Walter Renner (Editor)

Female Turkish Migrants with Recurrent Depression

A Research Report on the Effectiveness of Group Interventions: Theoretical Assumptions, Results, and Recommendations

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CONTENTS

ABOUT THE CONTRIBUTORS 10

WALTER RENNER & ELISABETH GROSSGASTEIGER
INTRODUCTION 12

WALTER RENNER & BIRSEN SLADKY
CHAPTER 1: THEORETICAL BASIS I: WOMEN OF TURKISH DESCENT IN AUSTRIA – PSYCHO-SOCIAL AND CLINICAL ASPECTS 18

1. History 18
2. Socio-Demographic Statistics 18
3. Prejudice towards Foreigners and Xenophobia among Austrians 20
4. Present Living Conditions and Psychological Aspects 22
5. Clinical Considerations: A Cultural View of Depressive and Somatic Symptoms in Turkish Migrant Women 29
6. Utilization of Health Care Facilities 32
7. The Need for Culturally Sensitive Interventions: How the Idea for the Present Study has developed 34
8. References 36

HERBERT JANIG
CHAPTER 2: THEORETICAL BASIS II: SELF-HELP GROUPS – THEIR DEVELOPMENT, FUNCTION, AND EFFECTS 42

1. Definition 43
2. History 44
3. Function 46
   3.1 What do the people concerned say? 46
   3.2 Individual and Societal Effects 48
      3.2.1 Augmenting Information 49
      3.2.2 Health Promotion and Salutogenesis 50
      3.2.3 Effects of Secondary and Tertiary Prevention 51
4. The Relationship between Self-Help and Professionals 52
5. Self-Help Groups for People with a Migration Background 53
6. Economic Gain 54
7. Future Perspectives 55
8. References 56
WALTER RENNER

CHAPTER 3: HOW THE RANDOMIZED, CONTROLLED STUDY HAS BEEN PLANNED, ORGANIZED, AND CONDUCTED 62

1. Outline of the Study: Project Aims and Hypotheses 62
2. Human Resources 64
3. Preliminary Phase 65
4. How Participants were Recruited, Selected and Allocated to Experimental Conditions – Descriptive Statistics of Final Sample 66
5. Rationale of Group Interventions 68
   5.1 Self-Help Groups 68
   5.2 Cognitive Behavior Therapy Control Groups 68
6. References 70

WALTER RENNER & DANIELA STROBL

CHAPTER 4: THE PARTICIPANTS' BIOGRAPHIC BACKGROUND 72

1. Traumatic Events 72
2. The Participants' Spontaneous Reports 74
   2.1 Current and Past Stressors 74
   2.2 Clinical Symptoms 75
   2.3 Resources 75
3. Summary and Conclusions 76
4. References 76

WALTER RENNER

CHAPTER 5: THE QUANTITATIVE STUDY: HOW THE HYPOTHESES HAVE BEEN TESTED BY QUESTIONNAIRES 77

1. The Participants' Descriptive Statistics 77
2. Measures 78
3. Overview of Results Obtained by the Questionnaires 79
   3.1 What the Self-Help Groups (SHG) Achieved as Compared to CBT and the Wait-List (WL) Control Group 80
   3.2 What the Wait-List (WL) Control Group Achieved in the of its Time-Delayed Intervention 80
   3.3 Follow-Up Measurement 80
   3.4 Analysis of Responders and Predictors of Outcome 81
4. Summary 82
5. References 82
HEIDE SILLER, BARBARA JUEN, & BIRSEN SLADKY

CHAPTER 6: THE QUALITATIVE STUDY: THE GROUP LEADERS' SUMMARIES AND SUPERVISION – INTERVIEWS WITH PARTICIPANTS

1. Method

2. The Group Leaders' Summaries: How Self-Help and CBT Groups Have Been Conducted
   2.1 Topics Pursued in the Group Sessions
   2.2 Structure of the Groups
   2.3 Aims
   2.4 Subjective Outcome

   3.1 The Beginning
   3.2 Testing the Leaders
   3.3 Becoming a Group
   3.4 Finding a Topic
   3.5 Gaining Trust and Group Cohesion

4. The Interviews with Participants: Subjective Outcome
   4.1 Sub-Categories with Sufficient Inter-Rater Agreement
      4.1.1 Category 1: Complaints Prior to Interventions
      4.1.2 Category 2: Behavior During Interventions
      4.1.3 Category 3: Changes in the Course of the Interventions
      4.1.4 Category 4: Generalizing Self-Help Behavior
   4.2 Sub-Categories with Non-Sufficient Inter-Rater Agreement
      4.2.1 Category 1: Complaints Prior to Interventions
      4.2.2 Category 2: Behavior During Interventions
      4.2.3 Category 3: Changes in the Course of the Interventions
      4.2.4 Category 4: Generalizing Self-Help Behavior
   4.3 Responders vs. non-Responders

5. Discrepancy Between Subjective and Objective Outcome
   5.1 Subjective Outcome
   5.2 Problematic Aspects
   5.3 Traumatic Experiences
   5.4 The Role of the Environment

6. Summary

7. References

Appendix
ASTRID LAMPE & MARIA-THERESA BARBIST

CHAPTER 7: AN UNINTENDED CONTROL GROUP: PSYCHODRAMA IN SUPPORT OF TURKISH MIGRANT WOMEN

1. Background
2. Therapeutic Concept
   2.1 Group Treatment
   2.2 Individual Treatment
3. Method
   3.1 Sample
      3.1.1 Group Treatment
      3.1.2 Individual Treatment
   3.2 Measures
      3.2.1 Number of Hospital Contacts
      3.2.2 Brief Symptom Inventory (BSI)
4. Results
   4.1 Number of Hospital Contacts
   4.2 Brief Symptom Inventory (BSI)
5. Discussion
6. References

VEDAT SAR

CHAPTER 8: DISSOCIATIVE DEPRESSION: A COMMON CAUSE OF TREATMENT RESISTANCE

1. Treatment-Resistant Depression and the "Trauma Model" in Psychiatry
2. "Dissociative" Depression
3. The Psychodynamics of "Dissociative" Depression
4. Family as the Origin of Trauma and Attachment Problems
   4.1 Complaisant Over-Adjustment
   4.2 "Apparently Normal" (Dissociative) Families
   4.3 Gender Roles
   4.4 Shame-Based Inhibition of Communication
   4.5 Interference as Chronic Interpersonal Trauma
5. A New Paradigm: Functional Dissociation of the Self
6. Conclusions
7. References
HEIDI SILLER

CHAPTER 9: GENDER AND DEPRESSION

1. Gender Role Orientation 125
2. Immigration 127
3. Empirical Results from the Present Study 128
   3.1 Gender 128
   3.2 Marital Relationships 129
   3.3 Emancipation 130
   3.4 Violence 130
   3.5 Immigration 131
   3.6 Subjective Theories of Illness 131
4. Summary and Discussion 131
5. References 132

WALTER RENNER & HEIDI SILLER

CHAPTER 10: SYNOPSIS AND RECOMMENDATIONS

1. Summary of Results 134
2. Effects of Therapy with Patients of Turkish Descent Reported by Other Researchers 135
3. Limitations and Shortcomings of the Present Research 137
4. Hypotheses Towards Explaining the Outcome 137
   4.1 Cultural Differences 137
   4.2 Dissociation 139
   4.3 Negative Social Support 139
   4.4 Contagion Effect and Co-Rumination 139
   4.5 Secondary Reinforcement 140
5. Recommendations 142
6. References 143
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INTRODUCTION

WALTER RENNER & ELISABETH GROSSGASTEIGER

In 2007, Walter Renner just had completed almost two years of research on the effectiveness of self-help groups for a population of refugees and asylum seekers from Chechnya (Renner, 2008; Renner, Bänninger-Huber, & Peltzer, accepted). The results had indicated that self-help had been effective in reducing anxiety and depression as well as post-traumatic stress in traumatized participants in the course of 15 group sessions. When discussing these positive findings with Dr. Regina Prunlechner, the head of the Psychiatric Outpatient Department at the University Clinic of Innsbruck and with Gertraud Gscheidlinger of Caritas Tyrol, we developed the idea of testing a similar approach for women of Turkish descent with Recurrent Depressive Disorder. Like in the previous research, this should be done in a randomized controlled study as part of a two-year research financed by the Austrian Science Fund (FWF).

