Chapter 9

General Discussion
OVERVIEW OF AIMS AND PRINCIPAL FINDINGS

The research projects in this thesis are motivated by the clinical impression that treatment outcome of depression and anxiety is poorer in non-Western migrant patients than in native Dutch patients. The general aim is to compare diagnostic characteristics of depression as well as risk or protective factors for depression and anxiety between the three largest non-Western migrant groups and native Dutch persons.

Diagnosis of depression in migrants

In a population survey in Amsterdam, we found that Turkish women and men 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 (Chapter 2).

Major depression is a heterogeneous disorder, with different individuals exhibiting different symptom profiles. Both clinicians and researchers have focused on racial or ethnic differences in the degree to which individuals report specific symptoms of depression. In the DSM-IV-TR clinicians are recommended to be alert to ethnic and cultural specificity in the presenting complaints (APA, 2004). We studied ethnic differences in the depressive symptom profile in 821 subjects who participated in the Amsterdam Health Monitor II (AHM II). Overall, the results did not support the idea that non-Western migrants are likely to ‘somatise’, or endorse different cognitive symptoms (Chapter 3). In the statistical analysis, we used differential item functioning, which has the benefit that it accounts for the potential confounding effect of depression severity in evaluating group differences.

The DSM-IV-TR also warns that non-Western patients may present with combined features of depressive and anxiety disorders (APA, 2004). Again, in our analysis of the AHM II data this assumption was refuted: we did not find an indication for a stronger overlap between anxiety and depressive symptoms in Turkish-Dutch and Moroccan-Dutch subjects than in native Dutch participants. 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 a higher overall prevalence rate of depressive disorders in Turkish-Dutch respondents and a higher severity level of the depressive disorder in Moroccan-Dutch respondents (Chapter 4). Ample evidence shows that anxiety-depression comorbidity is more common in patients with more severe disorders. In other words, there is no indication that non-Western, mainly low-educated migrants are less able than native Dutch citizens to differentiate between anxiety and depressive symptoms. In addition, the order of onset of the two disorders was similar in all ethnic groups, with anxiety disorder preceding depressive disorder.

Risk and protective factors for depression and anxiety in migrants

First, we explored ethnic differences in the association between personality traits and depression or anxiety. We hypothesized to find cross-cultural differences, because depression and anxiety in non-Western migrants are often supposed to result from their disadvantaged social situation, rather than from innate characteristics like personality. The role of personality traits in depression and anxiety has long been emphasized and studied. One of the most extensively studied models
of personality traits is the five-factor model of personality (Costa & McRae, 1992). In the AHM II personality was assessed in face-to-face interviews with the NEO Five-Factor Inventory (NEO-FFI) (Costa & McCrae, 1992; Dutch version Hoekstra et al., 2003). 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 showed the typical profile of high neuroticism and low extraversion, agreeableness, and conscientiousness (Chapter 5).

Second, we investigated ethnic differences in the association between cardiovascular risk factors and depressive and anxiety symptoms. In cross-sectional studies lipid disorders were more or less consistently found to be associated with depressive symptoms, whereas hypertension or hyperglycemia were not or only rarely (Reedt Dorland et al, 2010). Subgroup analyses have revealed a stronger association between obesity and depression in whites than in blacks or Hispanics in the US population (Simon et al, 2006). Using data of the AHM I, we found that in the population of Amsterdam the majority of the investigated cardiovascular risk factors is not associated with psychological distress. However, the association of obesity with psychological distress varies by gender and ethnicity: obesity is associated with psychological distress in native Dutch women but not in Turkish-Dutch or Moroccan-Dutch men or women nor in native Dutch men (Chapter 6). The ethnic differences in the association between obesity and psychological distress in women might be explained by ethnic differences in the prevalence rate of obesity. In our sample, 19.8% of the Dutch women were obese (Body Mass Index $\geq 30$ kg/m$^2$), in contrast with 48.0% and 48.2% of the Turkish-Dutch and Moroccan-Dutch women, respectively. The high rates of obesity in women in these two migrant groups may attenuate the association between obesity and psychological distress (Simon et al, 2006).

