Sven Barnow · Nazli Balkir (Editors)

# Cultural Variations in Psychopathology

## From Research to Practice

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Cultural Variations in Psychopathology

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## About the Editors

Sven Barnow, PhD, is a Professor and the Chair of the Department of Clinical Psychology and Psychotherapy as well as Head of the outpatient clinic at the University of Heidelberg, Germany. Since 2010, he has been a member of the Advisory Boards for Psychotherapy as well as Personality Disorders: Theory & Practice of the Social Ministry (Treatment for Personality Disorders) Expert Group at the Ministry of Health (BMG). In addition, he serves as an expert reviewer for the German Research Foundation (DFG), the German Academic Exchange service (DAAD), the Israel Science Foundation, and the Austrian Accreditation Council. He holds the Marsilius Fellowship (2011–2012) as part of the Excellence Initiative of the University of Heidelberg. His research combines behavioral and neurophysiological measures to examine emotion regulation and its relation to psychopathology. Further research interests are social and cultural aspects of emotion regulation. He has published more than 150 articles in peer-reviewed journals and book chapters on these topics.

Nazli Balkir is currently a senior-year doctoral candidate at the Department of Clinical Psychology and Psychotherapy of the University of Heidelberg, Germany, on a 3-year full doctoral scholarship from the Excellence Initiative of the university. During this time, she has served as a member and the coordinator of the research project on "How universal is depression?" supported by the German Research Foundation. She holds a BA degree in psychology as well as an MA degree in clinical psychology and completed her training in cognitive and behavioral psychotherapy in Istanbul, Turkey. Her current research explores the role of cultural factors in dysfunctional/abnormal behavior or experience. Further research interests involve the potential relevance of indigenous explanations of distress and healing techniques for culturally tailored modalities of psychotherapy, prevention programs, and mental health service delivery.

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# Foreword

Culture is an integral part of individual development and functioning. The impact that culture has on individuals may be acute or insidious. As the world becomes a global village as a result of globalization, it is inevitable that movement of resources, including people, will become more frequent.

We know that culture influences the way we express emotional distress, how abnormality is defined, how help is offered and from where therapeutic intervention is sought. Culture dictates expressions of illness as well as our understanding. The debate between cultural universalism and relativism is critical in psychiatry. As our patients migrate, mental health professionals move around as well. Therefore, the need to attempt to understand how cultures define and explain distress becomes urgent.

This book, emerging as a result of a closed workshop in Heidelberg, is a welcome addition to the ever-expanding field of our understanding of cultural variations. The reader will find stimulating topics that deserve further discussion and debate as we continue to strive towards providing better clinical care to our patients, irrespective of their ethnicities and cultures.

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# Preface & Acknowledgments

This book is based on an international closed workshop on "Cultural Variations in Emotion Regulation and the Treatment of Psychiatric Patients" organized by the research team of the Institute of Psychology at Heidelberg University, Germany, December 16–17, 2010. The workshop was organized in conjunction with and supported by grants from the Cluster of Excellence "Asia and Europe in a Global Context," of the Karl Jaspers Center for Advanced Transcultural Studies at the University of Heidelberg. Many of our colleagues assisted in the organization of the workshop and it is quite impossible to list all the people who contributed to the success of this effort. Our appreciation goes to the entire academic and nonacademic staff of the Institute od Psychology and of the Karl Jaspers Center for their help and support. Special thanks go to our colleague Elizabeth A. Arens, also the author of one of the chapters in this book, who gave her valuable assistance both for the organization of this workshop and for the editing process of the current book.

The aim of the workshop was to bring together a variety of distinguished academics and practitioners working with patients from ethnically diverse minority populations to exchange perspectives and methods for research and practice. We are grateful to all those who participated in the workshop and wish to thank them all for stimulating discussions. Our special appreciation goes to the contributors of this book, for devoting their valuable time to revising their papers for publication. The chapters included in the present book cover a wide range of subjects relating to cultural psychology – from basic issues to clinical matters from an interdisciplinary perspective. We genuinely hope that this volume will help researchers and mental health professionals working with ethnically diverse (migrant) communities in Europe and throughout the world to conduct relevant research and advance culturally sensitive practice in mental health care.

