

One Size Does Not Fit All in Psychotherapy: Understanding Depression Among Patients of Turkish Origin in Europe

Psikoterapide Tek Beden Herkese Uymuyor: Avrupa'da Yaşayan Türkiye Kökenli Hastalarda Depresyonu Anlamak

Nazlı BALKIR NEFTÇİ¹, Sven BARNOW²

¹Department of Psychology, Işık University, İstanbul, Turkey

²Department of Clinical Psychology and Psychotherapy, Heidelberg University, Heidelberg, Germany

ABSTRACT

Over the last decades, Europe has become an immigration country hosting an estimated 56 million international immigrants. Yet, a large amount of literature suggests that migration is associated with a higher risk of common mental disorders, such as depression and anxiety. As representatives of one of the largest immigrant groups in Europe, various studies have shown that Turkish immigrants exhibit a higher prevalence of depression and anxiety disorders than do the background population. Nevertheless, it is also well demonstrated that this particular patient group is more likely to terminate treatment prematurely and displays lower rates of treatment compliance than their native counterparts. This reluctance for service utilization might be partially because of the fact that people from non-Western ethno-cultural backgrounds (e.g., Turkey) often have a different notion and comprehension of mental health and illness as compared with those of the people from Western societies. Such mismatch often results in discrepancies between the needs and

expectations of immigrant patients and clinicians, which attenuate the communication and effectiveness of treatment and lead to unexplained high dropout rates. To provide continued provision of culture-sensitive, high quality, evidence-based mental health care, the advancement of researches exploring such sociocultural differences between the patients' and the clinicians' notions of mental health must occur. In response to these problems, the current review aims to explore the interplay between culture and mental processes that associate with the etiology, maintenance, and management of depression among Turkish immigrant patients. This is to inform clinicians regarding culture-specific correlates of depression among Turkish patients to enable them to present interventions that fit the needs and expectations of this particular patient group.

Keywords: Culture, immigration, mental health, depression, psychotherapy

ÖZ

Son yıllarda Avrupa, yaklaşık olarak 56 milyon uluslararası göçmen barındıran bir göç bölgesi haline gelmiştir. Bununla birlikte, göçün, depresyon ve anksiyete bozuklukları gibi sık görülebilen psikiyatrik bozukluklarda artışa neden olduğunu belirten çalışmalar bulunmaktadır. Avrupa'da yapılan çalışmalar, en kalabalık göçmen gruplarından biri olan Türkiye kökenli göçmenlerde, depresyon ve anksiyete bozukluklarının yaygınlığının, genel nüfusa kıyasla daha yüksek olduğunu göstermektedir. Buna rağmen, yine bu grubun, Avrupalı hastalara kıyasla tedaviye uyum sağlamakta daha çok güçlük çektikleri hatta tedaviyi erken sonlandırma eğiliminde oldukları yapılan araştırmalarla ortaya konmuştur. Batılı olmayan toplumların (ör: Türkiye), ruh sağlığı ve hastalıkları ile ilgili nosyon ve anlayışlarının, batılı toplumlarınkinden farklı olması, göçmen hastaların sağlık hizmetlerinden yararlanmaktan kaçınmalarına yol açabilmektedir. Anlayışlar arasındaki bu farklılıklar ise, göçmen hasta-

lar ve batılı klinisyenler arasındaki iletişimi dolayısıyla tedavinin etkinliğini zayıflatarak tedaviyi bırakma oranlarında açıklanamayan artışlara yol açabilmektedir. Kültüre duyarlı, kaliteli ve kanıta dayalı ruh sağlığı hizmetlerinin sağlanabilmesi adına, hasta ve klinisyenlerin ruh sağlığına ilişkin anlayışları arasındaki sosyokültürel farklılıkları keşfetmeye yönelik araştırmaların artması bir gerekliliktir. Buna yönelik olarak, bu makalede ruh sağlığı ve kültür arasındaki etkileşim ve bu etkileşimin Türk göçmen hastalarda depresyonu tetikleyen ve devam ettiren faktörler ile ilişkileri incelenmiştir. Buradaki amaç, bu hasta grubunun beklentilerine ve ihtiyaçlarına uygun müdahalelerin sunulabilmesi adına, klinisyenlere depresyonun kültürel öğeleri hakkında bilgi sağlamaktır.