Third, we studied the association between living in a neighbourhood with a high concentration of people of the same ethnicity (ethnic density, ED) and mental health. Protective ED effects are assumed to operate through improved social support or by reducing the frequency of experiences of racism. Population studies in the UK, Spain, USA and Canada have yielded contradictory results. We used data of the G4 Monitor, a postal survey in the four major cities of the Netherlands, to assess the association between ED and psychological distress, while adjusting for individual and neighbourhood level socioeconomic indicators. Multilevel analyses showed that gender, marital status, educational qualifications and financial troubles are associated with psychological distress in all ethnic groups, while neighbourhood level socioeconomic characteristics (% households with an income under the national minimum poverty threshold; mean property value) and ethnic density are not related to psychological distress in Surinamese-Dutch, Turkish-Dutch or Moroccan-Dutch respondents (Chapter 7). In other words, individual demographic and economic risk factors (age, gender, marital status, attained educational level, financial troubles) outweigh by far the influence of ethnic density on the psychological well-being in all ethnic groups.

Finally, we explored the associations between religious coping strategies and depression in non-Western immigrants and native citizens of Amsterdam (Chapter 8). People of all ethnic groups responded ten questions of the Brief RCOPE (Pargament et al, 2000). This instrument assesses whether in times of distress religion offers supportive coping (positive religious coping) or leads
to religious struggle (negative religious coping). Overall, Turkish-Dutch, Moroccan-Dutch and Surinamese-Dutch had higher scores than native Dutch on positive religious coping items, like ‘I look to God for strength’. Negative religious coping strategies had several positive associations with depressive symptoms, subthreshold depression, and major depressive disorder. The most consistent association, across Turkish-Dutch, Moroccan-Dutch and native Dutch groups, was found for the item ‘wondered whether God has abandoned me’. This is surprising, given the great variation in religious affiliation between the groups: largely secularized native Dutch and fairly orthodox Muslims. The association was sufficiently strong to consider these doubts about abandonment by God even as a symptom of depression: the experience of an existential void.

Summary of principal findings
The seven studies presented in this thesis sketch the same picture. Although the prevalence of depression is higher in some groups, depression in Turkish-Dutch, Moroccan-Dutch and Surinamese-Dutch citizens has similar characteristics as in native Dutch people: the symptom profile of depression and its overlap with anxiety symptoms is comparable. In the migrant groups and in the native Dutch group, depression and anxiety are associated with high levels of neuroticism. Ethnic density, a putative protective factor, is not associated with psychological wellbeing in any of the investigated ethnic groups. Across ethnic groups and religions, depression is accompanied by religious struggle, in particular the feeling of abandonment by God. Only in the study on cardiovascular risk factors ethnic differences were found. Unlike in Dutch women, obesity in Turkish-Dutch and Moroccan-Dutch women is not associated with anxiety or depression – probably due to the high overall obesity rates in these groups.

METHODOLOGICAL CONSIDERATIONS

Strengths
A major strength of this thesis is that all three datasets used (AHM I, AHM II and G4 Monitor) are population-based. Data from patients who are in treatment in general practice or mental health care might have been biased due to ethnic differences in help seeking behaviour, detection and management by the general practitioner, referral to mental health care, and diagnosis and treatment in mental health care (the so-called filter model by Goldberg & Huxley, 1992). Using among others data from the AHM II, Thijs Fassaert (2011) studied the filter model extensively in his thesis on ethnic differences in care for anxiety and depression. He concluded that differences between ethnic groups regarding access to good quality care for depression and anxiety were markedly smaller than anticipated. For example, detection in general practice and uptake of specialized mental health care was equal in most migrant groups compared to native Dutch, taking into account the level of mental health problems. Earlier, while working in the outpatient mental health department Osdrorpoplein (at the time part of GGZ Buitenamstel), we noticed that ethnic minority groups were catching up in their access to this local mental health center (Schrier et al, 2005). Although these findings will limit concerns on biases due to ethnic differences in passing the filters, still population-based data are the highest standard in this type of epidemiological research.
Both the AHM and the G4 Monitor oversampled respondents from ethnic minority groups to ensure sufficient numbers of individuals from these groups. Additional measures were taken to limit non-response. In the AHM I interviews and physical examinations were held in a neutral place, a community health centre (in Dutch: consultatiebureau). In the AHM II interviews were held at home. In the AHM II a lot of effort was put in collecting reliable information. Questionnaires were translated and back-translated. Interviewers were matched with respondents on gender and ethnicity, trained for a full week and intensively coached. Interviews were face-to-face in the language of choice.

