no object of experience that one could perceive as the self that is doing the perceiving. ... whenever one does [identify an object of experience with oneself], one identifies an object in experience with a thing which is not part of the experience, and this thing is the one which the person in question will refer to by I" [5]. Likewise, Shoemaker argued that "the reason one is not presented to oneself 'as an object' in self-awareness is that self-awareness is not perceptual awareness, i.e. is not the sort of awareness in which objects are presented. It is awareness of facts unmediated by awareness of objects" [55, p. 104-5].

In case we accept that such a prereflective awareness, a kind of intimate knowledge or feeling about one's own self, is a common experience at least in the European tradition, several questions arise. First, is this phenomenon a fundamental principle of self awareness and can it thus be found in non-Western cultures with quite different concepts of the self? Secondly, can it be lost or fundamentally altered in cases of "ego disorders" such as thought insertion or depersonalisation? And thirdly, how does the *reflective* concept of a person arise – even if we agree with Frank and Henrich that a prereflective self awareness is a fundamental aspect of human experience?

The first question will be discussed in more detail below. With the respect to the second question, we suggest to distinguish between prereflective core-subjectivity and a ("self-reflective") form of personal narration or self-interpretation, in which a subject ascribes certain qualities to its own self. Core-consciousness must be conceived of as not entertaining an explicit relation to a so-called 'self' or 'consciousness itself' as insinuated by talk of 'inward-glance', 'inner-monitoring' or 'self-representation'. All such models favour a distorted duplication of core-subjectivity. 'To represent' is a two-place verb; what we mean by 'self-awareness' or 'selfhood' cannot be dual. It has often been declared that 'being' and 'being-appeared-to-a-subject' are

entirely coincident and leave no space for countable/numerical difference (e.g. Shoemaker [55]). This is why 'representation' is inappropriate as a basic term for a theory of consciousness and self-consciousness, since it is poised to invite conceptual confusion of pre-reflective self-awareness with concept-based (and therefore fallible) self-interpretation. Were our primordial self-access interpretation-based (and hence theory-laden), there would be no space for a divide between standard and altered ways of self-apperception. Self-consciousness would, in principle, be fallible with regard to determination of its own content – and therefore no more distinguishable from self-alienation, de-personalisation or other mental disimprovements.

Irreflexivity is the crucial point of the stressed certainty concerning the *cogito*; this is so from Descartes through Brentano and Chisholm down to Horgan and Kriegel [10, 26]. This certainty may not be infallible but it is beyond reasonable doubt. Still *post festum* deformation can overlay or distort the starting state in mental disorders. Some authors suggest that such distortions can appear at least for moments and even impair pre-reflective self-awareness, causing e.g. the experience of alien thought insertion [53]. However, if pre-reflective self-awareness is temporally eclipsed, how then does the person know that these are alien thoughts in his/her mind? And if only pre-reflective self-awareness is eclipsed with respect to this one thought-why is it at all experienced as a thought and not as an external event? Therefore, deformation in self-apperception may rather be caused by reflective, conceptual misinterpretations of the grounding mental states or events or by misunderstandings concerning the agent or owner of those states. They are due to conceptual work.

The third question has been addressed by Honneth, who suggested that respect and appreciation (*Anerkennung*) of other persons and of myself is a prerequisite for human communication [25]. Honneth distinguishes three social forms of mutual respect: love, justice and solidarity. While love is seen as an individual relationship which fosters e.g. specific qualities of a developing human being, justice guarantees the fundamental equality of all humans and solidarity appreciates individual differences in each subject's contribution to society [25]. In case these forms of respect are violated, conflicts can result as evidenced e.g. by the Civil Rights Movement of African Americans in the 1950s and 60s. On the other hand, the positive experience of these forms of respect allows the individual to identify with the qualities that were appreciated in these forms of social contact. Reflective self-consciousness thus constructs a narration or "picture of myself" that is already formed by social interaction. Therefore it is plausible to assume that both biological (e.g. stress) factors and social forms of disrespect can interfere with essential aspects of the self-image of a human being and may result in depersonalisation. The person may thus no longer be able to identify with her desires or feelings, e.g. when social rejection forces her to suppress the emotions and thoughts and thus limit her ability to be in direct contact with her desires and with the world at which they are directed (derealisation, which often co-occurs with depersonalisation). Indeed, the symptom of depersonalisation is neuro-biologically unspecific and can be found after psychosocial trauma as well as in deliria, neurotic or psychotic disorders. Particularly in dissociative disorders, cultural factors can shape this specific form of experience as discussed below.

6. Ego disorders in psychosis – transcultural or modern Western correlate of self experience?

The question whether prereflective self-awareness can be conceptualized as a universal human trait and whether it can be altered in psychotic disorders is highly relevant for transcultural psychiatry and the diagnosis of psychotic disorders. So-called first rank symptoms of schizophrenia (Schneider 1942) include “Ego disorders”, e.g. passivity phenomena such as thought insertion or alien thought control and experiences such as telepathy, i.e. the feeling that other persons can read one’s own thoughts. As such, they are characteristic, so-called “first rank” symptoms of schizophrenia [54]. They describe a disturbance in a person’s awareness or knowledge of one’s thoughts or, as Karl Jaspers would put it: a procedural knowledge about our own thinking, to which – in contrast to the experience of outer objects – we have a privileged access [29]. Ego disorders are therefore distinguished from paranoid ideation, which concerns a misrepresentation of the meaning or implications of outer objects or processes to which patients and psychiatrists have equal access. The situation is different when a patient describes what is called “ego disorders”: it makes no sense to discuss with a person who describes that his thoughts are manipulated in his mind whether this experience is wrong – only the patient has a direct awareness of his own thoughts. It has been argued that one’s own thoughts are more closely connected with self-consciousness than the experience of one’s own body. For example, I may misidentify my own arm in case it is anesthetized and I find myself – after an accident – within a heap of human beings, while this misidentification is not possible with respect to my own thoughts [14].

However, this argument may be wrong: in the example just reported, the anaesthesia of the arm is required for me to be able to misidentify it – however, this is a pathological condition which results from nerve dysfunction caused by the accident. In such a pathological circumstance, I may misidentify my own arm – just as I misidentify my own thought as alien or inserted by somebody else in the pathological state of psychosis. Therefore, direct access may exist both to one’s own thoughts as to the representation of one’s own body, and as e.g. suggested by Metzinger, the phenomenal self-model may be maintained by continuous input of sensory and sensitive information from the body [42]. Likewise, Schneider counted passivity phenomena concerning one’s own body parts (namely that they are e.g. under alien control) among his “first rank symptoms” of schizophrenia – on an equal level with symptoms regarding alien thought control [54]. However, the claim that “my” thoughts are not really “my own” but instead “inserted” or “controlled” by someone else remains paradoxical in a way that “alien” control of visible objects (including visible body parts) is not: because how do I know that I suffer from inserted thoughts if they do not remain accessible and hence to some degree are still “my” thoughts?

To explain apparently paradoxical experiences such as thought insertion in psychosis, several models have been developed that distinguish a sense of “agency”, “control” or “authorship” with respect to one’s own thoughts from “ownership” [17, 18]. However, to date the topic remains controversial. Moreover, can such symptoms be found in all cultures during the manifestation of schizophrenic psychosis and do they thus

represent a common human quality of self-experience or does culture influence the way of attributing control over one’s own thoughts or body? A study of the WHO suggested that first rank symptoms can be found in all (examined) cultures independent of the degree of industrialisation, and that schizophrenic psychosis appear with comparable frequency in different cultures, specifically when schizophrenia is diagnosed using Schneider’s traditional concept of first rank symptoms [50]. On the other hand, ethnologists like Fortes and Mayer (1969) suggested that schizophrenic psychosis was not found in a traditional setting in Ghana but appeared once young men entered large cities as migrant workers [13]. Also, the German psychiatrist Wulff described that in the 1960s in Vietnam, he could not find ego disorders in schizophrenic psychosis [24]. He explained this finding with the structure of the local language: a speaker in Vietnam would not refer to himself as “I” but instead name his social status, for example, he would address himself as a father, older brother etc. An abstract, common denomination for any actor would only be found in love poems, in which the speaker wants to express his deepest despair, namely being reduced to the universal characteristic of any personal existence – to be a “slave of the king”, a state shared by all Vietnamese regardless of their social status [24]. It could be argued that such linguistic peculiarities only concern different ways of *expressing* (fundamentally similar) individual experiences; however, some authors such as Müller (1981) referred to Whorf’s linguistic studies and suggested that linguistic structures indeed interact with personal experiences [44]. For example, among Native Americans such as the Sioux, experiences are often expressed in the passive voice, which reflects a feeling of being affected by environmental constellations rather than being a determined actor within these circumstances. Also in Homers “Iliad” and “Odyssey”, it is not the individual person but rather the Olympic gods that stir up the anger in a subject or calm him down in time to avoid an active fight. The actions of the heroes of these stories can thus rather be attributed to such divine forces and not to individual intentions. Of course one can ask whether these are just poetic expressions of human experiences, which otherwise do not differ from our modern experience of the self. However, several findings suggest that our current Western way of experiencing and conceptualising our self is based on historically unique experiences and that concepts of mental disorders such as schizophrenia, which is characterized by ego disorders, require elaborate and widely accepted concepts of the self and of self-control. Only if a majority of subjects observe their own behaviour and agree that they are indeed in active control of their own thoughts and that the “I think” can accompany any of their mental representations, can the loss of such an ability be used as a pathological symptom that indicates “ego disorder” [52]. Indeed, the first description of schizophrenic psychosis in modern times can be found in England at the end of the 18th century, when a patient described how his thoughts were controlled by machines [39]. The hypothesis that cultural factors influence the way we observe ourselves and the signs and symptoms we use to diagnose a disorder is supported by the above quoted study of Fortes and Mayer (1969), who observed that among the Tallensi of Northern Ghana, schizophrenic psychoses were only described when the young men left their traditional surroundings and worked as migrants in the new colonial cities [13].

7. Psychoanalytical Self-models

Modern concepts of the self are deeply shaped by psychoanalytical concepts. Freud developed a theory of the “ego” (Ich) when trying to describe how a person’s relation to the environment is disturbed in paranoia or dementia praecox (later called schizophrenia). Freud suggested that narcissism is a normal developmental stage following the primary stage of autoerotism, and that it is characterised by organising autoerotic partial drives and directing them towards a unified object, the ego [16, GW VIII]. Freud assumed that the ego undergoes structural developmental changes during ontogenesis. Love of other persons (“objects”) characterises the next developmental step following narcissism. During its development, the psychic apparatus is originally driven by desires which directly aim at representations of the craved objects (Lust-Ich), which a suckling can even hallucinate. With time, the ego takes the demands of the external world into account and develops from the “Lust-Ich” into a “Real-Ich”. In the study on the famous case of “Schreber” and in his contemporary writings on narcissism, Freud suggested that psychoses are characterised by a retraction of libido from such outer “objects” (persons), e.g. when we lose a loved object. Libido as an expression of (sexual) desire would then have to be contained within the psychic apparatus, until it can be aimed again at new objects [16]. However, if there is a disturbance of libido development, the sexual energy “regresses” back towards the developmental stage in which the dysfunction occurred. If, for example, libido development was disturbed during the stage of narcissism, regression will cause the energy to occupy the ego structure itself, thus recreating the narcissistic developmental stage. Freud suggested that subjectively, the loss of libido directed at outer objects is experienced as an apocalyptic destruction of the world, as it may occur in psychotic disorders. Freud further argued that besides the libido, there are other forms of psychic energy, which are directly controlled by the ego and directed towards outer objects. In normal situations, these energies guarantee an interest in the environment; however, a regression of libido would also destroy the direction of such “ego energies” towards the representation of outer objects, resulting in the apocalyptic experience described above [16, GW VIII].

In Freud’s further work on “Das Ich und das Es” [16], Freud developed the theory of the ego as a rather weak mediator between the powerful forces of drives and desires located in the “Es” and the moral demands of the “Über-Ich”. He suggested that a person’s idealistic view of him- or herself, the “Ich-Ideal”, is formed according to the imago of the parents, while the moral demands of the “Über-Ich” are a set of rules and obligations which are usually handed down in rather unaltered forms by the parents, who received it from their ancestors. However, if there is such an “Ich-Ideal” as an idealised representation of one’s own self, should there not also exist less idealised representations of such a self? Indeed, Kohut (1992) suggested that the “self” is a representation of the psychic apparatus, which is occupied by psychic energy and which is characterised by temporal continuity. He further argued that there can be contradictory conscious and preconscious representations of such a self, which coexist either within the ego or within sections of the psyche, in which the “Es” and the “Ich” are closely associated [37]. Could this suggest that the self is easily fragmented? And if so, is this

due to a (secondary) pathological process, which causes the fragmentation or is fragmentation the (primary) natural state of self-representations, which are only secondarily unified into a coherent self by an integrative process? Different answers have been given to this question. Freud himself appears to have put forward two different opinions, which cannot easily be reconciled. On the one hand, Freud suggested there is a primary state of autoerotism, which is not characterised by any direction of the libido to outer objects, on the other hand, he suggested that the oral sexual energy is directed to a (partial) object, namely the breast of the mother. Melanie Klein’s concept (1962) was based on these latter remarks of Freud (1905) and suggested that a suckling splits his or her representation of the mother’s breast into the representation of a “good object” and a “bad object”, depending on whether it fulfils his desires or not [36]. The experience of rejection will stir up destructive energies, which fragment the “bad object”. With time, these objects are introjected and form core aspects of the self, which is more or less fragmented, depending on the prevalence of good over bad experiences. The next developmental stage results from the integration of good and bad objects. Melanie Klein’s ideas, although appearing to reduce human interaction on primary aspects of wish fulfilment, were rather influential, because they propose a fragile mechanism, which integrates the experiences of the self and the others into a more or less coherent self experience. Such psychoanalytical concepts of the “self” and its potential fragmentation appear to be highly relevant for the interpretation of cultural and individual alterations of consciousness as reported with respect to dissociation and “spirit possession”.

8. “False selves”, dissociation and spirit possession

Ronald D. Laing (1983) suggested that our civilisation suppresses not only desires but “any form of transcendence” [38]. A person can feel ontologically insecure and in case his or her different aspects are not adequately respected, he can dissociate into an outside façade, a (false) personality or mask, which tries to fulfil whatever society demands, and an inner self, that withdraws from the environment and does not feel responsible for the actions of the false self. Laing suggested that this process occurs quite frequently in our society and that our normal, socially adjusted behaviour too often includes lack of ecstasy and a betrayal of our true potentials. Too many of us, according to Laing, are only too successful in developing such a false self [38]. Laing’s explanatory model of the false self, originally constructed to explain schizophrenic psychosis, appears in the light of these arguments as a rather normal state of neurotic conflict solution or even as a strategy to adjust to social norms, which can run out of control and harm the persons who try to use it. If socially unacceptable desires and experiences are banned from conscious experience, they can return in a dissociative state – be this state interpreted as a pathological remanifestation of a primary disintegration of the self or as a neurotic compromise between desire and psychic defences. However, which forms can this return of the suppressed take in different cultures? Authors as Richard Castillo [6,7] hypothesised that spirit possession in India can be interpreted as a dissociative state, in which a “superhuman being” possesses the consciousness of a person for some time.

In this state, socially unaccepted feelings can be articulated, e.g. when a young woman is possessed by a gruesome demon, who can speak out of her mouth and voice aggressions against family pressure and traumatising which she is not otherwise allowed to express due to her social status. Castillo suggested that dissociative states are the manifestation of trance-like states of consciousness in life threatening situations. This explanatory model of dissociative states is akin to hypotheses trying to explain multiple personality disorder, which – nevertheless – are quite rare in India as compared to the United States of America [6,7]. In India, it has been described that multiple personality disorder is characterised by the manifestation of a glamorous, idealised self with western characteristics and traits, typically speaking in English and not in Hindi [1]. Varma and colleagues [61] reported phenomenological differences between multiple personality disorder and possession and suggested that a person suffering from spirit possession is usually aware of this possession, while persons suffering from a multiple personality disorder do not know about other personalities manifesting at different times. Moreover, demons or spirits of ancestors who possess a person are supernatural beings, while multiple personality disorder is characterised by the manifestation of different personalities that represent other humans. Varma and co-worker therefore suggest that culturally influenced expectations, for example related to the existence or non existence of spirits, influence symptom presentation [61].

Moreover, cultural differences in the ability to fall into trance (i.e. to enter a certain dissociative state) may contribute to the manifestation of spirit possession. Lewis-Williams and Dowson (1989) suggested that a majority of bush men in Namibia and South Africa can fall into trance when participating in community rituals [40]. The authors also suggested that trance experiences are depicted in the rock paintings and mythology of the bush men. Among bush men, to fall into trance is a normal ability of a healthy human being; the trance state is consciously and commonly induced and does not afflict a person in a socially isolated and psychologically stressful situation. In history, there have been attempts to compare trance states and other forms of experience related to religious rituals of non-Western people with “primitive” states of mind. Such ideas are also present in Freud’s “Totem und Tabu”. However, such models tend to mistake populations under the rule of colonialism at the beginning of 20th century for phylogenetic ancestors of contemporary human beings. Such hypotheses negate the history of colonised people and their specific cultural and cognitive achievements and developments, one of the reasons why modern social anthropology has criticised and abandoned such theories [23].

9. The embodied self in different cultures

Jung suggested in 1907 that the so called “ego complex” is a psychic structure representing the self, which exists due to continuous sensory input from one’s own body [30]. Also Metzinger [42] hypothesised that the phenomenal model of the self differs from all other mental representations because of a continuous, internally generated input, including sensory and sensible information as well as neuronal representation of the body and other neuronal structures. Metzinger went on

to suggest that this internally generated input explains why a part of the human self model is based on (internally generated) information. However, culture affects the specific ways in which such information is integrated into a conscious representation of one’s own body. For example, the anthropologist Sobo described traditional Jamaican concepts of the human body, which also influence explanatory models of physical and psychological disorders [56]. According to such a traditional explanatory model, the blood can be too “hot” or too “cold”, too “thin” or too “thick”, too “sweet” or too “bitter”. In case a doctor trained in modern Western medicine informs a Jamaican patient from such a traditional background that he suffers from diabetes mellitus, i.e. too much “sugar in the blood”, and that he therefore has to maintain a diet, the traditionally oriented patient will follow the advice, however, the diet will include bitter teas to balance the “sweetness” of the blood [22]. In different explanatory models, even the same terms may thus carry different meanings. Social rules and regulations influence the construction of the concept of one’s own body. For example, in Jamaica, blood represents the substance that “binds” relatives together and expresses obligations to kinship, i.e. to share not only one’s blood but also material resources among the relatives. This concept may be based in the matrilinear culture of West African people such as the Ashanti, who had been abducted to Jamaica in large numbers. In case an egoistic individual does not share food and resources, it is assumed that this inadequate behaviour blocks the flow of mutual exchange, just as excessive food consumption can block the flow of nutrients in the belly [56].

Wilhelm Reich suggested that the socially enforced control of one’s desires can directly affect the body [48]. Reich further hypothesised that sexual desires are suppressed due to the influence of parents and teachers, who act as agents of social power. Reich used the picture of a stream of water that is dispersed when hitting a rock and suggested that a drive can also dissociate when it is inhibited in its direction towards the object of desire due to social rules and regulations. The “ego” can now use the energy of this dissociated drive and pose it directly against the direction of the original drive; the conflicting drives will then inhibit each other. Reich further suggested that the energy of these drives is blocked and that the ego can transform this blockade into a “Körperpanzer”, which manifests itself in increased muscular tension and autonomic arousal [48]. Within the ego, automatic habits replace flexible affective reactions and condensate into habitual traits, which represent the character of a person. Physical illness can result from the increased muscular tension and hyperarousal of the autonomic nervous system. While Reich’s psycho-vegetative and psycho-motor models today appear to be somewhat out-of-date, his work represents a landmark concept of psychosocial interactions which suggested that the perception of one’s body is not simply affected by cultural factors but that – more specifically – interindividual and social conflicts can be represented in the experience and functions of a human body.