Anahtar kelimeler: Kültür, göç, ruh sağlığı, depresyon, psikoterapi

AN OVERVIEW ON MIGRATION AND MENTAL HEALTH IN EUROPE

Today, the demographic profile of Europe's population is considerably more heterogeneous than it has ever been before. The increased inflow of immigrants has been stated as a key force in this contemporary demographic diversity. Past and recent reports have demonstrated that throughout Western Europe, the number of foreign populations has been rising and is estimated to be 56 million international immigrants. In 2014, the number of people living in the EU-28 who were citizens of non-member countries was 19.6 million, while the number of people living in the EU-28 who had been born outside of the EU was 33.5 million (1). Turkish immigrants form one of the largest immigrant groups in Western Europe reaching a total population of nearly 4 million (2). The largest number of Turkish immigrant workers is found in Germany followed by France, the Netherlands, Austria, Belgium, Switzerland, the United Kingdom, Sweden, Denmark, Italy, and Norway (3).

As is well known, adaptation to a new culture, namely acculturation, can present difficulties that immigrants have to cope with. The process of integration into new styles of interpersonal relationships, social rules, organization of community services, etc., may be stressful in its own



Correspondence Address/Yazışma Adresi: Nazlı Balkır Neftçi, Işık Üniversitesi, Psikoloji Bölümü, İstanbul, Türkiye
E-mail: nazli.balkir@sikun.edu.tr

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right because immigrants may feel a threat to their sense of self-efficacy (4). Additionally, reconciling the norms and values of their new and old cultures may be difficult, particularly when these are conflicting (5,6,7). Together with the difficulties that normally occur during immigration (i.e., loss and bereavement), such adverse psychological effects, known as acculturative stress, put immigrants at increased risk of poor mental health. Accordingly, several studies indicated that the immigration and its related acculturation stress are associated with a higher risk of mental disorders, such as anxiety and depression (8). This might be especially true for immigrants with a Turkish background because they are one of the largest as well as one of the least integrated immigrant groups (9). The strong clash of values confronts Turkish immigrants with a particularly high risk of social isolation and psychological distress compared with that associated with immigrants from other parts of Europe and the background population (10,11). Consistent with this observation, an epidemiological study in Belgium (2007) demonstrated that immigrants originating from Turkey and Morocco reported significantly higher levels of depression and anxiety than those reported by other European immigrant groups and Belgian natives (11). Another study conducted in Germany indicated that Turkish patients in General Practice showed a higher number of psychological symptoms and a higher rate of mental disorders than German patients. Most prevalent amongst these were anxiety and depressive disorders (12). Despite the higher prevalence rates of mental disorders, depression in particular, recent studies provide evidence that patients from this particular group are less likely to seek professional care and exhibit higher rates of dropout and lower rates of compliance to treatment than native patients (13,14,15). For instance, studies conducted in Germany report lower rates of immigrant admissions to mental health care services than the admission rates of native population (13). Another study on service utilization in women immigrants in Amsterdam found that Surinamese, Antillean, Turkish, and Moroccan women made considerably lesser use of mental health care services than native born women. It was found that immigrant women consulted social work facilities and women's crisis intervention centers nearly 1.5 times more often than mental health care services (16). Furthermore, in Switzerland, it was demonstrated that Turkish female in-patients had higher rates of compulsory admission, lesser tendency for readmission, and significantly shorter stay in hospital than Swiss in-patients (17). In summary, these results demonstrate a significant underutilization of mental health services and delayed treatment among (Turkish) immigrants.