Limitations
Despite all efforts to facilitate enrolment in the study, the generalisability of the findings presented in this thesis is limited by non-response. In the AHM I the participation rate was 45%. The study sample was drawn from the Amsterdam municipal population register. People were invited by letter to participate in the study. Part of the non-response to this letter can be explained by incorrect or outdated information in the population register, which mounts up to 7.5 to 15% of all residential information (Slot & Janssen, 2006). First generation immigrants were more likely than second generation migrants to participate in the AHM I. At the end of the AHM I interview, 85% agreed to be approached for follow-up research, of which 71% participated in the AHM II (Chapter 2). Respondents and non-respondents to the AHM II did not differ significantly in first/second generation migrant status, nor in level of acculturation or psychological distress. The net result is a response rate of 26% over the two phases. Eventually, the Turkish-Dutch and Moroccan-Dutch respondents in the AHM-I and AHM-II consisted mainly of low-educated, first-generation immigrants, who preferred to be interviewed in their own language. Young, second-generation migrants with higher levels of education were underrepresented. Therefore, the results might tend to overestimate differences between non-Western migrants and native Dutch respondents in depression diagnosis or in the association between risk factors and psychological distress. In this light our results of similarity in depression characteristics across migrants and native Dutch is even more remarkable.

In every cross-cultural study, the question as to whether test scores obtained in different cultural populations can be interpreted in the same way across these populations has to be dealt with. Three kinds of bias are distinguished: construct bias, method bias and item bias (van de Vijver & Tanzer, 2004). The main challenge for the studies in this thesis lies in method bias. Method bias refers to problems deriving from instrument characteristics. In each paper the cross-cultural validity of the used measurement instruments is discussed. All outcome instruments (CIDI, SCL-90-R and K10) have been used in other cross-cultural studies. Moreover, with the exception of the study on prevalence rates (chapter 2), all studies in this thesis use a design in which intracultural differences are compared across cultures. Method bias is less likely to jeopardize the results of these type of analyses. It is only when bias sources affect intracultural comparisons differentially that method bias threatens the validity of the conclusions (van de Vijver & Tanzer, 2004). Construct bias occurs if the construct measured (in this thesis: depression) is not identical across cultural groups. In a way, the five papers in this thesis represent in itself studies on construct bias of depression,
anxiety, and psychological distress. By studying the symptom profile, overlap of depression and anxiety and the risk factors for depression across cultures, we investigated equivalence in these aspects of depression. The study on symptom profile of depression is also a study on item bias in the CIDI and SCL-90-R depression symptoms, using differential item functioning analyses.

The next methodological question is whether instruments show cross-cultural measurement equivalence: can the scores be compared across cultures? (van de Vijver & Tanz, 2004) Both the SCL-90-R and the K10 showed significantly higher mean sum scores in the three non-Western migrant groups than in the native Dutch respondents. Does this accurately reflect cross-cultural intergroup differences in the level of psychological symptoms, or does this reflect measurement inequivalence? In the association of the 16-item depression subscale of the SCL-90-R with impairments in functioning, measured by the World Health Organization Disability Assessment Schedule II (WHODAS II), we found no differences across ethnic groups (Chapter 3). Fassaert (2009a) showed that in order to obtain optimal sensitivity and specificity in identifying depressive and/or anxiety disorders as assessed by the CIDI, the K10 requires higher cut-off values for Turkish-Dutch and Moroccan-Dutch respondents. This finding suggests measurement inequivalence of the K10. However, it is too early to draw conclusions on the equivalence of the SCL-90-R subscales and the K10 across the migrant groups. Notwithstanding potential measurement inequivalence in the SCL-90-R and the K10, associations obtained within each ethnic group can still be compared across ethnic groups. And that was what we did in most of the studies: interethnic comparison of the association of anxiety disorders and depressive disorders, of association between personality dimensions and depression or anxiety, of the association between cardiovascular risk factors and psychological distress and of the association between ethnic density and psychological distress.

