Chapter 1

General Introduction
BACKGROUND

“All I can do, is just prescribing tablets”, complained a colleague, describing his struggle in treating elderly Turkish male depressed patients. No, I never felt that way, working as a psychiatrist in Amsterdam and Utrecht. Yes, I had felt powerless too, trying to improve the life of mr B., who passed his days smoking, sitting alone in a darkened bedroom, sleepless at night. What had happened to this man who as a youngster had come from Morocco to this new country, who had worked long hours in a bakery, and succeeded to have his loving wife and lively children come over to Amsterdam? Why had he fallen ill and why did he remain ill? By which means could I help him, as medication was only marginally effective and our conversation was limited to two-word answers from his part? By either frustration or compassion, my colleague and I concluded each that ‘they are different’. That explained why our depression treatment was ineffective. None of us had any difficulty in pointing out the difference between them and our other patients: they were immigrants from non-Western countries. Ethnicity as an obstacle in mental health care. My research question was born: how different is depression in migrant patients compared to native Dutch patients? In other words, a cross-cultural comparison of depression.

Laurence Kirmayer, an eminent anthropologist and psychiatrist, describing the cross-cultural psychiatry in historical perspective, stated that cultural psychiatry ‘emerges from a history of encounters between people of different backgrounds, struggling to understand and respond to human suffering in contexts that confound the alien qualities of psychopathology with the strangeness of the cultural ‘other’.’ (Kirmayer, 2007). Early studies focused on the exotic and were peppered with reports of so-called culture-bound syndromes. Julian Leff was one of the first to introduce epidemiological methods to make systematic cross-cultural comparisons (1973). The introduction of the DSM-III in 1980 stimulated a series of cross-national studies on the prevalence, course and outcome of major psychiatric disorders, which confirmed the assumption that depression is a medical condition occurring world-wide (WHO, 1983). Later comparative studies included anxiety disorders, which were found to have high prevalence rates too, although estimates vary widely across nations (WHO ICPE, 2000). But questions remained on the ‘strangeness’ of the symptoms and pathogenesis of depression and anxiety in patients from non-Western cultures.

MIGRANTS IN THE NETHERLANDS

In the Netherlands the four largest non-Western ethnic groups are from Turkey, Morocco, Surinam, and the Netherlands Antilles. Currently 7.5% of the Dutch population originates from one of these four countries; 51% of these are first generation immigrants and 49% second generation immigrants. In Amsterdam, Rotterdam, and the Hague these four immigrant group form a quarter of the population; in Utrecht 16.4% of the population (Centraal Bureau voor de Statistiek, 2012a). Labour migration from Turkey and Morocco started halfway through the 1960s, when Western Europe’s economy recovered rapidly and large labour shortages appeared. As in France, England,
Belgium, and Germany, Dutch companies recruited labourers from poorer countries: initially from Italy, Spain and Yugoslavia, later from Turkey and Morocco. Eventually the Dutch government entered special contracts with the Turkish and Moroccan government to realize labour recruitment on a larger scale. In Turkey, mainly people from the Anatolian plateau were thus recruited; in Morocco, recruitment took place particularly among the Berbers of the Rif mountains. Many Turkish and Moroccan workers settled in the Netherlands permanently and brought their wives and children over in order to reunite their families. When the children of the original immigrants reached marriageable age and preferred partners from their homeland, this resulted in a new influx of immigrants. Nowadays, increase of people of Turkish and Moroccan background is mainly due to childbirth, as many are in childbearing age (Sociaal Cultureel Planbureau, 2011).

Large groups of Surinamese immigrants settled in the Netherlands around the declaration of the independence of Surinam in 1975. Another immigration peak of the Surinamese occurred by the end of the seventies due to the deterioration of the economic and political circumstances in independent Surinam. It is estimated that approximately half of the Surinamese people living in the Netherlands are of Hindu origin, 40% of Creole origin, and the remainder of Javanese origin (like the father of Olympic gold medal winner Naomi Kromowidjojo), Amazon Indian, Chinese and Lebanese origin. In addition, the Netherlands has a considerable population of Antillean migrants. Officially, Antilleans are not immigrants, because the Netherlands Antilles are still part of the Kingdom of the Netherlands. Return migration among this group is high.