*Sven Barnow & Nazli Balkir*
July 2012

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# I. Introduction

## The Relevance of Culture for Mental Health and Illness

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# Introduction

Sven Barnow and Nazli Balkir

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In the era of globalization there is a significant increase in population movements and contacts between societies and cultures. Presently, more people are moving further and faster than ever before. Historically, the number of immigrants in the world has more than doubled since 1975, with most immigrants living in Europe (56 million), Asia (50 million), and Northern America (41 million). The increasing inflow of immigrants has led Europe to become a growing pluralistic society. Each year, an average of 1.8 million people who are in search of work or are asylum seekers immigrate to Europe permanently (Lindert, Schouler-Ocak, Heinz, & Priebe, 2008). Migration is known to have significant effects on mental health. It is well established that immigration and its related acculturation stress are associated with higher risk for mental disorders, such as anxiety and depression (e.g., Bhugra, 2003). The increased diversity of service users for mental health constitutes a substantial challenge to service providers not only in EU countries but also in other developed countries receiving international immigrants. People from different ethno-cultural backgrounds often have different perceptions and comprehension of *mental health* and illness and are habituated to different modes of mental health care as well. This often results in a detrimental discrepancy between the needs and expectations of patients and the service providers, which attenuate the effectiveness of treatment and lead to unexplained high drop-out rates (White & Marsella, 1982). In support of this argument, it has been well demonstrated that the members of ethnic minority groups exhibit higher rates of drop out and lower rates of compliance to treatment compared to the native population (Haasen, Lambert, Yagdiran, & Krausz, 1997).

In response to these problems, one of the central contributions that mental health professionals can make to this process is the continued provision of culture sensitive, high-quality, evidence-based mental health care. A major solution to enhance the quality of the mental health care is the advancement of research on all aspects of the interplay between culture and mental health, including epidemiology, assessment, diagnosis, course, outcome treatment, and prevention of psychopathology as well as appropriateness of the workforce and health services (see Figure 0.1). Although the ethical, social, and political importance of considering cultural diversity in mental health care is formally acknowledged, cultural psychology is still in its infancy and is not yet officially considered as an approach by the majority of the institutions and providers of mental health care in most of the developed countries (Kirmayer, Rousseau, Corin, & Groleau, 2008). Correspondingly, compared to the other fields of mental health, the quantity and