Another limitation in all studies in this thesis is the definition of ethnic background. In the AHM and in the G4 Monitor ethnicity was defined according to the country of birth of the respondent and of his/her parents, adopting the definition of the Dutch Centraal Bureau voor de Statistiek (CBS, 2012). Country of birth can be regarded as a proxy measure of ethnicity. Ethnicity has been called a ‘black box variable’. It refers to distinguishing characteristics in a variety of domains, including genetics, migration history, culture and acculturation, ethnic identity and position in the host country (Fassaert et al., 2009b). In the UK it is usually assessed by self-report. In the US race tends to form the basis of ethnic classifications (blacks, Asians), alongside with cultural demarcations (Hispanics). The CBS definition obscures ethnic distinctions within ethnic groups, such as between Hindustani and Creoles within the Surinamese-Dutch group, between Turks and Kurds within the Turkish-Dutch group, and between Berbers and Arabs within the Moroccan-Dutch group. Neither does it differentiate between e.g. manual labour migrants, international students or political asylum seekers within a particular ethnic group. As an example of the complexities of the concept of ethnicity, I cite Raj Bhopal, professor at the Medical School of Edinburgh: ‘As a Punjabi born Indian raised in Scotland I found the popular UK label “Asian” to describe people like me as simplistic’ (Bhopal, 2004). Ethnic groups as defined in this thesis therefore represent a mixed lot of people. I have been struggling with the terms I should apply to the migrant groups in this thesis. In the first place many people who are born and raised in the Netherlands (second-generation migrants) will not identify themselves as ‘migrants’ at all. At the time when I was working on this
thesis Barack Obama was elected the first African-American president of the United States. Elation was widespread and the New York Times claimed that the racial barrier had fallen (New York Times, 2008). Dutch commentators, trying to explain this miracle, pointed to political correctness in the US with respect to the terms used for migrants (NRC, 2008). For more than ten years all US-citizens consistently talk about African-Americans, Asian-Americans, and so forth. I copied this example and used for each migrant group the addition ‘-Dutch’ throughout this thesis.

Finally, a complicating factor is that ethnic differences in mental health tend to be confounded by socioeconomic factors. Wherever possible, we attempted to account for this by ‘controlling for’ attained educational level, employment status and/or financial household status in our statistical analyses. This common practice in epidemiological research has an important drawback: Controlling for socioeconomic confounders obscures the impact of these socioeconomic factors on the outcome measure. Stronks (1999) argue that ethnic differences in (mental) health can be explained in the first place by common risk factors which are unevenly distributed in the ethnic groups under study. So, well-known risk factors like unhealthy life-style and social stressors are more common in specific ethnic groups and subsequently cause health problems in these ethnic groups. This leads us to the pivotal question: how important is ethnicity, as defined in this thesis by country of birth and country of birth of parents, in determining mental health of migrants?

ETHNICITY: A FACTOR OF SIGNIFICANCE IN MENTAL HEALTH OF MIGRANTS?

The outline that emerges from the studies in this thesis is that ethnicity is not a defining feature in the diagnosis and risk factors of depression in Turkish-Dutch, Moroccan-Dutch, or Surinamese-Dutch individuals. On the neighbourhood level we did not find a protective effect of ethnic density, which illustrates again that ethnicity is not a factor of importance (Chapter 7). In contrast, financial insecurity proved to have an important influence on mental health in all subjects (Chapter 7). Worries related to socio-economic problems, like lack of resources, unemployment, poor housing conditions, or misbehavior of one’s children are but some of the tangible stressors in people’s lives. But there is more. These socio-economic factors are not just material factors influencing people’s health; they are related to people’s self-image and image of others - and as such they are cultural factors in itself. For example, social cohesion is lower in people with a low educational level, in people who are unemployed, or in people with a profession of low status (Gijsberts et al, 2008).

Selten & Cantor Graae (2005) coined the term ‘social defeat’, defined as the chronic stressful experience associated with a subordinate position or an ‘outsider status’, and proposed it as a mechanism contributing to the increased risk of psychosis in migrants. The chronic stress of living in a subordinated status might account for the increased risk of schizophrenia in migrants with a darker skin color and in migrants who live in neighbourhoods with a low level of ethnic density (Cantor-Graae & Selten 2005). The mechanism of social defeat is common to many situations of adversity, not just racism due to skin color, but also in situations of socio-economic adversity, where people have a marginalized status identity (Shaw et al., 2012). August 2012 violent riots erupted in the French city of Amiens, where youths, many from North African origin, and police
clashed. Analysts stated that deprivation and social exclusion had sparked the violence. The latter can be illustrated by a quote of a citizen of Amiens, Sabrina Hadji: “This is violence from anger! We’re not animals. We vote and pay our taxes like everyone.” (BBC, 2012). This lady is not complaining about her poor living conditions - she is outraged about her position in the local community. She feels that others do not consider her as a responsible fellow citizen of Amiens. It is hard to delineate whether this is the result of her ethnic background, of her socio-economic position, or – most likely – of a mix of the two. People are involved with a variety of social groups, like household members, colleagues at work, friends at leisure time. At the time when I am writing this discussion, mid August, the city center of Utrecht is populated with bunches of young adults on bikes or in boats. These youngsters are plunged in a new culture as freshmen. Each of these social groups has its own set of manners, attitudes and even self-image. The crisscross of social groups in which people participate is reflected in their identities, not one identity, but multiple identities (van Dijk, 2010). Particularly adolescents who are born abroad or have parents who are born abroad are creative in defining their identities. Second-generation Hindustan-Surinamese adolescents, for example, may identify themselves more with the Dutch democratic culture and with Indian culture as expressed by the movie industry, than with cultural traditions in Surinam. Adolescents are active in forming their own networks, which include people from their own ethnic background, as well as people from other ethnic minority backgrounds and native Dutch (Hoffer, 2009: chap 6). They express their self-defined identities by clothes, music preference and language (which can be a mixture of languages) (Boumans et al, 2001). Ethnic background as such has been given a too prominent place in the search for factors which influence mental health.