In their Annual Integration Report the Netherlands Institute for Social Research describes the structural integration of non-Western migrants into Dutch society (Sociaal Cultureel Planbureau, 2011). The educational disadvantage of migrants is diminishing. Over the last year, plagued by the economic crisis, the unemployment rate of non-western migrants has risen more steeply than among Dutch natives. Non-Western migrants are more often dependent on benefits, have a lower average income and are more often poor than the native Dutch. Non-Western migrants have been closing the housing quality gap in recent years. Home ownership, and thus overall housing quality, is increasing rapidly among the second generation of Turkish, Moroccan, and other non-Western migrants. This is accompanied by an exodus of non-Western migrants from the large cities to the peripheral municipalities. Non-Western migrants continue to be heavily overrepresented in the suspect rates. This general picture masks a very diverse reality. Of the four main non-Western groups, those of Surinamese origin are in the most favourable position. Their unemployment rate is relatively low, they are often in paid work, and their economic independence is high.

The immigrants brought new religious traditions to the Netherlands. The vast majority of immigrants form Turkey and Morocco are Muslims. They emphasize traditional aspects of Islam and have relatively high rates of mosque attendance ((Buijs & Rath, 2003). The divers ethnic composition of the Surinamese immigrants is reflected by the range of religious traditions to which they adhere: Christian, Hindu, Islam, and other religions. In contrast, the majority of native Dutch residents of Amsterdam has no religious affiliation; about one third has a Christian denomination.
MENTAL HEALTH IN MIGRANTS IN THE NETHERLANDS

Over the last decades, epidemiological studies have yielded information on the incidence and prevalence of psychotic and mood disorders in non-Western migrants compared to natives. The risk of psychotic disorders in migrants is consistently found to be increased. A meta-analysis of 18 studies of schizophrenia and other psychotic disorders estimated mean relative risks of 2.7 and 4.5 for first-generation and second-generation migrants respectively (Cantor-Graae & Selten, 2005). In a large first-contact incidence study in the Netherlands, Veling (2006) differentiated between the major immigrant groups. The incidence of schizophrenia was increased for all first generation non-Western immigrants. The risk was particularly high for second generation immigrants: the age- and gender-adjusted incidence rate ratio was 5.8 (95% CI, 2.9–11.4) for Moroccans, 2.9 (1.6–5.0) for Surinamese, 2.3 (1.0–5.4) for Turks, and 3.5 (1.8–6.8) for immigrants from other non-Western countries.

In contrast, population-based incidence studies on mood disorders have not yielded conclusive evidence of an increased risk in non-Western migrants. Epidemiological studies are few in number and limited mainly to the UK and a few other Western countries. In a meta-analysis Swinnen and Selten (2007) concluded that migrants have a small increase in relative risk of developing any mood disorder (mean relative risk of 1.38 (95% CI 1.17-1.62)). Anxiety disorders have hardly been focus of epidemiological research in ethnic minorities. Variation in incidence and prevalence studies of depression in ethnic minorities in Europe and the USA might result from differences in sites, ethnic groups, social class, migration history, acculturation and methodological issues (Bhugra & Mastrogianni, 2004). In the Netherlands no conclusive evidence is available on the prevalence of depression and anxiety disorders in migrants, due to lack of nationwide and methodologically sound studies that include non-Dutch speaking migrants. However, a general picture can be drawn from general health surveys and studies using psychiatric diagnostic instruments in selected groups of migrants or refugees. Most migrant groups report higher levels of psychological distress than the native Dutch population. More specifically, suicide is more common in Hindustan-Surinamese men; suicide attempts more in Hindustan-Surinamese women; alcohol abuse is more common in Creole-Surinamese men (Kamperman & de Wit, 2010).