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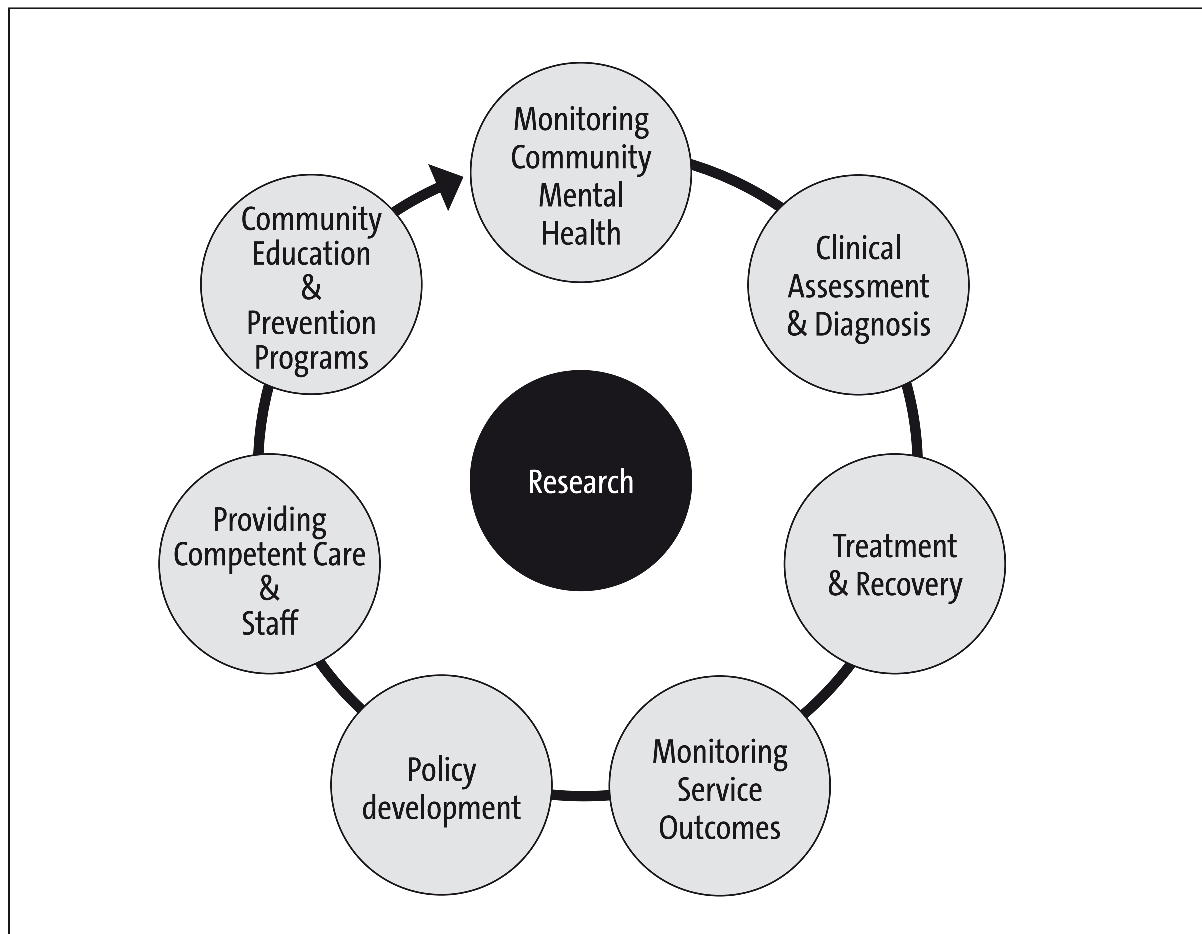


**Figure 0.1.** Areas of research in mental health care required for improving the quality of care provided to ethnic minority clientele.

quality of research relating to cultural psychology that is available to colleagues in and outside of Europe remains considerably limited.

In response to this limited research, with 16 chapters arranged into five sections, the objective of this book is to illuminate and understand the interplay between migration, culture, and psychopathology as well as its implications for service delivery in mental health care. We are of the opinion that an enhanced appreciation of the impact of socio-cultural factors on mental health will serve both to deepen the understanding of cultural diversity and to enhance the quality and acceptability of the mental health care provided to all. To this aim, we begin with the examination of repercussions of migration on mental health. In the first section, chapter 1 (Schouler-Ocak) provides an introductory overview of recent trends in immigration to Europe and a brief examination of epidemiology of common mental disorders prevalent among immigrants (e.g., suicidality, psychosis, affective and addictive disorders, and dementia) and thus facilitate the identification of risk and protective factors.

Subsequently, in order to obtain a better understanding of the interplay between culture and psychopathology, we provide a preliminary section that sheds light on the ways

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that culture shapes our brain. In chapter 2, Han provides fascinating data showing that neural substrates underlying self-related processing differ between Western and East Asian cultures. In chapter 3, Northoff and Panksepp explain how the self is related to emotion regulation and he presents data revealing that self-rated processing is related to activity in subcortical and cortical regions. Further, based on an evolutionary viewpoint he argues that self-related processing is present in different animals in different degrees. These findings can help us to understand how culture shapes self-rated processing in the brain.

Coming from this basic neurobiological research, our next focus is on the ways in which culture influences the development, course, and outcome of psychopathology. Given that emotion regulation is a transdiagnostic approach to the etiology and maintenance of psychopathology (Fairholme, Boisseau, Ellard, Ehrenreich, & Barlow, 2009), the third section starts with how cultural factors and socialization affects emotion regulation strategies, and how these strategies are associated with psychopathology. Accordingly, chapter 4 (Trommsdorff and Heikamp) discusses universal and culture-specific aspects of socialization of emotion regulation by providing some cross-cultural studies on the function of parental support, control, and sensitivity for emotion development and regulation. The authors argue that cultural models of self-other relations are transmitted through beliefs and culture-based practices, which in turn have an impact on emotion regulation. The main message from her work is that studying cultural context is important for the understanding of how emotion regulation relates to social competence and mental health.

