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Quality of life of Turkish patients with depression in Ankara and in Berlin

D. Iren Akbiyik[1*], O.E. Berksun[2], V. Sumbuloglu[3], V. Sentürk[4], S. Priebe[5]

[1] *Ankara Oncology Research and Training Hospital, Department of Psychiatry, Ankara, Turkey*
[2] *Ankara University, Department of Psychiatry, Ankara, Turkey*
[3] *Karaelmas University, Department of Biostatistics, Zonguldak, Turkey*
[4] *Ankara University, Department of Psychiatry, Turkey*
[5] *Social & Community Psychiatry, Newham Centre for Mental Health, London, UK*

Abstract

Background and Objectives – Quality of life (QOL) of immigrant groups with mental disorders should be compared with similar patients in the country of origin. Therefore, this study evaluated the QOL in Turkish patients who were in treatment because of depressive disorders in Ankara and Berlin.

Subjects and Methods – Patients with depressive disorders were recruited from services in Ankara and Berlin. The same researcher interviewed all patients and assessed socio-demographic characteristics, symptomatology, psychiatric diagnosis and QOL.

Results – QOL of patients in Ankara was significantly higher than that of patients in Berlin. Satisfaction with specific life domains also showed significant differences between the two groups. Factors positively associated with QoL in Berlin were marital status, shorter duration of marriage, fewer occupants per household, a relaxed religious attitude, being informed about the illness by the physician, and lower levels of symptoms. In Ankara, only initial help seeking behavior and level of depressive symptoms were associated with QOL.

Conclusion – QOL of Turkish patients with depression in Berlin appears lower than that of similar patients in Ankara. Different factors may influence QOL of Turkish patients with depression living in the place of origin and having emigrated to Germany.

Key words: Quality of life; Depression; Berlin; Ankara; Immigration

1. Introduction

Quality of life (QOL) depends on many factors including housing, job, education, health services, cultural and religious differences, expectations from the society and relationships, involvement in public life and mental health [10]. The literature suggests that immigrants often have lower incomes, poorer housing conditions, and higher unemployment rates than people of the host country [5]. Moreover, due to cultural and language differences, their education level is generally lower. The perception of mental and physical disorders, influenced by cultural factors can negatively affect the help seeking behavior of the immigrants. As a result, misdiagnoses and mistreatments can be frequent [7]. All of these factors may reduce the quality of life of immigrants with mental disorders as compared to the population of the host country [14].

The association between depression and subjective QOL is well known [16]. Depression can be associated with poor social functioning (Wells *et al.* [17]), and the negative impact on social functioning may persist in patients even after the remission of depressive symptoms [13].

This study aimed to assess the subjective QOL of Turkish patients with depressive disorders in Ankara and in Berlin and identify factors influencing QOL in each group.

2. Methods

2.1. Study design and patient selection

This is a cross sectional study for assessing QOL in Turkish migrants and non-migrants with depression. The two groups of patients compared in this study were.

* Corresponding author.
E-mail: deryaakbiyik@yahoo.com (D. Iren Akbiyik).

2.1.1. Group A

Turkish patients, who were residing in Ankara, attended the outpatient department of Psychiatry Clinic of Ankara University, were diagnosed with depression and agreed to participate in the study. The exact inclusion criteria were; (i) residing in Ankara for more than ten years; (ii) being diagnosed with major depression in the last two weeks by a psychiatrist; (iii) having no history of international migration; (iv) being older than 28 years (to be matched to group B).

2.1.2. Group B

Turkish patients in Berlin, who attended the offices of two Turkish psychiatrists located in different regions of Berlin, were diagnosed with depression and agreed to participate in the study. The precise inclusion criteria were; (i) residing in Berlin for more than 10 years; (ii) Being diagnosed with major depression in the last two weeks by a Turkish psychiatrist; (iii) Having immigrated after the age of 18 and still living in Germany for at least 10 years (this also meant that none of the patients in Group B were younger than 28 years old).

Patients with bipolar disorder, schizoaffective disorder, schizophrenia, alcohol and substance addiction, brain disorders (e.g. dementia, epilepsy, tumors), serious neurological and/or eye problems, serious and chronic physical illnesses like uncontrolled diabetes, severe orthopedic disabilities, or mental retardation were excluded from either group. Patients whose diagnoses were not certain at the time of the study and/or who were too depressed to participate in the research were excluded, too.