In the first study in this thesis, 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, and determined whether these differences can be explained by demographic or socio-economic characteristics (Chapter 2).

DIAGNOSING DEPRESSION AND ANXIETY IN MIGRANTS

The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR) explicitly warns in its section on the major depressive episode: ‘Culture can influence the experience and communication of symptoms of depression. Underdiagnosis or misdiagnosis can be reduced by being alert to ethnic and cultural specificity in the presenting complaints of a Major Depressive Episode. For example, in some cultures, depression may be experienced largely
in somatic terms, rather than with sadness or guilt.’ The descriptions of anxiety disorders are accompanied too by remarks that the content of the fears and phobias may be influenced by culture. The DSM-IV-TR also includes an appendix with a “Glossary of Culture-Bound Syndromes”. Many of these syndromes describe symptoms which agree with the symptoms of panic disorder (American Psychiatric Association (APA), 2004).

The cultural aspects of depression have created keen interest among cross-cultural psychiatrists since the 1960s, and was motivated by epidemiological studies showing that there was a low prevalence of depression in non-Western societies. In order to explain this, some clinicians used the concept of ‘masked depression’ developed in the past. The concept takes the view that when certain individuals react to loss or frustration, instead of manifesting the emotional reaction of depression, they show other clinical features, such as somatization or behavior problems (Tseng, 2007). Citing again the DSM-IV-TR: ‘Such presentations combine features of the Depressive, Anxiety, and Somatoform Disorders.’ (APA, 2004).

This knowledge, that culture may shape the expression of depression, is wide-spread among clinicians. It has led to a feeling that diagnosing depression or anxiety in patients from non-Western countries is difficult. More or less explicitly some psychiatrists tend to avoid treating non-Western migrants, as they anticipate that their diagnosis and treatment will be ineffective. These feelings and behaviours are seldom expressed by psychiatrists or psychologists, and even more rarely written down. Patient Ahmed is considered as another difficult case. Ronald May, a cultural anthropologist and formerly coordinator “Intercultural Management” of Altrecht Institute for Mental Health, used to shake up clinical meetings by asking: “If we change the name of Ahmed into Hans, would that matter?” Often understanding for the patients case grew and treatment options were proposed (May, 2010). Luckily, many immigrant patients find understanding and effective treatment in the regular psychiatric services. Still, many clinicians are hesitant about their ability to deal adequately with patients from a non-Western cultural background. The question is, whether this caution is warranted. Is it better indeed to be reserved in diagnosing depressive or anxiety disorders? This way of reasoning carries another risk: underdiagnosis and undertreatment of depressive and anxiety disorders in migrant patients. Under the provoking title ‘Are British psychiatrists racist?’, the British Journal of Psychiatry published in 1990 a case vignette study of psychotic disorders. The sex and ‘race’ of the vignette were varied and the responses of 220 psychiatrists compared. The Afro-Caribbean case was regarded as that of an illness of shorter duration, and requiring less neuroleptics than the white case. Cannabis psychosis and acute reactive psychosis tended to be diagnosed more often and schizophrenia less often in Afro-Caribbean cases, refuting the claim that psychiatrists tend to overdiagnose schizophrenia in this group. The results rather suggest underdiagnosis and subsequently inappropriate management (Lewis et al., 1990).

In Section A of this thesis we aim to give a scientific basis to the debate whether or not, and how, the diagnosis of depression in Turkish, Moroccan and Surinamese migrants in the Netherlands differs from the diagnosis in native Dutch subjects. We focus on the symptoms of depression and the overlap of symptoms of depression and anxiety. As we expected cultural variation in
the depressive symptom profile, we hypothesized mood symptoms and cognitive symptoms of depression to vary across migrant groups and native Dutch, while psychomotor and vegetative symptoms would be equally present in all groups. We also investigated the hypothesis that in migrant groups depressive symptoms are associated with less disability than in the native study group (Chapter 3). Next, we investigated the hypothesis that depressive disorders and anxiety disorders are more strongly associated in Turkish-Dutch and Moroccan-Dutch than in native Dutch subjects (Chapter 4).