Chapter 5 (Butler) completes the picture of the association between culture and emotion regulation by illustrating the ways in which cultural contexts modulate emotion regulatory processes and how this is related to mental health. Butler emphasizes that emotion regulation can be conceptualized in different ways. One is that the regulation of emotions is not constrained within a person; instead it is embedded in a larger cultural context. Thus, culture influences many aspects of emotional responding, which is often neglected in studies.

Chapter 6 (Arens) covers a recent study on how culture moderates the relationship between emotion regulation and mental health in the presence of psychopathology. The author asks whether or not cultural differences end where psychopathology begins. In her study she shows that healthy Turkish women less often use emotion regulation strategies such as reappraisal, but suppress their emotions more often in comparison to a healthy German control group. However, if one considers depressive patients these cultural differences disappear. These findings may indicate that although cultural differences in emotion regulation strategies exist, they are not dependent on psychopathology.

In section four, there are several chapters focusing on the cultural variations in the clinical course and manifestation of mental disorders and its implications for diagnosis and clinical assessment. For example, chapter 7 (Mezzich) aims to provide conceptual rationales for the inclusion of cultural factors in psychiatric diagnosis (i.e., cultural formulation approach) and suggestions for the content and use of this approach. Chapters 8 through 13 review the results of several studies of incidence and prevalence, patterns

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of clinical course, and outcome of common mental disorders prevalent among minority population. Readers are encouraged to understand the social world within mental illness and to realize the limitations of traditional constructions of illness.

The final point of consideration of this book is to shed more light on the ways in which the knowledge about the implications of cultural diversity is transferred into specific standards, policies, practices, and attitudes to eliminate ethnic disparities in mental health care. Therefore, cultural competence at individual (e.g., professionals) and systems level (mental health care organizations) was the focus of section five. In the first instance, chapter 14 (Balkir) reviews the sociocultural construction of mental illness and help-seeking behavior, in order to inform the professionals concerning the mental health care needs of ethnic minority clientele and therefore provide practical solutions for their differential service utilization. Here, we illustrate that culture is one of the major determinants of recognition of symptoms and consequently the interpretation, conceptualization, and reaction to distress, all of which determine the choice of and adherence to treatment.

Furthermore, chapter 15 (Qureshi and Eiroa Orosa) introduces cultural competence theory and practices that have the capacity to increase the mental health care professionals' proficiency in serving ethnic minority clients. This chapter presents an interpretive-relational approach to cultural competence conceptualized as a process of self-introspection rather than knowledge gathering. The final chapter (Machleidt et al.) deals with the ways in which the definition of cultural competence has been adopted by mental health care systems. By exemplifying Sonnenberg Guidelines for psychiatric-psychotherapeutic management of immigrants in Germany, the authors provide practical solutions for translating such guidelines into hands-on strategies that would renovate mental health services to make them more effective for ethnic minority populations.

To summarize, this book examines the current state of the art by exploring the broad scope of cultural psychology. It is our hope that readers' understanding of the multiple ways in which culture and human behavior can be intertwined will be enriched. We believe that an enhanced comprehension of the interplay between culture and mental health will strengthen the quality of every phase of mental health care continuum – from research to clinical practice.

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# Chapter 1

# Migration and Mental Health

## An Overview from Europe

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**Abstract**

The total number of immigrants living in Europe in 2010 was 32.5 million, representing 6.5 % of the EU-27's population. Given that migration is strongly associated with higher risk for mental disorders, multiethnic societies in Europe are faced with a multiplicity of challenges, including meeting the diverse mental health care needs of ethnic-minority groups. These days, mental health specialists have regular contact with patients from different cultural backgrounds, whose health conditions also differ due to their immigration history and the social conditions in which they live in the receiving country. In this chapter an overview on risk and protective factors associated with migration and acculturation with special emphasis on suicidality, psychosis, affective and addictive disorders, and dementia are given. In order to promote mental health and its care among immigrant groups, clinicians, policymakers, and service providers need to be aware of specific needs of these immigrants.