To minimize the disability, meeting the deficits of the treatment gap (i.e., the absolute difference between the prevalence of the disorder and the treated proportion of the individuals) is essential (18). However, the treatment process with minority patient groups results in additional difficulties for clinicians compared with the treatment of patients from the background population, particularly when the patient and the clinician are from different ethnic or cultural backgrounds. Patients from non-Western cultural backgrounds (e.g., Turkey) often have different notions and correlates of what is considered mentally ill/dysfunctional or healthy/functional, based on their own social and cultural context, which can be different from those of patients from Western societies (19,20,21). As expected, culture is not the only important characteristic of the patients. The notions of clinicians concerning mental health are also a function of their own ethno-cultural background and professional training (22,23). Such cultural differences often result in a detrimental discrepancy between the problem conceptualization, needs, and expectations of patients and clinicians. This generally attenuates communication and effectiveness of treatment, thereby leading to high unexplained dropout rates (24). In support of this, empirical evidence suggests that patients are most satisfied and adhere to treatment when their treatment provider recognizes and shares their problem conceptualization and presents interventions that suit their needs and expectations (23,25,26).

To prevent poorer health results for minority patients, the exploration of such sociocultural differences between patients and clinicians must occur. Hence, the role of culture in the development, maintenance, and management of mental disorders should be recognized as an important step in improving mental health care for culturally diverse (Turkish) minority patients.

LINKING CULTURE AND PSYCHOLOGY

Although in the literature, too many cooks spoil the broth in defining culture, in the current paper, the term refers to a shared, learned system of values, beliefs, and attitudes that shape and influence perception and behavior (27,28). It is suggested that such collective programming of the mind distinguishes the members of one group or category of people from others. The most popular model for comparing and contrasting cultural orientations is Hofstede's model of national culture, which consists of six dimensions (e.g., power distance, individualism vs. collectivism, uncertainty avoidance, masculinity vs. femininity, long-term orientation vs. short-term orientation, indulgence vs. restraint) (29). This does not imply that everyone in a given society is programmed in the same manner; there are considerable differences between individuals (30). Nevertheless, upon its conception, Hofstede's model was important because it organized cultural differences into tangible and measurable patterns, which promoted the understanding of how culture relates to psychological processes in a systematic manner (31).

The aforementioned cultural dimensions can be conceptualized as world views that determine beliefs, attitudes, norms, roles, values, and behaviors in different cultures (32,33). Of these, the most popular is the view of individualism-collectivism, which basically refers to how people define themselves and their relationships with others. On the individualist side, we find societies [e.g., Germany, the Netherlands, the UK, Sweden (34,35)], in which the individuals view themselves as independent of one another. Likewise, according to Hofstede's definition, individualism reflects a focus on rights above duties, a concern for oneself and one's immediate family, an emphasis on personal autonomy, self-fulfillment, and personal accomplishments (29). On the other side, the main characteristic of collectivism is the conjecture that people are integrated into cohesive in-groups, often extended families, which provide affinity in exchange for unquestioned loyalty (33). Similarly, Schwartz (35) defines collectivist societies (e.g., Turkey, Lebanon, Morocco) as communal societies characterized by mutual obligations and expectations based on ascribed positions in the social hierarchy (34).

There is some evidence that cultural orientations have implications for psychological processes such as self-concepts, motivation sources, emotional expression, and attribution styles (31). Correspondingly, a large body of clinical research demonstrates that these psychological processes are also associated with etiology, maintenance, and management of depression and present important targets of psychotherapeutic interventions.

THE SELF AS A CULTURAL PRODUCT

Several studies have demonstrated that a major cultural influence on depressive experience is the concept of self- or personhood as defined by a particular cultural orientation (36,37,38). The "self" has been conceptualized within a social-cognitive framework as a manifold, dynamic system of constructs, i.e., a constellation of cognitive schemas (39,40,41). According to Beck's cognitive theory, depression is caused by negative depressogenic cognitive schemata that predispose an individual to become depressed when stressful events or losses occur (42). These depressogenic cognitive schemas involve a negative outlook on the self, the future, and the world. As defined by theory and numerous studies on depression, self-view plays a crucial role in the development and maintenance of depression. However, it has been widely acknowledged by cross-cultural researchers, that the nature of the self is culturally constructed (43,44,45,46). Both cultural