Both colleagues agreed that a large number of Turkish migrant women were suffering from depression which could at least partly be understood by taking into account their dire living conditions, being dependent on their husband's extended families, lacking autonomy, and being deprived of their social networks many of them have left back in Turkey. At the same time we agreed that patients with a Turkish migration background frequently were reluctant to use "western" offers of psychiatry and psychotherapy and thus would benefit from a community based self-help approach which would take cultural specificities into account and which would also promote empowerment, self-acceptance, and assertiveness.

At that time, Elisabeth Großgasteiger, who now is vice-president of the association of self-help groups in the district of Eastern Tyrol, under Walter Renner's supervision had started to prepare her diploma thesis on the evaluation of self-help at the University of Klagenfurt (Großgasteiger, 2010) and thus contributed important conceptual ideas in the course of the research.

3 Correspondence should be addressed to walter.renner@uibk.ac.at
4 Financed by the Austria Science Fund, Project Number P 18789-G14, Principal Investigator Klaus Ottomeyer
5 Due to delays in recruiting clients – see Chapter 3 for details – a third year has been added to project duration with no additional costs involved.
Contemporary community based self-help has originated in 1935, when two Americans motivated by their own concernment established the first Alcoholics Anonymous self-help groups. They demonstrated the power of self-help based on ideological support through the later "Twelve Step program". In due course, alcoholics recovered from their disease, while conventional medical treatment had turned out to be of no avail. Notwithstanding the evident success of the method, the effectiveness of self-help groups was not recognized on a larger scale until after World War II.

Mass movements like the civil rights movement, the power-to-the-people-movement and the feminist movement in the 1960s, introduced even more people to the power of group initiatives. In the late 1970s, self-help groups also gained growing academic attention. Several books (Caplan & Killilea, 1976; Katz & Bender, 1976) about self-help as well as a special issue of "The Journal of Applied Behavioral Science", on the "new social movement" (Borman & Lieberman, 1976) have been published. They were thought to provide an increased understanding not only of the phenomenon itself but equally of the more general social and psychological processes observed in a then "new medium". Professionals and laypeople became more aware of the value of mutual support available to participants in self-help groups. Academic interest in self-help systems was not restricted to the United States as the self-help ideology at that time already had been expanded to western Europe (Moeller, 1981) as well as to Japan (Oka, 2000).

During the 1980s, international networks of self-help and support groups were created. So called self-help clearing houses not only provided information as to how to locate appropriate groups or how to initiate a new group, but they also linked the groups to researchers which viewed the clearing houses as a new development and a methodological invention towards studying and analyzing self-help group systems and self-help group participants which became increasingly important to the global public health perspective (Warren, 1993).

Primarily as a response to growing expectations for a new public health movement around the world, in 1986, the first international WHO Conference on Health Promotion was held in Ottawa, Canada. A charter has been released stating that empowerment of the communities was seen as the heart of health promotion. Material and human resources should be invested in enhancing self-help and self-support in developing flexible systems towards strengthening public participation in health matters. Consequently and as a result of the self-help movement's progressive internationalization, a book has been published presenting papers from the conference and focusing on international and multicultural perspectives (Lavoie, Borkman, & Gidron, 1994).
During the last four decades, much research has taken place with regard to self-help groups, first of all concerning their efficacy, the helping processes involved, as well as the advantages and disadvantages of participating. One of the common findings was that self-help groups and support groups work by many of the same helping processes found in psychotherapy groups but also differences between the two approaches were found.

Yalom (1989) defined eleven therapeutic factors in psychotherapy groups, many of which are also found in self-help groups, such as “instillation of hope”, featuring the belief that the intervention will help, "universality", that is to learn that others in the group are in the same boat, "information or direct advice" and "group cohesiveness". Cohesiveness was higher in self-help groups and support groups than in other types of groups and members of a group for people with depression reported cohesiveness as the most helpful factor (Llewellyn & Haslett, 1986).

Apart from common therapeutic factors, there are some mechanisms of change specific to self-help groups, such as transforming identities, meaning to rewrite one's life story as in the Alcoholics Anonymous' "Twelve Step Program", or becoming empowered or achieving insight or reframing ones understanding of the problem. Helping factors of both, self-help and support groups are similar, their primary purpose being to give support and to impart information which is sometimes brought to the group by outside experts as well as to convey a sense of belonging.

The idea of the present research was to apply the basic philosophy and the central principles of the self-help movement to the ethno-cultural background of female migrants of Turkish descent in Austria, suffering from recurrent depression. In the randomized design of the study, the effects of 15 weekly sessions of guided self-help have been compared with Cognitive Behavior Therapy (CBT) and a Wait-List Control condition. The present book intends to give an account of this research and of its socio-political framework as well as of its implications for clinical psychology, psychiatry, and for the health-care system.

Chapter 1 of this book by Walter Renner (who served as the Principal Investigator of the research) and by Birsen Sladky (who is of Turkish descent and who has prepared her doctoral dissertation in the course of this research) will present the theoretical framework of the study from the standpoint of Clinical and Cultural Psychology by summarizing the participants' living conditions as well as their clinical implications. Chapter 2, by Herbert Janig, who acted as a guest author, will give an account of the theoretical background with respect to the working mechanisms and the effects of self-help groups in
much more detail than it could be done by the introductory considerations above.

In **Chapter 3** Walter Renner will report the method and design of the empirical study, including also the participants' descriptive statistics and practical details of how the self-help groups as well as the CBT and the Wait-List Control Groups have been implemented. In Chapter 3, the psychometric instruments employed towards evaluating the interventions will also be introduced. The participants' description will be supplemented by **Chapter 4**, where Walter Renner and Daniela Strobl, who had carried out the initial psychiatric screening, will summarize their biographic background from a clinical point of view.

In **Chapter 5**, Walter Renner will give a short account of the outcome of the randomized controlled study on the symptom level which will be reported in detail in a forthcoming journal article (Renner & Berry, accepted). The outcome with respect to symptom reduction was a negative one, both for the self-help groups and for the Cognitive Behavior Therapy (CBT) Groups. Both interventions in some single cases were effective, but in other cases clinical symptoms deteriorated and thus, overall the interventions had no effect superior to the Wait-List Control Group. As opposed to the quantitative results, the qualitative evaluation by the participants and by the group leaders as reported in **Chapter 6** by Heidi Siller, Barbara Juen (who had supervised the group leaders), and Brisen Sladky led to a more optimistic view. Content analysis revealed that most participants benefited emotionally and gained from social support provided by the self-help groups.

Nearly simultaneously and initially without knowing of our research, Astrid Lampe had conducted an empirical study on the effects of psychotherapeutic group treatment on Turkish migrant women at the Innsbruck University Clinic. Also in this case, quantitative results with respect to symptom reduction were negative. In **Chapter 7**, Astrid Lampe and Maria-Theresa Barbist will summarize this study for comparative reasons.