Cultural influences on the respective self concept and the concept of a human body can further be elucidated when we compare ideas among the matrilinear Ashanti, living in Southern Ghana, with traditional concepts of the embodied self in Jamaica. Among the Ashanti, marriage means that the husband leaves his home and lives with the family of the wife, and in this family

the oldest brother of the spouse possesses the highest authority. Children thus have to get along with potential conflicts between the loyalty to their father and to the brother of their mother, just as wives have to bridge the potential gap between the interests of their husbands and their relatives on their mother's side [43]. These conflicts are reflected in the Ashanti concept of a person. According to the traditional concept, a person consists of "Okra", the soul and the seed of vitality, which is understood (in a way that resembles Aristoteles' concepts) as the functional principle of a person. Among the Ashanti, "Okra" is understood in a non dualistic way as composed of both material and spiritual parts. It is given to a human being by the highest god in the moment of birth, and as a soul or principal of life, it can be reincarnated in different bodies. "Sunsum", on the other hand, is the spiritual aspect of a person, which is received from the father. As an active principle, "Sunsum" is associated with personality traits and the moral behaviour and character of a person. "Sunsum" can leave the body during sleep and can be damaged by (black) magic. "Ntoro" is sometimes used synonymous with "sunsum" and directly refers the origin of the personal character, the semen of the father, which is the source of individual desires and hence potentially "anti-social", while "Mogya", the blood, is derived from the mother and controls social conformity to the family and clan with which the blood is shared. After a person's death, "Mogya" turns into a spirit that retains the physical form of the person. This latter idea illustrates that "Mogya" – like all other Ashanti concepts – includes spiritual and material aspects and that the dualism commonly known in the Western tradition cannot usefully be applied to these West African concepts [43].

In Jamaica, traditional beliefs also hold that clan cohesion is guaranteed by the common "blood" shared in the kinship [56]. This similarity of concepts could be more than a coincidence, since it is assumed that about half of all African slaves abducted to Jamaica were Ashanti. This may be due to the fact that West Africans reacted quite differently when forced into slavery, depending – among other factors – on whether they grew up in regions with strong collectivistic traits or in slave holding societies. The Ashanti kingdom was such a slave holding society, which was formed during centuries of hunting for and trading of slaves. Subjected to regular slave hunts, African societies were thus transformed into states that themselves specialised in slave trade, particularly when located in coastal areas [41]. West Africans coming from inland regions with predominant village structures and rather strong ties to their neighbours often starved themselves to death on board of the slave ships or even committed suicide. The Ashanti, on the other hand, were well acquainted with slavery and therefore often employed as supervisors of plantations in the Caribbeans. However, riots were so often started by Ashanti that most Western European states did not allow any further import of Ashanti into their colonies; only the British Empire continued to abduct Ashanti and ship them to Jamaica, an island conquered in the 17th century from Spain. Here, African slaves that escaped to the mountains ("Maroons") founded free villages and fought two wars against British colonial authorities, thus achieving a limited degree of self-rule [41,4]. Would this mean that we should distinguish between 1) West African concepts of a person, which are developed within a village community and constitute a "collective ego" on the one hand, and 2) an "individual ego" on the other hand, which arises

in Westernized slaveholding societies? The answer is no, because concepts such as the "collective ego" and the "individual ego" are rather crude simplifications, which do not give adequate consideration to culturally complex differences in the respective concepts of a person.

For example, the Tallensi, a population living in Northern Ghana, developed a concept of the person, that differs strongly from the concept established among the Ashanti in Southern Ghana, even though both populations live in the same state [43]. The Tallensi assume that all living beings are composed of a body and the breath. Human beings also possess a soul ("Sii"), which differs from the breath. This soul can leave the body during sleep (a concept also found among the Ashanti) and appear in the dream of another person. The Tallensi also assume that there is a self ("Meng"), which is closely linked with the soul. However, the status of a "full person" is only acquired in a lifelong, stepwise process, which is associated with the (increasing) social status of the individual: only a male person, who represents a social authority (an elder) in a social group and who has male children, possesses the full status of a "person". After death, such a person becomes an ancestor, who is religiously venerated and who can interfere with the fate of living human beings. Whenever a child is born, the group of ancestors who protects the child will also control its future fate. Ancestors thus become protectors of tradition. In this concept, the focus of attention is directed towards the collective ancestry of the population, however, the individual status of any human being is determined by his own children and the individual social status he acquired. Therefore, the anthropologist Morris repeatedly cautions against reductionist and simplifying concepts such as the idea that an individualistic tradition in Europe can be juxtaposed to a collectivist tradition in Africa – instead, Morris emphasises that each culture balances mechanisms and concepts, which mediate between individuals and society and their respective desires and demands [43].

10. The self in neuroscience

Recently, the construction of the self has also been studied in neuroscience. Similar to some contemporary philosophers, such as Thomas Metzinger [42], neuroscientific approaches to the self assume that the self is not an entity outside or independent of the brain, but rather an entity that is realized in the brain. The assumption is that the self is a model created by the brain. According to this assumption, how is the brain creating the self? Most neuroscientific theories refrain from the idea that "the self" is processed in a particular brain area which would serve as a homunculus-like observer of processes going on in other parts of the brain. Such a model would, again, raise the problem of the infinite regress: which brain region is "observing" the observer-region? Instead, most theories favour the idea that "the self" as a complex phenomenon is emerging from the interplay between several brain areas, which function as a kind of self-network; each brain area might subserve a specific aspect of self-related information processing and the interaction between these neuronal networks thus constitutes our experience of a phenomenological self. According to a model proposed by Northoff and Bermpohl [45], self-referential processing in cortical midline structures is a fundamental component in

generating a model of the self within such neuronal structures. They suggest that the orbitomedial prefrontal cortex (OMPFC) accounts for the continuous representation and reflection of self-referential inputs from the body and the environment [4]. Once *represented* in the OMPFC, self-referential information appears to be *monitored* in the supragenual anterior cingulate cortex and *evaluated* in the dorsomedial prefrontal cortex [45]. These functions might be complemented by the *integration* of this information in the emotional and autobiographical context of one's own person; this latter function may be related to the posterior cingulate cortex.

Whereas philosophers aim at defining a coherent and differentiated concept of the self, neuroscientists address questions like the following: How can we study self-related mental processes empirically, i.e. how can we reliably operationalize self-related processes? What are the neural correlates of self-related mental processes? A typical example for such an operationalization is a functional magnetic resonance imaging (fMRI) study by Kelley and colleagues [33]. In this study, participants were asked to judge trait adjectives (for example, "polite") as to whether they properly described the participants themselves (self-referential), the current US president (other-referential), or a given case (case-referential). Comparing the self-referential trials with the other-referential and case-referential trials allowed identifying brain areas particularly associated with self-referential processing. In this experiment, effects were observed in the above mentioned cortical midline structures. Like most, if not all, neuroimaging studies of the self, this experiment does not examine the self *per se*, but rather self-referential stimulus processing. Although study participants need to have a coherent model or construct of their own self (which is in some way composed of individual experiences, beliefs, preferences, and capacities) to perform the task, the experiment does not explicitly focus on this model. Instead, the experiment examines how this model is implicitly used by the study participant to judge the self-referentiality of the trait adjectives presented.

Self-referential processing is a heterogeneous process, entailing a complex set of operations. Consequently, a large series of experiments is needed to identify the neural correlates underlying the specific subprocesses. On the one hand, these studies aim at disentangling self-referential processing from closely related processes, such as emotion processing [47], episodic memory [49], theory of mind [62], reward processing [19] and realism [57]. On the other hand, these studies examine self-referential processing in different domains. Besides the above mentioned personal trait judgement, these domains concern the centeredness of an individual's multidimensional and multimodal space upon one's body [63], the recognition of one's own face [35], the experience that one's own body and environment are perceived as closely related to one's own self (ownership [11]), the feeling of being causally involved in an action [17], and the perception of signals of one's own body, e.g., heart beat [9]. Evidently, these domains of self-referential processing concern both automatic, pre-reflective self-awareness and higher-order conscious self-reflection. Strikingly, self-referential processing across these different domains consistently activates the cortical midline structures and connected subcortical brain areas [46].

The concept of the embodied self draws on the idea that the human self model is based on the continuous processing of internally generated inputs. At the physiological level, this continuous self-referential process may correspond to the high level of neural activity found in the cortical midline structures and connected subcortical areas during so-called resting conditions, such as viewing a blank screen [45]. This high level of neural activity at "rest" (i.e., in the absence of externally-oriented tasks) has been characterized as the "physiological baseline" or "default mode" of the brain [20]. Given this high baseline activity, it comes as no surprise that cortical midline structures are mainly modulated by deactivation during non-self-referential tasks. This deactivation might reflect the temporary eclipse of subjective experience during tasks with externally-oriented cognitive and behavioral demands.

Although self-referential processing involves pre-reflective, continuous, internally-directed processes, recent neuroimaging studies suggest a strong influence of social interaction and culture on these processes. Support for the link between self-referential processing and social interaction comes from neuroimaging studies showing a striking overlap between brain areas involved in referring to one's own actions, sensations and emotions (and to those of others. So why are similar brain areas "used" for these two processes that seem to differ so much at first glance? On the one hand, activation of the self-network during social cognition may reflect simulations that translate the bodily, emotional and mental states of others into the neural language of our own states [34]. According to simulation theory, such simulations are used by humans to understand others' mental states. On the other hand, the pre-reflective as well as the self-conscious relationship to one's own bodily, emotional and mental states seems to be established (phylogenetically and ontogenetically) through social interaction. We seem to "learn" about such states through prelingual and lingual communication about these states when they occur in oneself or the other [58].

Recent transcultural neuroimaging studies have demonstrated that one's cultural background can influence the neural activity that underlies self-referential processing [21]. Similar to the above-mentioned study by Kelley and colleagues [33], a fMRI study from China [65] measured brain responses while study participants judged personal trait adjectives regarding "self", "mother" or "a public person" and compared self-referential processes between Western and Chinese subjects. In both groups, the medial prefrontal cortex and anterior cingulate cortex showed stronger activation in self- compared to other-judgements. In addition, mother-judgements (relative to other-judgements) activated the medial prefrontal cortex in Chinese but not in Western study participants. The authors suggest that these findings might reflect two distinct types of self-representation, namely a "Western independent" type of self versus an "East Asian interdependent" type of self [65]. These fMRI findings demonstrate how neuroimaging can be used to distinguish culture-sensitive from culture-invariant neural mechanisms of self-referential processing.

Another cross-cultural fMRI study by Chiao and coworkers [8] focused on the influence of so-called individualistic versus collectivistic views on self-referential processing. Starting point of the study was the rough and preliminary distinction between

two self-construal styles: People who endorse individualistic values think of people as independent of each other and describe themselves using stable personality traits. This is reflected in a preference for general self-descriptions, e.g., "I am honest". By contrast, subjects who endorse collectivistic values think of people as highly interconnected to one another and describe themselves as embedded in specific social contexts. This is reflected in a preference for contextual self-descriptions, e.g., "When talking to my mother, I am honest". During fMRI, Japanese and European American study participants were presented with general and contextual self-descriptions. Brain responses were measured in the medial prefrontal cortex, a core area of the cortical midline structures associated with self-referential processing. The authors report that agreement with individualistic cultural values was associated with greater medial prefrontal activation during general self-descriptions. In contrast, agreement with collectivistic values resulted in greater medial prefrontal activations during contextual self-descriptions [8]. These effects of self-construal styles were observed *across cultures*, i.e., among Japanese as well as among European American study participants, supporting the hypothesis that individualistic and collectivistic values are present *within* different cultures. The authors conclude that self-referential processing in the medial prefrontal cortex varies as a function of self-construal style.

11. The social performative and narrative construction of identity

Cultural constructions of identity influence not only the self concepts of individual persons but also of social groups and classes. This can be illustrated looking at the Rastafarian religion. How can it be explained that Jamaicans started around 1930 to venerate Ras (i.e. Duke) Tafari, the Ethiopian heir to the throne, who is better known by his crown name Haile Selassie I., and based a religious movement on this veneration? In his book "Rasta and resistance", Campbell turned to the social conflicts in Jamaica to explain this religious movement [4]. In the 1930ies, Jamaica was a colony of Great Britain, and each class room was decorated with the respective picture of the ruling British king or queen. Africa, on the other hand, was described both in the colonial discourse and in the view of the upper classes as a "primitive" place, devoid of history. Such prejudices were challenged when pictures of an African king appeared in the news, who was the heir to the throne of an ancient African civilisation. Black nationalists in Harlem, in other cities in the United States and in Jamaica used this picture to promote self-consciousness among African Americans. In Jamaica, Howell and Hinds suggested that Jamaicans could only show loyalty to one king and that this king is not the British monarch but Haile Selassie I. Both were imprisoned, however, the new movement was not successfully suppressed. The Rastafarian movement early on started to identify with the anti-colonial struggles in Africa. The movement further gained momentum after fascist Italian troops invaded Ethiopia, when pictures of Ethiopians resisting this invasion and of Haile Selassie I. appeared in the news. One of the signs of the Rastafarian movement, the long uncombed hair, was originally shown by the anti-colonial "Land and Freedom Army" (Mau Mau) in Kenya, where it was worn

to demonstrate a "natural" African hair dress, which resisted Western concepts of artificially straightened hair [4]. Social identity was thus formed using symbols of successful resistance against colonial rule. Of course most Africans who were abducted to America came from West Africa and not from Ethiopia [41]. However, historical exactness is not the goal of such a social construction; instead, the Rastafarian movement used symbols and practices which represented the dignity and successful fight for equal human rights and used them against the devaluation of African traditions in the colonial situation.

What goes on in such movements can be explained with Turner's concept of performance: The anthropologist Turner suggested that also in less antagonistic societies than in colonies, group conflicts can arise, which are represented and reflected in social drama [65]. Turner used the example of the Brazilian "Umbanda" cult, a religion that intentionally integrates African elements, which are supposed to represent "pure nature" in opposition to the threatening urban reality. During the performance of these rituals, social conflicts among the participants are reflected in the roles acquired by the participants. Thus put into scene, the performance of the social drama can heal the violated social order and support the individual identity that is threatened in its impoverished urban environment. The supposedly "natural" African and Native American traditions are used in a syncretistic way, which links catholic saints, spirits derived from native American traditions and African gods ("Orishas") of the West African Yoruba. The Umbanda cult and the organisations supporting these performances thus constitute a parallel society, which supports oppressed classes and groups by providing a place in an imaginary hierarchy, which strengthens their identity via the ritualised expression of their conflicts, emotions and social status within this cult [60]. The decisive element of such a ritual is thus not the historically correct and "authentic" use of African traditions but the self-conscious identification with the African heritage, which is otherwise quite too often not appreciated and respected – also in the post-colonial discourse.

12. Summary and outlook

These considerations show that the "self" is a fluid concept; rather than resembling a rock which stands firmly in the sea of events, perceptions and emotions, the "self" is socially constructed and articulated around experiences which appear to be shared by all human beings. Such universal experiences appear to include the prereflective access to individual thoughts and feelings, an automatic knowledge that (at least in non-pathological states) these emotions and cognitions belong to my self. Conscious self-reflection, on the other hand, is necessarily imbued with social and cultural norms, narratives, images and events, often of conflicting nature, and the social and individual struggles underlying such self-images can often be identified and understood. To do so, it is not decisive to possess complex lexical knowledge about each culture and its history; instead, each individual synthesis has to be respectfully approached, so that we can try to understand how a person constructs the personal image of his or her self by using available parts and pieces of the respective cultural, social and autobiographic experience and tradition.

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Conflict of interest statement

None

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Explanatory models and concepts of West African Malian patients with psychotic symptoms

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ABSTRACT

Keywords:
Transcultural psychology
Illness concepts
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Migration
Psychotic symptoms
Explanatory models
Community psychology

Background. Subjective explanations of illness concepts and disease can differ from culture to culture. We examined explanatory models of West African patients with schizophrenia in a community-centred department of psychiatry in Mali, West Africa.

Methods. Patients and experts volunteered to be interviewed in the Department of Psychiatry of the University Hospital, Pont G, in Bamako, the capital of Mali. We used semi-structured interviews to explore key psychotic symptoms and explanatory models of psychosis in five experts and fifteen patients with schizophrenia. All interviews were analysed using computer assisted content-analysis with the program Atlas.ti.

Results. African patients displayed key symptoms of schizophrenia such as commenting and imperative voices, inserted thoughts and other phenomena of alien control, which were often subjectively explained as obsession by witches or jinns. Explanatory models differed depending on occidental migration experience and age. The involvement of family members in the treatment-setting facilitates inclusion and recovery. Experts emphasized the need to integrate traditional and ethno-pharmacological approaches and modern medicine to treat their patients in a culture sensitive manner.

Discussion. Our data suggests a strong influence of illness concepts on the experience of psychotic symptoms, treatment expectations and health-related behaviour.

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1. Introduction

Subjective illness concepts can be defined as opinions, interpretations, explications and predictions regarding factors that impair a person's health [26,21]. They reflect the patients beliefs about the constitution, aetiology, the expected duration and treatment of their individual health problem, and their disease-related emotions [4,25]. In the European context, Leventhal and colleagues developed a "processual Common-Sense-Model",

which explains how expectations and experiences of the causes, symptoms and consequences of disease are influenced by subjective illness concepts. According to the model, illness signals are recognized and linked with mental representations. This association helps to create cognitive representations of a problem and is accompanied by specific emotions. They include the subjective view towards a patient's illness symptoms, causes, consequences, duration of the illness, treatment efficacy, personal influence and disease-related emotions [25].

Some authors suggest to use the theoretical concepts of "explanatory models" rather than "subjective illness" concepts, because the first explicitly considers the sociocultural context and thus reflects social and cultural differences in illness experience and explanation [3,19,20,21,32]. According

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to Kleinman, explanatory models consist of the illness and disease concepts of a single person in a given illness episode in interaction with his/her cultural context and socio-cultural environment (e.g. caregivers including experts, family members etc.).

The research by Williams & Healy, 2001 [41] suggests to apply the term “explanatory map” as an alternative to “explanatory model”, because the term “map” reflects the diversity and complexity that can be found in conceptions of illness and disease [41]. That implies that “explanatory models” do not consist of a coherent set of beliefs, but a multiplicity of illness and disease explanations constructed in specific socio-cultural settings, which may be influenced by time and “historical development of traditional cultural knowledge” [33,4].

It has been suggested that the way patients feel to be understood and accepted in the process of treatment has an important influence on the compliance and the experience of therapeutic relationships [26,5,18,35]. Explanatory models and concepts also play an important role in terms of beliefs and estimations of the social consequences of a disease and the social role of a patient. This can include aspects of social stigmatisation and ideas about the participation of the patient in social life or the working environment [9].

In the African context, illness is very often regarded as a family affair, i.e. a collective experience of different subjects [32]. The influence of cultural knowledge (social rules, rituals, traditions, symbolisation, communication styles) and (collective) narratives thus plays an important role in the constructions of “explanatory models” or “explanatory maps”.

Research on explanatory models of schizophrenia in Africa is complicated by the history of psychiatric explanations of psychosis. For example, Bleuler termed the word “schizophrenia” when closely cooperating with Freud, and assumed that schizophrenic thought disorder reflects a loss of evolutionarily higher cognitive functions and a return to a “primitive” mode of wishful (autistic) thinking that characterizes both children and “the Negro” (in singular!) [2]. Bleuler suggested that ideas in the mind are normally connected in a logical way and this connection is enforced by the experience of ‘reality’. He claimed that a pathological destruction of the connections can lead into psychosis. If the logical connections between ideas are lost, the psyche splits up into incoherent ideas, and the only force which regulates their manifestation is desire. This split up of the mental process gave the disease its new name – schizophrenia [15]. During colonialism, Western psychiatrists claimed that healthy Africans resemble Europeans after lobotomy (a destruction of prefrontal cortex function), which was supposed to explain symptomatic differences in mental disorders between Europeans and Africans [6]. However, in the 1950ies and 60ies, the “race” concept was increasingly rejected, because it wrongly assumes categorical genetic differences between populations when indeed only gradual differences in allele frequencies are observed [27]. In psychiatry, Lambo showed that differences in psychotic symptoms in Nigerian patients are strongly influenced by their individual upbringing, with subjects from traditional backgrounds displaying mainly polymorphic psychoses and subjects with Westernized socialisations reporting “classical” key symptoms of schizophrenia such as certain acoustic hallucinations or passivity phenomena [24,37]. Using such symptoms

as diagnostic criteria, the World Health Organization later observed comparable frequencies of schizophrenia in different countries around the world, including Nigeria [36]. While these data falsify hypothesis that suggest fundamental differences in mental disorders between Africans and Europeans, cultural and religious differences in e.g. concepts of “the soul”, “the self” or the existence of supernatural beings and their impact on human life and experience may cause profound differences in illness experience.