Role of ethnicity in mental health care
Looking back I wonder what my implicit ideas were about the role of ethnicity in mental health. Kramer, a cross-cultural psychologist, provides stepping stones for such an analysis in his historical overview on perception of migrants and refugees in mental health care. Kramer (2011) distinguishes four overlapping periods: 1972-1983 migrant patients are viewed as an exceptional group and peculiarities in their cultural background are highlighted; 1983-1993 mental health care workers focus on the socio-economic adversities shared by all migrants, as well as the common impact of their history of migration; 1993-2002 differences between migrants call for attention. At the same time similarities between migrants and natives are emphasized. Migrant patients appear not so peculiar after all; 2002-2010 most of the time cultural diversity is seen as a fact of daily life and daily work in mental health care. Sometimes, however, cultural differences in the consultation room are experienced as troublesome issues.

This research project had the general aim to investigate whether and how depression in people from Turkish, Moroccan and Surinamese background differs from depression in native Dutch subjects. Although it was conceived in 2006, the basic assumptions fit in the themes of period 1993-2002: We certainly admitted the possibility that the comparison would yield similarities rather than differences between migrants and native Dutch. And in our analyses we distinguished between the three major non-Western migrant groups. The results from the studies on diagnosis of depression (Chapter 3 and 4) and from the studies on the associations of depression with personality
General Discussion

(Chapter 5) and religious coping (Chapter 8) fit in with the general conclusion at the time: non-Western migrants are not so different from natives – ‘they’ are like ‘us’ in how and why they suffer from depression. In the study in Chapter 7 we showed that living in a neighbourhood with many people of the same ethnic background does not offer social support or other protective effects against psychological distress. Citizens in the four major cities in the Netherlands have grown used to the ethnic diversity in their neighbourhoods, just as Kramer described for the time frame 2002-2010. So, the assumptions in mental health care – which gave rise to this research project – lag behind the developments in society. What could be the reason for this? I think that two mechanisms play a role. First, as delineated above, the impact of socio-economic status is underestimated in mental health care. Second, ethnicity has a ‘strategic role’ in the consultation room.

Van Dijk (2010), a medical anthropologist working for many years as senior advisor in Parnassia Group, describes how workers in (mental) health care put forward ‘culture’ as a strategic argument. As long as they can diagnose and treat non-native patients without difficulty, they will not pay attention to the their ethnic background. They perceive native and migrant patients in the same way. However, when problems arise in the consultation room, like drop-out or non-response to treatment, then ‘culture’ is the culprit. Mental health workers interpret problems in their medical treatment as problems that go together with the patient and his/her ethnic background. This mechanism has been illustrated in a study in the gastroenterology outpatient clinic of the Sint Lucas Hospital in Amsterdam on patients with unexplained chronic abdominal pain. The medical specialists reported having problems in treating foreign (Dutch: ‘allochton’) patients. In order to explain why their patients did not participate actively and successfully in the treatment, the medical specialists looked for personality characteristics and mental problems in their native Dutch ‘problem patients’. In foreign problem patients, on the other hand, the medical specialists described experiencing a cultural distance between the culture of the patient and his or herself (van Duursen et al, 2004).

Alas, a small percentage of patients with depressive or anxiety disorders who are treated in inpatient or outpatient mental health care are treatment refractory. My clinical impression is that this percentage is higher in non-Western migrants, due to a vicious circle of ‘culture distance’ in the patient-doctor relation and under-treatment. If treatment of depression or anxiety in a non-Western migrant patient is not successful after the first step of the treatment protocol, mental health workers may fall in the pitfall, described above, of assuming that the patient’s ethnic background makes him or her not fit for treatment in the regular mental health care. Subsequently they will refrain from implementing additional diagnostic work-up or from introducing next steps of the treatment guidelines. As a consequence, the patient fails to recover – which is interpreted as a proof that he or she is untreatable. The results in this thesis show that there are several reasons that warrant an exact and thorough diagnosis and treatment in non-Western migrant patients: depressive disorders are more common in Turkish-Dutch women (Chapter 2); Turkish-Dutch, Moroccan-Dutch and Surinamese-Dutch people have higher symptom levels of depression and anxiety, and this is reflected in high levels of functional impairment (Chapter 3); one in every three Turkish-Dutch or Moroccan-Dutch persons with a depressive or anxiety disorder is suffering...
from both disorders concomitantly (Chapter 4); and neuroticism is equally common in Turkish-Dutch and Moroccan-Dutch patients with a depressive or anxiety disorder as in native Dutch patients (Chapter 5).