dimensions (individualism vs. collectivism) value personal traits that reflect their predominant goals and, thus, assign different components of the self as central aspects of identity (e.g., independence vs. interdependence) (47,48,49). For instance, Western European societies sustain an individualistic model of a person as endorsed by their theories of personality and social psychology (48,50). This model of the person influences an individual's self-view, resulting in the development of an independent self-construal (48). However, the individualistic, independent model of the self fails to describe the self-concepts of all people. Cross-cultural research has revealed that members of many collectivistic cultures, such as Turkey, see the person as part of the social network, rather than as a unique individual. Therefore, members of such societies tend to construct an interdependent self-construal (48). Given that the conceptualization of the self has been shown to vary across cultures, members of individualistic and collectivistic societies may differ in personality (self-hood) characteristics, from which they derive their feelings of self-worth, i.e., self-esteem, to maintain a positive view of themselves (51). Consequently, the relationship between different characteristics of the self and depressive experience may vary as a function of cultural orientation. Correspondingly, Markus and Kitayama argued that the positive view of the self, which people need to maintain to derive feelings of self-worth, differs according to their self-construals (48,51,52). Individuals holding an independent self-construal sustain a positive view of themselves when they are in control, assert themselves, and achieve success. For individuals with interdependent self-construals, maintaining a positive self-view requires fulfilling social obligations and maintaining harmony with the group to gain social acceptance (21). In support of this argument, a recent study has revealed that a highly interdependent self-construal is related to lower psychological distress in Asian-American university students, whereas there was a positive correlation in European-Americans (53). However, an independent self-construal was found to be negatively correlated with psychological distress irrespective of cultural orientation (53,54). One explanation could be that these findings primarily come from studies that examined people with a bicultural identity such as immigrants from collectivist cultures residing in individualistic societies (55). Given that culture is a non-static and ever-changing construct, for these people, in spite of their collectivist background, an independent self might serve as a functional way to fit into the Western context. Similarly, another study has investigated cultural differences in the patterns of interdependent/independent self-construals and their relation to psychopathology in a clinical sample of Turkish immigrant and German depressive women. The results indicated that Turkish patients scored significantly higher in interdependence, whereas both groups exhibited similar levels of independence (56). In both groups of patients, the association between psychopathology and an independent self-construal tended to be negative. On the other hand, a higher level of interdependence was associated with lower levels of psychopathology for Turkish patients, whereas the reverse was true for German patients. By comparing a Turkish and an American student sample, another study investigated cultural variations in the relationship between psychopathology and an allocentric (i.e., tradition, conformity, and sociability oriented persons) or idiocentric personality style (i.e., competence, hedonism, and autonomy-oriented people) (57). Similarly, an allocentric style was related to better mental well-being in the Turkish sample but was found to be a risk factor for the American sample. These results provide evidence that the relationship between the interdependent view of the self and depression is moderated by the participant's ethno-cultural background (19,21,58).

WHO MAKES THE CHOICE?

Recently, the integration of motivational and cognitive approaches has been added to the literature to reveal a better understanding concerning differentiation of concepts of the self. Accordingly, two different self-systems have emerged as a result of this integration, namely, autonomy and relatedness. Autonomy refers to "self-rule", a sense of agency and control. Relatedness, on the other hand, is characterized by the emotional and personal bonds

between individuals. It has been theorized that individuals are motivated to achieve some sense of autonomy and relatedness (21,59,60,61,62). The need for autonomy encourages people to strive for being agents of their own life, having the capacity to make informed, uncoerced decisions (63). The need for relatedness is the urge to interact, to be connected, and the experience of caring for others and being cared for by others (64). The roles of autonomy and relatedness have also been a topic of debate in etiological studies of depression. As supported by some empirical evidence, a well-known explanation for depression and its etiology suggests that a diminished sense of personal control (autonomy) and a lack of social support (relatedness) are two important pathways to the disorder (42,65,66,67).