Therefore, the goal of our study was 1) to assess key psychotic symptoms and explanatory models/maps of West African patients and their caregivers, and 2) to investigate how psychotic patients are treated in a Malian community-orientated psychiatric context. We tried to focus not only on symptoms and impairments but to also assess how salutogenetic resources of the patients are taken into consideration in local treatment settings [1].

2. The setting

Our investigation was based in the Department of Psychiatry of the University Hospital, Point G, in Bamako, Mali. The inpatient service is organized as a communal treatment setting. Since the 1980ies, a reform movement in Mali has focused on changing the classical view and associated stereotypes of psychiatric treatment [23]. This movement is interested in minimizing social stigmatisation and tries to give patients a voice to integrate the families into the therapeutic process, and to facilitate reintegration into society. The movement intends to overcome treatment models in which patients are isolated from their social reality, placed in the passive role of an “ill patient” and treated nearly exclusively with medication [23].

In 1984, the Ministry of Health developed treatment guidelines including the demand for an amelioration of treatment conditions. Since then, patients who are treated in the so-called “psychiatric village” at the University Hospital in Bamako are only admitted when accompanied by a family member [10]. The family and patients live together in small houses on the compound and they share the social reality of the patient during the whole therapeutic process. The patient and his/ her companion live together, cook together and sleep in the same house, similar to their home environment.

The centre of the therapeutic village is the “Toguna”, a small round house where the experts hold clinical consultations with the patients and their families. The architecture of the small house has a therapeutic meaning: on the one hand the “Toguna” is constructed in a round form to include all professionals, relatives and patients during the consultation, and the “Toguna” has a very low ceiling. Thus, a person who becomes angry during the expert consultation is not able to stand up, which, in the experts’ opinion, calms the anger of the person and suppresses aggression.

A patient’s companion can play an important (salutogenic) role for the healing process. The family member who accompanies the patients during the whole therapeutic process acts as a mediator. The role of the mediator is to clear the way for the communication between the experiences of the patient and the socio-culturally constructed realities of the family members.

That means that explanatory models previously held by the patient and his/her family, those which had been created anew during therapy as well as those of the professional caregivers can be communicated by the mediator to the family members or friends who stayed at home.

In Mali, like in most African countries, the extended family traditionally includes all members of the families (cousins, sisters, uncles, ancestors etc.) [17,32]. A family member's mediator role can help to demystify illness concepts that can otherwise lead to stigmatisation, for example the interpretation of being 'bewitched by someone'. Thus reintegration is facilitated and the patient is not isolated from the family. The isolation of the group (family) and the loss of the subjective position in the group have often been discussed as factors for the aetiology and maintenance of negative mood states in African patients [11]. The therapeutic "Koteba" theatre, which is a part of the treatment setting and performed weekly by the patients to enact typical social conflicts, further supports exchange between patients and relatives. The Koteba has its origins in the traditional Bambara theatre and was integrated as a treatment tool in the 1980ies. Koteba has always been used as an instrument to break taboos and speak about issues that are otherwise not allowed to be addressed in traditionally oriented Malian society.

3. Subjects and methods

We interviewed twenty persons (fifteen patients and five medical practitioners) with semi-structured, problem-centred qualitative interviews. All patients who volunteered to participate in our study suffered from psychotic symptoms caused by schizophrenia or schizoaffective disorder according to DSMIV/ICD10. All interviews with the patients and experts except one with a traditional Healer where conducted at the clinic Pont G. in Bamako, Mali. Data were collected regarding age, sex, date of birth, marital status, ethnicity, religion and admission status. The interviews were mostly recorded in "the Toguna" (house) of the "therapeutic village"; the average duration was 1 hour. We gathered our information with the assistance of culturally informed translators who were aware of the socio-cultural matrix. This helped avoid linguistic barriers and facilitated transcultural understanding for this study.

Methodologically, we applied qualitative content analysis, i.e. an approach for the methodologically controlled analysis of texts within the context of communication that follows content analytical rules and applies step by step models [29]. We selected this qualitative content analysis approach because the methodology takes subjective views and social meanings into account, which allow a better understanding of the social reality of the patients. The focus of this qualitative approach can be seen as an attempt to understand the complexity and uniqueness of the subjects being researched [29].

The semi-structured interview guidelines included questions about how the patients describe their illness or disease, which key symptoms of schizophrenia are experienced by the patients, what they believe is the cause for their problems and how the patients and their families think they should be treated. In particular, the last question was constructed and evaluated in previous research the semi-structured guideline

was first used in 2007, when we examined West African migrants with psychotic symptoms in the Department of Psychiatry of Charité, University Medical Centre Berlin, Germany [43]. This first investigation of the explanatory models of African migrants gave us an impression how patients of West African descent deal with psychotic symptoms in the Diaspora. We used the same questionnaire with some variation for the present study as a guideline and redefined questions in the field according to the context and situation while taking the interviews. Flexibility is a main characteristic of the methodology and this was very important for the research, because some of the Malian patients started their narratives spontaneously after we introduced ourselves (or the caregivers introduced us) as researchers from Germany who intended to explore patients views and beliefs about their illness. We explained that we also aimed to learn from the patients as experts of their illness. The introduction created confidence, because we explained the purpose of the interviews and asked for permission.

The semi-structured interview guideline consisted of the following questions:

1. *Why are you in the hospital? Did you have unusual or threatening experiences or what makes you suffer?*
2. *How do you explain and integrate your problem/illness/disease in your lifecourse?*
3. *What things in life make you feel happy and what create fear?*
4. *How did the family react with regard to your illness?*
5. *What did the family counsel you to do with regard to your problem/illness/disease?*
6. *What is "illness" and what is "healthiness" for you?*
7. *Which activities or treatments help you to recover?*

The interviews were analysed with a computer assisted content analysis programme, ATLAS.ti, to explore the explanatory models and concepts of the West African patients and professional caregivers. The programme ATLAS.ti is an instrument supporting the analytical work and interpretation of the data by helping to structure the text and to build and group categories, which can be found in the transcripts according to our research questions. Moreover, it supports the visual representation of interpreted data, because it offers tools which can be useful to create networks of the explored categories found in the interviews.

1. In a first step we structured the interview transcripts and reviewed the texts explicitly with regard to our research question: How do West African patients and their caregivers experience and conceptualize illness and disease? We marked passages in the transcripts, for example "my family brought me to a traditional healer", which seemed to be of importance for the study of explanatory models and therapeutic activities. This step can be supported with ATLAS.ti by generating so called "in-vivo codes", which give specific codes for quotations in the transcripts that were deemed important according to our research interests.

2. This process of paraphrasing was the basis for creating categories. In the course of this mostly inductive but also deductive research process, we defined new or redefined selected codes from the first trial, until all important information from the transcripts was included.

The text interpretation always followed the research question and was put into categories. The process of finding

categories was performed very carefully and the categories were revised within the process of analysis through feedback loops [24].

3. In a third step, we built “supercodes” by creating “families” to reduce the material by grouping meaningful codes and quotations into a single meaningful concept. This process was accompanied by the use of the function “query tools” in the ATLAS.ti programme.

4. Finally the programme ATLAS.ti lists the most meaningful concepts, which can then be interpreted by the researcher. To support this process, network analyses were built within the programme ATLAS.ti to formulate theoretical models. The network is defined by a set of nodes and links, which allows us to specify the relationship between the codes and to present a theoretical construct of our data at the end of the research process (Handbook, Atlas.ti 5.0, 2010).

4. Results

The results consisting of 454 created codes and their relation suggest that psychosocial factors like the break of taboos and family conflicts are seen by patients and experts as playing an important role in causing schizophrenia in Mali.

We noticed that:

1. The interviewed patients often assumed external causes for their disease (like the “evil eye”). In all our interviews, patients never blamed themselves (except in terms of an occidental migration experience in the patient’s biography). Experts suggested that the externalized explanatory models appear to play an important role for the resilience of the patients.

2. Psychopathologically, patients reported key symptoms of schizophrenia [3] such as thought insertion and thought control by jinn’s or witches, coenaesthesia and commanding voices, as evidenced by the following patient interview: How would you describe your problem/illness/disease?

“I just got here for a treatment reasons, because I have problems with the family... regardless I am ill.”

“There are witches, they are in my stomach and my throat and they are also in my whole body. ... Someone of the family sent the witches to destroy everything...they creep into my body and want to eat me.”

“The witches are also in my organs and they control me and my thoughts.”

“They control my connections with other people, with the people I keep company with...When I intend to read a book, they try to disturb me. Therefore I am reading very loud, thus they cannot prevent me from reading.”

Furthermore, local concepts such as “Hakili bana” played an important role in patients’ explanatory models of their suffering; this term denotes loosing one’s soul, mind, spirit and (control of) thinking.

The interviews suggest that the company of a family member during hospitalisation reduces aggression and stigmatisation and increases the patient’s compliance. Also the reintegration process of the patient after the psychiatric hospitalisation appears to be facilitated.

We observed that:

1) Patients and experts report that the expected and preferred treatment includes modern medicine (psychotherapy, medication, etc.) and utilisation of traditional treatment by patients and families (plants, Koteba, etc.).

2) The Koteba, the traditional African theatre, plays an important role in the struggle against stigmatisation. Here, typical conflict situations are enacted by patients in front of the whole therapeutic village, i.e. other patients, their relatives and the professionals. Patients and their social environment are thus on the same level and no one can easily distinguish between “illness” or “health”. The Koteba has a social function and supports the resilience by reminding the patients of their integrity, self-respect, importance for the community, responsibility for others, etc. The Koteba breaks taboos and leads the individual to concentrate on his resources.

5. Discussion

Our study confirms the eminent role of individually and culturally influenced explanatory models on patients’ symptom presentation, social interactions and expectations towards therapy [4,21,25,30]. In spite of such cultural and religious differences in the explanation of psychotic symptoms, patients described “classical” first rank symptoms of schizophrenia [35] such as thought insertion, which they explained in terms of local beliefs in witches or jinns (spirits). The Malian experts also emphasized that in a Westernised psychiatric setting, psychiatric professionals diagnose a symptom of schizophrenia (for example when a person believes that he is able “to talk to the witches in his body”), while West Africans can have alternative concepts of the “self” or the “ego” influenced by cultural, ethnical norms and traditions, which often include beliefs of magical interference. However, if such local beliefs in spirits and witches exist, how can experts distinguish between common beliefs and psychotic symptoms? The experts as well as the patients’ relatives told us that in this part of Africa, possession by evil spirits is supposed to cause bad luck but not thought insertion or imperative voices. Therefore, it is necessary to involve family and community members in the diagnostic process, which helps to distinguish between commonly shared beliefs and idiosyncratic explanations of psychotic experiences. For example, family members of one psychotic patient who experienced “thought insertion by witches” clearly labelled his report as an unusual and alarming experience, which indicates a state of illness. They emphasized that this experience cannot be understood within traditional concepts of spiritual interference, as spirit possession may cause suffering and misfortune but not “insertion” of thoughts. These considerations highlight the fact that the symbolisation and language of the patients shape their presentation of symptoms and the interpretation of these symptoms within diagnostic contexts. The specific way how patients and relatives describe psychic and somatised symptoms and syndromes thus play a decisive role for a cultural sensitive diagnosis and can help to reduce false diagnoses [12,7,24,25,21,33].

Professional treatment in Pont G actively involved family members and public display of typical conflict situations in the Koteba theatre. Strengthening family bonds can thus counteract

isolation, stigmatisation and social exclusion of psychiatric patients. In fact, social isolation may further augment mental disorders: Makanjoula and Olaifa (1987) reported in their study on negative mood states among Nigerians that "depression in particular, may be then considered both as a reaction to the loss of the position of the subject in the group to which the person belongs and as a reaction to the threat of a catastrophe" [27].

Prof. Baba Koumaré, the head of the department, explained that the existence of beliefs in external evil agents enables patients e.g. suffering from major depression to externalize their feelings of guilt and shame and thus to blame evil outside agents for their suffering, which then may be misdiagnosed by psychiatrists as paranoia or a psychotic rather than an affective disorder. On the other hand, a salutogenetic perspective emphasizes mechanisms that facilitate "resistance to psychotic symptoms": external agents can evoke "self resistance" and power of the patient. It appears that the attribution of misery and pain to external agents also mobilizes group and family support. Explanatory models and concepts that are supported by a common belief may thus facilitate that the patient and accompanying family work together against the perceived threat.

The interviewed experts also suggested that the apparent resistance of their patients against a perceived "external source causing illness" can reduce suicidal tendencies. A common enemy which often appears in the role of an "outsider" to the family clan may thus strengthen or reunite the family bond. The Malian experts emphasized that professionals should not deny the cultural influence on illness concepts and rather integrate traditional and local explanatory models of suffering as an important resource for the therapeutic treatment for the patients. This includes respect for traditional ways to heal mental illness, which were explicitly named by all patients as a necessary step for recovery.

Altogether, our study underlines the importance of a culturally sensitive diagnostic process and of strengthening family bonds and social inclusion. Regularly involving relatives in a communal psychiatric setting offers an important perspective of integrating and transforming the subjective conceptions of patients suffering from psychotic symptoms. This African treatment perspective includes systematic approaches as well as transculturally relevant aspects and focuses on the resilience of patients and their families within a practical, salutogenetic approach.

Conflict of interest statement

None.

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How to express mental health problems: Turkish immigrants in Berlin compared to native Germans in Berlin and Turks in Istanbul

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ABSTRACT

Keywords:
 Immigration
 Germany
 Turkish immigrants
 Free Listing
 Mental disorders

The paper explores expressions used by Turkish immigrants in Berlin to delineate psychiatric illnesses and psychological problems. These are compared to expressions used by native Germans in Berlin and Turks in Istanbul to assess possible cultural differences in articulating mental disorders. For this purpose, results of a Free Listing carried out with the three above mentioned groups are presented. The data suggest that relevant items which are connected to mental health issues vary between the groups as well as within the groups, thus showing dependency on factors such as education.

For the group of Turkish immigrants the data further suggest that this group connects psychic stress to family problems. Concerning help seeking, Turkish immigrants, like members of the other groups, mention professional psychological/psychiatric help as useful for solving mental health problems.

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1. Introduction

Studies concerning mental health and migration show different results as immigrants are not a homogeneous group. Certain immigrant groups have a higher risk of being diagnosed with a schizophrenia or a depression but in general epidemiological data on mental health status of immigrants is rare [13]. Generally, immigrants have lower access to mental health care services [9,11,13,15]. For Germany it has been reported that immigrants use psychiatric inpatient services as often as native Germans [20], but that they are underrepresented in psychotherapeutic outpatient services [14].

Several barriers to the mental health care system have been discussed in recent years. Concerning drug addiction counselling services, Gaitanides [7] lists barriers such as a lack of knowledge of these services, fear of legal consequences, alternative therapy possibilities in home countries and on the side of the institutions fear of extra work of the staff and ethnocentric and middle class oriented therapy settings. Also minority status, language and cultural barriers, lower social status of immigrants [17] and differences in explanatory models [16] are named as barriers.

Concerning the group of Turkish immigrants' several reasons for lower use of mental health care institutions are mentioned. Besides experiences of discrimination and fear of legal consequences concerning drug addiction [8], a sceptical attitude of Turkish immigrants towards psychotherapy [1] and an illness concept that differs from the German majority population is discussed. It is suggested that Turkish immigrants have more pessimistic illness attitudes concerning mental health issues and that they believe less in their own influence on the illness [6]. Furthermore it is depicted that Turkish patients have a different understanding of mental illnesses than Germans, for example naming external causes for illnesses more often [5], believing in the evil eye, locating suffering in certain organs and tending more to somatisation [23]. A similarity between most of these studies is that they use the dichotomy "modern" versus "traditional" medicine and that Turkish people are located in the field of "traditional" health beliefs.

In contrast to these deficit oriented approaches that stress cultural factors, we would like to broaden the perspective by considering social factors as well and focusing on the vocabulary used for expressing mental health problems. As immigrant

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1 The definition of the „group of Turkish immigrants“ varies among authors or remains unspecific in some cases. The definition used in this article is given below.

patients (often with lower social status) communicate with professionals (often stemming from the middle class) a potential barrier may lie in the different meaning that immigrants and professionals connect to certain terms or expressions. Thus we would like to address the question if people from different cultural and social backgrounds use different words and concepts when asked about mental health problems. A further question is if religious terms figure prominently in the group of Turkish immigrants as it is suggested in the literature that connects illness concepts of Turkish immigrants to traditional world views.

This paper examines terms concerning mental health problems that were named in a Free Listing process of three groups. The biggest minority group in Germany, Turkish immigrants, is compared to native Germans and to a group in the country of origin of the immigrants, Turks in Istanbul. By comparing these three groups, possible differences not only between the native and immigrant populations but also between Turkish persons in Germany and Turkey can be asserted. Thereby differences in the subjective meaning of terms can be investigated which in turn might be the source of communication pitfalls. Secondly, this comparison along cultural lines is transcended by deepening the analysis and evaluating the results according to the parameter of educational background of interviewees. In this way, the assertion of mere "cultural" differences is put into perspective and the complexity of the data is emphasized.

2. Method

The research project "Mental health and migration" of the Department of Psychiatry and Psychotherapy of the Charity University Medicine in Berlin is approaching the mental health status of immigrants and the utilization of health care services from different angles. An epidemiological survey on prevalence of mental health problems among the biggest minority group in Germany, Turkish immigrants, is conducted to yield missing data on the mental health status of that immigrant group. Complementary, the status of Intercultural Opening of German community mental health care institutions in Berlin is assessed, thus focusing on how institutions address immigrants' needs (see Penka et al. in this volume) and a cross-cultural competence training is developed, implemented and evaluated. Furthermore barriers to the mental health care system and resources in handling mental disorders of Turkish immigrants are assessed by using the methods Free Listing and Pile Sort [4,19].

In the paper at hand the results of this Free Listing process will be discussed. They allow insights into differences in vocabulary concerning mental health problems, which are indications for possible differences in health beliefs and may impair the communication between patients and professionals in the health care system. Furthermore the homogeneity of ideas about mental health problems inside the investigated groups is analysed.

In the Free Listing process relevant items of the field of mental health problems were collected through interviews, structured by short interview guidelines. In this way information about the "spectrum of words" connected to the concept of mental health issues could be gathered and relevant items be identified. For the Free Listing the study group "Mental health and migration" interviewed 220 persons aged between 18 and 65. 70 persons

were native Germans in Berlin, 66 were Turkish immigrants² living in Berlin and 79 were Turks in Istanbul. In each group users and non-users of the mental health care system were interviewed and additionally professionals in Berlin and in Istanbul were included in the sample. Users were defined as currently using or having used in- or outpatient mental health care services in their lives before, while non-users were defined as persons who haven't been treated in in- or outpatient mental health care institutions. Borgatti [4] suggests interviewing a minimum of 20 persons per group to gather the relevant items. As the groups in this study were quite heterogeneous and specific inner differences such as educational background, gender and age were to be addressed, the number of interviewees was raised. The Free Listing process was stopped when a saturation of answers could be observed. For choosing the participants, the theoretical sampling method [12] was used to equally include both genders and diverse academic backgrounds and ages, and thereby collecting data from different sub-groups in order to prevent bias.