RISK FACTORS FOR DEPRESSION AND ANXIETY IN MIGRANTS

Clinicians have more reasons to show reservation in diagnosing and treating depression in non-Western migrants. It is taken for granted that the stress associated with the process of migration and adjustment to an unfamiliar, sometimes discriminatory and hostile, culture leads to depressive feelings. Moreover, the level of education and the socio-economic status of many non-Western migrants is low, and as a consequence poverty and unemployment are common. To state this type of reasoning boldly: Migrants suffer from the clash of culture and from deprivation, not from depression. In Section B of this thesis we investigate whether more-or-less established risk or supportive factors for depression hold in non-Western migrants. If the assumption is true that depression in migrants is a mere expression of social and economic distress, we would expect that the established risk factors are not, or only weakly associated with depression in the migrant groups. We investigated the following risk and protective factors: personality dimensions (Chapter 5); cardiovascular risk factors (Chapter 6); lack of social support in the neighbourhood (Chapter 7) and religious coping (Chapter 8).

The association of the five-factor model of personality with depressive and anxiety disorders is extensively studied. It is well established that these disorders are associated with high neuroticism, low conscientiousness, low agreeableness and low extraversion (Malouff et al., 2005). It has been shown that more than 50% of patients in secondary care who have major depressive disorder also have one or more personality disorders (Kool et al., 2005). In treatment resistant patients or patients with chronic recurrent disorders, assessment of personality is important. This may lead to adjusted treatment plans, like additional psychotherapy aimed at the personality problems. However, it looks as if non-Western migrants are less often indicated for additional treatment of personality disorders (van Schaik & van Loon, 2012: p. 68). In Chapter 5, we study ethnic differences in the association of personality dimensions and depression and anxiety. We hypothesized to find cross-cultural differences, with weaker associations between each of the personality dimensions and anxiety or depression in the non-Western migrant groups.

Of more recent date is the attention for somatic conditions and depression. Anxiety and depressive disorders are associated with coronary heart disease (CHD) (Vogelzangs et al., 2010). Several hypotheses exist to explain this high comorbidity, one of which suggests the metabolic syndrome as a linking mechanism. The metabolic syndrome is a constellation of interrelated CHD risk factors. Current evidence suggests a vicious cycle of depression, visceral fat accumulation, metabolic...
syndrome and depression. In a large study in elderly persons in the USA, Vogelzangs (2007) found a relationship between depressive symptoms and metabolic syndrome in white persons, but not in black persons. Whether this was a chance finding or whether interaction effects with race/ethnicity exist, needs to be examined. If the association of cardiovascular risk factors and depression varies between ethnic groups, this would indicate a need for different prevention strategies in each of these groups. In Chapter 6, we analyze ethnic differences in the association of cardiovascular risk factors and psychological distress. Beforehand, we assumed to find similar associations in each of the ethnic groups, because the biological mechanisms underlying the symptoms are likely to be universal.

In the past few years, interest has increased in the health impact of living in disadvantaged neighbourhoods. Evidence indicates that the neighbourhood in which people live influences their health, either in addition to or in interaction with individual characteristics. People living in neighbourhoods in Amsterdam with high levels of nuisance from neighbours, rubbish on the street, youngsters hanging around and high proportions of people in the neighbourhood who are unemployed, report more often poor health (Agyemang et al., 2007). On the other hand, the local neighbourhood can be a source of social support. The term ‘social capital’ is used to summarize the mechanisms which may be active in a neighbourhood: features of social organizations, such as social networks, interpersonal trust, forms of mutual aid, and reciprocity (Drukker, 2004). From the perspective of ethnic minorities, the social organization of their neighbourhood might be another one than from the perspective of the native majority population. If people preferably receive social support from people of their own kind, or if nuisances originate mainly from people from other ethnic groups – like daily racist experiences – then the impact of the neighbourhood on health will differ by ethnicity and by the density of ones own ethnic group in the neighbourhood. The ethnic density hypothesis suggests that living in areas with a high concentration of people with the same ethnic background may be protective for mental health (Pickett & Wilkinson, 2008).