So far, I have discussed the role of ethnicity in the treatment relation from the perspective of a therapist with a white, ethnic majority background. As the education level of second generation Turkish and Moroccan migrants is rising quickly, more and more psychiatrists, psychologists and social workers from Turkish and Moroccan background will be available (Sociaal Cultureel Planbureau 2012). This offers the possibility of ethnic matching of therapist and patients, which results in higher patient satisfaction and has been proven effective (Edrisi & Kramer, 2012: blz. 46).

Others argue that the quality of the treatment relation, tailoring treatment goals, and practicing problem solving strategies are more crucial factors than ethnic matching (de Jong, 2010). Over the last decade, i-Psy and other intercultural mental health organizations are growing rapidly. November 2012 i-Psy received the ‘Wisseltrofee interculturalisatie’ (challenge trophy), an annual prize for mental health institutions which remarkable achievements in cultural diversity (Mikado, 2012). Anyway, ethnic matched patient-therapists relations remain prone to pitfalls, as the example of dr. Ozerdem illustrates. In the psychiatric department of Izmir, one of the major cities in Turkey, she introduced Family Focused Treatment, a psycho-educational family intervention in bipolar treatment (Ozerdem et al., 2009). At an informal dinner, dr. Ozerdem confided to me that it had been a surprise to the staff of the department that these low-educated patients from the Turkish countryside were receptive to psychotherapy. This shows how the diversity within countries can be as large as between countries.

**IMPLICATIONS**

**Clinical implications**

How should we cope with ethnic diversity in mental health care? In the first place, the results in this thesis urge clinicians to apply regular state-of-the art psychiatric treatment to their non-Western patients. Indeed, this is the point of departure of the ‘Intercultureel Addendum Depressie’, which was published September 2012 as a supplement on the Multidisciplinary Guideline for Depression (Richtlijnherziening, 2011). The Multidisciplinary Guideline for Depression offers evidence-based guidelines for first-line interventions, pharmacotherapy, and psychotherapy of depression. Since the first guideline in 2005, this document offers a standard for state-of-the-art psychiatric treatment. Using the same methodology, and based, amongst others, on results of this thesis and the thesis of Thijs Fassaert on accessibility and quality of mental health care, the ‘Intercultureel Addendum Depressie’ (2012) describes how the Guideline should be applied in patients from ethnic minority groups. The authors state that the Multidisciplinary Guideline for Depression is applicable to patients from foreign background, unless interventions tailored to specific ethnic groups have proved more effective.
I want to highlight two topics, the use of standardized measurement instruments and the indication for psychotherapy. It has been shown extensively that the art of diagnosing depression improves when clinical judgment is complemented with a structured assessment of psychological symptoms and disorders. This applies to all patients, and fear for misdiagnosis in non-Western migrant patients is unwarranted (Chapter 3). It may be necessary to adjust cut-off scores in instruments that measure the level of symptoms (Fassaert et al. 2009a). Still these instruments will prove useful for treatment follow-up. Standard diagnostic assessment will also lead to a better identification of comorbid disorders, like depressive and anxiety disorders (Chapter 4).

Over the years, several effective treatments for depression have been developed, including several forms of psychotherapy. A review concluded that the available data suggest that results are comparable in minority patients, although effectiveness of most of these treatments for these groups has been scarcely investigated (Schraufnagel et al, 2006). In The Hague, Blom (2010) showed that Interpersonal Psychotherapy (IPT) is both feasible and effective in ethnic minority groups. Implementation of guidelines always lags behind the development of the guidelines, but in ethnic minority patients more and higher barriers have to be evened. I quote van Schaik, psychiatrist and one of the authors of the Addendum: ‘Because there are so many psychosocial problems [in migrant patients – AS], therapists focus on that. Often they don’t get to structured psychotherapy, which focuses on how the patient himself or herself can influence his or her life. I think this is underestimated. Therapists assume that migrant patients are unable to reflect or will not be appealed by psychotherapy. I have seen many examples which evidenced the contrary’(Kramer, 2012: p. 18). The indication for psychotherapy is underscored by our finding that personality traits are associated with depressive illness in the same way in non-Western migrants as in native Dutch (Chapter 5).