During Free Listing the interviewees were asked four questions about the definition, the meaning, the causes and possible cures concerning mental health issues: 1. What is a psychological problem/mental disorder in your opinion? 2. What does it mean to have psychological problems or mental disorders? 3. What could be causes of psychological problems or mental disorders? 4. If a friend of yours had psychological problems or mental disorders, what would you advice him to do and who could help? The interviewees were asked to answer these questions by listing items that came to their mind first and they could list as many items as they wanted. The Free Listing questions were deliberately asked in an open way, such that no own cultural categories of the study group were conveyed to the participants and that the latter could name items that were truly relevant to them. All participants could choose if they wanted to answer the questions in written form or orally and in the latter case answers were noted by the interviewers. Allowing for oral answers was meant to ensure that possible non-literate persons or those for whom writing down the answers would represent a barrier for participation could be included in the study. Additionally, the interviewees could choose if they wanted to be interviewed in German or Turkish, as the interviewers could speak both languages fluently.

The users were recruited in psychiatric outpatient clinics in Berlin and Istanbul and in a counselling centre for chronic mental ill people in Berlin. Non-users were contacted through several social institutions and, starting with the first few participants, through linkage sampling [22].

After conducting the interviews, the items were counted. Altogether around 2700 different items were mentioned in the Free Listing. These items were coded into categories, because in many cases different terms with almost the same meaning had been used and thus items had to be abstracted. In an iterative process the codes were approved several times under multi-disciplinary perspectives to prevent possible bias of a single researcher. After finishing the coding process 750 categories remained in total.

² In the study "mental health and migration" the group of Turkish immigrants are defined according to the Mikrozensus in Germany as persons who have immigrated themselves to Germany from Turkey after 1947 or whose parents have immigrated. For the study the criterion of mother tongue as Turkish was also used.

3. Results

The high number of named items in each group shows that the ideas concerning mental health problems are very heterogeneous. The groups listed different amounts of items. Germans and Turkish immigrants listed almost the same amount of items resulting in 390 categories for the German group and 398 categories for the group of Turkish immigrants. Turks in Istanbul mentioned less items resulting in 312 categories. This indicates the complexity of the field. Notable is the low consensus concerning relevant items for the field of mental health issues. For example the most frequently mentioned category

in the German group, "depression", was listed by merely 51% of the interviewees. That means, almost half of the group did not spontaneously consider this term relevant for the field of mental health issues. The frequency of all other categories was even much lower, so that we can hardly speak of a uniformity regarding relevant categories within groups or even across the groups.

When comparing the most mentioned categories between the groups there are noticeable differences. The items listed most frequently can be seen in table 1 to 4. Regarding question 1 (definition of a psychological problem/mental disorder) the categories named by native Germans resemble categories that

Table 1
Most mentioned categories regarding the definition of psychological problems/mental disorders.

Germans	Turkish immigrants	Turks in Istanbul
Depression (51%)	Depression (30%)	Not normal behaviour (14%)
Anxiety, fear (24%)	Being sad/unhappy (18%)	Distress/annoyance (14%)
Schizophrenia (16%)	Anxiety, fear (15%)	Being sad/unhappy (10%)
Anxiety disorders (14%)	Schizophrenia (14%)	Compulsive disorders (9%)
Emotion disorder (13%)	Loneliness (11%)	Illness of the brain (9%)
Not normal behaviour (11%)	Not feeling well (9%)	Depression (9%)
Bipolar disorder (11%)	Difficulties with environment (9%)	
	Withdrawal from outside world (9%)	
	Not normal behaviour (9%)	

Table 2
Most mentioned categories regarding the meaning of having psychological problems/mental disorders.

Germans	Turkish immigrants	Turks in Istanbul
Restrained life (44%)	Withdrawal from outside world (27%)	Being sad/unhappy (10%)
Exclusion (27%)	Exclusion (17%)	An illness like every other (10%)
Withdrawal from outside world (21%)	Problems with family/partner (15%)	Bad thing (8%)
Anxiety, fears (20%)	Being sad/unhappy (14%)	Withdrawal from outside world (8%)
Problems in dealing with other people (19%)	Missing joy of life (14%)	No real life (6%)
Problems in coping with daily life (14%)	Restrained life (14%)	Distress/annoyance (6%)
Family and friends suffer as well (13%)	Weariness/indifference (11%)	Therapies (6%)
Somatic complaints (e.g. pain, gastro-intestinal problems, blood pressure problems) (11%)	Bad thing (9%)	
Low self-esteem (11%)	Not normal behaviour (9%)	
Missing understanding of environment (10%)		

Table 3
Most mentioned categories regarding causes of psychological problems/mental disorders.

Germans	Turkish immigrants	Turks in Istanbul
Childhood/upbringing (30%)	Family problems (38%)	Genetic (24%)
Trauma (29%)	Pressure (23%)	Stress (22%)
Genetic (29%)	Problems with partner (17%)	Financial problems poverty (22%)
Severe experiences (23%)	Childhood/upbringing (17%)	Difficulties with environment (17%)
Work (23%)	Stress (15%)	Environmental factors (15%)
Loss of a beloved person (21%)	Anxiety, fears (15%)	Family problems (13%)
Stress (19%)	Genetic (15%)	Social factors (11%)
Drugs (19%)	Loss of a beloved person (14%)	Bodily causes (10%)
	Financial problems poverty (14%)	Pressure (10%)

Table 4
Most mentioned categories regarding possible cures for psychological problems/mental disorders.

Germans	Turkish immigrants	Turks in Istanbul
Talk (with a person of trust, e.g. family, friends) (47%)	Doctor (35%)	Psychologist (35%)
Psychologist (37%)	Psychologist (33%)	Psychiatrist (33%)
Psychotherapy/psychotherapist (24%)	Talk (with a person of trust, e.g. family, friends) (24%)	Doctor (22%)
Psychiatrist (21%)	Family (24%)	Friends (14%)
Counselling offices, social care services (e.g. crisis intervention service, drug addiction counselling service) (20%)	Friends (23%)	Family (14%)
Doctor (20%)	Therapy/therapist (20%)	Psychiatry (9%)
To distract yourself (hobbies, to go meet people, activities that are fun) (17%)	Hospital/clinic (18%)	Professional help (9%)
Friends (17%)	To distract yourself (hobbies, to go meet people, activities that are fun) (17%)	

are listed by Turkish immigrants in Berlin, for example the most frequent listing of the term “depression”, listing of “fears” and “schizophrenia” (see table 1). In contrast they do not appear among the most frequently listed terms of the Turkish group in Istanbul.

Another interesting result is that both Turkish groups use specific Turkish terms for which there is no equivalent expression in the German or English language, as for example “rahatsızlık” which comes close to the meaning of “not feeling well” or “sıkıntı” that might be translated as “distress/annoyance”.

Regarding the meaning of psychological problems (Table 2), the terms “exclusion” and “restrained life” were only mentioned by the two groups in Germany. Additionally, the native Germans named some categories that do not appear among the most mentioned terms in the other groups, as “anxiety, fears”, “problems in dealing with other people”, “problems in coping with daily life”, “family and friends suffer as well”, “somatic complaints” and “low self-esteem”. Both Turkish groups list the categories “being sad/unhappy” and “bad thing”.

Also the categories concerning causes for mental disorders or psychological problems vary between the different groups. Native Germans as well as Turkish immigrants list “childhood/upbringing”, “stress” and “loss of a beloved person” often as cause, but the other terms named by these two groups differ from each other. The native Germans list categories like “trauma”, “genetic”, “severe experiences”, “work” and “drugs” while these categories do not seem to be equally important for Turkish immigrants. The latter list “family problems” relatively often as well as “pressure”, which were listed by Turks in Istanbul as well. Turks in Istanbul list also “genetic” causes relatively often, in which they resemble the German group.

With regard to possible advice or help (Table 4) differences between the groups are not as strong as for the other questions. The categories resemble each other in the three included groups. Only two German answers are not found in the other groups: “psychotherapy/ psychotherapist” and “counselling offices”. The answers of both groups in Germany resemble each other in the terms “doctor”, “psychologist”, “talk”, “friends” and “to distract yourself”. Turkish people in Istanbul put an emphasis on professional help like “psychiatrist” and “psychiatry”, “psychologist” and “doctor” which are terms that appear only partly in the other groups. Terms that are connected to traditional healers are missing in both Turkish groups.

Although there are similarities between the groups, the results suggest that the differences are linked to cultural background. However, when evaluating the data in each group in more detail and aggregating them by educational background, the variations within a group turn out to be as big as the intra-group differences observed so far. We will exemplify this fact with the answers of the two groups in Germany to question 3 (causes of psychological problems/mental disorders) (Table 5 and 6).

In the German group the categories “trauma”, “genetic” and “severe experiences” are named by university graduates as well as non-graduates, but the university graduates most frequently mention “work”, “experience of violence” and “drugs” while the non-graduates list “difficult childhood/problems in upbringing”, “loss of a beloved person” and “stress”.

In the group of Turkish immigrants, the categories differed substantially according to university degree. Only the terms

Table 5

Most mentioned categories regarding causes of psychological problems/mental disorders in the German group.

German university graduates	German non-graduates
Trauma (35%)	Difficult childhood, problems in upbringing (41%)
Genetic (35%)	Loss of a beloved person (27%)
Work (e.g. stress, discontent, hierarchies) (29%)	Genetic (24%)
Severe experiences (e.g. accidents, shock situations) (27%)	Severe experiences (e.g. accidents, shock situations) (21%)
Experience of violence (e.g. domestic violence, war, rape) (21%)	Trauma (21%)
Drugs (21%)	Stress (21%)

Table 6

Most mentioned categories regarding causes of psychological problems/mental disorders in the Turkish immigrant group.

University graduates with Turkish immigration background	Non-graduates with Turkish immigration background
Pressure (43%)	Family problems (49%)
Childhood/upbringing (29%)	Problems with partner (22%)
Problems with environment (25%)	Stress (18%)
Genetic (24%)	Loss of a beloved person (16%)
Anxiety, fears (19%)	Anxiety, fears (13%)
Financial problems poverty (19%)	Pressure (13%)

“pressure” and “anxiety, fears” is mentioned by both sub-groups. Besides that, university graduates mention “childhood/upbringing”, “problems with environment”, “genetic” and “financial problems poverty” while non-graduates mentioned “family problems”, “problems with partner”, “stress” and “loss of a beloved person” most often. Especially the categories “family problems” and “problems with partner” are thus put into perspective as it becomes obvious that these terms are more relevant for the sub-group of non-graduates with Turkish immigration background and not for the Turkish group in Germany as a whole.

In summary, the data show that some of the listed terms are specific to cultural background or immigration status. At the same time there are similar differences in terms according to subgroups, shown by the example of persons with and without a university degree. In general the inventory of knowledge about mental health issues appears to be very broad in all the groups and it is barely possible to identify a “cultural” consensus concerning certain categories as even the most mentioned terms were named by not more than half of the interviewees.

4. Discussion

The main findings are that the answers in each group are very heterogeneous and thus it is difficult to name specific vocabulary that is unique for one group. The analysis of listed categories thus shows diverse results as the differences between the groups are as big as the differences within one group.

Concerning the answers of the group of Turkish immigrants with lower education degrees, the question is raised if for this group psychic stress results from family problems and is expressed in social terms. However, counselling institutions (social institutions where social workers work) were not named spontaneously as a help possibility although these answer the needs of people with family problems in the German psycho-social health care system.

Concerning resources in handling mental health problems it can be stated that all three groups name professional help,

although using different terms. While native Germans speak explicitly of “psychotherapy/psychotherapists”, Turkish immigrants name “therapy/therapist”. To what extent these terms are connected to the same meaning has yet to be proven in the next step of the research, the Pile Sorts. In general, the answers concerning professional help resemble each other in the three groups and can be interpreted as low influence of cultural differences. This is strengthened by the fact that no “traditional” help possibilities like hocas were mentioned which extends Penka’s [16] findings that hocas do not play an important role for young Turkish immigrants in seeking help from drug addiction. Thus our findings show that no major cultural divide along spiritual versus medical lines can be observed as some studies suggested [2]. Yet as barriers to the mental health care system in Germany can still be observed for immigrants [9,15], these may not only lie in different ways of expressing mental disorders but problems in communication, e.g. not feeling understood by professionals.

The strength of the study is its semi-qualitative approach. By using open questions interviewees could list items that were truly relevant for them. This explorative method is complemented by counting the frequencies of so found categories and comparing them among groups. As a result the complexity and heterogeneity in expressing mental health problem can be illustrated. Limitations of the study are that the findings reveal vocabulary concerning mental health problems but not the way people act or decide in concrete situations. As the Free Listing is the first step of the research, the next step (Pile Sorts) will show how the categories are connected to each other.

While most of the literature points out to different health beliefs of Turkish immigrants and relate them to tradition, this study shows that there is a large diversity in the Turkish community concerning expressing mental health problems. Especially concerning professional help possibilities (Table 4), answers between native Germans and Turkish immigrants just vary slightly. The differences in answering behaviour according to sub groups matches the results of the representative Sinus study [21] that analyzed everyday life worlds of immigrants in Germany. The results point out to the fact that immigrants with the same ethnic background may belong to quite different everyday-life worlds with different norms and different sub-cultures. Also Bollini and Siem [3] point out to the fact that social background of patients is crucial for utilisation praxis.

For the practical work with patients the results implicate the importance for looking at each case individually, not ignoring cultural factors as well as considering the social and educational background. The avoidance of generalizations is important as health beliefs of patients of the same ethnic origin may vary considerably. One should be careful to judge immigrants’ behaviour through the “cultural” lens like Kürşat-Ahlers stated “It is as if Turkish people have culture and Germans have a psyche” [18]. Therefore it is useful to keep in mind the questions Kleinman noted to elicit concrete explanatory models³ [10], i.e. to ask patients

³ The questions are: What do you call this problem? What do you believe is the cause for this problem? What course do you expect it to take? How serious is it? What do you think does the problem inside your body? How does it affect your body and your mind? What do you fear most about this condition? What do you fear most about the treatment?

for their assumptions about their illness. Using these questions professionals can avoid to walk right into the cultural trap but still be aware of different ways of thinking patients might have.

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Conflict of interest statement

None.

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Health services and the treatment of immigrants: data on service use, interpreting services and immigrant staff members in services across Europe

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ABSTRACT

Keywords:
 Immigrants
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 Europe

Background.- The number of immigrants using health services has increased across Europe. For assessing and improving the quality of care provided for immigrants, information is required on how many immigrants use services, what interpreting services are provided and whether staff members are from immigrant groups.

Methods.- Structured interviews were conducted with 15 health services (9 primary care, 3 emergency departments, 3 mental health) located in areas with high immigrant populations in each of 16 European countries (n=240). Responses were collected on the availability of data on service use by immigrant patients, the provision of interpreting services and immigrant staff members.

Results.- Data on service use by immigrants were recorded by only 15% of services. More than 40% of services did not provide any form of interpreting service and 54% of the services reported having no immigrant staff. Mental health services were more likely to use direct interpreting services, and both mental health and emergency services were more likely to have immigrant staff members.

Discussion.- For assessing and improving the quality of care provided for immigrants, there is a need to improve the availability of data on service use by immigrants in health services throughout Europe and to provide more consistent access to interpreting services.

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1. Introduction

The number of immigrants using health services in Europe has increased in recent years [26], which has given rise to the challenge of maintaining service quality, whilst still meeting the needs of diverse populations of patients [7,8]. A reflection of these changes can be seen in an increase in the research on health service provision for immigrants in Europe [4]. However, there remains a lack of data across several European countries on key service features including: data on service utilization [29], data on the availability of interpreting services, and staff members from immigrant groups. Data on factors such as the availability and use of interpreting services are essential as they represent some of the basic elements of good practice when implementing services for immigrants [22,32].

2. Availability of information about service use among immigrants

Composition and extent of service use by immigrants differ between health services and countries. Information is therefore required to capture the distribution of immigrants actually using services. This requires the recording of disaggregated data on immigrant use within individual health services. At present, information on service use at this level is scarce, limiting the opportunity for comparative analysis across services and countries within Europe [4,26]. Various studies have attempted to describe immigrant preferences for accessing health services. In the United Kingdom, for example, McCrone et al. [27] reported that Somali refugees with mental health issues preferred to seek the help of general practitioners and refugee services, rather than accessing community mental health services. In addition, several other countries have reported that immigrants have a tendency to overuse emergency departments for general health problems [3,10]. Findings such as these emphasise the importance of capturing health service use across different types of service, as well as between countries.

3. Interpreting services

Several challenges can arise when providing health care to meet the needs of immigrants. Notable difficulties have included: the lack of knowledge about the health care system; mistrust of public institutions [15,26]; disparities in the explanatory models of illnesses used in different cultures [19,31]; and lack of complete entitlement to the utilisation of health services [36]. The most frequently mentioned difficulty in providing suitable health care to meet the needs of immigrants has been the barriers in language and communication [2,16,18,35]. For this specific reason, we have focused on the provision of interpreting services in response to challenges associated with language barriers.

Roberts et al. [33] reviewed the evidence on language barriers and concluded that language barriers hamper access to health services [1,23]. Language barriers can also result in longer visit times, fewer visits, more misunderstandings, more emergency room visits, and a reduction in satisfaction with the treatment received [26,40]. Some authors also speculated

that language differences can lead to negative judgements and stereotyping [39].

Health services have attempted to adapt to the linguistic needs of their patients with several solutions aimed at improving communication between practitioners and immigrant patients. One example has been to employ bilingual staff, however this solution favours large services with a high demand for bilingual staff and the resources to adopt this solution for all the main patient languages [21]. Another solution has been the use of interpreting services, which can offer assistance in a variety of languages [9]. The importance of language barriers might differ in different types of health service. For mental health services, language and communication are particularly salient as they represent the principle means for diagnosis and treatment, particularly in the application of psychotherapeutic treatments [20,21].

4. Staff members with immigrant backgrounds

To improve the quality of health services for immigrant patients, authors have argued for the use of 'culturally sensitive' or 'culturally competent' service provisions [6,37]. Some have supported the mainstreaming of cultural sensitivity in all health services, while others have favoured separate service provisions for immigrants [6]. One method for promoting cultural sensitivity has been the use of specific training programmes for health service providers and practitioners. Some experts have recommended actively recruiting staff from the same cultural and ethnic backgrounds as the patient population [11,13,14]. The latter could contribute in both direct and indirect ways to improving understanding between patients and health services. Exposing services to the experience of diverse cultural understandings of health and treatment [31] may increase awareness of cultural norms and values, while indirectly lessening the impact of stereotypical views [12,38]. However, services are primarily concerned with employing staff that are competent in their work. Matching the cultural or ethnic backgrounds of their patients with their staff is a difficult task, and of secondary concern to most services. Nevertheless, a workforce that is more representative of the population from which patients come from, may increase sensitivity to the dynamics of alienation and cultural differences [38].

In this paper, we present the availability of data on service use, immigrant staff, and the provision of interpreting services across 16 European countries and three types of health service. The participating countries were: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Hungary, Italy, Lithuania, Netherlands, Poland, Portugal, Spain, Sweden, and the UK. The range of countries was selected to obtain a cross-European view of data availability and allocation of provisions. In each country, emergency hospital departments, mental health care services and primary care services were included in the study to gather data on the extent to which variations in service use by immigrant patients are based on service type as noted in previous findings (e.g. 4, 9, 25). This study provides a descriptive analysis of data collected from interviews with representative staff from these services, across the participating countries, to identify the availability of routinely collected data across Europe on service use and service provision for immigrants.

5. Method

The data were gathered as part of the project: European Best Practices in Access, Quality and Appropriateness of Health Services for Immigrants in Europe (EUGATE). Questionnaires were conducted with representatives from emergency departments, mental health services and primary care services, across all 16 participating countries. In each country, services were selected based on their location to ensure they provided care to immigrant populations. For each country, three districts within a major city with the highest proportion of immigrants were selected. In most cases the selected major city was the capital, with the exception of Lithuania (Kaunas) and Spain (Barcelona), and four cities were selected instead of three districts for Finland (Malax, Oravais, Pietarsaari & Vaasa) and the Netherlands (Amsterdam, the Hague, Rotterdam & Utrecht). These deviations reflected the different distributions of emergency departments and mental health services in different countries. For a full list of services by country, see previous publication [32].