In fact, there is also some evidence that the degree of autonomy and relatedness required for optimal functioning may vary as a function of cultural context (21,48,50,68,69,70). Correspondingly, it has been stated that in Western psychology, the development of a strong sense of autonomy is referred to as a prerequisite for healthy personality, moral, and cognitive development (58). Therefore, more emphasis is given to the development and maintenance of autonomy rather than relatedness. In contrast, collectivistic cultural orientations place greater emphasis on relatedness (rather than autonomy). This might be because of the fact that strivings for autonomy may conflict with the social values of a collectivistic culture (e.g., development and maintenance of social bonds and group harmony) (71,72). In support of these assumptions, a recent study documented that Turkish immigrant parents in Germany tend to focus more on family interdependence and less on the promotion of autonomy in long-term socialization goals for their children than German mothers do (73). Moreover, another study demonstrated that autonomy significantly and positively correlated with life-satisfaction in many highly individualistic societies such as Germany, whereas it was not related to life satisfaction in most collectivistic countries, including Turkey. Additionally, relationship-orientation was not associated with measures of life satisfaction in individualistic nations, including Germany (69). Similarly, a recent study examined the relationship between autonomy/relatedness satisfaction and psychopathology in a sample of healthy and depressed Turkish immigrant women residing in Germany, and their German counterparts (74). Findings indicated that healthy German women benefited only from autonomy satisfaction, whereas relatedness and psychopathology were not related at all. In contrast, only relatedness satisfaction was associated with lower levels of psychopathology, but not autonomy, in healthy Turkish women. These results are in line with those of several studies (58,73,75,76). On the other hand, similar to healthy controls, the experience of relatedness was negatively associated with psychopathology only in Turkish, but not in German patients. Nevertheless, experience of autonomy was negatively associated with psychopathology in both groups. One explanation for this might stem from the clinical profile of the sample of Turkish depressive women suffering from moderate to severe depression and exhibiting very low levels of autonomy. A sense of controlling one's own life might reduce depression, as it might encourage problem solving and promote autonomy regarding stressor-related decisions.

Given that the self is seen as an independent, autonomous, and differentiated entity in Western societies, psychiatric problems are usually conceptualized as deficits in intrapsychic structures (77). Accordingly, an emphasis on autonomy and de-emphasis of relatedness are also evident in contemporary Western psychotherapy approaches (e.g., Cognitive Behavioral Therapy) (78). So, far, the literature indicates a need for further consideration of the interpersonal aspects of depression while working with patients of collectivistic origins.

MANAGING EMOTIONS AS A CULTURAL NECESSITY

Along with cognition and motivation, the role of emotion in psychotherapy has long been a topic of importance in clinical psychology and has been

subject to a great deal of research. For many psychotherapy approaches, emotions play a pivotal role in the intervention process. For instance, Acceptance and Commitment Therapy or Dialectical Behavioral Therapy is often used to address long-term problems regarding emotions, interpersonal functioning, and behavioral change. A major statement of such therapies is that emotions constitute a form of action readiness that adapt people to their environment and therefore promote their mental health. From this perspective, change occurs by encouraging the patients to make sense of their emotions through awareness, expression, regulation, reflection, and transformation (79,80).

However, the mental health outcomes of emotional expression are presumed to be determined by cultural value orientations (81,82,83,84). For instance, in a recent cross-cultural study conducted in 23 countries (82), individualism, egalitarianism, and autonomy were shown to be associated with less frequent use of expressive suppression because of the fact that some cultures encourage assertiveness and free and open emotional expression. On the other hand, collectivism, hierarchy, and relatedness have been shown to be positively associated with the use of expressive suppression because of the fact that some cultures discourage assertiveness and encourage self-regulation to maintain social order and harmony (85). These results are also supported by evidence from facial expression literature (86,87), illustrating that individuals with collectivistic backgrounds tend to control (e.g., mask or neutralize) the display of their feelings more than individuals in samples from individualistic societies do. It is well established and in line with these arguments that the consequences of emotional suppression for mental health are also culture dependent. For instance, in studies conducted with samples from Western individualistic cultures (e.g., Euro-American or European), expressive suppression has been shown to be related to poorer mental health (88,89,90,91), which is more likely to be employed by depressed individuals (89). In contrast, it has been revealed that in collectivistic cultures emotional suppression was used more frequently (89) and was related to lower levels of negative emotion and better mental health (92,93,94) than those in individualistic cultures.