2.2. Study procedures

General demographic and socio-cultural characteristics of patients were recorded using the Socio-cultural Characteristics Questionnaire (SCQ). The Mini International Neuro-psychiatric Interview (MINI) was used to aasess the diagnosis. Symptoms were self rated on the Symptom Check List-90 Revised (SCL-90-R) and the Beck Depression Inventory (BDI). QOL was assessed on the Manchester Short Assessment of Quality of Life (MANSA). The MANSA is a brief instrument for assessing QOL focusing on satisfaction with life as a whole and with life domains [15]. It is comprises of 25 questions in total, 12 of which are rated on a Likert type satisfaction scale ranging from 1 (low satisfaction) to 7 (high satisfaction). The Turkish version was developed using translation and back translations by the authors, and this atudy focuses on the analysis of the 12 satisfaction items reflecting subjective QOL.

The same study researcher who has no migration background personally interviewed patients in both Group A and Group B.

The researcher informed the patient about the study and, if participation was accepted, the patient was asked to sign the Informed Consent Form in Turkish. The patients who met all the criteria for inclusion after the interviews by MINI were asked to fill in the self-report instruments. None of the patients in Group B and few of the ones in Group A could complete the self-report instruments by themselves without getting help from the researcher.

2.3. Statistical Analyses

All study data were analysed using descriptive statistics. In- and between-group comparisons and univariate analyses were performed using parametric or non-parametric tests depending on the type of data. P was set at 0.05 and the results were interpreted within a confidence interval (C.I.) of 95%.

For multivariate analyses, the independent variables were screened for inclusion in the multivariate model and included based on their association with the dependent variables in a univariate analysis. The cross-correlations between independent variables were screened to prevent biased and imprecise estimates from the multivariate model.

3. Results

The study flowchart for patients in Ankara and Berlin is shown in Figure 1.

Patients in Berlin were significantly older with more working years. Their subjective perception of household income was mostly low whereas it was moderate in the Ankara Group (Table 1).

The total BDI scores of patients living in Berlin were significantly higher than that of patients living in Ankara (29.4, SD 6.6 vs 22.6, SD 9.7; $p<0.001$).

Total MANSA score of patients living in Ankara was significantly higher than the total MANSA score of patients living in Berlin (Table 2).

In multiple regression models with subjective QOL as the dependent variable, BDI scores and help seeking behaviour were statistically significant independent predictor variables for the sample in Ankara, whereas age, gender, marital status, duration of marital status, initial help seeking behavior and total BDI score were statistically significant independent predictor variables in Berlin (Table 4).

Subjective QOL of patients living in Ankara was significantly higher than of patients living in Berlin. The only life domain with which patients in Berlin were more satisfied was personal safety.

Immigrants were least satisfied with their sex life and mental health. Although they had mainly immigrated for better employment and financial status, their job or employment satisfaction were lower than that of the non-immigrant group.

Total subjective QOL scores of divorced patients, patients seeking medical help initially from family doctors,