Why did, contrary to our expectations and to previous results of similar studies, none of these approaches lead to a substantial reduction of clinical symptoms? Vedat Sar, an Istanbul based Professor of Psychiatry who had contributed to our research by conducting one of the workshops towards training the group leaders (see Chapter 3 for details), will put forward a possible answer to this question in **Chapter 8**. According to his view, many participants might have suffered from concomitant dissociative symptoms going back to early traumatization which might have prevented them from responding to short-term interventions like we employed them in the present research. **Chapter 9** by Heidi Siller will act once again on the qualitative results and will interpret the findings from a gender perspective.
Finally, Walter Renner and Heidi Siller will summarize and discuss the findings in Chapter 10 and will offer additional suggestions for possible explanations of the outcome from the theoretical view of learning theory and group dynamics, especially taking psycho-social factors into account. Chapter 10 will also provide suggestions for future interventions for women of Turkish descent with recurrent depression.

Although, on the symptom level, no change had been achieved, we believe that the present study is an important one for methodic reasons: Results have shown that there is no "simple solution" towards improving the living conditions of Turkish migrant women in Austria, nor can their clinical symptoms of depression be easily treated by short-term interventions. In the first place, on the societal level, a substantial improvement of these women's living conditions should be aimed at. Moreover, psychotherapeutic interventions should rather be offered on an individual than on a group basis and, ideally, should be conducted by same gender, experienced therapists who share their patients' ethnic background. Such interventions must be expected to last for several months or in some cases for years, in order to accompany the clients until substantial changes of their personal psycho-social conditions will be achieved. It is one of the main intentions of this book, to draw the readers' attention to these necessities and desiderata which have been outlined by the results of the present study.

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CHAPTER 1
THEORETICAL BASIS I: WOMEN OF TURKISH DESCENT IN AUSTRIA – PSYCHO-SOCIAL AND CLINICAL ASPECTS

WALTER RENNER & BIRSEN SLADKY

1. HISTORY

In many European countries, people of Turkish descent are among the most prominent groups among migrants. Five percent of the Turkish were reported to live abroad in 1998. As a consequence of the shortage of workers in central Europe at that time, most of these migrants came as foreign workers following labor recruitment agreements between Turkey and various European countries during the sixties of the twentieth century. They initially intended to stay as sojourners only for a limited period of time, but with continuing economic pick-up they decided to remain permanently. Austria signed a labor recruitment agreement with Turkey in 1964 and in order to reduce the country's unemployment rate, Turkish government encouraged its citizens to migrate. Consequently, in the face of dire economic circumstances in their home country, the migrants achieved substantial improvements in their economic situation, while for the host country migration was instrumental in prolonging the economic upswing. As far as women were concerned, most of them were married when they came to Austria, either accompanying their husbands or following them after a period of separation. Still, a smaller number of women migrated on their own (Sahin, 2006).

2. SOCIO-DEMOGRAPHIC STATISTICS

Current socio-demographic statistics with respect to population, citizenship, age, marriages, and childbirths as well as to schooling, education, employment, and

6 Parts of this text have been taken from a grant application submitted by the first author to the Austrian Science Fund (FWF) (FWF-Research Grant Nr. P20523-G14).
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the migrants' economic conditions in Austria have been provided by the "Austrian Integration Fund" (ÖIF, Österreichischer Integrationsfonds, 2009a), an NGO, which has been founded in 1960 by the Austrian Federal Ministry of the Interior and the United Nations High Commissioner for Refugees (UNHCR) (Österreichischer Integrationsfonds, 2009b). According to ÖIF sources, people whose parents have been born abroad are defined as having a "migration background", regardless of their citizenship. As Turkish migrants pose the third largest group among persons with a migration background, the ÖIF handbook provides detailed statistics with respect to Turks: in 2007, a total of 179,538 inhabitants with a Turkish background were living in Austria which has a general population of approximately eight million people. Among the inhabitants of Turkish descent, 109,716 are non-Austrian citizens most of whom (86,977) have been born abroad.

In Austria in the year of 2007, 61% of people with a foreign background, thus including a substantial number of people from Turkey, have been living in urban areas (i.e., places with > 20,000 inhabitants). On the contrary, only about one third of the Austrian native population is living in cities of this size. Consequently, in 2007, in small rural places (< 5,000 inhabitants) the percentage of foreign descent only was only 8.2%, whereas it was 27.4% in urban areas (> 20,000 inhabitants). Overall, about 10% of Austrian inhabitants stem from abroad.

ÖIF reports that mothers of Turkish descent on average were about 24 years of age when having their first child as compared to Austrian mothers who were about 28 years old. In 2007, the average number of children for Turkish women was 2.61 whereas it was 1.29 for Austrian mothers. Children born to unmarried mothers were infrequent among Turks (5%) whereas they were quite common among Austrians (44%). Accordingly, ÖIF reports that Turkish women got married (for the first time) at an average age of 21.7 years and Turkish men at an average age of 25.1 years as compared to Austrian men who got married at an average age of 32 years and Austrian women who got married at 29 years on an average.

Among Turkish mothers, in 2007 about 14% were working fulltime and 17% part-time as compared to 29% and 37% among Austrian mothers. With respect to schooling, children of Turkish descent clearly had disadvantages. More frequently they had to repeat classes at school and in schools for handicapped children the proportion of children with foreign descent (mostly Turks) was twice as high as it was in regular schools. On the other hand, only five to six percent of children of foreign descent reached university qualification (i.e., the Austrian "Matura" or German "Abitur").
Severe disadvantages continue to exist during vocational training and are especially marked among Turkish women, 86% of whom only have completed nine years of compulsory schooling without having learned a trade. The equivalent number among Turkish men is 66.9%, among Austrian women it is 22.0% and among Austrian men it is 10.7%.

Consequently, according to ÖIF statistics, a smaller percentage of Turks, as compared to other inhabitants of foreign descent and to Austrians were economically active. While in 2007 79.1% of Austrian men and 66.3% of Austrian women between 15 and 64 years of age belonged to the work force, only 71.4% of men and 39.8% of women with a Turkish background and within the same age range were gainfully employed. Accordingly, the unemployment rate among people of Turkish descent was 15%, while it was only 4% among Austrians. Unemployment was even higher among Turkish youth (i.e., within a range between 15 and 24 years of age), where the unemployment rate amounted up to 18%.

The Austrian Integration Funds (Österreichischer Integrationsfonds, 2009a) also deplored the dire economic situation of Turkish migrants even when they were working. Twenty-nine percent of them, as compared to only 6% among Austrians, could be characterized as "working poor" (p. 60). While 66% of Turkish men and 69% of Turkish women were affected by chronic diseases, this was the case in only 59% of Austrian men and 63% of Austrian women. Eleven percent of Turkish men and 7.2% of Turkish women (as compared to 5.9% of Austrian men and 3.0% of Austrian women) were reported to have had a workplace accident in 2007.

3. PREJUDICE TOWARDS FOREIGNERS AND XENOPHOBIA AMONG AUSTRIANS

According to Friesl, Polak and Hamachers-Zuba (2009) during the post-war era Austria was ethnically homogenous to a large extent, whereas during the eighties and nineties the country turned multicultural. With growing numbers of inhabitants of foreign descent, many native people tended to see them as scapegoats for current social problems in the country.

Friesl et al. (2009) reported empirical evidence on changes in society's values which took place among Austrians between 1990 and 2008. This large scale study was part of the European Values Study (cf., Halman, Luijckx & Zundert, 2005), which examined values and attitudes towards work, family relationships, religion, and politics in 33 European countries. With respect to Austrians, Friesl et al. (2009) reported increased xenophobia as compared to the nineties. While
in 1994 45% of respondents had answered positively to xenophobic items, in 1999 54% and in 2008 55% of respondents answered in an affirmative way to questions like:

"If unemployment increases, foreigners should be sent back home."

"Foreigners should be forbidden to engage in any kind of political activity in their host country."

"Foreigners should try to adapt their lifestyle a bit better to that of the native population."