A recent study investigated the use of expressive suppression and the resulting implications for psychopathology among healthy and depressed Turkish immigrant and German women (95). The results indicated that expressive suppression was associated with lower levels of psychopathology in healthy Turkish women, but not in their healthy German counterparts. It was illustrated that the positive mental health outcomes of expressive suppression in Turkish women could be attributed to their more flexible use of emotion regulation strategies (i.e., additional use of other emotional regulation strategies such as cognitive reappraisal). However, cultural differences in the mental health outcomes of suppression were absent in depressed samples. Both groups—depressed Turkish and depressed German women—exhibited a rigid use of expressive suppression (without any other emotion regulation strategies) and suppression was positively associated with psychopathology. These results are in line with the literature, showing that depression is not related to specific emotion regulation strategies (e.g., frequent use of expressive suppression), but that it is rather associated with an inflexible use of specific strategies (e.g., rigid use of suppression) and the disability to adjust emotional responses to changing situations (96). Therefore, it can be concluded, especially for Turkish depressed patients, that the factors that relate to poor mental health is not the presence of suppression, but rather the absence of other functional emotion regulation strategies. These results have important implications for mainstream Western psychotherapeutic interventions, which are usually designed to encourage the open expression of emotion in patients (e.g., open expression of emotions in interpersonal conflicts), although this kind of directness may not be socially acceptable in a collectivist (e.g., Turkish) cultural context.

Furthermore, cultural variations regarding norms related to emotional expression have a potential influence on the experience and expression of forms of dysphoria (i.e., an emotional state marked by anxiety, depression, and restlessness), such as depression. It has been shown that individuals from cultural orientations which restrain open emotional expression are often condemned when expressing emotional problems; their problems are not viewed as appropriate issues to be brought to mental health care. Instead, they are rather viewed as problems which are to be brought to the attention of a family member, an elder, or someone who is familiar with the network of social ties (97). Thus, it is presumable that cultural norms for emotional expression might have further implications for help-seeking behavior, which is an emerging topic subjected to cultural psychology because of low rates of utilization of mental health care services by minority patients.

WHAT CAUSES DEPRESSION AND WHO CAN FIX IT?

Kleinman's Explanatory Model perspective has directed attention to eliciting the cognitive aspects of patients' conceptualization of their illness to unravel the correlates of their choices for treatment and responses to clinical interventions (98). The Explanatory model concerns the patient's understanding of the cause, severity, and prognosis of an illness (i.e., what is the cause? how serious is it?); the expected treatment (i.e., what can be done? who can heal it?); and how the illness affects his or her life. Causal attributions (i.e., attributions that patients make concerning the causes of their health problems) are suggested to present a pivotal cognitive process in the construction of the explanatory model of illness (99) and to a large extent are culturally determined (98,100,101). Theoretical literature suggests that individualistic cultures, attribution style, and causal reasoning are generally directed toward the person rather than the situation or social context, whereas, in collectivistic cultures, social context, and social roles are prevalent in causal reasoning (102,103,104,105). Correspondingly, several psychiatric/psychological and anthropological studies have reported cultural variations in causal attributions about mental distress (106). For instance, among Europeans, the causes of mental illness are more likely to be located within the individual, whereas many non-Western and minority cultures with a collectivistic background cite social relationships as causal (106,107). In support of this argument, some studies conducted with Turkish psychiatric outpatients in Turkey have reported that these patients mainly attribute the cause of their disorder to interpersonal conflicts, conflicts with the current family, conflicts with the family of origin, marital problems, personal characteristics, blame on others, problems at work, fate, and bad luck (108,109). Above all, conflicts with the current family were reported most frequently. In contrast, Townsend (110) demonstrated in a cross-cultural study that German patients regarded mental illness as biologically determined, whereas American patients believed that mental illness is a behavioral phenomenon.