Our experiences in the data collection show that the Turkish-Dutch and Moroccan-Dutch Muslims were willing to respond to questions on religious believes and feelings. The majority affirmed that, more or less often, they interpreted events as a punishment by God. Other experiences, like questioning whether God exists or expressing anger to God, were denied by most. So, discussing supportive and distressing aspects of religiousness is by and large feasible in these groups. As the majority of the Turkish-Dutch and Moroccan-Dutch patients adhere to their religious life, discussing these topics may facilitate the mutual understanding in the clinical relationship (Chapter 8).

However, sometimes cultural adaptations to ‘just doing the usual’ are necessary. Whitley (2011) explored the practice of Evidence Bases Medicine (EBM) in ethnic diverse populations in Canada. He summarizes the strategies to cope with questions about the generalisability and appropriateness of EBM for ethno-cultural divers populations: cultural adaptations of evidence-based interventions; integrating idiographic knowledge; training in cultural competence; promotion of primary mental health care. Many of the essential cultural adaptations are in fact adaptations to patient’s lack of fluency in the Dutch language and to their lack of knowledge of the Dutch health care system. This may require the need to call in interpreters and/or peer counselors. In many cases clinicians need to invest more time in psychoeducation. More specific adaptations to prevention and treatment programs have been and are being developed. Currently the Netherlands Organization for Health
Research and Development offers funds for a program titled ‘Winst door verschil – etniciteit en gezondheid’ (‘gains by difference – ethnicity and health’) aimed at improving the health(care) of non-Western migrants (ZonMw, 2010). For many years GGZ inGeest offers a group treatment called ‘de Gezondheidsmarkt’ for Moroccan men with a chronic depressive disorder. The weekly sessions integrate peer support, psychoeducation, referral for financial or other practical problems and psychomotor therapy (Schrier et al, 2005; GGZ inGeest, 2013). While the content of the sessions resembles that of other rehabilitation programs, the cultural adaptations lie in the language (Berber) and atmosphere (privacy of personal information, respecting taboos, informality).

Training in cultural competence is another strategy listed by Whitley (2011), and this goes hand in hand with the strategy of incorporating the personal context of the patient in the treatment. One of the main goals of such a training is to learn to communicate with an open attitude (Hoffer, 2009: p. 283; Hoffer, 2010). Clinicians are trained to attend to patients’ belief systems, values and treatment preferences. Although courses in cultural competence exist in many forms, they share the effect of making clinicians feel more competent in their encounter with non-Western migrant patients. And this self-confidence will help them to keep at bay feelings of powerlessness and the pitfall ‘culture is the culprit’.

Public health implications

The findings in this thesis underscore the results of research on ethnic differences in mental health in a non-random community sample in Amsterdam in 2005. Kamperman concludes in her thesis ‘Deconstructing ethnic differences in mental health of Surinamese, Moroccan, and Turkish migrants in The Netherlands’: “Although the emphasis on differences is necessary to make these [ethnic -AS] groups visible to mental health care professionals and other parties involved, it also carries the risk of alienation between the Dutch, western trained professional and the non-Dutch client. The down side of the ‘celebration of culture’ is an unsurmountable cultural gap. [] The results of this research project suggest an important role for classical determinants of mental health among migrants, such as socio-demographic characteristics, coping and social support mechanisms, and somatic health characteristics.” (2005; p. 161). Our multilevel study on the impact of individual socioeconomic status (SES) indicators and neighbourhood characteristics on mental health showed this point most clearly: Apart from demographic characteristics, the most important predictors of psychological well-being were educational level and financial troubles (Chapter 7). If the aim is to promote people’s mental health, a policy aimed at investment in education and work deserves priority (Letki 2008).

Promotion of access to (mental) health services has been an point of special interest to Public Health authorities. In a range of projects bicultural counselors offered psycho-education to mainly low-educated first-generation non-Western immigrants. This policy has contributed to the present situation in which the majority of Turkish-Dutch, Moroccan-Dutch and Surinamese-Dutch immigrants are able to find their way to primary and secondary mental health care (Fassaert, 2011). In outpatient mental health care for depressed patients, treatment characteristics (timeliness of initial contact, treatment intensity, dropout and early re-registration) for patients from non-Western background are by and large equal to treatment characteristics for native
patients (Fassaert et al., 2010). In addition, many migrants have integrated and are sufficiently educated, so that the role of traditional barriers like stigma and taboo in help-seeking behavior is diminishing (Knipscheer & Kleber, 2005).