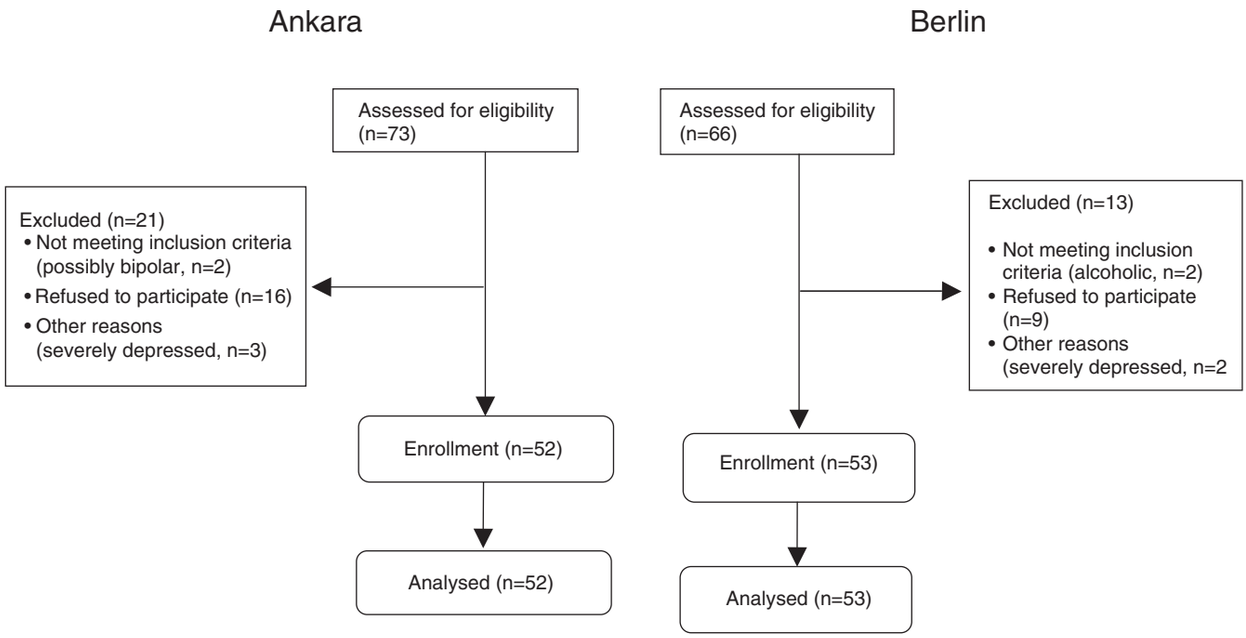

Fig. 1. Study flowchart for patients in Ankara and Berlin.

Table 1
Comparison of demographic and social characteristics of patients living in Berlin and Ankara*

		Berlin (n=53)	**Ankara** (n=52)	**Total** (n=105)	**P value**
Âge (years)		49,4±8,4	44,7±9,2	47,1±9,0	0,007**
Sex	Male	19 (35)	14 (26)	33 (31)	0,325***
	Female	34 (64)	38 (73)	72 (68)	
Marital status	Married	43 (81)	41 (78)	84 (80)	0,612****
	Divorcee	7 (13)	4 (7)	11 (10)	
	Widow	2 (3)	3 (5)	5 (4)	
	With a partner	–	1 (1)	1 (1)	
	Single	1 (1)	3 (5)	4 (3)	
Duration of marriage (year)		23,9±10,5	20,4±10,8	22,2±10,7	0,046†
Years in the city		26,8±7,8	30,3±10,7	28,5±10,5	0,246†
Total work years		20,0±10,0	12,3±12,5	16,2±11,1	0,001†
Household income (subjective)	Very High	3 (5)	–	3 (2)	<0,001****
	High	6 (11)	1 (1)	7 (6)	
	Moderate	14 (26)	43 (82)	57 (54)	
	Low	29 (54)	7 (13)	36 (34)	
	No income	1 (1)	1 (1)	2 (1)	
Religious affiliation	Strict	7 (13)	23 (44)	30 (28)	<0,001****
	Moderate/no effect on routine	44 (82)	29 (55)	73 (69)	
	Not religious	2 (3)	–	2 (1)	
Number in household		2,8±1,4	3,4±1,2	ND	0,006†

* Data were given as mean ± standard deviation or n (%). **Student t test. ***Chi square test. ****Fisher's exact test (Monte Carlo). †Mann Whitney U. ND: Not determined.

Table 2
The total and item scores of MANSA of patients living in Ankara and Berlin* (Only significant variables are shown)

Items of MANSA	**Berlin** (n=53)	**Ankara** (n=52)	***P* value****
How satisfied are you with your life as a whole today?	2.6±0.7	3.7±1.4	*<0.001*
How satisfied are you with your job (or sheltered employment, or training/education as your main occupation)? *Or if unemployed or retired* How satisfied are you with being unemployed / retired?	2.5±0.7	3.5±1.7	*<0.001*
How satisfied are you with your financial situation?	2.9±1.0	3.4±1.3	*0.048*
How satisfied are you with your leisure activities?	3.0±0.9	3.5±1.6	*0.048*
How satisfied are you with your personal safety?	5.0±1.2	3.9±1.5	*<0.001*
How satisfied are you with your sex life?	1.7±0.7	3.5±1.5	*<0.001*
How satisfied are you with your physical health?	2.2±0.9	3.7±1.3	*<0.001*
How satisfied are you with your mental health?	1.8±0.5	3.4±1.7	*<0.001*
Total MANSA score	44.3±4.6	51.6±11.2	<0.001

*Data were given as mean±standard deviation, **Student t test.