In 2008, 69% of Austrians said that foreigners would contribute to the problem of criminality and 66% of them thought that migrants would pose additional problems to the social system. Fifty-six percent of Austrians thought that migration could develop towards a menace for Austrian society. About half of the respondents said that they did not wish foreigners to continue their cultural tradition; consequently, only about 50% of them thought that Austrian cultural life would benefit from migration. Among Austrians, 65% answered in the affirmative to the question, whether there would live too many migrants in Austria and 52% said that they had begun feeling as foreigners in their own country. While in 1990 and in 1999 15% of respondents stated that they would not like to have Muslims as their neighbors, in 2008 31% of respondents answered in the affirmative to this question.

According to Friesl et al's (2009) results, xenophobia was correlated negatively with the respondents' educational level, but this influence was lower in 2008 as compared to two earlier surveys. Xenophobia was not correlated, however, with the respondents' economic situation.

In an attempt to interpret their findings, Friesl et al. (2009) reported a tendency towards "increased anomy" (p. 262) in 2008, which was correlated with xenophobia and which was characterized by being discontent with Austrian democracy, right-wing attitudes and a lack of interest in political issues.

As opposed to these findings, the extent of authoritarianism in the sense of Adorno, Frenkel-Brunswik, Levinson, and Sanford (1950) as well as the correlation between xenophobia and authoritarianism had decreased since the early ninetieths. Xenophobic people deplored, however, that modern society would grant too much freedom to young people; they also had difficulties towards understanding and accepting plurality in modern Austrian society and they tended to emphasize personal, individualistic interests as opposed to the welfare state's issues.
Friesl et al. (2009) also pointed out that xenophobia went along with a "social Darwinistic" attitude and an increasing lack of solidarity. According to the authors' interpretation, xenophobic people tend to be tradition-minded, right-wing conservatives who frequently are frustrated, suspicious and anxious rather than being affected by a real decline in economic conditions.

4. PRESENT LIVING CONDITIONS AND PSYCHOLOGICAL ASPECTS

The majority of Turkish migrants tend to affiliate with their compatriots rather than with the host culture, also in the second generation still adhering to their ethnic identity and their mother tongue and referring to Turkey as their home country (Sahin, 2006). Thus, as a strategy of adaptation they choose rather separation than integration in the sense of Berry (1970), meaning that they prefer cultural maintenance to participation in the host culture, which increases acculturative stress (Berry, 1997; 2006). The idea of an eventual remigration to Turkey is still an important – though hardly ever realized – concern to many of them (Sahin, 2006). They tend to idealize their country of descent and thus, homesickness as well as feelings of loss are frequent among them. Most Turks living abroad continue celebrating Islamic festivals and usually retain old customs known to them from childhood (Sahin, 2006).

According to Sahin (2006) it is doubtful, whether migration leads to an increase of self-determination and freedom for Turkish women. Traditional gender roles are adhered to anxiously, especially with respect to child rearing practices and education of female adolescents, as Austrian culture is perceived to be overly permissive with respect to contact among boys and girls. Mergence of cultures is deemed undesirable and thus children (especially girls) are expected to mate with Turkish partners, often even against their will. Women frequently are abused by their husbands if they do not meet their expectations (Akpinar, 2003; Yöksel et al., 1999).

Sahin (2006) pointed out that Turkish migrants in Austria mostly are unskilled workers who often have to accept poor working conditions and housing as well as financial discrimination and bullying. Especially women frequently are confined to assembly-line work and they have to carry the double burden of household tasks in the face of paternalistic gender roles. Additional economic strain results from the fact that most first generation migrants use to support their extended families who are still living in Turkey.

Many Turkish women expect to come to the Promised Land when they arrive in Austria as a consequence of getting married, where they would be able to achieve whatever they like. They expect to realize their dreams, to be better off than before, and to achieve a higher level of welfare for their children. Quite
rapidly, however, Turkish women come down to earth, seeing many things in a different light. They get aware of not being able to speak the foreign country's language and their hopes, dreams and expectations, get confused. There are more difficulties than they expected. Women are torn out of their social networks at their home country and they are unaware of their host country's language and traditions. In addition, there are multiple responsibilities as a wife, accompanied by homesickness and limited prospects.

In the course of the interviews conducted in the present research (cf., Chapter 6, this book) some women said that they would have staid back home if they had anticipated what would be expecting them. Sometimes women have attained a higher level of education than men and some women said that in Turkey they would have been living in freedom. When coming to Austria, however, they had underestimated the degree of dependency they would be living in. They use to be kept tightly, having no friends and nobody to exchange with, living a life of servants. Soon after migration, they use to give life to their children, whom they are not even allowed to educate according to their own conceptions (Akpinar, 2003). Being unable to accept and to tolerate surrounding conditions in Austria, women frequently break down psychologically (cf., Case Example 1).

Case Example 1:

Like many other Turkish women in Austria, Mrs. A. came here by marriage. She is a slender, attractive 35 years old woman, dressed fashionably and not wearing a veil. Many young Turkish men and their parents, when looking for a woman to marry, decide on a woman from Turkey because they perceive girls of Turkish descent living in Austria as too "westernized". Most of them wish to get married to a woman who shares and practices traditional Turkish values. Many Turkish men living in Austria do not realize, however, that a lot of things have changed in Turkey in the past decades; many young women living in Turkey have been educated in a climate of modernity and liberality. While traditional values are still kept up in rural areas of Turkey, in large cities like Istanbul or Izmir, lifestyle has changes dramatically. Inhabitants of large Turkish cities share more similarities with native Central Europeans than with the rural Turkish population. Thus, many of the Turkish people who have come to Austria 30 or 40 years ago still practice old traditions, which are not practiced any longer in Turkey.

Mrs. A. is one of these women who were born in a large city and grew up there. She attended school and has been educated by their parents in a liberal and open-minded manner. When she got to know her prospective husband who was looking for a wife in Turkey, she was studying at the university. After meeting a
Case example 1 continued

couple of times, they decided to get married. Mrs. A. discontinued her studies and moved to Austria, where she experienced "culture shock" (Ward, Bochner, Furnham, 2006) in the sense of the word. She had come to a country, whose language she was unable to speak or understand and were everything fell short to her expectations. She moved to parents-in-law with a very rigid and narrow worldview and extremely traditional preconceptions.

Mrs. A. told us that she had not been allowed to leave her apartment on her own. She was treated like a child, and her parents-in-law or her husband did all the shopping. As an assertive young woman she had expected to enjoy even more freedom in Austria than she did in Turkey, but now she found out that she had been sent to jail. If she had known what expected her, she told us, Mrs. A. would never have married. Now she regrets that she did not stay in Turkey and that she did not finish her studies. After a short while, Mrs. A. had developed symptoms of depression as she was unable to adapt to the new situation. She had no friends or acquaintances and was locked in by her husband's family at her home feeling extremely lonesome. During that time, her husband used to comfort her, telling her that things would change as time would go by. Without his support, she said, she would have been unable to bear her living conditions any longer. Quite frequently she considered returning to Turkey, but quite soon she expected her first child and more and more she came to terms with her life situation. In the meantime, Mrs. A., who is still living with her husband, has given birth to three children and deplored that she lost so many years of her life.

Most women cannot expect to be supported by their own families when they wish to take leave of their husbands. From the time of marriage, the woman's family of origin does not feel responsible any longer for their daughter and their commitment has been delegated to the husband. Thus, many women are warned against getting separated from the husbands because of an uncertain future: "What are you going to do?" "You have been married before, think of your children, think of what happened to other women who got a divorce!" "Who will marry a woman who got divorced and who has children?" In this way, women use to be pressurized and left alone by their families and by Turkish society. Thus, many women who consider to get separated from their husbands finally just haven't got the courage and lack the necessary support to realize their plans. A divorce would not only mean to be separated from the husband, it would also mean to get separated from Turkish society.
Mrs. F. told the second author of this chapter about her ordeal when she had to accept the role of the "first daughter in law" (gelin) as a subordinate of her parents in law. Many years after, she blamed herself for not having rebelled against her parents in law and for having put up with so much. Today, Mrs. F. is suffering from depression. Although her parents in law had discontinued pressuring her, she was unable to cope with these experiences successfully. She regrets that at that time she had lacked today's ability to assert herself. Out of filial piety the husband did not take his wife's part nor did he support her otherwise.