In Chapter 7, we investigate ethnic density effects on psychological distress of migrants and native citizens. Studies of the Netherlands Institute for Social Research (Sociaal Cultureel Planbureau (SCP)) show that identification with their homeland, as well as intensity of contacts with people of the same ethnic group, is strongest in Turkish-Dutch, less strong in Moroccan-Dutch, and weakest in Surinamese-Dutch citizens (vd Broek, 2008; Gijsberts & Dagevos, 2007). Therefore, we hypothesized that a protective ethnic density effect would occur most strongly in Turkish-Dutch, followed by Moroccan-Dutch and Surinamese Dutch ethnic minorities.

An important aspect of the cultural background of non-Western immigrants is their religious affiliation. Islam (in Turkish and Moroccan immigrants and part of the Surinamese immigrants) and Hinduism (in part of the Surinamese immigrants) are relatively unknown religious traditions in the Netherlands. Mental health care professionals may hesitate whether it is convenient to inquire after religious issues such as prayer. Moreover, their knowledge is limited about the potential role of these religions in times of despair. Is religion in these immigrant groups a resource for consolation and adaptation (positive religious coping)? Or is it related to negative psychological adjustment (negative religious coping), because it induces religious struggle or leads to fears of
divine punishment (Ano & Vasconcelles, 2005)? In Chapter 8, we explore whether the association of religious coping and depression in the different ethnic groups disposes of universal characteristics or whether it reflects cultural diversity.

**SOURCES OF INFORMATION**

The data for all the studies included in this thesis were obtained from surveys performed by the Public Health Services (GGDs). The Amsterdam Health Monitor (AHM) is conducted every four years with a focus on the general health situation of the Amsterdam population. It is a population-based survey of all adults (aged ≥ 18). Amsterdam citizens with a Turkish or Moroccan background were oversampled, as they experience different health risks. In 2004 the AHM I paid special attention to the CVD risk factors and included a health interview, a limited physical examination, and blood tests. A full description can be found in the thesis of Joanne Ujcic-Voortman on ethnic disparities in cardiovascular disease risk (Ujcic-Voortman, 2011). The study in this thesis on the association of cardiovascular risk factors and psychiatric wellbeing draws on these data (Chapter 6). In 2005 this survey was followed by a second phase, which consisted of a structured interview at home that was specifically aimed at mental health. This AHM II was a collaborative initiative of the Amsterdam Public Health Service and the three mental health care institutions of Amsterdam: AMC de Meren, Arkin and GGZ inGeest. The AHM II provided data for the prevalence study (Chapter 2), the two studies on the diagnostic concept of depression (Chapter 3 and 4), the study on personality dimensions and depression and anxiety (Chapter 5) and the study on religious coping and depression (Chapter 8). In the AHM II participants were also extensively questioned on their use of (mental) health care. Thijs Fassaert analyzed these data, resulting in a thesis on ethnic differences regarding accessibility and quality of health care in relation to depressive and anxiety disorders (Fassaert, 2011).

The next health survey, in 2008, was executed as a combined postal survey of the Public Health Services of the four major cities of the Netherlands: Amsterdam, Rotterdam, Den Haag, and Utrecht. Hence the name G4 Monitor (English Translation: Big Four Monitor). Sampling was stratified by age, ethnicity and borough (van Veelen et al, 2009). On the base of these data we analyzed ethnic differences in the impact of neighbourhood characteristics on psychological wellbeing (Chapter 7).