Table 3
The coefficients (β) with standard error (estimated precision of coefficients [SE]) and *P* values of explanatory variables in multiple linear regression model in which total MANSA score is dependent variable for patients in Ankara

Variable		Ankara		
		β	SE	*P* value
Age		0.21	0.36	0.554
Gender (Female vs Male)		3.61	4.08	0.382
Marital status (Married vs Other)		10.56	5.90	0.083
Duration of marital status (year)		–0.54	0.36	0.147
Household Income		4.58	2.87	0.120
Number of household		–2.25	1.50	0.145
Total work years		0.07	0.20	0.738
Years in the city		0.11	0.12	0.334
Religious affiliation	Religious-strict or not	2.01	2.81	0.480
	Religious-loose or not	1.90	4.47	0.674
	Effect of religion on routine life or not	ND	ND	ND
Informed about illness by physician	Yes, very good or not	–2.68	4.59	0.563
	Yes, sufficient or not	–7.39	4.37	0.101
	Previously known or not	–4.56	4.77	0.346
Initial help seeking	Family doctor or not	–16.15	6.93	*0.026*
	Non-psychiatrist specialist or not	–8.24	5.15	0.120
	Psychiatrist or not	–10.95	5.06	*0.038*
BDI		-0.81	0.20	*<0.001*
SCL-90R		2.27	2.89	0.438

ND: Not determined because of low number of data.

Table 4
The coefficients (β) with standard error (estimated precision of coefficients [SE]) and P values of explanatory variables in a multiple linear regression model in which total MANSA score is dependent variable for patients in Berlin

Variable		Berlin		
		β	SE	P value
Age		0.27	0.12	0.039
Gender (Female vs Male)		0.97	1.30	0.459
Marital status (Married vs Other)		5.63	2.32	0.021
Duration of marital status (year)		–0.28	0.11	0.014
Household Income		–0.70	0.59	0.247
Number of household		1.01	0.44	0.028
Total work years		–0.04	0.09	0.695
Years in the city		0.07	0.12	0.579
Religious affiliation	Religious-strict or not	–1.10	3.12	0.726
	Religious-loose or not	–6.82	2.86	0.023
	Effect of religion on routine life or not	–4.51	2.79	0.115
Informed about illness by physician	Yes, very good or not	0.32	1.77	0.857
	Yes, sufficient or not	–3.99	1.68	0.023
	Previously known or not	–7.59	2.80	0.010
Initial help seeking	Family doctor or not	ND	ND	ND
	Non-psychiatrist specialist or not	2.57	1.48	0.091
	Psychiatrist or not	5.09	1.54	0.002
BDI		–0.28	0.12	0.028
SCL-90-R		–0.51	2.15	0.816

ND: Not determined because of low number of data

patients with lower personal and household incomes, and those living in Berlin were lower. The relationship between initial help seeking from family doctors and total subjective QOL score also held true for patients living in Ankara. In both groups, patients with higher symptom levels had poorer subjective QOL in the multivariate analysis when the influence of other factors was controlled for.

4. Discussion

This study showed that QOL of patients with depression in Ankara is higher than that of similar patients in Berlin. The factors affecting positively the QOL of Turkish patients with depression living in Berlin were marital status (i.e. being married), shorter duration of marriage, lower number of occupants per household, having a relaxed religious attitude, being informed about illness by a physician, initial help seeking from a psychiatrist, and a low level of depressive symptoms. The association between depressive symptoms and subjective QOL ratings has been consistently found across samples with different disorders and from different countries.