**Keywords:** migration, mental disorders, Europe

## Introduction

*Migration* is a process in which a person moves from one cultural setting to another in order to settle semi-permanently or permanently (see http://www.un.org/esa/population/publications/ReplMig). Immigrants may move en masse or singularly in many forms, including forced or voluntary movement for several reasons, such as political, economic, or educational. Although it is difficult to distinguish between forced and voluntary migration, the forms of migration often include both elements. While precise figures for the number of people moving for economic reasons remain elusive,

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it is estimated that over 200 million people move every year to find work and a better life. Of these, at least 30 million are so-called undocumented immigrants (Lindert, Schouler-Ocak, Heinz & Priebe, 2008). Historically, the number of immigrants in the world has more than doubled since 1975, with most immigrants living in Europe (56 million), Asia (50 million), and North America (41 million) (Lindert, Schouler-Ocak et al., 2008). In 1990, immigrants accounted for over 15% of the population in 52 countries. Most of the migration was from developing to developed countries (see http://www.eds-destatis.de/).

The total number of immigrants (people who are not citizens of their country of residence) living on the territory of the EU Member States on January 1, 2010 was 32.5 million, representing 6.5% of the EU-27's population. One year earlier, on January 1, 2009, the number of immigrants was 31.8 million, or 6.4% of the total population. More than one-third (a total of 12.3 million) of all immigrants living in the EU-27 on January 1, 2010 were citizens of another EU Member State. In absolute terms, the largest numbers of nonnationals living in the EU on January 1, 2010 were in Germany (7.1 million), Spain (5.7 million), the UK (4.4 million), Italy (4.2 million), and France (3.8 million). In relative terms, the EU Member State with the highest share of immigrants was Luxembourg, where immigrants accounted for 43.0% of the population at the beginning of 2010. The vast majority (86.3%) of nonnationals living in Luxembourg were citizens of other EU Member States (see http://epp.eurostat.ec.europa.eu/statistics_explained/index.php/Migration_and_migrant_population_statistics).

Similarly, the immigrants in Europe constitute a heterogeneous group in regard to their reasons for migration, legal status, and country of emigration as well. For instance, the majority of immigrants in Central and Eastern Europe and Scandinavian countries come from elsewhere in Europe. Germany's immigration field is also strongly European, and along with Austria and Finland receives a high proportion of its immigrants from Central and Eastern Europe. Mediterranean countries, together with the UK and The Netherlands, attract a high proportion of immigrants beyond Europe. Almost a third of the UK's and Spain's immigrants come from outside Europe (Carta, Bernal, Hardoy, & Haro-Abad, 2005). In recent years, there has been a sharp decrease in the number of asylum applicants in the EU. Having peaked in 1992 (670,000 applications in the EU-15) and again in 2001 (424,500 applications in the EU-27), there were an estimated 263,400 asylum applications received in the EU-27 in 2009. In absolute terms, the highest number of positive asylum decisions in 2009 was recorded in the UK (15,555), followed by Germany (12,060), France (10,415), Italy (9,110), and Sweden (9,085). Altogether, these latter Member States represented no less than two thirds of the total number of positive decisions issued in the EU (see http://epp.eurostat.ec.europa.eu/statistics_explained/index.php/Asylum_statistics).

Given that migration is strongly associated with higher risk for mental disorders (Bhugra, 2003), multiethnic societies in Europe are faced with a multiplicity of challenges, including meeting the diverse mental health care needs of ethnic-minority groups. These days, mental health specialists have regular contact with patients from different cultural backgrounds, whose health conditions also differ due to their immi-

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gration history and the social conditions in which they live in the receiving country. Besides, various studies demonstrated that culture plays an important role in the presentation of distress and illness, and cultural differences impact upon the diagnosis and treatment of immigrant populations in part due to linguistic, religious, and social variation from the clinician providing care (Bhugra et al., 2011). In order to achieve optimal results in diagnosing and treating mental disorders, it is important to consider the cultural and migrational background of the patients, which may have an impact on their explanatory models of mental disorders (see chapters 7, 8, and 14). Moreover, cultural competency and using cultural formulations are other important issues that should be dealt with (see chapter 15).