After getting married many women are forced to live at their parents-in-law's home for a while, attending them and cooking for them. When going to work they have to deliver all their earnings to their father-in-law who "administers" their money which quite frequently never will be refunded neither to the women nor to their husbands. Usually this practice is being justified by the enormous expenses of the wedding ceremonies that had to be covered by the parents-in-law. Turkish society refrains from commenting topics like this and just speaks of cultural tradition (cf., Case Example 2).

Case Example 2:

Mrs. M. is about forty years of age, she has a round face and does not wear a veil. She is a self-confessed Muslim. Mrs. M. relates how she got to know her husband who had been on vacation in Turkey together with his family in order to choose a bride. Their families had been acquainted before and Mrs. M. had been short-listed as she was known to be a "good girl", meaning that she would be a suitable wife, daughter-in-law, and mother. At that time, Mrs. M. was 17 years old and she did what her parents advised her to do. After a couple of meetings with her prospective husband, engagement was celebrated and the wedding followed very soon. After getting married, Mrs. M. moved to her husband's and her parents-in-law's place in Austria. Among young Turks it is common practice to live at the young man's parent's home until the couple moves into an apartment of their own.

Mrs. M's. father-in-law, as well as her father, was addicted on alcohol. On her arrival in Austria, Mrs. M. was treated very badly by her parents-in-law and the whole family lived under extremely congested conditions. Like a slave, she had to take care of the household on her own. Her father-in-law never called her by her name and abused her verbally in the meanest possible way. Mrs. M. characterized her husband as an extremely withdrawn, quiet, and passive individual who had been suffering under his father's regime, being unable to support...
(Case Example 2 continued)

his wife and to speak up for her interests. Very soon she gave birth to her first child, who was brought up by her parents-in-law, while Mrs. M. had to take on a job. The old man "administered" the money she earned while Mrs. M. and her husband were fobbed off with a small allowance which was allocated according to the old man's whims. When Mrs. M. was expecting her second child, the young family moved to a place of their own and got separated from their parents-in-law, but even today Mrs. M. is suffering from her unpleasant memories of that time. Her oldest son, who is now 17 years of age, is suffering from a massive drinking problem and is contemptuous of his parents. Both parents are on their wit's end having tried all they could to change his behavior. They tried to be strict, they tried to be tolerant, but to no avail. Late in the evening the young man uses to come home intoxicated, shouting at the family, waking up and terrorizing everyone. This behavior remembers Mrs. M. of her father and her father-in-law, old memories and hidden fears coming back. Since several years, Mrs. M. has been suffering from depression, which has been treated both in Turkey and in Austria. She is blaming herself for not having brought up her son herself, for not having been with him when he was a little child, for having worked so much and for having delegated his education to her parents-in-law.

Many Turkish parents cannot cope with their children's education in Austria. They wish to put over Turkish culture and values to their children, while Austrian values and societal norms are incompatible with the Turkish ones. When children come to school, at the latest, they realize that there is a second, different culture outside their home. Girls are especially "attended to" by their families in order to prevent them from getting in contact with boys, so the family's honor will not be endangered.

Today Mrs. M. is feeling strong; at the same time she says, however, that she had attained this kind of strength far too late in her life. So many things have happened which cannot be undone. Now she tries to accept as her fate what has happened and to dissociate herself emotionally from her son. She wants him to move out, as she is unable to bear the present situation any longer. On the one hand, she reproaches herself for wanting to get rid of him, on the other hand she is trying to bear in mind her own needs as well as her other two children's requirements.

The wedding is the absolute highlight in a Turkish family's life. Marrying their sons and daughters in an honorable way and arranging suitable celebrations is the parents' chief duty. To this primary aim, other life goals, e.g. adequate
vocational education, are being subordinated. Weddings frequently are prepared over many months and are celebrated at enormous costs, as an expensive wedding ceremony enhances a family's reputation (Kelek, 2005).

Turkish society is stratified by age and gender: older people are free to express their opinion as they like to without giving sound arguments for what they say; it is a person's social rank that matters, not his or her competency. Women who came to Austria as a consequence of getting married, live exclusively within their families and without social contacts outside the Turkish community. They know neither the town nor the country they are living in. They do not speak German, they are unaware of their rights and they don't know whom to ask for assistance when in difficulty. During the first months they depend entirely on their husband's family which is still strange to them. Quite soon they use to have one or two children and thus are bound to their homes for years. They are expected to educate their children as they have seen it in Turkey and they are going to speak Turkish to the child, to educate him or her as they had been educated themselves, according to Islamic tradition. In most cases these women do not show up in public. Even open-minded Turkish migrants who are in favor of democracy and who are aware of these problems tend to put them under taboo as they fear damage to "the Turks' " reputation.

These women are most likely to be met at Turkish cultural clubs, quite a lot of which have been founded at most larger places by now, or at the local mosques which function as cultural meeting points in Austria to an increasing extent. People go shopping at the stores affiliated to the mosques, or meet in order to pray and to read the Qur'an or to learn it by heart (Kelek, 2005). Turks enjoy meeting at the cultural clubs where they use to spend their leisure time and to meet their extended families. For Turkish migrants it is especially important to motivate their offspring to visit these cultural clubs on a regular basis in order to make them acquainted with Turkish compatriots, thus preventing Turkish culture from getting lost.

Turkish parents use to transmit collectivist rather than individualistic values to their offspring (Oppedal, 2006), although child rearing practices tend to be more westernized among younger mothers and with higher educational levels of parents (Herwartz-Emden & Westphal, 1997). Children are not expected to internalize the rules and guiding principles of Austrian society but rather to get acquainted with and to perpetuate Turkish norms and values. Thus parents attach great importance to their children's knowledge of the Turkish language and encourage them to speak it in everyday life. By no means, parents would allow children to forget parts of their language and progress in the knowledge of the Turkish language is especially reinforced and promoted. Thus, Austrian society more and more looses contact and access to these migrants who usually do not wish to deal with the native population. Neither they speak their language nor do
they understand their culture and the Austrian way of life is condemned by Muslims with firm religious beliefs.

At arrival, Turkish women do not speak German and in many cases it may take years until they attend German classes, usually without much avail. Women say that in the meantime they had lost the capacity to acquire knowledge. Learning is very difficult for them and there is little progress. Some women attend the courses with the wrong expectation that after a few weeks they would be able to converse perfectly in German and tend to be quickly disappointed. An additional problem is most women's low educational state: most of them have attended only five years of compulsory schooling in Turkey. Thus, they lack experience in learning and many of them only have little knowledge of Turkish grammar which would be the basis for acquiring a foreign language. After a couple of such attempts, women are too frustrated to have another try and they don't participate in any further German courses. Moreover, in the meantime their knowledge of German suffices for most everyday purposes (e.g., shopping) and, if necessary relatives or friends can serve as interpreters, e.g., when visiting a doctor or an administrative office. Thus, German courses do not solve the problem.

A continuing and important obstacle against successful acculturation stems from so-called "family re-union": young Austrian born men of Turkish descent continue to mate with girls from Turkey, who migrate to Austria without knowing the country's language and culture. Thus, the steps of a whole generation towards integration in Austrian society are being canceled out.

In their Turkish environment (i.e., their extended family or clan), women stay among themselves. Only rarely they get in contact with Austrians and thus they are hardly interested in learning German. On the other hand, their poor knowledge of German keeps them from getting in contact with Austrians and becoming friends with them. Contact between Turkish and Austrian women in almost all of the cases is initiated by the natives, mostly neighbors or mothers of the children's schoolmates. Due to their poor command of the German language, many Turkish women feel embarrassed by such encounters; while being ashamed of not being able to speak proper German, on the other hand, for the above mentioned reasons most women are not able to learn the host country's language.