Depressed persons have been reported to be disadvantaged in many respects and our findings show a similar relationship [6]. Regarding the marital status, Meltzer *et al*. reported that persons with depressive episodes have a significantly increased risk of living as single parents or alone. They are also prone to being unemployed or economically inactive [11]. Several epidemiological studies conducted in Turkey, revealed that being female and living alone were significant risk factors for depression [4]. Because of the cross-sectional nature of our study we cannot conclude on causal relationships (e.g. social disadvantages observed in our sample might be results as well as antecedents of depression). However, our results are consistent with the assumption that living alone and longer durations of marriage (possibly by the mediating effects of relationship problems) further decrease the QOL of depressed patients.

Evidence suggests that the marital status – possibly as a proxy measure for living in a partnership – may play a significant role in mental health [1]. Divorced persons feel most burdened by negative life events. This also has a negative effect on their satisfaction with life. It was demonstrated that depressive symptoms were higher among people living alone [4,18]. In line with these findings, married patients had higher subjective QOL in our study.

The fact that patients who initially seek help from a psychiatrist had higher subjective QOL scores than those who were initially treated by family doctors or by non-psychiatrist specialists might reflect a more accurate and therapeutic approach of psychiatrists to patients with depression, resulting in better treatment and a higher subjective QOL [9]. Yet, one might also speculate as to whether seeking help from a psychiatrist is a sign of higher social competence and/or assertiveness which can be associated with better coping behavior and lead to more favorable QOL.

There are various results reported by the studies searching about the relation with spirituality and quality of life. When some of them have found spirituality not to be a significant factor contributing to QOL [12], others report that a firm belief system was an important predictor for a better therapy outcome which also means a higher quality of life [3]. The findings of this study showed that the degree of being religious had no effect on quality of life in Ankara group who had more often reported to be strictly religious than Berlin group. A looser belief system in a foreign community might be affecting the quality of live negatively in migrant group because of absence of its preventive effect on mental health as reported by Brune *et al.* [3].

Although the quality of life assessed subjectively for patients in Ankara was higher than that of patients in Berlin, personal safety score was found to be significantly higher in Berlin group. This issue may be related to living in Germany in which a social government provides the peoples' confidence in future, compared to a liberalist, free market attitude in Turkey [2].

Interestingly, no difference was found between groups for having friends and relationships with friends. This shows that Turks in Berlin have relationships with each other which are similar to Turkey, since 60% of them have no relationship with Germans. This latter rate shows the degree (or lack) of communication between ethnic groups and increasing bonds and communication between those two groups may be a viable therapeutic aim.

Although the scores reflecting the satisfaction of accommodation, of the people lived together and of family relations were the highest for both groups, possibly because of close and supportive family relations of Turkish people, the highest satisfaction rate was only 4.3. This may reflect the ambivalent nature of communication in a small and close-knit group.

Another interesting finding was that the main purpose of migration was to earn more but the satisfaction of immigrants from their financial situation was lower than Ankara group. There are some possible explanations to this. First, patients with chronic depression might be subjectively dissatisfied and complain about reduced well-being while their objective functioning and/or actual living conditions, including social support might be appropriate [8]. Second, the expectation of immigrants for their financial situation could be too high to be met. Third, as explained before, their relatively lower financial situation in the community they live could cause dissatisfaction.

This study had some limitations regarding study design, sample size, patients'selection and recruitment procedures. It is a merely cross-sectional study, and the sample size is rather small to reach reliable results in multivariate analyses. Thus, differences in the results of the multivariate prediction of subjective QOL between the two groups must be interpreted with great caution, and the statistical power was not

sufficient to establish negative results. Additionally, the recruitment procedure in Berlin included only patients who sought help from Turkish-speaking physicians, possibly excluding well adjusted patients with good knowledge of German who went to see German psychiatrists.

Yet, the study also has methodological strengths. The same researcher interviewed patients, an advantage eliminating between-researcher variability of the results. The interviewer was a native Turkish speaker, and well established instruments with good validity were used in the study. Additionally, the study settings included similar patients seeking help from office based practices in Ankara and Berlin.

5. Conclusions

It may be concluded that subjective QOL in patients with depression living at the place of origin and having emigrated may differ significantly. QOL scores of immigrant patient groups should not automatically be seen as "typical" for a given cultural background, but need careful analysis of the specific sample characteristics and context. Different factors may influence QOL of Turkish patients with depression in Ankara and Berlin possibly leading to different implications for therapeutic approaches and the social management of patients.

Conflicts of interest: None.

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