There is every appearance that the wider determinants of immigrants' mental health are often different from those of the settled community and require a different approach from health care professionals. Given the provision of mental health care is highly determined by the needs of its clients, an understanding of the illness experience of ethnic minority patients seems highly relevant in order to seek out and attempt to effectively address their mental health needs (Maffla, 2008). However, relevant data on immigrants' mental health concerning incidence, prevalence, and etiology of mental disorders and the utilization of mental health and psychosocial care facilities are relatively outnumbered (Lindert et al., 2008). Therefore, a major issue facing Europe is filling the current gap in the availability of high-quality data on mental health determinants, mental health status, and service utilization among immigrant populations throughout the region. As evidence-based decision making in public health and mental health care greatly depends on the availability of relevant health information, improving the collection of valid and comparable ethnic-minority health data should be regarded as a high priority (Rafnsson and Bhopal, 2008) (see chapter 14).

## Risk and Protective Factors Associated with Migration and Acculturation

Migration can be a critical life event that is characterized by the processes of adaptation and readjustment, such as adjustment to a new culture, a new language, or a new religion, in which the coping strategies that were successful in the past are sometimes not suited for the new situation. This gap between the culture of origin and the host culture places immigrants at particularly high risk of social isolation, psychological distress, and reduced quality of life (e.g., unemployment, low education, poor living conditions, etc.) (van Bergen, Eikelenboom, Smit, van de Looij-Jansen, & Saharso, 2010; Berltolote, 2004). Other risk factors include loneliness, homesickness, loss of status, language problems, resident permit status, and open racism, which particularly result in higher prevalence rates of mental disorders in immigrants compared to the native population. For instance, various studies demonstrated that compared to the native population, the prevalence rates of depression, anxiety, or suicidal behavior are higher in immigrant

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populations (Hovey, 2000a, 2000b; Hovey & King, 1996; Kiev, 1980; Trovato, 1986; Hovey & Magaña, 2000; Merbach, Wittig, & Brähler, 2008; Bhugra, 2004; Bermejo, Mayninger, Kriston, & Härter, 2010). Bermejo et al. (2010) reported a migration-sensitive reanalysis of the supplement survey "mental disorders" of the German Health Survey 1998/1999, in which 143 immigrants were compared with 3,740 Germans. The authors pointed out that the results demonstrated significantly higher 4-week, 12-month, and lifetime prevalence rates of mental disorders for immigrants in comparison to Germans. These differences are highest regarding affective disorders (4-week prevalence: 11.7 vs. 5.8%; 12-month prevalence: 17.9 vs. 11.3%; lifetime prevalence: 24.9 vs. 18.2%) and somatoform disorders (4-week prevalence: 15.5 vs. 6.9%; 12-month prevalence: 19.9 vs. 10.3%; lifetime prevalence: 24.1 vs. 15.4%). The authors underlined that this study was a basis for further investigation of the relation between migration and mental health as well as for developing a culturally sensitive health care (Bermejo et al., 2010). On the other hand, it was also revealed that some key protective factors such as level of networking with other immigrants from the same country of origin, similarities between norms and values of the country of origin and the receiving country, and being successful after migration are associated negatively with mental disorders, which can be used in treatment planning (Porter & Haslam, 2005; Grüsser, Wölfling, Mörsen, Albrecht, & Heinz, 2005).

The following sections aim to provide an overview of some key epidemiological studies related to common psychiatric conditions prevalent in immigrants and in order to highlight potential interventions for promoting mental health among this specific patient group.