Once cities and districts were identified, representatives from three emergency departments, three mental health services, and nine primary care services were recruited in each of the 16 participating countries. Resulting in representatives being contacted in 48 emergency services, 48 mental health services, and 144 primary care services across Europe. In total 240 structured interviews were conducted on questions regarding service organisation, utilisation of services by immigrants, and monitoring systems within the services. An interview tool, developed using a Delphi process among partners within the participating countries, was used to collect the necessary data. This tool is publicly available from the EUGATE web page <http://www.eugate.org.uk/outcomes/index.html>.

Immigrants were defined as persons born outside of the country of current residence. In line with EU directives, this included: regular immigrants who are non-EU nationals but legally residing in the country (e.g. labour immigrants); asylum seekers awaiting a decision on their application; refugees as defined in Article 1 of the 1951 Convention; victims of human trafficking; and irregular immigrants as defined as persons who have not been granted permission to enter, or to stay, in a given country (e.g. undocumented immigrants). Immigrant populations were not differentiated on grounds of ethnicity, culture or country of origin for this study, as these data were too heterogeneous for the participating countries.

Data collected included: levels of service utilisation; patient characteristics; existence of any immigrant specific departments, programmes and policies; availability of specialised staff for immigrant patients; staff diversity; interpreting services and evaluation issues. Information collected concerned the preceding 12 months, or the most recent 12 month period for which figures were available. All data were descriptively analysed. The present paper describes findings concerning service use by immigrants, the existence of data registers, the provision of interpreting services, and the presence of staff members from immigrant backgrounds. Results concerning other aspects of the dataset have been published elsewhere [32].

Ethical approval was not required for this study in the participating countries, as no patient data were sought, and the study was regarded as service evaluation.

6. Results

6.1. Availability of data registers

Only 114 of the 240 services (48%) kept data-based usability figures on use of services by all patients. In another 109 services (45%), reported rates were based on estimates. For the remaining 17 health services (7%) neither data on actual figures nor estimated figures were made available to the interviewers.

Data on immigrant status was available for regular immigrants in 8% of services, refugees 7% of services, and asylum seekers 5% of services. Those figures had been lower, than for victims of human trafficking (10% of services) or irregular immigrants (14% of services). See Table 1, for the number of all services with available data on different groups of immigrant patients by status. These figures do not necessarily indicate actual rates of service usage by different immigrant groups based on status, but were more indicative of when information was recorded and for which groups based on immigration status.

There were marked differences on the availability of actual data on all patients and immigrant patients for the different types of services. Comparing the three different types of services, the highest level of data availability for all patients was found in emergency departments, 69% (n=33) of emergency departments had usage data for all patients, followed by mental health services, where 56% of services (n=27) had data for all patients, whereas primary care services had the lowest proportion with 36% of services (n=54). Variations were also noted between countries

Table 1
Proportion of services with available data on the immigration status of patients.

Data available on	All services (n=240)	Primary care (n=144)	Mental health (n=48)	Emergency care (n=48)
All patients in the service	48% (114)	36% (54)	56% (27)	69% (33)
All immigrants patients	15% (35)	10% (14)	25% (12)	19% (9)
Regular immigrant patients	8% (18)	6% (9)	15% (7)	4% (2)
Asylum seeker patients	5% (13)	4% (5)	13% (6)	4% (2)
Refugees patients	7% (16)	5% (7)	13% (6)	6% (3)
Victims of human trafficking patients	10% (24)	10% (14)	13% (6)	8% (4)
Irregular (undocumented) patients	14% (34)	14% (20)	21% (10)	8% (4)

on the availability of service usage data by all patients. In Germany and Austria, only in emergency departments usability figures had been based on data (for the other services, registers had been based on estimates), in Denmark, no data-based figures were available for any of the nine primary care services interviewed, and Finland only kept such data in the mental health services.

The order for the availability of data about service usage among immigrant patients differed from that for all patients. One in four of the mental health services (12 services) registered data on service usage by immigrant patients separately. This was the case for 19% of emergency departments (9 services) and only 10% of primary care services (14 services).

Only 15% of the figures on immigrant patients were based on actual data, while 69% were based on estimates and 16% of professionals interviewed did not provide any general figures on the number of immigrant patients. There was again considerable variation in the availability of data registers across countries. The highest numbers of services collecting data on immigrant patients were in Spain (9 out of 15 services interviewed) and Sweden (6 out of 15 services interviewed), whereas in Austria, Belgium, Denmark, France, Germany and the Netherlands, none of the services interviewed collected data on service use by immigrant patients.

From a country-level perspective: eight countries had at least one service interviewed that collected data on service use by refugees, while seven countries reported as least one service with data on asylum seekers, six countries for victims of human trafficking and 11 countries for irregular immigrants.

6.2. Information on the use of services

Despite the relative sizes of these services, the highest proportion of immigrant patients was found in the mental health services (23%), followed by 16% for primary care services and 13% for emergency departments. There was no overall pattern across the participating countries. Taking all the services into account, the average reported number of immigrant patients was higher in Austria, the Netherlands and Sweden. For emergency departments, this was the case again for Austria and the Netherlands, as well as for Greece. In primary care services, the number of immigrant patients was especially high in France, Germany and the Netherlands. For mental health services immigrant patient numbers were high for Greece, the Netherlands, and Sweden compared with the other participating countries.

6.3. Interpreting services

The dataset distinguished between three different types of interpreting services: 1) direct/face-to-face interpreting services, 2) telephone interpreting services, and 3) a mix of other kinds

of interpreting services, such as bilingual staff and mediators. 53% of services never provided any direct interpreting service, and 59% of responding services never provided a telephone interpreting service. In addition, 24% of the responding services reported always using direct interpreting service for patients with language difficulties, and only 17% of services always used a telephone interpreting service when language barriers were present. For figures on the frequency of availability of direct and telephone interpreting services see Table 2.

The availability of information on interpreting services within the three types of services studied varied across countries. Altogether 101 out of the 240 services (42%) did not provide any form of interpreting service. In Finland, Sweden and the UK, all interviewed services provided some kind of interpreting service. In Denmark, the Netherlands and Spain, 14 out of the 15 services had interpreting services available for immigrant patients. In Greece, no interpreting service use was reported in any of the services, whilst in Lithuania only two services offered some type of interpreting service. By contrast, in Spain, three services offered all the three types of interpreting service listed above (direct, telephone and mixed), followed by Belgium and Germany with two services providing all three types of interpreting service. All of the interviewed services in the UK had access to two different types of interpreting service. The same was the case for 14 of the 15 services in Sweden and 10 of the 15 services in Germany. In Denmark, at least 14 of the 15 services provided one or more of the types of interpreting service.

In addition to these figures, differences were noted between the countries regarding access and use of telephone interpreting services, which were absent in some of the participating countries. For all the services in Austria, Greece and Poland there was no access to such service, and in Germany and Hungary it was only offered by one service of the 15 interviewed.

Except Greece, where there was no interpreting service at all, all other countries had at least one service with a direct interpreting service.

Mental health services most often provided direct interpreting services (35%), followed by emergency departments (23%) and primary care services (20%). Emergency services had a higher proportion of telephone interpreting service use, as time critical care cannot wait for an interpreter to arrive, whilst mental health services provided telephone interpreting services less often than either of the other two types of service.

6.4. Staff members with immigrant background

For the 240 services interviewed in this study, 147 (61%) stated that they employed individuals with immigrant backgrounds among their staff. A quarter of those that did (16% of the total) had only one member of staff with an immigrant background. Eighty

Table 2
Responses given for how often direct and telephone interpreting services were used for patients with a language barrier.

Type of interpreting service	Never used	Sometimes used	Always used
Direct interpreting service (n=239)	53% (128)	23% (54)	24% (57)
Telephone interpreting service (n=211)	59% (124)	24% (50)	17% (37)

eight services (37%) reported having none, while data from five services (2%) were not available to report. In summary, for the 126 (54%) out of the 235 providers for which data were available, either no staff with an immigrant background were employed in the service or only one member of staff with an immigrant background.

In Sweden, all services reported having some immigrant members of staff, followed by Belgium, the Netherlands and the UK (14 out of 15 services interviewed), whereas in Lithuania none of the services reported having immigrants among their staff members. These differences did not appear to be related to variations between countries in terms of service size. The percentage of services that employed immigrants among their staff members was considerably higher within mental health services and emergency departments, than in primary care services (see Table 3 for figures by service type).

7. Discussion

7.1. Main findings

This study highlights the difficulty in investigating service use by immigrant patients, due to limited availability of data on service use for all patients in most of the participating countries, and across the three different types of health service investigated. In nearly half of the participating European countries, none of the services studied had any data available, and the availability of data registers for immigrant patients was much smaller. Only 15% of the services interviewed held any figures for service use by immigrant patients that were based on actual data. In most cases, the data were unavailable or based purely on estimates. These findings could be attributed to lower immigration rates for some European countries, or the view that collecting such data on immigrant patients might be regarded as discriminating or is not considered as necessary for planning service provision. Alternatively, some services and countries may consider current service provision as suitable for meeting the needs of immigrant patients, or that the needs of immigrant patients do not differ greatly from those of nationals.

In terms of specific provisions, the availability and use of interpreting services seemed generally low [5], particularly in primary care where only a few services reported using either direct interpreting, or telephone interpreting services. More than half of the assessed services did not provide any direct interpreting service. Telephone interpreting services were even less often available than direct interpreting services. Considering the lower cost and the relative convenience of organising tel-

ephone interpretation, it is surprising that telephone services are not more widely used.

There was also considerable variation between countries in the use of the different types of interpreting services (direct, telephone, and mixed). Mental health services tended to provide more direct interpreting services, than did primary care services and emergency departments. These findings reflect the structure of the services and the methods they apply to diagnose and treat patients. Longer treatment periods with longer contact sessions with single patients, and a lower case-load affords greater benefits from using more direct interpreting services. Where communication timing is more critical, as is often the case in emergency departments, then telephone interpreting services offer more distinct advantages and are therefore more widely used. The choice of interpreting service needs to compliment the way services actually function, in order to provide a suitable and effective health care.

For the Scandinavian countries participating in the study, Spain, the UK, and the Netherlands, interpreting services tended to be more mainstreamed in their delivery for immigrant patients. This was quite different for Austria, Finland, Greece and Lithuania, where there was either no interpreting services available or only very few services. For Finland and Lithuania, this could be attributed to immigration and health service provision for immigrants being a relatively new issue for policy and practice, but this would not explain the case for Austria. While for Denmark, Finland, Sweden, Spain and the UK, there were regulations and policies concerning the costs of interpretation. This is not the case for Austria and Germany, where the costs are not covered by state funds or health insurance regulation [21]. In the Netherlands, interpreting services have been provided free by the government since 1985, but these subsidies are to be abolished from 2012 [28].

The data presented here indicate wide heterogeneity between the 16 countries and the three types of services studied in terms of the provision of services for immigrant patients. Some of the data seemed to suggest that countries with fewer individuals from immigrant backgrounds tended to have fewer immigrant staff members employed within their services. Also to test this hypothesis further, research is required to compare these data with data on the different backgrounds of immigrant groups served within the catchment areas of these services.

7.2. Comparison with literature

In keeping with previous studies, our data confirms that very little data is available on the use of health services by immigrant patients. Unlike the study conducted by Nielsen et al. [29], which surveyed national statistics agencies and relevant national health authorities, the EUGATE study was based on a direct assessment of service provision. These two approaches for gathering information on the use of health services by immigrant patients yielded similar results. But Nielsen et al. found registry data on the utilization of health services at least in 11 European countries (Austria, Belgium, Denmark, Finland, Greece, Italy, Luxembourg, the Netherlands, Poland, Slovenia and Sweden). Austria, Belgium, Denmark and the Netherlands were included in the EUGATE study, but no registry data were available at the service provider level for these four countries.

Table 3
Responses given for whether immigrants were among staff members employed by services.

Service type	Immigrants among staff employed by the service	
	Yes	No
Primary care (n=142)	54% (77)	46% (65)
Emergency care (n=47)	74% (35)	26% (12)
Mental health care (n=46)	76% (35)	24% (11)

Studies in some European countries have shown that immigrants tend to make more use of emergency departments than national born populations do [3,30,34]. Secondary or tertiary services, such as mental health services [24,26], tend to be used to a lesser extent by immigrant patients. For this study, data records were either too fragmented or totally missing in the majority of cases for previous findings to be compared with our dataset.

Our study was able to suggest that telephone interpreting services were more frequently used in emergency departments, a finding confirmed in previous studies. Leman [25] pointed out that telephone interpreting services were more appropriate for emergency departments for their immediate availability and 24 hour coverage. He stated that there has been an enormous effort in the UK to improve telephone interpreting services, especially for emergency departments [25]. Our data extends this finding somewhat to other European countries. However, several countries did not provide any form of telephone interpreting services in any of the three types of health services included in this study. The impact of the missing payment regulations in some of the participating countries might have been one of the reasons for the lack of interpreting services in some of the services assessed [5,16].

7.3. Strengths and Limitations

This study had a wide scope, including service providers from three different types of services in 16 European countries. The collaboration of partners from different European countries, and research centres, was regarded as an advantage when collecting data from local health services. However, the limited availability of suitable data in these services restricted the analyses that could be conducted on this dataset. Collecting data simultaneously in multiple countries also had its limitations, especially when local factors, such as the definition of an immigrant, differ from country to country [17]. Considerable design and planning was required to produce consistent assessment tools, agreement on definitions of the several immigrant groups, the types of services studied, as well as providing training of interviewers across countries to ensure consistent data collection for comparative analyses. Despite the efforts to ensure consistency of study procedures, a degree of variation should be taken into account in line with national variations on local policy and health service practice.

Furthermore, only a small fraction of the total number of service providers in each country was included in this study. By singling out services situated in the largest cities, in areas with the highest proportion of immigrants among the population, we encountered the services with the most challenges in the provision of health services to immigrants. The findings presented here as a consequence, would most probably misrepresent the situation in rural services and services in smaller urban areas.

7.4. Implications

A better knowledge base and further scoping studies are required on the use of health services by immigrant patients for valid conclusions to be drawn at the national level in most

European countries. An obvious next step would be to relate national data on the use of health services by immigrants, to percentages of immigrants located in areas served by these services.

Although interpreting services were regarded as one of the most important elements of appropriate health care delivery for many immigrant patients in the literature [7,8], several European countries have yet to take steps to implement such services. Provisions for covering the costs of interpreting services are rare; the absence of such provisions in countries like Germany is one factor contributing towards the low availability of interpreting services [21]. By contrast, in Sweden where the costs of interpretation are covered by the government [9], there is a high level of interpreting service availability. Such variations are likely to have an impact on both the utilization of services and their quality in terms of patient satisfaction. Due to recent cut backs in the financing of interpreting services, as had been the case in the Netherlands, the development of such services across European countries might be on the decline.

The discussion on the employment of staff with immigrant backgrounds needs to be informed by the extent to which immigrants use certain health services, and whether the employment of staff from immigrant backgrounds actually increases integration, sharing of cultural practices, and acceptance of immigrants into mainstream services and society. Also, previous papers from the EUGATE project have suggested advantages for both the inclusion of qualified staff from immigrant backgrounds, and the training of all health service staff on cultural sensitivity and the specific needs of immigrant patients [6].

Summarising the data presented in this paper, there is still a lack of general good quality data within health services on the use and service provisions for immigrant patients across European countries. Notwithstanding, some differences do exist between countries and different types of health service. The findings presented here do increase the knowledge base somewhat for services providing health care in areas densely populated with immigrants, particularly on the availability and use of interpreting services and employment of staff with immigrant backgrounds.

Conflict of interest statement

None.

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The concept of “intercultural opening”: the development of an assessment tool for the appraisal of its current implementation in the mental health care system

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ABSTRACT

Keywords:
Immigration
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Assessment tool

The German concept of “intercultural opening” is an approach to facilitating migrants' access to the health care system and improving the care they receive. No data exist concerning the current status of the implementation of this approach in Germany, and the concept has never been analysed in practice. To assess the status of “intercultural opening” in the German mental health care system and to further analyse the concept, we developed a tool by combining pre-existing instruments. In order to review the preliminary tool we combined experts' knowledge by carrying out a consensus-oriented, expert-based Delphi process with actual practice by piloting the instrument in each type of institution to be assessed. The assessment tool thus developed¹ is the first one to evaluate the current status of “intercultural opening” in the community mental health care system in Germany from a broad perspective. This paper is intended to present the development process of our assessment tool for demonstrating the benefits of this approach and as a model for future studies, as well as to increase transparency in relation to the current German approach to health care structures in dealing with migrants.

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1. Introduction

In the past, European countries have developed different approaches to improve the accessibility and quality of health and social care services for migrants. In the United Kingdom, for example, an approach named “Equality and Diversity Strategy” has been implemented while other European countries like Italy and the Netherlands have adopted “intercultural health strategies” [23], based on “cultural competence” concepts borrowed from the United States [1,3]. Since the 1990s, an approach called “intercultural opening” [2,13] has been promoted as a way of improving the accessibility and quality of services for migrants in Germany. Based on this approach, guidelines for the mental health care system were announced by professional psychiatric

associations in 2002 [22]. Researchers and practitioners started to face the fact that immigration into Germany and the integration of migrants could only be successful if German society changed and started adapting to the needs of these citizens [17]. Particular importance was placed on changing the way German institutions dealt with migrants.

The basic principle of the concept of “intercultural opening” is to change institutions to improve the accessibility and quality of services for migrants. Each institution should be competent to ensure equal access and quality for all migrants regardless of their country of origin or native language. “Intercultural opening” represents a long-term process of organizational development with consequences for structure, processes and results [12]. Its goals include different main approaches on four various levels (Fig. 1).

In 2004, a new immigration law (ZuwG) was passed. For the first time, the integration of foreigners was defined by law

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¹ See: http://www.segemi.de/delphiprozess/download/IKOE_P_1_English.pdf

Management level	<ul style="list-style-type: none"> - Managements "top-down" initiative, support/ promotion of concept's implementation, staff standing behind change of management ("bottom-up") [27] - Implementation of migrant-sensitive skill enhancement and supervision by management [14]
Organizational level	<ul style="list-style-type: none"> - Inclusion of goal of "intercultural opening" into institution's policy [14] - Installation of ombudsman to make sure migrants' concerns are being heard if interests are not equally considered [6] - Networking and cooperation with migrant organizations and migrant communities [12] - Consideration/ promotion of employees with migration background to offer treatment in native language, to create "intercultural working teams" etc. [14,2] - Encouragement of treatment of clients by teams of professionals consisting of people both with and without an immigration background to learn from each other [25]. - Promotion of discussions about immigration, culture, each professional's cultural competence [14,25]
Structural level	<ul style="list-style-type: none"> - Documentation of goal of "intercultural opening" by e.g. displaying information material, newspapers in waiting areas in different languages [14] - Consideration of religious issues in food services [22] - Consideration of religious holidays in everyday practice [22] - Employment of cross-culturally trained interpreters [22]
Outcome level	<ul style="list-style-type: none"> - Consideration of criteria related to migration background (e.g. mother tongue, country of origin) in evaluation of client/ patient data [27] - Comparison of data about clients/ patients with migration background with data from native population of the area [27]

Fig. 1. Main approaches of "intercultural opening".

as a political and societal challenge [24]. In 2007, the German government announced a nationwide integration plan [9], which includes the official goal of implementing the concept of "intercultural opening" in all German health and welfare systems.

2. Background

No data exists on the current status of the concept's implementation in the German mental health care system. Studies are available concerning arrangements for migrants within the mental health care system, but they do not adequately cover the concept of "intercultural opening" [18-20]. Instead, they focus on data about care utilization by migrants and/or services provided for this population group. Not every aspect of the concept has been taken into account, nor has there been a survey of an entire service delivery system. A thorough study of a single system is important in order to make statements about the situation of migrants with regard to (mental) health care provision. In general, scientific reflection on the concept of "intercultural opening" has also been scarce [4].