Notably, the given literature also suggests that the patients' beliefs regarding the cause of their illness have an impact on the decision whether or not to seek medical care, their adherence to treatment, and their adjustment to prognosis (111,112). For instance, a comprehensive study has demonstrated that patients who endorse medical beliefs about the causes of their illness are more likely to seek help from medical sources and exhibit higher levels of compliance than the patients who hold non-medical beliefs (113). Given that most of the Turkish immigrants in Europe came from (more) traditional rural areas of Turkey, were poorly integrated, and had a strong commitment to the extended family and social milieu (114), one can argue that the reluctance to seek professional help, premature treatment termination, and low treatment adherence can be attributed to such cultural variations in conceptualizations of mental illness. Although there is considerable evidence demonstrating culturally diverse attributions among Turkish patients regarding the cause of illness, the link to their choice for treatment providers was poorly investigated. To this end,

a recent study investigated the ethnic differences in causal attributions for major depression and whether ethnicity or discrepant causal attributions are most relevant for treatment preferences (115). Turkish immigrant and German depressive patients were interviewed for their beliefs concerning the factors responsible for their health problems (causal attributions) and the appropriate source for help. The results revealed that both groups adopted social factors as causes of their condition. However, German patients were far more likely to name psychological and biomedical factors responsible for their health conditions than Turkish patients were. Concerning treatment, compared to Turkish patients, Germans were again far more likely to recommend professional treatment (e.g., psychotherapy, medication, psycho-education, alternative therapies like relaxation or ergo) as the most valuable tool for recovery. On the other hand, Turkish patients were more likely to recommend non-professional help sources (e.g., social support, self-initiation) than Germans were. Further, it has been shown that causal attributions (attribution to psychological and biological factors) mediate the relationship between ethnicity and the preference of professional treatment resources. That is to say, the difference between Turkish and German depressive patients concerning the preference for seeking professional help could be explained by the differences in their attributions concerning the causes of depression (predominance of psychological and biological attributions in German patients). In accordance with the view of Western medicine and according to most of the German patients, depression was regarded as a disease resulting from the malfunctioning of biological and/or psychological processes and a breakdown in the social realm, which requires professional treatment. In contrast, Turkish patients usually conceptualized depressive experience as social/life problems or emotional reactions to situations resulting mainly from familial or social conflicts and did not have a notion of the biopsychological facts. Thus, the Turkish patient group rarely considered professional treatment (e.g., psychotherapy, psychotropic drugs, psycho-education) as a valuable tool for recovery. Instead, the source for recovery was seen in the regaining of social harmony within the family and social environment. Not surprisingly, it has been reported that Turkish immigrant women in Amsterdam consulted social work facilities and women's crisis intervention centers nearly 1.5 times more than mental health care services (116). As Kirmayer and Sartorius (117) also noted, these results suggest that those patients are not only seeking mitigation of symptoms but also individually and socially meaningful explanations and psychosocial treatments for their illness.

IMPLICATIONS FOR PSYCHOTHERAPEUTIC PRACTICE

The literature suggests important implications for psychotherapeutic work with Turkish immigrant patients. The findings clearly present the significance of collectivistic values, such as social solidarity, collectivity, and embeddedness for the mental health of Turkish patients. This directs attention to the fact that the individualistic approach of Western psychotherapy should be extended to encompass collectivist principles when working with Turkish immigrants. More specifically, given that the self is deemed as an independent, autonomous, and differentiated entity in Western societies, psychiatric problems are usually conceptualized as deficits in intra-psychic structures (77). Consequently, conventional Western therapies (e.g., Cognitive Behavioral Therapy) are often aimed at addressing the autonomy and intrapersonal development of the patient (e.g., promotion of self-efficacy, self-acceptance, self-management, etc.) (118). However, it has been established that Turkish patients also benefit from being interdependent and from having a sense of relatedness. Therefore, the processing of interpersonal issues seems to be functional and necessary for this group (118,119,120). It seems crucial to address person-society conflicts in addition to intra-psychic conflicts so as to meet the needs of this particular clientele and therefore acquire positive treatment outcomes. Additionally, although independence and autonomy were positively related to psychopathology in Turkish patients, one should consider