Taking on a job usually does not improve the women's knowledge of German. As they earn their money as unskilled workers or cleaning staff, a short initial instruction suffices and no knowledge of German is necessary to do the job. All the women's colleagues usually are of Turkish descent as well and thus the women speak their mother tongue at their workplace.
5. CLINICAL CONSIDERATIONS: A CULTURAL VIEW OF DEPRESSIVE AND SOMATIC SYMPTOMS IN TURKISH MIGRANT WOMEN

Lassetter & Callister (2009) have presented an extensive review of the literature on the health status of voluntary migrants worldwide (see also Wyssmüller & Kaya, 2010). With respect to anxiety and depression in voluntary and involuntary migrants, recently a meta-analysis has been conducted by Lindert, von Ehrenstein, Priebe, Mielck, and Brähler (2009) (with respect to depression see also Bhugra, 2003).

With respect to migrants from Turkey, Erim (2009) gave a detailed account of how the values of traditional, collectivist extended families with a high degree of cohesiveness as well as "arranged weddings" contribute to their psychological conditions, with special emphasis on clinical issues. Kleinemeier, Yagdiran, Censi, and Haasen (2004) pointed out that an individual who is unable to react to persisting conflict in his or her environment, family or workplace, will resort to illness as a last resource. Uslucan (2005) declined the so-called selection hypothesis, according to which there is a bias toward mental problems in migrants because emotionally unstable individuals would be more prone to migration than emotionally stable ones. On the contrary, the author argued that cultural isolation after migration, especially in large cities would contribute to mental illness. The author focused on the problem of homesickness which most frequently could be found among people from rural areas like Anatoly going along with symptoms of rheumatic pain, headache, and psychosomatic illness.

From anecdotal evidence, Sahin (2006) reported a high incidence of sadness and chronic depressive symptoms as well as of digestive, respiratory, and circulatory disorders and increased accident proneness in Turkish women after their migration. Accordingly, and contrary to the notion of "somatization" of depressive symptoms in Turkish patients, Small, Lumley, and Yelland (2003a) found a high degree of both, depressive and somatic symptoms in Turkish migrant mothers. In this comparative study of mothers from Turkey, Vietnam and the Filipines, Turkish women scored lowest on a measure of physical health (SF-36) and highest on self- and other-reports of depressive symptoms. A second study by the same working group (Small et al., 2003b) found that depressive symptoms among migrant mothers in Australia were surprisingly consistent across cultures. In all three ethnic groups just mentioned, feeling alone in the foreign country had the strongest effect on depressive complaints. Women who suffered from homesickness or from a lack of social support or who were physically ill, as well as those who complained about family related problems or whose babies were ill were especially prone to depression. In accordance with these results, Cicek (1990) had found marked somatic
symptoms without a physical basis in 71% of female and 55% of male respondents of Turkish descent living in Germany; 81% of female and 45% of male respondents complained about a lifetime incidence of depressive disorders. Seventy-four percent of women and 31% of men stated that sexual intercourse had an aversive quality for them.

When seeking medical care, Turkish women frequently complain about symptoms of listlessness and depression combined with somatic symptoms: Kleinemeier et al. (2004) reported that in a German sample of Turkish migrants in a psychiatric outpatient department, 88% complained about depressive and 71% about somatoform symptoms; 57% reported symptoms of anxiety and 22% psychotic symptoms. Schwab and Tercanli (1987) found a high rate of depressive and somatic symptoms especially in Turkish women, going along with role conflict and social isolation.

Diefenbacher and Heim (1994) systematically compared depressive symptoms in women of Turkish and German descent with respect to their structure and severity according to the well-known diagnostic system of AMDPT (Association for Methodology and Documentation in Psychiatry). According to this study, "Turkish patients scored higher only on the Vegetative-somatic syndrome scale but did not differ on the Depressive of Apathetic syndrome scale of the AMDP System" (Diefenbacher & Heim, 1994, p. 551).

Koch (1995) focussed on cases of "unsuccessful migration" among Turks in Germany, which mainly led to depressive and/or somatic symptoms, usually following periods of external strain. In some cases, women had left their children back home in Turkey with their grandparents, bringing them to Germany later, which resulted in feelings of guilt and self-reproach. Also feelings of guilt after the death of parents who had been left back in Turkey were reported frequently by first generation migrants who had been unable to care for their relatives during long periods of illness.

Zarifoglu and Zeiler (1995) pointed to racism and xenophobia as factors contributing to depression in migrants. They also indicated that experiences of discrimination frequently were underreported to German clinicians as a result of the desire to conform to social norms and not to appear impolite or as a consequence of shame or pride. Similarly, in a recent German compendium on cross-cultural psychotherapy, Erim (2009) pointed to restricted chances for people of Turkish descent to develop in Germany which contributed to the development of clinical symptoms.

According to Razum and Zeeb (2004), suicide rates among migrants at first are comparable to those of their countries of origin and thus tend to be lower than those in most western countries. With increasing duration of stay and especially
among succeeding generations, however, the migrants' suicide rates tend to become equal to those of the host countries, possibly as a result of a loss of cultural roots and of increasing socio-economic difficulties (Löhr, Schmidtke, Wohner, & Sell, 2006). Accordingly, in general the suicide risk of Turkish women living in Germany is only about 0.3 times as high as that of Germans. Religious reasons as well as a high degree of social coherence among people of Turkish descent may serve as explanations. Among young Turkish migrant women, however, the age adjusted suicide rate is 1.8 times as high as among comparable German women, which may be due to familial and cultural conflict among them (Razum & Zeeb, 2004). Moreover, attempted suicide is more frequent among Turkish than among German women (Löhr et al., 2006).

Günay and Haag (1990) examined a sample of female Turkish migrants in Germany on the basis of a symptom checklist and by clinical interviews with respect to psychosomatic symptoms. They found that acculturated women had significantly less depressive symptoms, hypersensitivity or listlessness as compared to the less acculturated subgroup.

Some results with respect to specific age groups can be found in literature: Van Oort et al. (2006) found significantly more internalizing (i.e., anxiety and depression) and externalizing (i.e., socially deviant, aggressive and delinquent) behavior in youth of Turkish descent living in the Netherlands as compared to native youth (cf., various sources cited by Erim, 2009).

With increasing tendencies among young Turkish women towards abandoning the classic Islamic worldview a growing number among them also tend to conform to the current Western ideal of beauty. Thus, eating disorders are of increasing importance especially among young Turkish migrant women (Krieg, Penke, Wohlfart & Heinz, 2003). Difficulties of young Turkish mothers with respect to behavioral problems of their children in relation to various socio-demographic variables were highlighted by Kukulu and Buldukgolu (2006).

On the other hand, van der Wurff et al. (2004) found depressive symptoms in 61.5% of older Turkish migrants in the Netherlands as compared to 14.5% among age adjusted Dutch natives, on the basis of the Center for Epidemiologic Depression Scale (CES-D). Spijker et al. (2004) pointed to the fact that older people among Turkish migrants are at special risk towards developing depression because a number of known risk factors (low socio-economic status, exposure to psycho-social stress, poor perceived health status) apply to them. Accordingly, Friessem, Stiemer, & Münzenmayer (1996) emphasized the high prevalence of somatic symptoms in Turkish women in Germany, although total morbidity was lower in Turks than in Germans. Affective disorders and psychogenic reactions, however, were common especially among Turkish women, whose prevalence rates for these diagnoses exceeded the ones of native
Germans and (being on a par with women from former Yugoslavia) also exceeded the prevalence rates of other foreigners.