Our study project, funded by the VW Foundation, analyzes the concept of "intercultural opening" in three ways: by assessing the current status of implementation in one community mental health care system, by conducting semi-structured interviews with staff and migrants as clients/patients, and by doing fieldwork in selected institutions, depending on their status of implementation.

To examine the status of the concept of "intercultural opening" in the German mental health care system we are assessing the community mental health care system in one Berlin district. In Germany, community mental health care is based on sectorization. Each institution is responsible for a geographical region and is therefore accessible for each resident of this area. With few exceptions interregional cooperation is not possible. Sectors usually correspond to municipal districts or counties. Each Berlin district one mental health care sector, which provides inpatient care, day hospital care, outpatient services and complementary

care (e.g. in the home or workplace of the patient, support with daily activities, rooms in flats, etc) [26]. The study group's aim is to assess one district in Berlin, because it represents a closed system, comparable with other urban sectors in Germany. Thorough results are expected as it will be possible to examine whether the migrants living in this sector are being reached by the system.

An assessment tool was developed for assessing the current status of implementation of the "intercultural opening" approach. This paper focuses on the process of the development of this tool in order to demonstrate the benefits of our approach, suggest a model for future studies and increase transparency in relation to the current German approach of health care structures in dealing with migrants.

3. Methods and preliminary results

3.1. The development of a preliminary assessment tool

In Germany checklists and assessment tools for evaluating the status of "intercultural opening" do exist. However these were either created for self-examination [5,15,29], or they focus only on certain aspects of the concept such as migrant-specific offers and number of migrants using the service, and do not cover it adequately². Additionally, they have yet to be validated. European questionnaires [16] were not valuable for our study project as they do not reflect the specific German concept of "intercultural opening" in detail which was in our focus. The use of questionnaires from the United States assessing "cultural Competence" at the agency level [28] did not appear useful as no analysis exists comparing the approaches for consistency with one another.

Instead of simply taking one of the German checklists or assessment tools over, both inadequate for the purpose of

² see e.g. „Landesverband Rheinland, Befragung des Arbeitskreises Migration der Rheinischen Kliniken zu migrationspezifischen Angeboten in der Gemeindepsychiatrie" [not published]

our study, we composed an assessment tool in the form of a checklist based on them. Because our research is focusing on the concept of “intercultural opening” as it moves at an abstract and cross-institutional level, tailoring different modules for different settings of institutions was deemed unnecessary. For general information about the institutions in the study, we used one part of a questionnaire from a former study project. The preliminary assessment tool we developed included 17 different parts and 17.5 pages.

A further review of the instrument was essential in order to insure that the developed tool incorporated all facets of “intercultural opening”, that it was applicable to every type of institution later assessed and to shorten it. We used two methods combining theoretical and practical views in two subsequent steps.

3.2. Web-based, two-round consensus-oriented Delphi process

As the concept of “intercultural opening” is an expert-designed concept, in a first step, we used a web-based expert interview, based on a two-round consensus-oriented Delphi process [21] to review the developed instrument for missing aspects of the instrument and, if possible, to shorten it.

The general idea of the Delphi approach is to collect expert opinions on a topic in successive interview rounds and to publish the anonymous results from each round to everybody in the next round. Some Delphi approaches are consensus-oriented, which means that the desired goal of the Delphi process is consensus. The number of participants in Delphi processes has varied in other studies [11]. We decided to interview 12 leading German experts (see acknowledgment) with experience and/or expertises in the fields of immigration, improving access to care for migrants, and the concept of “intercultural opening”. These experts come from both scientific and practical background, which also speaks to their different views on the topic of “intercultural opening”. The participants were chosen by conducting a research for experts in these fields as well as by recommendations of experts [11]. They were contacted by email and asked for their participation. Only four out of the twelve selected experts declined participation and were substituted by four different recommended experts from the same areas as those who had declined to participate. One expert had to be excluded after the first round due to incomplete answers.

3.2.1. First round of Delphi process

The first round of the Delphi process via internet was conducted from October 2010 until early January 2011. A website was created displaying the preliminary assessment tool as developed to that point. In the first round, three questions were used to evaluate each item in the assessment tool and its corresponding response categories. The first question concerned the significance of the particular items in the context of “intercultural opening”, with the response categories “very important”, “important”, “less important” and “not important

at all”. The other questions asked for an assessment of the question’s wording and for comments on the questions/items and response categories in general. Overall 170 items had to be rated by the interviewed experts. After the data were collected, the results of the first round were analysed.

Because of our primary goal of shortening the tool, essential criterion were defined as being rated “important” or “very important” by every expert. Each item that was judged as either “important” or “very important” by all experts (“Md” 12) was considered consensual and essential for determining the status of “intercultural opening”. Items reaching this criterion were kept in the assessment tool. Those which did not reach the criterion were presented again for evaluation in the following round.

3.2.2. Results of the first round of Delphi process

In the first round, 62 items reached the definition of consensus and were therefore approved for use in the assessment tool, thus playing no further role in the second round. 108 items, on the other hand, had failed this condition, not having been judged as “important” or “very important” by all experts. However, the majority of these items were judged as less or not important by only one or two experts. 41 items, for example, had been rated by only one expert as “less important”, while 13 by only one expert as “not at all important”. 54 items thereby only reached Md= 10 within the field of “importance”. 31 items had been judged by two experts as not (very) important (Md= 9).

In addition, we worked some changes into the questionnaire based on the comments given regarding the open questions. Some items were made more specific, as experts had told us that they could easily be misunderstood. Some response categories were added that experts had missed. Some questions were split into two, which explains the higher number of items to be judged in the second round.

3.2.3. Second round of Delphi process

The second round of Delphi process took place between January and February 2011. We displayed the revised questionnaire on the website. Only the 116 items and the corresponding response not found consensual in the first round were included. Every participant was asked to evaluate them again. We published the ratings of each of these items in the first Delphi round. In order to get new reflections and judgement of the topic and to avoid simple repetition, we did not inform participants about their own previous judgements [11].

3.2.4. Results of the second round of Delphi process

We analysed the collected data using the same criterion as in the first round. However, after the second round items which did not reach the criterion of consensus were taken out of the assessment tool. 65 items reached consensus in the second round while 51 did not. Again the majority of these items were judged as less or not important by no more than

one or two experts, e.g. 27 had been rated by only one expert as “less important” and 11 by only one expert as “not at all important” (Md=10).

After two rounds of expert-based Delphi process 127 items have been confirmed and are therefore part of the revised final assessment tool which was created. None of the original 17 main topics missed the defined consensus. Only subordinated items failed consensus and therefore had to be deleted (e.g. form and length of supervision, ethnical background of clients/patients, rates of drop out).

But contrary to the result of the Delphi process we decided to keep some items in the assessment tool, which should have been taken out. This concerned issues important for the structure of the tool other questions were based on, e.g. the question for job advertisement in the previous four years seemed important to us as the following question, if positions could have been filled with persons with migration background, based on it. As well we decided to resume the question about the ethnic background of patients/clients with migration background in the assessment tool. The question seemed imperative to us as the upcoming assessment of the current status of “intercultural opening” is aiming to check whether or not every group of migrants is reached by the mental health care system.

In the end, the assessment tool piloted by the Delphi process still comprised 15.5 pages and 147 items.

3.3. Pilot-survey using the developed preliminary assessment tool

Our intention is to assess each institution in the community mental health care system in one Berlin district using the same instrument for each kind of institution, which therefore had to be applicable to all of them. For this reason, we piloted our revised assessment tool in every relevant type of institution to verify applicability and to possibly make further revisions. The focus in this process was on missing response categories, as well as on possible misunderstandings or lack of pertinence. A manual was developed containing instructions and notes for interviewers. Three members of our study group had been trained in advance in doing the interviews.

In the pilot assessment, 14 facilities of the community mental health care system, three different types of psychosomatic services and one migrant-specific offer, later also be assessed in Berlin's district Mitte, were included (Fig. 2). Private practice psychiatrists and psychotherapists were excluded as the concept of “intercultural opening” applies to institutional structures, which do not usually exist in these services. A list was made of institutions not located in the later assessed district but in other Berlin districts, representing each relevant type of institution. We chose three institutions of each type randomly distributed over Berlin. The goal was to conduct at least one interview with representatives from each type of institution. In the end, 17 representatives, mainly project managers, of 15 different types of institutions were interviewed. The course of each interview was documented to identify relevant items not covered by our assessment tool, as well as less feasible questions and reactions of the interviewees. We analysed these protocols and incorporated the results into the revised questionnaire.

Assisted forms in the field of living - Assisted living (1) - Therapeutic living communities in one flat (2) - Therapeutic living communities of separate 1- person flats (3) - Transitional residence (4)
Contact and Counselling Centre (5)
Additional income project (6)
Psychiatric Clinical services - inpatient offer (7) - outpatient offer (8) - outpatient day clinic (9)
Day Care Centre (10)
Berlin Crisis Service (11)
The Sociopsychiatric Service (12)
Sociotherapy (13)
(Drug) Addiction Counselling Centre (14)
Migrant-specific offer (15)
Psychosomatic clinical services - inpatient clinic (16) - outpatient clinic (17) - outpatient day clinic (18)

Fig. 2. Institutions included into the pilot study.

3.3.1. Preliminary results from the pilot survey

In general, the pilot study confirmed the applicability of the tool. Response categories had to be added as they were deemed necessary to represent the day-to-day practices of some types of institutions. With regard to the question for access routes to facilities of clients/patients “counselling center” and “administration office” had to be complemented in the assessment tool. Concerning criteria on which the number of clients/patients of an institution are based, additional response categories, e.g. “persons”, “appointments” and “hospital admissions” were included as they were missing before. One item eliminated in the Delphi process had to be included again, regarding the use of freelance professionals in an institution. The pilot assessment showed the importance of the item, as freelancers appeared to play an important part in some institutions because the institutions tend to employ freelance staff with an immigration background. Some additions had to be done with regard to information about facilities working inter-regionally (e.g. percentage of clients/patients from the later assessed district). Other questions were split into two. Only the question for the differentiation of employees by gender had to be eliminated as it proved too time-consuming for interviewees of larger working units.

Furthermore we received important information for improving data collection in the upcoming assessment of one Berlin district. As some interviewees did not have details available for answering questions about numbers of e.g. clients or employees, we decided to send in advance an excerpt of every question concerning statistical data. Concerning the status of interviewees clinic directors seemed not to be involved in the everyday practice of each service of their institution and therefore are excluded from participation. Project managers are also excluded from the upcoming assessment if they are not involved into the actual treatment/care. Each respondent must have been employed the entire year in question in the facility.

With regard to content, the pilot assessment revealed weaknesses in the explanation of questions and instructions for interviewers. We were able to improve this for the assessment of the community mental health care system in Mitte district.

Overall the assessment tool could not be shortened by the pilot survey. Instead, in the end, it comprised 16.5 pages/157 items. But the length of the documented interviews appeared feasible with an average number of 1.5 hours duration. Interviewees did not complain about it and seemed to be motivated. As a final product, an assessment tool for the current status of “intercultural opening” in the community mental health care system³ was developed using a three-stage procedure (Fig. 3).

4. Discussion

Based on pre-existing questionnaires and checklists [15,5,29] aiming to assess interculturally opened institutions but either developed for self-examination, focusing only on specific aspects of “intercultural opening” and missing validation we constructed a tool for broad assessment via an expert-based Delphi process and pilot study. The resulting assessment tool is the first one to give an all-around assessment of the current status of “intercultural opening” in mental health care sector in Germany. It could be used in further studies as well as an instrument for self-evaluation and quality management. With little changes concerning response categories the tool could also be used in other care facilities, which should be piloted first.

To a very large extent, the experts of the Delphi process felt that all the items in the preliminary assessment tool composing “intercultural opening” were essential. But as an assessment tool should not be too long, we had to apply a strict definition of consensus of the Delphi process. We could not take into account at least one dissenter ($x_{mod}=10$). The definition of $x_{mod}=10$ would have identified further 54 items reaching consensus which therefore should have been kept in the assessment tool.

Nevertheless each main topic of the developed preliminary instrument was confirmed by the experts of the Delphi process. Only subordinated items were dropped out. Contrary to the result of the Delphi process we decided to keep questions in the assessment tool concerning issues being important for the structure of the tool or for one goal of the upcoming assessment.

Because of the definition of consensus used in the Delphi process, we did not take into account the exact distribution of expert opinions with regard to the judgment of “very important” or “important”. Therefore we decided to use these distributions for building up a scale judging the current status of “intercultural opening” of each assessed institution in detail when analyzing the data. That means the implementation of aspects which have mostly been judged as very important by experts in the Delphi process have to be weighted higher than others which have mainly been validated as “important”.

The pilot study represented another important part, as it combined theoretical with practical expertise. Further revision and optimization of the preliminary assessment tool was

possible, as it gave important insight into the actual practice of each type of institution. One item, taken out of the assessment tool as a result of the Delphi process, had to be added again as its importance in actual practice became apparent in the pilot survey data. This example highlights the importance of our three-stage procedure, as Linstone pointed out that a panel of experts does not constitute expertise on human behavior, group dynamics and the whole system [21].

In the pilot survey we did not ask interviewees for missing aspects with regard to improved accessibility and the quality of treatment of migrants as the goal of the study project is to check the concepts' implementation, which has been discussed in Germany for many years, and its actual effect on the actual practice. Through additional fieldwork and qualitative interviews in selected institutions we will gain some more details about experiences and opinions of staff which will be important for the later evaluation of the concept of “intercultural opening”.

As the assessment of the current status of “intercultural opening” is at risk of being influenced by answers given for reasons of “social desirability”, we can also compensate this with these additional methods and complete the results.

Our tool is directed to assess institutional level policies, however individual cultural competencies are a crucial part of the institutional level concept of “intercultural opening” [2,13,14,25]. Therefore, we decided to assess the cultural competency of the staff in some selected institutions in parallel independently from our survey applying one pre-existing checklist [e.g. 10].

In Germany and other European countries a new approach is increasingly needed for dealing with barriers to social or health care systems and improving quality of treatment for migrants, based on “responsiveness to diversity” [8,7]. Contrary to “intercultural health strategies”, diversity concepts focus on all aspects of the variety of pluralistic societies, e.g. gender, disabilities, marginalized population, socio-economic status [27]. One of the multiple benefits is that the focus is no longer placed on migrants and therefore the reproduction of difference in terms of migrants is softened. However in Germany, the adoption of this approach is only reluctantly accepted [27], while the concept of “intercultural opening” has achieved political and practical support and gained a central status. The developed tool represents the German concept of “intercultural opening” and does not aim at Diversity Strategies being increasingly important in Europe [7,8]. We decided to pick Germany up where the actual political and practical discussion is right now. With the help of the investigation of the concept of “intercultural opening”, on which our study project is focusing, the discussion in Germany will perhaps be pushed forward.

No comparisons exist about European “intercultural health strategies” [23] and the “Cultural Competence” approach of the United States [1,3], which at first glance appear very similar. Even within Europe, there is little known about the actual procedure of each country in detail. A future goal might be an analysis about these different approaches for improving global transparency in dealing challenges of migration.

In addition to the detailed presentation of the development process of our assessment tool for demonstrating the benefits of our approach and being a model for future studies, this paper has intended to increase transparency in relation to the current German approach of health care structures in dealing with migrants.

³ See: http://www.segemi.de/delphiprozess/download/IKOE_P_1_English.pdf

Item	Subpoints
1. Institution	1.1. General information about institution (function, profession of interviewee etc.) 1.2 Policy of institution (existing policy)
2. Staff	2.1 Number of staff in previous year (divided by salaried employees, freelancers, trainees etc.) 2.2 Information about staff with migration background (divided by salaried employees, freelancers, etc; country of origin) 2.3 Job advertisements (in the last four years, migrants encouraged to apply, filled by migrant) 2.4 Occupational categories (number of staff per occupation, number of migrants per profession, number of employees without German citizenship)
3. Clients/ Patients general	3.1 Number of clients/ patients (number previous year, data base)
4. Clients/ Patients with migration background	4.1 Utilisation by migrants (subjective assessment of claims made by migrants, reasons) 4.2 Information about migration background (recording data relation to migration background, etc.) 4.3 Number of clients/ patients with migration background in previous year (number, data base)
5. Access	5.1 Access routes to institution (number of clients/ patients per each route, predominant routes by migrants)
6. Aftercare	6.1 Aftercare (specialized aftercare protocols, inclusion of contacts with intercultural or migrant- specific facilities, description)
7. Migrant-specific offers	7.1 Migrant specific offers (existing migrant specific offers, description, reasons for (non-) existing)
8. Facilities and services	8.1 Offer of facilities and services (Non-German newspapers in public areas; multilingual door plates, inscriptions etc. in and outside of institution; rooms for religious practices; provision of suitable food according to religion etc.)
9. Linguistic communication	9.1 Language skills of staff (number and names of foreign languages and mother tongue of staff divided by occupation) 9.2 Linguistic communication with Non-German speaking clients/ patients (percentage of clients / patients care / treatment in German language not being possible; frequency of communication with the help of use of gestures, persons accompanying client/ patient, use of native-speaking employees, use of professional interpreter etc.) 9.3 Interpreters (work with interpreters, frequency of involvement, financing of interpreters, Reasons for non- involvement of interpreters etc.) 9.4 Cultural mediation (Provision of cultural mediation, description)
10. Continuing intercultural education, cultural competence and team-work	10.1 Continuing education on intercultural subjects, intercultural competence and intercultural team work (participation of employees in continuing education on these topics, encouragement by management to participate, employees regularly asked to participate etc.) 10.2 Intercultural competence (understanding of intercultural competence of interviewee, intercultural competence of staff etc.) 10.3 Intercultural team work (employees with migration background in charge of clients/ patients with migration background, existing tandem-counseling etc.) 10.4 Case discussion (consideration of cultural and migration-specific aspects, frequency of taking into consideration, occupational groups taking part etc.) 10.5 Supervision (employees receiving supervision; frequency; occupational groups participating, consideration of subjects interaction with migrants etc.)
11. Survey of demand, demand planning	11.1 Quality control (employed measures, consideration of persons with migration background or migrant-specific topics, how)
12. Information	12.1 Information material and information paths (information leaflets in various languages, client-/ patient- information in various languages, multilingual website, outreach activities in migrant community structures etc.)
13. Empowerment/ Participation of migrants	13.1 Contact person for migrants (existing contact point/ contact person for patients / clients in general, support of specific migrant- issues etc.) 13.2 Self-help groups (support of patients/ clients in finding or founding self- help group, support of migrants etc.)
14. Cooperation	14.1 Cooperation with institutions (existing cooperation, with whom)
15. Intercultural opening	15.1 Management Level (support/ promotion of intercultural opening by management, management interested in improving care/ treatment of migrants, person with migration background employed at management level etc.)
16. Goals reached	16.1 Services utilized by persons with migration background to equal degree as other clients/ patients
17. Outlook	17.1 Estimation with regard to equal access to psychosocial care compared to indigenous Germans 17.2 Kind of interaction generally likened to see in psycho-social care

Fig. 3. The final assessment tool.

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Conflict of interest statement

None.

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Cross-cultural training in mental health care – challenges and experiences from Sweden and Germany

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ABSTRACT

Keywords:
 Cross-culture
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Globalization and cultural diversity challenge mental health care in Europe. Sensitivity to culture in mental health care benefits effective delivery of care to the individual patient and can be a contribution to the larger project of building a tolerant multicultural society. Pivotal for improving cultural sensitivity in mental health care is knowledge in cross-cultural psychiatry, psychology, nursing and related fields among professionals and accordingly training of students and mental health professionals. This paper will give an overview, and a critical examination, of current conceptualisation of cross-cultural mental health training. From German and Swedish experiences the need for cross-cultural training and clinical research on evaluation will be presented.

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1. Introduction

Sensitivity to culture in mental health care benefits effective delivery of care to the individual patient and can play a role in the larger project of building a tolerant multicultural society including space for diverse traditions, value systems and social cohesion [22]. Among the common basic principles for immigrant integration policy in the European Union are the acceptance of diverse culture and immigrants' right to access to institutions as well as to public services on a basis equal to national citizens and in a non-discriminatory way [15]).