Mental health and physical health are interrelated. Well-established in prospective studies is the association between obesity and depression, influencing each other in either direction (Luppino et al., 2010). We replicated this finding in native Dutch women, but we did not find an association between obesity and psychological distress in Turkish-Dutch and Moroccan-Dutch women. This is probably due to the fact that obesity is endemic in these populations (Ujcic-Voortman et al., 2011; chapter 6). Even more alarming is the fact that 32% of Turkish-Dutch and 27% of Moroccan-Dutch children and youngsters are overweight (RIVM, 2012). The Public Health Service Amsterdam, as well as Public Health Services in other major cities, executes projects aimed at the promotion of a healthy way of living. Examples of these projects are an anti-smoking competition for secondary education pupils, a project to combat obesity in Turkish and Moroccan women and a project to encourage children to move and practice sports (GGD Amsterdam, 2012). In this way the Public Health Service brings into practice the call for targeting common risk factors in specified age, gender and ethnic subgroups.

Future research
Should ethnicity remain a topic in mental health research? My answer is a conditional ‘yes’. Prevention programs as exemplified above are based on epidemiological data. The core technique of medical epidemiology is to compare groups in search of differential characteristics or exposures. This type of research will remain a crucial tool in identifying the distribution of common risk factors in specified ethnic groups, because these groups are changing due to influx of new immigrants, and demographic and lifestyle changes within the groups. However, for the majority of studies on the etiology and pathogenesis of mental disorders a critical evaluation of the definition of ethnic groups is needed. The overall results in this thesis show that defining groups according to the definition of Netherlands Statistics (CBS, 2012) - based on country of birth and country of birth of their parents - does not yield differences in depression diagnosis and associate features. In future studies, researchers should tailor the definition of their study groups according to the study topic. First/second generation status or Dutch language proficiency can be far more important defining characteristics than ‘ethnicity’ according to the CBS definition. Whitley (2011: p. 517) goes one step further by proposing a cross-cultural research strategy focused not on ethnic groups, but on culture-related variables which are potentially associated with (mental) health or treatment. These variables may be biological, psychological, existential or social. This strategy facilitates the transfer of knowledge from one ethnic group to another.

Over the years the focus in mental health care and research has shifted from socio-economic to socio-cultural explanatory factors. Socio-economic characteristics deserve renewed attention. Their direct impact as stressors is huge. And they are one of the factors that influence people’s identities. Mr. B., the Moroccan-Dutch depressed patient I presented in the General Introduction, described himself in the first place as unemployed and failing as husband and as father.
Unraveling the multiple identities and how they are interwoven can be achieved when researchers from the disciplines of psychiatry, psychology, anthropology and sociology cooperate. This will also stimulate a focus which is broader than the individual subject, and include patient-doctor relationships, groups membership and so on. Cooperation with researchers from other disciplines will bring into sight adjacent fields of research and literature. It will also stimulate the use of qualitative methods, which is essential to highlight the dynamic and contextual nature of mental health problems in migrants (de Jong et al, 2010). The Medline article index, commonly used by researchers in the field of psychiatry, is a tremendous source of medical papers, but limited in its scope for researchers interested in the bio-psycho-social background of mental disorders. For me, a new world opened when I scrolled through the website of the Dutch Sociaal Cultureel Planbureau – to name but one resource. If psychiatrists cooperate with other disciplines, they will be stimulated to broaden and deepen their understanding of mental illness in the wide variety of their patients.

IN CONCLUSION

Depression and anxiety have similar characteristics in Turkish-Dutch, Moroccan-Dutch, and Surinamese-Dutch persons as in native Dutch persons. So, in these patient groups ethnicity is not an important defining factor of these mental illnesses. The findings in this thesis may help to diminish concerns about the application of state-of-the-art diagnosis and treatment of depression and anxiety in the three major ethnic minority groups in the Netherlands. In conclusion, I want to cite Bhugra & Mastrogianni (2004) in their review article in the British Journal of Psychiatry: ‘In this era of globalization, the challenge for cultural psychiatry is to identify genuine differences between populations, without being misled by ethnic stereotyping. Individual differences are as great as ethnic ones, and the clinician treats the individual within the larger socio-economic context, not the ethnic group.’
REFERENCES


GGD Amsterdam (2012). http://www.gezond.amsterdam.nl/