The AHM I had 1,736 respondents, a response rate of 44%. Of these respondents, 85% gave permission to be approached again. For the AHM II respondents with backgrounds other than native Dutch, Moroccan, Turkish, Surinamese or Antillean were excluded. The response to the approach in this phase was 71 %, resulting in 812 participants in the AHM II. In the G4 Monitor 20.877 people responded to the digital or postal questionnaire, a response rate of 50%.
Table 1 | Overview of studies and datasets

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<thead>
<tr>
<th>Chapter</th>
<th>Study</th>
<th>Dataset (year)</th>
<th>Migrant groups</th>
<th>Outcome measure</th>
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<td>Symptom profile</td>
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AHM indicates Amsterdam Health Monitor; G4 Monitor, Big Four Monitor, referring to the four major cities in the Netherlands; CIDI, Composite International Diagnostic Interview, version 2.1, section D and E; SCL-90-R, Symptom Checklist-90-Revised; K10, Kessler Psychological Distress scale, 10-item version.

In the Netherlands ethnicity is usually defined by country of birth and/or country of birth of the parents (Centraal Bureau voor de Statistiek, 2012b). We adopted this definition in this thesis. Respondents were classified as Turkish-Dutch, Moroccan-Dutch or Surinamese-Dutch if he/she was born in Turkey, Morocco, or Surinam respectively, or if one of their parents was born in these countries. Respondents who were born in the Netherlands and whose parents were also born in the Netherlands were defined as native Dutch respondents. In the prevalence study (Chapter 2), the study on symptom profile (Chapter 3), and the study on religious coping and depression (Chapter 8), all based on the AHM II, respondents with a Surinamese or Antillean background were combined. In the studies on anxiety-depression comorbidity, personality dimensions, and cardiovascular risk factors (Chapter 4, 5, 6), Surinamese and Antillean respondents were excluded, because the number of respondents was too small for analysis.

Mental health disorders were diagnosed in the AHM II by means of the Composite International Diagnostic Interview, section D and E on anxiety and depressive disorders, version 2.1 (WHO, 1977). In addition, the severity of mental symptoms was assessed through the Symptom Checklist-90-Revised (Arrindell & Ettema 2003). Designed as surveys of the general health of the population,
the AHM I and the G4 Monitor incorporated the Kessler Psychological Distress scale (K10). The K10 is a screening scale for depressive and anxiety disorders in the general population (Kessler et al., 2002; Fassaert et al., 2009).

SUMMARY OF THE AIMS AND OUTLINE OF THIS THESIS

This thesis focuses on a cross-cultural comparison of depression and anxiety in the three major migrant groups in the Netherlands: Surinamese-Dutch, Turkish-Dutch, and Moroccan-Dutch. Section A describes the diagnostic concept of depression. The cross-cultural validity of the diagnosis depressive disorder, as defined by the DSM-IV, remains debated (APA, 1994). The first study examines the prevalence of depressive and anxiety disorders among the different ethnic groups (Chapter 2). The next paper explores ethnic differences in the symptom profile of depression (Chapter 3). Then we compare the overlap of depressive and anxiety disorders in migrants and native Dutch subjects (Chapter 4). Section B contains four selected topics on risk factors for anxiety and depression in migrants. Each risk factor proved to be associated with depression in western populations. Ethnic differences in the associations of these variables with depression would point to ethnic differences in the depression concept, whereas similarities in the associations support the view that the depression concept is shared by migrants and native Dutch. The four studies explore ethnic differences in the association of depression with personality dimensions (Chapter 5), with cardiovascular risk factors (Chapter 6), with ethnic density (Chapter 7) and with religious coping (Chapter 8), respectively. Finally, the results of Chapter 2 through 8 are summarized and interpreted in Chapter 9, the General Discussion.
REFERENCES