European studies have identified migration as a risk factor for schizophrenia, especially for migrants from developing countries and second generation migrants [13]. Migration and acculturative stress are associated with depressive symptoms [26,21]. Refugees leave situations of social conflicts and human rights abuse. Traumatic events may lead to psychiatric disorders such as PTSD (Post Traumatic Stress Disorder), major depression, specific phobias, personality disorders and panic disorders [18,42].

In multicultural areas mental health care services are challenged not only by the fact that migration, especially forced migration, may be a risk factor for a worse mental health status [17], but also that the diagnostic procedure can be more challenging as symptoms of mental disorders may be influenced by cultural background [2]. In Germany, a migration background is also associated with lower access to, and use of, inpatient and outpatient mental health care services [31,32] and a higher level of overall mental stress at the beginning of the treatment and partly worse treatment results [32]. The treatment process can be associated with language barriers [52], cultural diverse health belief models [35] and negative feelings on behalf of the staff in encounters with foreign patients in mental health care institutions [50].

Models in health care for responding to the diversity in multicultural societies vary within the EU [23]. For example, in France and the UK migration has been patterned by the colonial history. Therefore the responses in France have emphasised traditional healing and in the UK on the fight against racism [23]. In general the health care systems respond to cultural diversity with regard to their migration patterns, national politics and national history of health care delivery.

In this paper an overview and a critical examination will be given of current conceptualisation of cross-cultural mental health training. The need for conceptualisation of

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cross-cultural mental health training and further research on evaluation will be discussed. The need for the development of cross-cultural training will be exemplified from German and Swedish experiences. Development is necessary as both Germany and Sweden have a high proportion of migrants and refugees, and a scanty history of institutionalized support for cross-cultural mental health training. Both countries face the urgent challenge to adapt mental health care to the increasingly more culturally diverse population in combination with some form of social and political acceptance for adaptation of mental health care delivery.

2. Cultural diversity and mental health care in Sweden and Germany

In the EU-27 states there are currently 47.3 million foreign-born residents, corresponding to 9.4% of the total population [16], 1.6 million recognised refugees and about 514,000 stateless people living in the EU-27 [47]. In Sweden, immigration consists to a great extent of refugee immigration and family reunions. First and second generation migrants in Sweden constitute 18.6% [40] of the population. The main country of origin is Finland (172,218 persons), followed by Iraq (117,919 persons) and former Yugoslavia/ Serbia Montenegro (71,578 persons). The total population is 9.3 million [40].

Germany currently has 16 million people with a so-called migration background. These are foreign-born residents and their offspring, which is an equivalent of 19% of the general population of 82 million [41]. Germany is the industrialized nation with the largest refugee population (594,000) [18]. The largest migration groups are comprised of people with their roots in Turkey (3.0 million), in the succession states of the former Soviet Union (2.9 million) and in the succession states of the former Yugoslavia (1.5) [41].

Sweden and Germany have made various attempts to adapt the mental health care system to the needs of patients with a migration and cultural minority background. In Sweden, clinics for treating victims of trauma were established in the 1980s. The use of interpreters is free of charge and separately financed. Over the years there have been several local time-limited projects on improving care for refugees and migrants [3].

In 1999 the Transcultural Centre was established by Stockholm County Council, the regional government responsible for care in the area of Greater Stockholm. Today the Transcultural Centre offers support and training to health professionals in hospitals and local health care units in psychiatric care, somatic care and dental care in the Stockholm area. The Centre also provides supervision, networking, and information regarding issues related to culture, migration and asylum and refugee status [3].

Until recently very little has been done to educate immigrants and refugees about the possibilities of, and routes to, the (mental) health care system. In the past few years projects with health communicators have been established in some counties in Sweden. The health communicators inform newcomers about health care and health-related issues [4].

In Germany, psychological counselling services were the first institutions in the 1970s offering specialised services for

migrants. Since then a movement called "intercultural opening" ("Interkulturelle Öffnung") has tried to focus more on the needs of patients with a migration background [20]. More and more bilingual in- and outpatient treatment programs have been implemented. Currently more than two dozen institutions offer such a bilingual psychotherapeutic treatment program [33]. A major impact was a health political movement to improve the psychiatric, psychotherapeutic as well as the general practitioners' health care service for migrants resulting in the "12 Sonnenberger Guidelines" [29]. These addressed issues of easier access to psychosocial health care institutions, cross-cultural sensitive and competent staff with heterogeneous cultural background, organisation and usage of psychological trained interpreters, provision of information material in different languages as well as specific (further) education opportunities.

3. Cross-cultural training

3.1. Conceptualisation of cross-cultural training

Conceptualisation of training to improve professionals' capacity to work with culturally different patients has often, especially in the USA, been in terms of cultural competence training [37]. Qureshi et al [37] point to that cultural competence represent an approach in the provision of mental health service and that is not a unitary concept, but rather a generic term that has no fixed definition. This is apparent given the vast amount of definitions as well as models of cross-cultural competence [12,14]. The National Centre for Cultural Competence in the USA define cultural competence as a developmental process that evolves over an extended period where both individuals and organisations are at various levels of awareness, knowledge and skills along the cultural competence continuum [34].

In general, cultural competence training aims to increase cultural awareness, knowledge and skills of the staff and to modify their sensitivity and behaviour as well as to improve patient-staff interaction. It is seen as an instrument to improve communication between health-care providers and patients. Tseng [46] adds the aspect of cultural appropriate attitudes and empathy. Cross-cultural competence is seen as an on-going, active and nonlinear process [43].

How competence training has been carried out varies. It has a broad spectrum of approaches with regard to target group, duration, content and method. Published cultural competency training programmes have been developed for different health care groups, e.g. medical students [25], nurses [12], physicians [30], mental health counsellors [48], geriatric care settings [51] and mixed groups of mental health care providers [49]. Training can vary from 4 hours [48] to 10 weeks full-time [19] and the contents in general health care settings range from language training, specific cultural content, general concepts of culture to patient-provider interaction [36]. Little content has been published specifically regarding cultural competence training in mental health care settings [9].

The concept of cultural competence has been criticised. Kleinman and Benson, e.g. [24] point out that it is not defined and operationalized for clinical training and best practice. Further, that a major problem with the idea of cultural competence is that it suggests that culture can be reduced to a technical skill. The popularity of the cultural competence concept in the USA might be related to the fact that American literature and research often refer to broad historically established ethnic groups such as Afro-Americans, Latinos, etc. In Europe, globalisation is patterned by a great diversity according to culture, ethnicity, religious affiliation, language, and social situation. Accordingly, culture needs to be approached in an individualised way not stereotyping or falsely ascribing certain characteristics due to the patients assumed belonging to a group.

Cultural humility has been proposed as an alternative concept as it includes self-evaluation [45]. From the colonial context, with poor health status for the Maori population in New Zealand, the concept of cultural safety has been developed and this includes analysing power imbalance [38]. Another suggested concept is cultural responsiveness.

3.2. Research and Evaluation results of cross-cultural training

In contrast to the large amount of existing cross-cultural training programmes and cross-cultural training providers, there is a shortage of transparent documented and published studies of such training, especially for mental health professionals. Most published studies focus on somatic care and are anchored in the framework of cross-cultural competence. The existing three reviews on cross-cultural competence training are based on a total of 69 analysed programmes between 1980 and 2010 written in English. There is evidence that cross-cultural competence training for health care providers is a strategy to improve knowledge, attitudes, and skills [36,7,28]. There is excellent evidence that the cross-cultural competence training improves the knowledge of health professionals and improves attitudes and skills [7]. There is good evidence for a positive impact on patients' satisfaction but poor evidence for patients' adherence. The evidence for improving patient outcome is not very compelling. The overall quality of competency training with regard to patient outcome was low to moderate [28]. Evidence is poor as research is lacking.

A randomized control study of training effects on how Swedish primary care child nurses evaluated their own cultural competence indicated that training improved the participants' cultural competence and had a positive impact on their ability to cope with the demands of the work activities [8]. To maintain the positive effects of training Berlin et al. [8] stressed the importance of additional supervision.

There is a shortage of research evaluating cross-cultural competence training for mental health care professionals. According to the nine evaluated North American cross-cultural competence programmes for mental health care staff [9] there is limited evidence for their effectiveness, as quantitative measurements are missing in most of these studies. Very little has been published with regard to content methods.

3.3. Experiences of cross-cultural training in Sweden and Germany

3.3.1. Swedish experiences

In Sweden, cross-cultural mental health training for students and clinical professionals has until recently been limited. In 1997, a public health report by the Swedish Board of Health and Welfare [39] drew attention to the fact that education for health professionals included little training time for issues related to cultural diversity. Some improvement has occurred with lectures about Transcultural issues introduced in some educations, a one week course in Transcultural psychiatry for residence in psychiatry at the Karolinska Institutet, and some training about working with trauma for health professionals. Still, the situation means that after basic training many professionals still start working with little or no training in the fields of migrant health and cultural diversity. This in turn implies a great need for training of clinical professionals.

The Transcultural Centre in Stockholm has conducted some pioneering cross-cultural training for mental health and health professionals. An advanced course in "Transcultural psychiatry" was, for several years, supported by the Division of Social and Transcultural Psychiatry of McGill in Canada, one of the important cross-cultural training and research institutions worldwide. Over the years, cultural perspectives on mental health care were introduced to a large number of practitioners in Sweden [3]. More and more of the programmes organised by the Transcultural Centre have taken place at local work places. The planning of such in-house training starts with a contact from the local units followed by an survey of the needs and expectations of the health care professionals.

Through in-house training new knowledge can be transferred to whole work places or a group working together. Themes that professionals have often raised over the years are: difficulties in cross-culture encounters; influence of migration on health and mental health; cultural variety in expressions of distress; challenges in cross-cultural communication; consequences of trauma and social upheaval; medical ethics, and conventions and regulations guiding care for asylum seekers and undocumented refugees. These themes give the opportunity to convey new research findings from cross-cultural psychiatry/psychology, social sciences and other disciplines to clinicians and to connect theory to daily clinical praxis.

In the training programmes special attention has been given to the outline for Cultural Formulation in DSM-IV [2] as a practical model to improve cross-cultural diagnosis of mental disorders [6]. Psychiatric diagnosis is today a gateway to mental health care and planning of treatment. The Cultural Formulation in DSM-IV consists of five sections: cultural identity of the individual; cultural explanations of the individual's illness; cultural factors related to psychosocial environment and levels of functioning; cultural elements of the relationship between the individual and the clinician and the overall cultural assessment for diagnosis and care [2]. As a support for training and clinical implementation an interview guide has been used [5,6]. The training in the use of the Cultural Formulation has been the hub around which different topics related to cross-cultural psychiatry have been introduced and linked to clinical situations. So far there has been little evaluation of cross-cultural mental health training in Sweden.

3.3.2. German experiences

Despite the situation several years ago, meanwhile a number of cross-cultural training programmes for health care (budding) professionals are offered. For example, medical students have the opportunity to learn about a variety of cross-cultural issues in some of the 36 German university medical centres. Other educational institutions also offer cross-cultural training with various perspectives catering for different occupational health care groups. So far there are hardly any studies of evaluated cross-cultural mental health training in Germany.

In general there is a high degree of interest in cross-cultural educational programmes for this occupational group. The result of a census of psychotherapists in private practice showed that 72% of mental health care providers think that cross-cultural competence training is helpful for the therapeutic work for patients with a different migration background [31]. Nine per cent of the providers have already participated in such training. The need for such training is also highly valued by medical educational providers. More than 80% of the heads of these psychiatric educational institutions see a great need for cross-cultural issues in further education with focus on cross-cultural competencies and cultural aspects of mental disorders [11].

Although health care providers and educational institutions see the need for, and are interested in, cross-cultural issues there is much work to be done before they are an integral part of the educational curriculum for mental health care professionals in Germany.

A promising development in further promoting cross-cultural issues in the education of health care professionals is characterised by two initiatives. Psychotherapeutic educational institutions are doing more and more to integrate cross-cultural issues in their curricula. Also, there is a national initiative for developing a nationwide list of cross-cultural learning targets for university medical education, which will be later integrated in the teaching and examinations.

4. Discussion

4.1. On conceptualisation of training

Cross-cultural psychiatry, psychology, nursing and related fields are important in the basic education of health and mental health professionals. Institutionalised training of students as well as mental health professionals is essential. In treating culturally different people with mental disorders self-reflection is a necessary component. Developing, conducting and evaluating helpful, adequate and sustainable cross-cultural training programmes that fit the very special needs of professionals in the particular mental health care services is a major challenge.

So far research on cross-cultural training has often been focused on the cultural competence perspective. However, we consider using the cultural competence conceptualisation in mental health care training to be a problematic issue as it encourages an understanding of culture in biomedical terms. The term cultural competence easily directs thinking towards some form of specific entity or skill that one can achieve. In terms of culture it also implies something static.

Medical professionals are trained to have faith in their own competence. In cross-cultural encounters between patient and provider the opposite stance is important, i.e. relinquishing the stance of expert in the encounter and instead grasping the opportunity to learn about patient's culture. After basic knowledge in topics such as intercultural communication and migration and health, a humble self-reflective position and an interest in the individual and his/her sociocultural context should characterize the care provider's attitude. Ethnographic approaches, of curiosity and a desire to learn about the culture and context of the other, may contribute to non-stereotyping knowledge about the individual patient and improve the interaction. Clinging to a position of being a competent cultural expert may result in stereotyping of the patient. In contrast, the professional who does not feel culturally competent may refrain from continuing to help the patient, thus excluding her/him. Further, current work in anthropology looks at culture with a processual understanding, whereby culture is located 'between' people and not in the minds of individuals [27]. This interactive perspective on culture may be difficult to grasp if the focus is mainly on competency.

For training and evaluation research an alternative conceptualisation to the cultural competence framework needs to be considered. Several interesting conceptualisations have been suggested, such as culture humility and cultural safety. The approach of the Transcultural Centre, by using a needs assessment as a part of the training conceptualisation, can be one way to meet the participants where they are. However, in the long run, needs assessment has to be combined with theoretical conceptualisations. Practical tools such as the Cultural Formulation (CF) of the DSM-IV can be helpful to enhance the providers' diagnostic competence and to contribute to improvement of clinical praxis. The CF means an ethnographic approach that supports an individualised understanding of the patient's perspective on suffering, meanings given to illness and self-reflection.

Additional to the problems with conceptualisation of cross-cultural training, there is a lack of documentation about training content and the didactics of cross-cultural training. To promote further research on cross-culture training standardised, psychometric evaluated and validated instruments need to be developed and used [12,10]. The use of additional instruments and qualitative methods like direct observations, videotaped sessions, or Objective Structured Clinical Examination (OSCE) [1] will be helpful. The improvement of content quality can be achieved by evaluating different training components of cross-cultural aspects related to diagnostically (e.g. cultural formulation) and process-related issues. In the future, various aspects of evaluation research should be focused. As the duration of different training programmes varies greatly a dose-response relationship has to be taken into account. If the dose is substantial a catamnesis should be considered in order to evaluate the long-term effect.

Due to the methodological restrictions of quantitative evaluation, complementary qualitative analyses, particularly in institutional settings, may enhance the validity of the study results. Anthropological fieldwork can help to explore the dynamics of the possible consequences of training by employing a descriptive approach, as everyday experiences of prejudice and hidden or open discrimination cannot be assessed with self-reporting instruments.

Finally, a financial evaluation of cross-cultural training is missing [7]. In order to evaluate the economic benefit of training from the perspective of an institution the direct and indirect costs of training have to be considered. To further enhance the quality of cross-cultural training the development of quality standards will be an important aspect. With the help of such quality standards the conceptualisation of future training will be upgraded. This will also make it easier to compare studies and study outcomes.

5. Implications

In order to adapt mental health care systems to globalisation and migration in European countries like Sweden and Germany a general awareness of cross-cultural issues and a shared knowledge base among professionals can provide a platform for improved care and also new knowledge. To give an example, both the diagnostic systems DSM-IV and ICD-10 have the ambition of universal validity. For DSM-IV some efforts have been made to incorporate cultural awareness. However, the validity of western psychiatric categories for non-western populations is questioned [44]. Cultural sensitivity among professionals and working with structured models taking culture into account, like the Cultural Formulation, can contribute to obtaining more information about variety in the phenomenology of mental illness. This might in turn shed more light on the discussion of universal validity of psychiatric categorisations and how to adapt treatment to the existing variety in the population.

In an essay on multicultural medicine, Kirmayer [22] argues that intercultural health care services can contribute to the larger project of building a pluralistic society that allows the coexistence and co-evolution of diverse traditions. He points out that the clinical encounter offers a space for exploring ways of living and working with cultural differences and it can promote trust that encourages the other to consider a new point of view.

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Conflict of interest statement

The authors declare that there is no conflict of interests.

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Teaching psychiatry and establishing psychosocial services – lessons from Afghanistan

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ABSTRACT

Keywords:
Afghanistan
Mental health
Training of psychosocial counsellors

We describe the extremely limited psychiatric resources of war-torn countries like Afghanistan. In such countries, we suggest to apply experience from training medical students in industrialized countries to teach a very basic and simplified understanding of psychiatric classifications and core diagnostic symptoms to medical students (who will later serve in various medical disciplines in regional and district hospitals) and to medical staff including nurses and psychosocial counsellors working in health posts and district hospitals. We describe such a brief but clinically relevant list of symptoms and classifications based on experiences with medical student and practitioner training.

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1. Introduction

Countries suffering from long term civil war, such as Afghanistan, are characterized by high rates of traumatization [14]. Quite often, such prolonged conflicts also impair the education of medical students, particularly in topics that –in spite of evidence to the country– are widely not recognized as urgent or life saving such as mental health.

In spite of a population in which more than 50% have been reported to suffer from symptoms of posttraumatic stress disorder and other symptoms of affective disorders [9], Kabul, a city with more than 5 Million inhabitants, hosts only two public psychiatric inpatient services besides newly developed addiction centers. Such sparse medical resources for the treatment of mental disorders are rather normal in large parts of the world: the average number of psychiatrists in high income countries is 200 times greater than that in low income countries [11].

In the academic teaching hospital of Kabul's Medical Faculty, training of medical students in psychiatry and psychotherapy is limited to a two week internship during the last year of medical

education. Psychiatric services including outpatient facilities are extremely rare both in Kabul and the countryside. Doctors dealing with mental disorders often tend to prescribe neuroleptics, anti-depressant medication and antiepileptic medication at the same time in varying doses, and there are hardly any organized meetings to ensure quality control of medical care for the mentally ill [6].

Lack of treatment resources for mental disorders contributes to the persistence of widespread psychosocial problems in Afghanistan: subjects suffering from posttraumatic stress disorder and other affective disorders often also display further problems such as high rates of opiate abuse and dependence and high frequencies of impulsive violence, particularly in domestic contexts [5,10,15]. Therefore, there is a spiralling continuation of violence within families and thus within society.

Here we report our experiences with establishing basic mental health care by training psychosocial counsellors (often with medical background such as nurses) and by establishing a road map for psychiatric care within the Afghan Medical System, report on teaching efforts within the Mental Health Hospital, a psychiatric clinic owned by the Ministry of Public Health, and the Ali Abad Teaching Hospital of Kabul's Medical Faculty. We focus on aspects of mental health care and training that can easily be generalized and applied to other countries and contexts, in which medical infrastructure is impaired by long lasting civil and military conflicts.

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2. Psychosocial care as a necessary foundation for psychiatric medical care

The very low number of doctors focusing on mental health care in Kabul (about 30 medical doctors mainly trained in internal medicine with varying degrees of exposure to psychiatric patients) compared to the number of inhabitants of Kabul (about 5 million) shows that even with the highest efforts, training of medical specialists for mental health care cannot match the need for psychosocial care in a highly traumatized and large population. Therefore, medical care should only be secondary to primary psychosocial interventions addressing domestic, family and social conflicts that often result from traumatization and suffering from mental disorders.