## Migration and Suicidality

The major risk factors for suicide are described as potentially modifiable and nonchangeable factors. Gender, age, ethnicity, sexual orientation, and previous suicide attempts belong to the nonchangeable factors while access to methods, history or presence of a psychiatric disorder or a physical illness, social isolation, unemployment, anxiety, hopelessness, and reduced life satisfaction, most of which are associated with immigrant status as well, are placed under the rubric of potentially modifiable risk factors (Berltolote, 2004). Furthermore, it has also been revealed that suicide risk increases in the 10 years following migration (Kwan & Ip, 2007) if the age at migration was less than 12 years (Peña et al., 2008; Borges, Nock, Medina-Mora, Hwang, & Kessler, 2009) and with the frequency of residential changes (Ott, Winkler, Kyobutungi, Laki, & Becher, 2008).

Studies demonstrated substantial differences in suicidal ideation and suicidal behavior between immigrant groups. Whereas some studies have reported lower risk for suicide among some ethnic minority groups compared to majority population (Razum, Zeeb, Akgün, & Yilmaz, 1998; Razum, Zeeb, & Rohrmann, 2000; Razum & Swamy, 2001; Razum & Zeeb, 2004), other studies revealed that some ethnic groups exhibit higher suicide rates than those found in their countries of origin and in the host country

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into which they have immigrated (Garssen, Hoogenboezem & Kerkhof, 2006). Likewise, data of the mortality statistics from 1980 to 1997 in Germany revealed lower suicide rates in immigrants than in Germans (relative risk: 0.3). However, the group of young Turkish women shared out of line with a rate twice as high compared to same-aged native women (relative risk: 1.8) (Razum & Zeeb, 2004). In comparison to this, the suicide rates in Turkey were much lower than in immigrants of Turkish origin in Germany, which can be explained by the social coherence in the Turkish society (Sayil, 1997). Furthermore, it has been revealed that the higher rate of suicides in young Turkish immigrant woman is moderated by family conflict, which appears to be a precipitating factor. This family conflict might be due to an intergenerational culture conflict when those young women start to individuate. Likewise, another study demonstrated that the rate of suicide attempts in Turkish female immigrants who were treated in a psychiatric hospital increased by the factor 3.02 compared to the rate of German female patients (32.2% Turkish immigrants) (Grube, 2004). Another study on suicide attempts of Turkish immigrants in emergency rooms revealed that the group with the highest risk to attempt suicide is the second generation (Yilmaz & Riecher-Rössler, 2008; van Bergen, Smit, van Balkom, van Ameijden, & Saharso, 2008; Peña et al., 2008; Borges et al., 2009; Fortuna, Perez, Caninco, Sribney, & Alegria, 2007). In the Netherlands young immigrant women of South Asian, Turkish, and Moroccan origins demonstrated disproportionate rates of nonfatal suicidal behavior. For instance, van Bergen et al. (2008) collected data on suicidal behavior and ideation among female Turkish immigrants (aged 16–24), who had significantly more suicidal ideation (38.1%) compared to Dutch girls of the same age (17.9%) and compared to the same-aged Moroccan girls (12.8%). In a similar study, van Bergen et al. (2010) found that rates of attempted suicide among Turkish and South Asian-Surinamese young women were higher than that of Dutch females, while Moroccan females had lower rates than Dutch female adolescents. The authors pointed out that physical and sexual abuse and an impaired family environment, as well as parental psychopathology or parental substance abuse, contributed to nonfatal suicidal behavior of females across ethnicities. These risk factors, as well as low social economic class and level of education, did not fully explain the vulnerability of Turkish and South Asian-Surinamese females (van Bergen et al., 2008, van Bergen et al., 2010). The analysis of van Bergen et al. (2010) included a comparison of class factors as well as psychiatric and psychological risk factors. In at least half of the cases, South Asian, Turkish, and Moroccan women experienced specific stressful life events related to their family honor. Although these findings can be incorporated into strategies for prevention, the origins of ethnic disparities in suicidal behavior deserve further examination.

## Migration and Psychosis

A growing body of evidence suggests that migration is a risk factor for the development of schizophrenia, although the putative mechanism remains unclear. Several European studies indicated a higher prevalence of schizophrenia and schizophrenia spectrum disor-

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