As a result of a large scale British cross-sectional investigation, the so-called "Islington Study", Livingston et al. (2001) pointed to the high rate of depressive disorders in senior Turkish migrants. While in the total sample of N = 1,085 London residents who were older than 65 years of age, 18.3% showed symptoms of depression, the depression rate among Cypriots of Greek or Turkish descent amounted to 27.2%.

6. UTILIZATION OF HEALTH CARE FACILITIES

According to Erim (2009), two main aspects must be considered when dealing with patients in a cross-cultural setting: on the one hand dynamics within therapeutic relationships vary between cultures, on the other hand, culturally specific symptoms, illness models, and therapeutic methods should be considered.

With respect to the second point, for example, Bäärnhilm and Ekblad (2000) highlighted the presence of pain and other somatic symptoms in Turkish-born women in Sweden which were frequently attributed to "traditional Turkish folk explanations [...] and [...] factors like weather and temperature". Accordingly, "traditional ways of explaining illness in terms of forces like misfortune and the evil eye were used by some participants" (p. 440). The interviewees emphasized that only Turkish doctors would really be able to understand the causes of their illness and only they would be able to prescribe really effective cures. Thus, according to Bäärnhilm and Ekblad (2000) and to Kleinemeier et al. (2004), Turkish women tend to distrust Western medicine and to consult medical experts (including traditional healers or hodschas) in their home country in addition to Swedish clinicians, feeling that their compatriots would give them clearer diagnoses and directives as compared to their Swedish colleagues. In addition, the women's expectation towards being able to manage their diseases on their own was extremely low.

Günay and Haag (1990) reported in their comparative study of female Turkish migrants with different degrees of acculturation, that the well acculturated subgroup was less reluctant to use the German health care system as compared to the less acculturated one. In particular, the better acculturated women more frequently were certified ill by their physicians as compared to their less acculturated counterparts.
According to Kleinemeier et al. (2004), Turkish migrants frequently are reluctant to utilize psychiatric, psychotherapeutic, or psychological care because they fear stigmatization and discrimination, sometimes even to be deported as a consequence of being mentally ill. In addition, Western medical and psychological services frequently are unable to understand the culturally specific meaning of Turkish patients' symptoms as well as psycho-social problems and often the language barrier poses additional difficulties (Koch, 1995). Haasen, Boyali, Yagdıran and Krausz (2000) examined the prevalence of mental disorders among the patients of general practitioners and concluded that Turkish migrants also in this sector of the medical system were not cared for sufficiently.

Ete (1995) indicated that, as a consequence of their holistic view of diseases, Turkish patients frequently do not report exact somatic symptoms. Rather they tend to generalize such symptoms, saying, for example, "The whole body hurts", expecting the doctor to find out the disease. Especially patients with lower educational levels try to test the doctor's knowledge in this way, but also want to express their respect towards the doctor's authority as they would do in Turkey when consulting a Turkish medical expert.

Erim (2009) highlighted the different views, patients and professionals have of each other in different cultures. While collectivist cultures like the Turkish one, rather emphasize a passive role of patients, attaching a high degree of respect to the medical doctor or psychotherapist, individualist western cultures promote the patients' responsibility and autonomy.

Wössmer and Sleptsova (2006) pointed to the fact that current concepts of psychotherapeutic management of pain had little effect in Turkish women, which can be explained by culture based difficulties to monitor one's feelings and sensations as well as by a lack of schooling and by language problems. Thus, the authors indicated that existing psycho-educational programs of pain management should be adapted to the culture-specific needs of migrants.

In the face of language problems, psychotherapy has to be conducted with the help of interpreters by central European therapists, usually with little or no knowledge of Turkish culture. Conventional, interpreter assisted psychotherapy, however, cannot account sufficiently for culture-specific facets of symptomatology and coping mechanisms. Erim (2009) pointed to possible problems than can be brought about by interpreters in psychotherapy. Most importantly, at the present time, a sufficient number of clinical psychologists/psychotherapists of Turkish descent are not available in Austria.
7. THE NEED FOR CULTURALLY SENSITIVE INTERVENTIONS: HOW THE IDEA FOR THE PRESENT STUDY HAS DEVELOPED

According to the evidence summarized above, Turkish migrant women have an extremely high incidence of depression, characterized by culturally specific symptomatology and frequently are reluctant to accept "western" types of psychotherapy. This corresponds to the fact that women of Turkish descent tend to affiliate only with their culture of descent and even tend to seek medical treatment in Turkey rather than in Central Europe.

A holistic view of illness and the importance attached to "lay theories" (p. 795) about possible causes of and remedies for depressive symptoms in Turkish migrants has been shown by Cirakoglu, Ködemir and Demirutku (2003). Quite different methods like "hobby, sensation seeking, avoidance, professional help, religious practices, esteem, and spiritual activities" (p. 795) were considered most helpful as remedies for depression by students at Baskent University in Ankara, Turkey.

From these considerations, it could be expected that Turkish migrant women with recurrent depression would benefit from a culturally specific and sensitive approach towards treating depression, including somatic symptoms. Our own recent research with asylum seekers and refugees from Chechnya, Afghanistan, and West Africa has shown that clinical symptomatology as well as coping strategies vary systematically between cultures (Renner, Salem, & Ottomeyer, 2006; Renner, Salem, & Ottomeyer, 2007). These findings are consistent with the literature on culturally specific variations of symptomatology (cf., for example, Mezzich, Kleinman, Fabrega, and Parron, 1996).

A research\(^8\) recently conducted by the editor of this book (cf., Renner, 2008 and Renner, Bänninger-Huber and Peltzer, accepted) has been addressing culturally sensitive, resource oriented peer-groups of Chechen asylum seekers and refugees in Austria. These guided self-help groups were conducted separately for women and men and were led by a same gender Chechen compatriot. As compared to a Wait-List Control Group, fifteen sessions of this kind of self-help groups have been shown to be effective in reducing symptoms of post-traumatic stress, anxiety, and depression, whereas they were not able to instigate "Post-Traumatic Growth" in the sense of Tedeschi and Calhoun (1996).

Encouraging experiences with indigenous lay counselors from the same culture assisting refugees in Sudan also were reported for example by Peltzer (1998-99). Accordingly, Eisenbruch, de Jong, and van de Put (2004) described a nine-step program conducted by supervised indigenous para-professionals, which has

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\(^8\) FWF grant P18789-G14, project leader Klaus Ottomeyer
been shown to be successful in helping refugees for example in Northern Uganda and Cambodia. The main idea of this program, implemented by the "Transcultural Psychosocial Organization" (TPO) was to integrate "western" and "cultural" approaches and to teach the participants strategies of empowerment and self-management (for additional examples see de Jong, 2002). Based on encouraging experiences in Nicaragua, Perren-Klingler (2001) instigated a community based self-help program designed to facilitate settlement in refugees from former Yugoslavia in Switzerland and Lerner, Mirsky, and Barasch (1994) focused on self-help activities by migrants to Israel. In Australia, the Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) implemented a community based program aiming at facilitating the process of settlement and coping with post-traumatic stress in refugees (Aroche & Coello, 2004).

Along these lines, Erim (2009) in the introductory chapter of her textbook of cross-cultural psychotherapy argued in favor of ethnic, bilingual psychotherapists but also in favor of self-help activities:

A migrant's treatment by a psychotherapist from the same ethnic group, speaking his or her mother tongue, is similar to the principle of "peer counseling". The term "peer counseling" has been coined by the movement demanding a self-determined life for handicapped persons in the U.S.A. and is based on the experience of self-help groups (http://www.peer-counseling.org). In self-help groups people similarly affected by difficult living conditions, e.g., handicapped people, find together and affiliate. They support each other and exchange their experiences, thus experiencing their identity in a more conscious way. Methodically, "peer counseling" encompasses principles of C. Rogers' Client Centered Psychotherapy, namely appreciation, emotional warmth (acceptance), verbalizing emotional contents of the conversation, empathy as well as authenticity and self-congruence. (Translated from Erim, 2009, p. 33).