Within a so called Basic Package of Health Care Services, the Afghan government supports the establishment of positions for psychosocial counsellors (PSCs) in comprehensive health care centers (CHCs), which care for a population about 100 000 inhabitants [11]. The PSC trainees are selected according to selection criteria set by the Mental Health Department of the Ministry of Public Health, e.g. preferably a medical background (medical doctors, nurses, midwives), or a degree in social sciences or social work, over 25 years of age, not overburdened by own psychological problems, and with high motivation, i.e. interest for a deeper understanding of social relations within defined cultural contexts. After the selection process, they enter one year training. After the first three months intensive training, they take their first examination and after 9 months practical work under supervision their second examination. Only then can they work as PSCs in the Comprehensive Health Care Centers.

Counsellors can address family conflicts and violence e.g. resulting from drug (particularly opiate) abuse and from affective disorders in traumatized family members [15]. Psychosocial counselling can help to strengthen women's rights by increasing contact between the women's original family and the extended family into which a woman married, and by identifying family members that can help mediate conflicts and protect women and children. Psychosocial counselling can also help to deal with milder forms of depression and traumatization that do not require medication. Furthermore, a well-established network of psychosocial counsellors can help to distinguish between patients with major psychiatric disorders such as schizophrenia, who can live within a family and are treated rather well, and those who urgently need more specialized medical care in order to facilitate their life within a family context. Given the average prevalence of schizophrenia is at least one percent of the population [8], in a city like Kabul, at least 50.000 subjects will suffer from schizophrenia, clearly indicating that any outpatient hospitalized care delivered by medical departments and clinics is currently illusionary. Therefore, medical facilities have to focus on those few subjects who, due to the severity of their symptoms, can currently not be integrated and supported by their families. Therefore, medical staff in health posts, district and regional hospitals needs basic knowledge in order to transfer those few patients who need more intensive therapy towards specialized psychiatric units and to help stabilize the vast majority of psychiatric patients with the help of psychosocial counsellors and some basic medication skills. Foreseen were two psychosocial counsellors (PSCs) in each Comprehensive Health Care Center

(CHC), one female and one male. At the time being, the Basic Package of Health Care Services foresees only one, which would mean that half of the population would be excluded, since men cannot treat women and vice versa. This is supported by the European Union and USAID. Officially only one counsellor per CHC is found in Basic Package of Health Care Services guidelines. The Ministry of Public Health is aware of this unbalanced situation and currently plans to amend it.

3. Training of psychosocial counsellors

Besides basic knowledge in the classification of mental disorders (which is required e.g. to decide when referral is necessary), it is of main importance for psychosocial counsellors to be able to understand and interpret social conflicts from different perspectives and the meaning of the symptom in the given cultural context. The key to successful treatment is to help the patient feel again that she/he can actively influence their lives again. Furthermore, counsellors need to have the skills to explore together with the client solutions based on the patient's values and his resources, and they need to refrain from giving advice.

For example, without proper training, one drug counsellor was rather proud of convincing a drug addicted woman to marry the man that her family had selected for her, feeling that this helps social integration of her client. However, she did not consider the case from the perspective of the individual, neither did she compare family values with overall traditional values or with perspective of "true love" as experienced by the client.

Well trained counsellors, on the other hand, are able to consider the values and intervene in a culturally appropriate way. For instance, a desperate father felt forced by traditional values to kill his daughter because she was raped by a family member. The empathetic counsellor helped the father to accept and reconnect with his feelings of love for his daughter. The client was thus able to take a stand to defend his daughter and to develop a conflict resolution strategy within the family.

In order to avoid that psychosocial counsellors just intervene on the side of tradition without discussing different perspectives and behavioural and social options with the client, counsellors have to experience themselves how social interactions can be interpreted within diverse contexts and to understand their own biases and prejudices. Therefore the training plan foresees that all training contents are first reflected through self experience - no "cold knowledge". During the first three months of intensive training, all afternoons are filled with self experience in different groups, supported by single talks. In the mornings, case-centered intervention skills are taught. There are now well-trained Afghan counsellors in place; the team of the core trainers is working together since 2004. The first curriculum has been developed by Inge Missmahl based on experiences within a pilot phase. This first curriculum was taught to 30 Afghan men and women, who then worked in 15 centers in Kabul from 2005-2008, where they treated more than 11.000 patients, 70% with good results according to symptom- based pre-post evaluations. After this phase, the training was evaluated and improved and the second training period started in 2008. The trained counsellors then worked in 9 CHCs in Herat, Mazar-e-Sharif and Bamyan. After the second evaluation of the training's content and methodology [4],

the manuals were approved by the Ministry of Public Health and are now obligatory for all psychosocial counsellors who want to work in the Health system.

This curriculum and training methodology differs from the WHO mental health Gap Action Programme (mhGAP). Intervention Guide in so far as it is not so much orientated on a diagnosis based on DSM IV or ICD10 and the associated case management but rather puts the main emphasis on the understanding of the symptom in a given cultural context. Specific attention is given to the question how far standard diagnostic tools developed in a Western cultural setting can assess culturally significant indicators in the local context. Starting point of the therapy is the most pressing problem of the patient, which is usually connected to those forms of social distress that contribute most strongly to social isolation and functional impairment. Already after the first session the patient should feel that he or she will be able to regain some influence on their life situation. Subsequent psychotherapeutic interventions are then resource-orientated and based on a problem solving approach focusing on the main problem of the client; they apply basic elements of standard therapeutic techniques including the salutogenetic approach of Antonovsky [3].

In 2011, more PSCs have been trained for the Northern Provinces and after their one year examination, the best ones with the background of medical doctors will receive a skillbased training in methodology and teaching skills and will become National Trainers for Psychosocial Counselling. In 2012, this program will be rolled out in all provinces of Afghanistan and by 2014, there will be National Mental Health Trainers in all Provinces who are able to train further PSCs for all CHCs. Careful training can thus assure that counsellors proceed in a way that is both culturally sensitive [1] as well as individually focused on the needs of their clients. Moreover, psychosocial counsellors – like medical personal in general – need to acquire basic psychiatric knowledge. However, most manuals available for psychiatric care are too complex and it cannot be expected that psychosocial counsellors are really able to correctly diagnose psychiatric illness according to ICD-10 or DSM-4 [16,2].

4. Learning a Basic Medical Approach to Psychopathology

An alternative approach to identifying psychopathology is based on university experience in the training of medical students around the world. This training also does not focus on clear identification of single disorders in ever more complex classification systems. Rather, medical student education focuses on distinguishing between six types of psychiatric disorders: Acute and chronic exogenous psychoses (e. g. delirium and dementia as examples of cognitive disorders with a “brain organic” background and the associated syndromes of drug dependence), endogenous psychotic disorders and major affective disorders (such as schizophrenia and bipolar as well as severe unipolar disorder), psycho reactive / adjustment disorders (formally classified as neuroses) and personality disorders (Fig.1).

Being able to classify mental disorders at least with respect to these broad categories helps to decide whether somatic diagnoses is urgently required, whether certain kinds of medications can help and how urgent psychotherapeutic and psychosocial

Exogenous psychoses	Endogenous psychoses	Variations
Delirium	Schizophrenic Psychoses	Neuroses
Dementia	Bipolar Disorders	Personality Disorders

Fig. 1. Pragmatic grouping of disease entities in psychiatry and psychotherapy.

counselling may be. Furthermore, a few core symptoms can help to systematically distinguish the most pressing acute brain disorders (with potentially lethal outcome within a few hours, e. g. acute deliria) from chronic neurodegenerative disorders and from psychoses and severe affective disorders (Fig. 2).

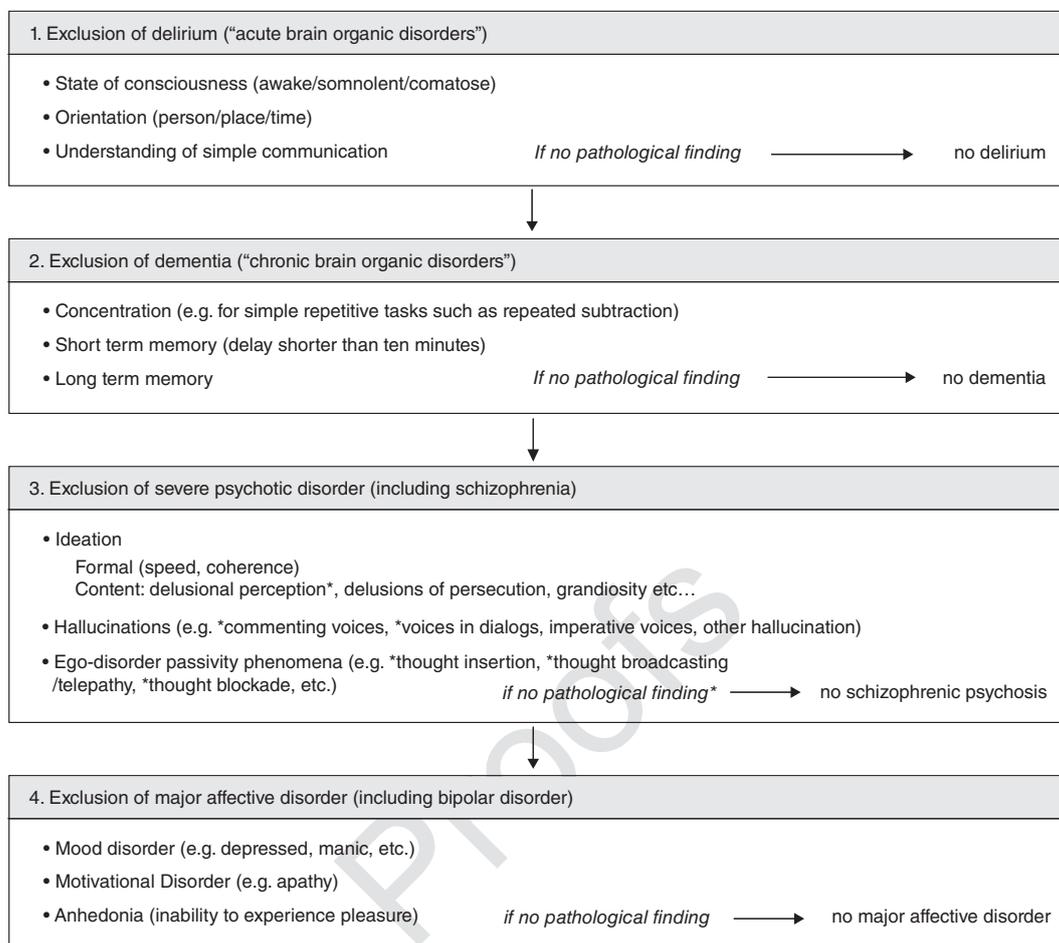
We are aware that such broad classifications and a limited list of symptoms are presenting an extreme reduction of psychiatric complexity, however, in our own experience, knowledge of such basic symptoms and categories can greatly help medical students, non-psychiatric medical personal and psychosocial counsellors to understand when and how urgently a psychiatric specialist should be contacted. Furthermore distinguishing between these basic categories can help to limit medication to many patient groups and prevent e.g. use of neuroleptics outside of “endogenous psychoses” and, more specifically, patients from being wrongly classified as suffering from schizophrenia.

5. Training of psychiatric specialists

Our experience in Kabul revealed that even doctors trained in internal medicine and specializing on mental disorders within mental health hospital require training in basic neurological examination skills. Clinical examination, a mainstay of neurological diagnosis until recently, when brain imaging became available is a must in countries with limited medical resources such as Afghanistan. Of extreme importance is also the distinction between epilepsy and dissociative states. Therefore, the relatively cheap and repeatedly usable EEG is a highly relevant diagnostic tool in such settings, and doctors require training to use this instrument: However, when we taught in Kabul in 2009 and 2010, no EEG was available in any public mental health institution. Finally, in our experience, medical training in a mental health hospital involved rather profound knowledge of DSM-4 symptoms and syndromes, however, there was a certain lack of practical training e. g. in applying such criteria to individual patients and to discuss diagnostic and differential-diagnostic considerations. Moreover, discussion of adequate dosage of pharmaceutical medications, particularly neuroleptics, is strongly required and - at least in our experience - greatly supported by basic knowledge of e.g. required neuroleptic doses to reach therapeutic levels of dopamine-D2-receptor blockade. The rather low dose of haloperidol (below 5 mg) required to assess such therapeutic receptor blockade was generally not known to psychiatric practitioners, who tended to dose much higher even in never medicated subjects [6].

Since there is no hope to have psychiatric specialists in the immediate future in smaller or larger regional hospitals, interested practitioners of internal medicine or other related disciplines require training in basic medication skills with respect to antidepressant, neuroleptic and sedative medication and

These symptoms can successively be used to exclude major psychiatric disorders.



* First Rank Symptoms according to Schneider (12)

Fig. 2. Pragmatic schedule of clinically relevant psychopathological symptoms.

case-based discussions on when a patient should be transferred to a more specialized psychiatric unit. Given the very limited medical resources in psychiatry in countries with a history of civil strife requires that the vast majority of cases is treated without the aid of psychiatric specialists, who in our opinion are most strongly needed not to treat individual patients but to train medical students in basic psychosocial and psychiatry-relevant pharmacological skills and to encourage them to work with the psychosocial counsellors.

6. Summary and outlook

In countries which limited financial resources such as Afghanistan, a vast majority of patients with psychiatric disorders profit from psychosocial intervention and will never see a doctor trained in psychiatry. In such settings, limitation of unnecessary medication and polypharmacy in order to prevent

iatrogenic harm appears to be as important as basic training in helpful medical interventions. With respect to psychosocial training, intervention skills alone are not enough in order to prevent unreflected personal and traditional values of the counsellor being uncritically used as advice for a client, independent of her or his point of view. In Afghanistan, counselling based on a person-centered approach is now established in several provinces and is currently under evaluation. Such studies are urgently necessary in order to close the gap in evidence-based knowledge about psychosocial counselling, which in our opinion can be very helpful and provide necessary treatment resources also in situations where medical specialists trained in psychiatry are extremely rare.

Conflict of interest statement

None.

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Epilogue

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It is so important to see European, and especially German, anthropologists and psychiatrists deal with the health and health care problems experienced by immigrants and ethnic minorities. This is evidence of several important 21st century developments: the increasing diversity of European societies, the growing interest in culture in European medicine, the connection of cross-cultural studies in the mental health field to global health, and interdisciplinary efforts of social scientists and physicians to go beyond conventional biomedical categories and practices in order to construct a new object of enquiry: that is, a more patient and family oriented way of examining caregiving and care-receiving. This collection illustrates the value of taking culture seriously in medicine because of the cultural processes that affect patients, families and communities. But the collection points toward yet another reason why culture matters; and that is that medicine itself is affected by cultural processes and in turn is one of the leading edges of the wedge of culture that remakes everyday life everywhere today. Furthermore, in the face of anti-immigrant political movements in Europe and North America, medicine and anthropology can exercise a countervailing influence that carries its own long-term cultural significance.

Perhaps the most infamous recent example of how the culture of medicine operates to affect health and health care is medicalization or what is also called overdiagnosis. Worldwide, ICD and DSM categories legitimize practices that end up redefining normality as pathology, that convert risk factors into disease and that also make such early diagnosis of disease that physiology and symptoms diverge ever more with people feeling well who can be shown to have the earliest possible biological evidence of treatable conditions, at which point it is entirely uncertain whether to treat or not.

DSM-5 has stirred controversy even prior to its formal release by the American Psychiatric Association by removing bereavement as a reason to exclude the diagnosis of depression. Since depression and grief have the same symptoms, this means in effect that after 2 weeks of grieving, individuals will be diagnosed as clinically depressed and treated with drugs and psychotherapy. There is no evidence such treatment works with normal individuals who are overdiagnosed or pressured by medicalization to trade normality for pathology. Hence what becomes a profit center for the psychopharmacology-psychiatry industrial complex is simultaneously an enormous cultural change with potentially profound consequences for individuals, families, communities and medicine itself. At the same time, we have come to understand that medicine can be, unfortunately, a powerful source of stigma for conditions like mental illness, AIDS, and TB. This is yet another example of culture at work in medical practices and relationships.

Globalization not only increases migration, and thereby diversifies and pluralizes societies; it also is responsible for deep and extensive culture change. The new generations of young adults and children have been so thoroughly influenced by the internet, social media, and other new technologies that their subjectivity and interpersonal relations are distinctive. For example, my colleagues and I in our recent book, *Deep China: the Moral Life of the Person*, show that Chinese today, especially young adults and children, are much more individualistic, materialistic, and globalized than earlier generations. Their priority for relationships, unlike their parents and earlier generations, is for horizontal rather than vertical ties. Romantic love has replaced filial relations as the core emotional and moral attachment. This generation is more interested in personal happiness, selfish interests, and sexual fulfillment, and spiritual quests than their

parents' generation. They are also more likely than their parents and grandparents to be critical of local government, interested in protecting the environment, and oriented to middle class concerns for higher standards and eliminating corruption. This is a large culture change with serious implications for health and mental health care.

How to take culture into account is another important question. Anthropologists have become increasingly critical of the dangerous effects of ethnic stereotyping, and for this reason they are hesitant to acknowledge culture as an independent variable. Cultural competence proponents have created a new industry by over selling the idea that they can train health professionals to become instant experts on how to diagnose and treat "culture" as a problem. At the same, ethnic politics have infiltrated back into medicine.

All of which makes research, like those research findings reported here, more than ever necessary to get at hidden values and practices that influence people's lives. The study of lived values is still in its early period, but we can expect it to expand rapidly in the years to come. And that study is part and parcel of research on immigrants, migrants and ethnic minorities, because when cultural differences make a difference they become issues in controverted and contested moral practices.

Such research must begin with an understanding of the economic barriers and political pressures these groups face all over the world [1]. Those potent forces are intensified by cultural differences which make race, religion and citizenship/undocumented states additionally explosive in society, including its health care systems. Stigma associated with disease is easier to affix on those without power who are already stigmatized by their social conditions. Marginality places poor migrants in settings that are at higher risk not only for violence but also for school problems, joblessness, and physical and mental health problems. The experience of cultural difference in the health care system, as the preceding chapters show, adds to the difficulties immigrants have in getting quality health care. It also can make caregiving more challenging for professional caregivers. That is why practical interventions from medical anthropology and cultural psychiatry have been found useful in health care systems. This book adds to the expanding story of what can be done to improve services for immigrants and other marginalized groups.

The presence of ethnic minorities like Turks who have resided in European countries like Germany for generations means that the entire health care system needs to be prepared to address cultural issues in care and that health policy experts have to understand how economic, political and cultural processes

influence each other to affect access, quality, adherence and outcome. Here the case needs to be repeatedly made that these social and humanistic realities are so central to medicine and nursing that they must be systematically taught at all levels of the professional curriculum. The issue has two parts for medical educators and health systems managers: recognition that migrant and immigrant status really matters; and emphasis on methods that can be used to teach practitioners what best practices are in the care of ethnic, migrant and immigrant patients and families.

The approach I have advocated is straightforward and has been spelled out in places like the Cultural Formulation in the Appendix of DSM-IV.

The first step is affirmation and acknowledgement of the patient and family as respected persons whose religious and ethnic differences matter.

Second is the effort to elicit their explanatory models of the sickness and the treatment as a basis for soliciting an illness and treatment narrative that focuses on what is most at stake for patients and families.

Third is recognition and assistance over differences that matter: not just cultural but financial, social relational, work-related, community-based, and so on. The purpose is not to achieve some idealized and exoticized cultural competency, but rather to practice empathic, competent and humane care. The major barriers that get in the way—language, class, financial issues, time, bureaucratic structures, and professional indifference—need to be assessed as well. The template is commonsensical, and yet failures are still all too commonplace. I think the studies summarized in the preceding chapters give ample illustration of why. Medicine is inseparable from moral, economic, political and bureaucratic processes over which physicians and nurses have limited influence. But they do have some control. And anthropologists and health care researchers also have agency to improve practices. What needs to be done is for all parties to insist that these issues are as basic to caregiving as any, and they must receive priority. This book you are now reading provides the kind of information and understanding that can improve health and health care for vulnerable people. Let's hope that it is evidence of a movement to improve the health care of at risk minorities everywhere.

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