SUMMARY

Over the centuries, the Netherlands have been an immigration country for people from Europe and other continents. Nowadays, the largest non-Western ethnic groups are first- and second-generation immigrants from Turkey, Morocco, Surinam and the Netherlands Antilles. In the four major cities these four groups form up to a quarter of the population. Migrants have an increased risk of developing a mood disorder, as has been shown in a meta-analysis. Increasingly, patients with depressive or anxiety disorders from Turkey, Morocco, Surinam and the Netherlands Antilles seek treatment not only in primary care services, but also in psychiatric services. Their access to mental health services is more or less equal to that of native Dutch patients. However, many clinicians experience difficulties in treating these patients. They are concerned about their ability to make an adequate diagnosis because of the widespread knowledge that culture may shape the expression of depression and anxiety. Clinicians also show hesitations about the type of treatment they should offer, because the factors that precipitate the depressive or anxiety disorder supposedly differ from those in native patients: depression in migrants is the result of socioeconomic deprivation or from the stress related to living in another culture, they assume. And treatment programs in psychiatric services tend not to address these stressors. In other words, ethnicity is an obstacle in mental health care. However, are these assumptions valid? Evidence is inconclusive, because it is limited to case reports, studies in specific ethnic groups, research among patients who are in treatment, or studies in non-random community samples. Moreover, findings are often not tested against data from native patients. Therefore, the general aim of this thesis is to examine whether depression and anxiety in non-Western immigrants differ from depression and anxiety in native Dutch people (Chapter 1). If we find cross-cultural differences, this would point to the need for ethnicity-specific mental health care; if we find cross-cultural similarities, this could help to diminish concerns about the application of state-of-the-art diagnosis and treatment of depression and anxiety in the major ethnic minority groups in the Netherlands. In the studies presented in this thesis I compared the clinical picture and several risk factors or supportive factors of anxiety and depression in Turkish-Dutch, Moroccan-Dutch, Surinamese-Dutch and native Dutch subjects. To study these research questions I used data from several surveys performed by the Public Health Service (GGD) of Amsterdam (Chapter 2-6 and 8), and by the Public Health Services of Rotterdam, Den Haag and Utrecht (Chapter 7).

In the first study (Chapter 2), using structured diagnostic interviews in the respondents mother tongue, we estimated the prevalence of depressive and anxiety disorders in the different ethnic groups in Amsterdam, based on a weighed population sample (N = 830). Turkish men and women and Moroccan men had a higher risk of current affective disorders than native Dutch residents. These ethnic differences could not be explained by socioeconomic differences. In the same sample, we studied ethnic differences in the depressive symptom profile (Chapter 3). The results showed that the depressive symptoms were comparable across ethnic groups. So, we did not find support for the ideas that non-Western migrants are likely to ‘somatise’, or that they endorse different cognitive symptoms. Moreover, depression severity was equally associated with functional impairments in the ethnic minority and native Dutch groups. Next, we examined the assumption that non-Western
patients may present with combined features of depressive and anxiety disorders, rather than with ‘pure’ depressive or anxiety disorders (Chapter 4). Turkish-Dutch and Moroccan-Dutch subjects reported a higher prevalence rate of combined anxiety and depressive disorders than native Dutch subjects, but this was due to higher overall prevalence rate of depressive disorders in Turkish-Dutch respondents and a higher severity level of the depressive disorder in Moroccan-Dutch respondents. We did not find a stronger overlap between anxiety and depressive symptoms in immigrants than in native Dutch subjects. In addition, the order of onset of the two disorders was similar in all ethnic groups, with anxiety disorder preceding depressive disorder.

In the second part of this thesis I investigate whether more-or-less established risk or supportive factors for depression and anxiety hold in non-Western migrants. In Chapter 5, we explored the role of personality traits, using the five-factor model of personality. The association between personality factors and disorders or symptoms of anxiety and depression appeared to be very similar in the Turkish-Dutch, Moroccan-Dutch and native Dutch respondents: all groups showed the typical profile of high neuroticism, and low extraversion, agreeableness and conscientiousness. Provoked by recent prospective studies on the association between the metabolic syndrome, and particularly (abdominal) obesity and depression, we also investigated ethnic differences in the association of cardiovascular risk factors and depressive and anxiety symptoms, using data from a more extensive survey of the Public Health Service Amsterdam (N = 1,183) (Chapter 6). In this study, the majority of the investigated cardiovascular risk factors was not associated with psychological distress. However, the association of obesity with psychological distress varied by gender and ethnicity: obesity was associated with psychological distress in native Dutch women, but not in Turkish-Dutch or Moroccan-Dutch men or women, nor in native Dutch men. Next, we studied the protective effect on mental problems of living in a neighbourhood with a high concentration of people of the same ethnicity (ethnic density) (Chapter 7). Protective ethnic density effects are assumed to operate through improved social support or by reducing the frequency of experiences of racism. We used data of the G4 Monitor (N = 16,832), a postal survey by the Public Health Services in the four major cities of the Netherlands, to assess in a multilevel model the association of ethnic density with psychological distress, while adjusting for individual and neighbourhood level socioeconomic indicators. The results showed that individual demographic and economic risk factors outweighed by far the influence of ethnic density on psychological well-being in all ethnic groups. Finally, we explored whether the association of religious coping and depression in the different ethnic groups dispose of universal characteristics or whether they reflect cultural diversity (Chapter 8). Citizens of Amsterdam vary widely in their religious affiliations: the majority of the Turkish-Dutch and Moroccan-Dutch are fairly orthodox Muslims; the Surinamese-Dutch adhere to a range of religious traditions and the native Dutch are largely secularized. Nevertheless, across the ethnic groups, religious struggle (negative religious coping) was associated with depression. The most consistent association was found for the item ‘feeling abandoned by God’, which suggests how depression represents an existential void, irrespective of the religious background.

The outline that emerges from the studies in this thesis is that ethnicity is not a defining feature in the diagnosis and risk factors for depression and anxiety in Turkish-Dutch, Moroccan-Dutch
and Surinamese-Dutch individuals. Ethnic background has been given a too prominent place in the search for factors which influence mental health of immigrants. In the general discussion (Chapter 9) I propose two mechanisms which may play a role. Firstly, the impact of ethnic identity is overrated, while the impact of socio-economic status is underestimated. Secondly, ethnicity has a ‘strategic role’ in the consultation room. As long as clinicians can diagnose and treat non-native patients without difficulty, they do not pay attention to their ethnic background. However, when problems arise in the consultation room, like drop-out or non-response to treatment, then clinicians tend to interpret problems in their medical treatment as problems that go together with the patient’s ethnic background. The findings in this thesis may help to diminish concerns about the applicability of state-of-the-art diagnosis and treatment of depression and anxiety in the three major ethnic minority groups in the Netherlands. They urge clinicians to apply structured assessment of psychological symptoms and disorders. Psychotherapy is feasible in more patients with non-Western background than assumed. Training in cultural competence for mental health workers stimulates to communicate with such an open attitude. Further implications of this thesis are the need for critical evaluation of the definition of ethnic groups in further research, renewed attention for socio-economic characteristics and cooperation with other academic disciplines to deepen our understanding of mental illness in the wide variety of patients.