that traditionally-minded healthy Turkish women from rural backgrounds with low levels of education do not precisely benefit from a differentiated and autonomous self when it comes to mental health. Most traditional non-Westerners are more dependent on their families than people stemming from individualistic and Western societies, and autonomy or self-actualization is rarely accepted by them (119). Likewise, Fisek (121) points out that Western therapists usually overlook the cohesive family structure of Turkish patients, which leaves very little room for the individuation of the person. Therefore, it is important to note that the promotion of independence and autonomy without any consideration of its social counteractions might lead to conflictual family or social environments, with which these patients might be unable to cope (119).

A similar conclusion can be derived from our finding of a positive relationship between suppression and psychopathology in Turkish women. Traditional Western therapy approaches maintain the assumption that suppression of negative emotions is generally harmful and that open expression is the more adaptive strategy (122). Therefore, psychotherapeutic interventions are usually designed to encourage patients to openly express emotion in their everyday lives. However, one should keep in mind that expressive suppression can be functional for Turkish patients for maintaining their interpersonal relationships, as is the case with healthy Turkish women. Moreover, it was indicated that the aforementioned positive consequences of expressive suppression in Turkish women were owing to their additional use of cognitive reappraisal. This finding can lead to the conclusion that what relates to a poor mental health is not the presence of suppression *per se*, but rather the absence of cognitive reappraisal or the rigid and exclusive use of suppression. Hence, rather than discouraging suppression, promoting a more flexible use of emotion regulation strategies (e.g., additional use of adaptive emotion regulation strategies) in psychotherapy seems more fitting for the needs of this patient group. Therapists should be aware that Turkish patients might benefit from expressive suppression to avoid social or familial conflicts-which are frequently reported as causes of their mental distress.

As already mentioned, most Turkish patients conceptualize depression as a social problem or an emotional reaction to situations resulting from a disruption in social/familial relationships. Unlike patients with Western origins, they did not have a notion of biopsychological causes. Therefore, instead of professional treatment, these patients' suggestions for management and health-seeking emphasized self-management and social support. This highlights the importance of psychosocial treatment for this particular clientele. As noted before, without ameliorating familial or social conflicts, working mainly on personal conflicts or using medication alone would probably fail to achieve the desired treatment outcomes. Accordingly, given these patients' group and family orientations, acknowledgement and inclusion of family members in the psychotherapy process (e.g., assessment and therapeutic goals/decisions) might bring better outcomes. For instance, there is some evidence that such biopsychosocial holistic approaches work quite successfully with patients from collectivistic non-Western cultures (e.g., Egypt) (123). A similar recommendation also came from some practitioners working with Turkish patients in Germany. Erim and Mustard (124) highlighted the importance of extending classical Western individualistic treatment approaches with collectivist principles. This could be, for instance, on the one hand working with interpersonal conflicts and the involvement of family members in the therapy; on the other hand, encouraging patients' individuation and social relationships (e.g., through participation in regular activities in clubs or language courses) to promote their integration and, hence, their mental health.

Despite the higher prevalence rates of mental disorders among Turkish patients, the literature points to low service utilization and treatment adherence among this particular group. Consequently, there is an increasing 73

need for the continued provision of culture sensitive, high-quality, evidence-based mental health care. A major solution to enhance the quality of mental health care is the advancement of research on all aspects of the interplay between culture and mental health, including epidemiology, assessment, diagnosis, course, treatment outcome, and prevention of psychopathology as well as appropriateness of the workforce and health services (125). To this end, the current paper attempted to address the cultural correlates of psychological processes underlying mental health among patients in Europe with Turkish origin; this was to inform clinicians concerning culture-specific correlates of psychopathology so as to enable them to present interventions that fit the needs and expectations of this particular patient group. Thus, Turkish patients who have difficulties in initiating and maintaining contact with mental health providers may be more likely to continue treatment if they encounter these culturally congruent aspects of the care process.

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