With respect to Turkish migrants, in Germany, a variety of self-help activities for women already exist, dealing, among other problems with psychiatric disorders (BIKIS, 2007; Cindik-Jungermann, 1993; Kofahl, Hollmann, & Möller-Bock, 2009), with separation experiences (Tilli & Orduhan, 1989), or with communication deficits (Wendlandt, 1989).

In Muslim countries, daily concerns are used to be discussed in same-gender groups rather than in one-to-one contacts with professionals. Especially women are frequently restrained by their culture from seeking individual contacts outside their extended families, and thus can be expected to be profiting from group interventions (Yüksel et al., 1999). Thus we considered culturally homogenous self-help groups, led by indigenous paraprofessionals to pose a promising alternative to conventional psychotherapy with Turkish immigrant women. Up to now, however, evidence based empirical research on the
effectiveness of the above mentioned community based activities is scarce, while anecdotal evidence is encouraging.

These considerations formed the theoretical basis to the study presented in this book. In the light of encouraging previous results we intended to test the effectiveness of guided self-help groups for Turkish immigrant women in Austria, suffering from Recurrent Depressive Disorder as compared to group Cognitive Behavior Therapy (CBT) and Waiting List Control Groups. To our knowledge, this type of intervention for Turkish women suffering from recurrent depression has not yet been subjected to a randomized controlled trial.

According to the experiences reported by Lara et al. (2003) and by Laitinen et al. (2006) with patients with depression, and according to our own experience in our study with Chechen asylum seekers and refugees in Austria, it would be important that self-help activities would be guided by indigenous same-gender paraprofessionals. Without such guidance, meetings would have tended to be unorganized and without obligation. It was also obvious that in the work with depressed patients, it would be important to be able to organize immediate professional help in cases of severely depressed mood and/or suicidal tendencies.

We expected the guided self-help groups to promote autonomy, empowerment, and self-management skills in the participants, with special emphasis on culturally sensitive, indigenous aspects. Most importantly, however, we expected that women of Turkish descent would be less reluctant to use this type of intervention as they are towards conventional, typically "western" psychotherapy and pharmacotherapy. Details on how the group leaders were prepared for their work, how group meetings were organized and realized will be given in Chapter 3 of this volume.

8. REFERENCES


Chapter 1: Theoretical Basis I


Chapter 1: Theoretical Basis I


CHAPTER 2

THEORETICAL BASIS II
SELF-HELP GROUPS – THEIR DEVELOPMENT, FUNCTION, AND EFFECTS

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In self-help groups people associate on a voluntary basis, attempting to cope jointly with their disease or with other problems and their consequences. In some cases they are affected themselves by such problems, in other cases their relatives are concerned (cf., DAS, 1987). In any case, self-help is provocative, i.e., it poses a challenge or an invitation to the social security and the health system. Self-help groups and their effects remind us of our disease proneness, vulnerability, imperfection, and even of our finite nature. They also instill hope, however, pointing to the resources of self-healing processes by strengthening the (remaining) functions somebody has access to.

Our highly technical, economically oriented health system fulfills the expectations towards top qualified medical treatment and in many cases achieves the unexpected and unbelievable. It does not, however, satisfy in everybody his or her wishes for information, security, attention, reduction of fear, or assistance in coping with illness. Higher chances to survive, rising life expectancy, and multi-morbidity pose challenges to everybody's capacity of coping with illness. Patients surviving with a chronic disease or handicap are in need of psychological, social, and humanitarian support. They need contact persons helping them to cope with changing living conditions and impediments and to reach an acceptable degree of quality of life, apart from therapeutic professionalism.

Self-help announces a new generation of patients which will re-define the allocation of roles. Patients will actively take responsibility for their selves and for their health. Coping with and integrating illness to a large extent must be delegated to private networking. In times of medical achievements getting more and more impressive, the patients' individual responsibility must be increasingly emphasized.

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1. DEFINITION

"Self-help comprises all forms of individual and common forms of action which pertain to coping with health related problems by the persons concerned. Help by others, on the contrary, refers to the paid or unpaid assistance either by lay people not affected themselves, or by professionals and/or experts" (Borgetto, 2004, p., 80; cf., Borgetto, 2002).

Matzat (2003b) differentiated between three types of lay involvement within the health system:

(1) individual assistance which is based on social and moral attitudes, including social involvement which is expressed in personal aid, altruism, and private nursing;

(2) socio-political involvement, which is borne by a critical attitude towards the structures and institutions of medical care and which has been expressed in the "health movement", though with little practical effect;

(3) involvement out of being engaged directly and personally, as it is being expressed by self-help groups.

The self-help movement has developed towards various forms and definitions. The guiding idea of self-help pertains to the competency of the persons concerned (cf., Borgetto, 2004). Being an expert about oneself, the disease, the handicap, and about ones personal concern enables a person to act competently, effectively, and sensibly. In this respect, self-help differs from professional medical service and also differs from civic involvement.

As far as several persons are concerned by a health related problem and affiliate, we speak of common self-help. Taking the definitions by AOK-BV et al. (2000), Borgetto (2004), Katz & Bender (1976), Matzat (1999) and by Trojan (1986) into account, self-help groups are voluntary associations of people on a local or regional level, towards sharing activities related to coping with illness or problems effecting themselves or their relatives. Such non-profit activities are intended to change one's living conditions and to affect one's social and personal environment. Self-help groups are chaired by members of personal concern, regardless of their status as lay-people or medical professionals. Occasionally, medical experts are consulted by the groups with respect to various questions.

As compared to Austria or Switzerland, Germany has a very complex and differentiated self-help movement with self-help groups, self-help organizations and self-help contact points. A total number of 70,000 to 100,000 self-help groups are being estimated, operating locally, but in some cases also affecting the provincial or federal level. In addition, there are about 360 self-help
organizations, operating on a more formalized, supra-regional basis which maintain multiple contact to the professional health system (Borgetto, 2004). About 270 self-help contact points are operating locally (Hundertmark-Mayser, 2004).

In the course of a phone based health survey, in 2003 a total of 8,318 German respondents were interviewed with respect to being involved in health-related self-help groups (cf., Gaber & Hundertmark-Mayser, 2005). There were 8.9% of respondents, who already had participated in such a self-help group and another 13% had gathered information on self-help. Among chronically ill or handicapped persons, there were twice as many positive answers. Borgetto (2004) pointed to marked national differences with regard to the self-help movement. In Southern Europe the self-help idea has attained little popularity as compared to Central and Northern Europe and especially the United States of America. Still, internationally little empirical knowledge exists in this respect.

Out of 1,654 self-help groups currently existing in Austria, 4.4% have been founded before 1973 and afterwards their number has continually increased. Approximately half of the groups have been founded between 1998 and 2007. While 34% of health related self-help activities refer to mental diseases, psychosocial strain or addiction, 66% are concerned with somatic diseases (nervous system, neoplasms, musculoskeletal system, blood circulation, or metabolic diseases to name only a few examples (Braunegger-Kalleger et al., 2009).

Whereas modern self-help groups have outgrown the time of the pioneers in the sixties and seventies, who were often fighting professional treatment in a militant way, they still need to be recognized by patients, health insurance, and health professionals. Objective evidence is needed that self-help has effects beyond subjective well-being and its health related effects must be shown on a scientific basis (cf., Janig, 2002).

2. HISTORY

Individual self-help, e.g. within families and social forms of self-help by no means are phenomena of the present time but probably already have existed in the time of Early History, when professional systems of support also have developed (cf., Moeller, 1996). Apart from health related activities, the self-help idea has characterized the crafts and guilds of craftsmen and the social schemes of miners during the Middle Ages (cf., Dinklage, 1976; Moeller, 1996, Trojan, 1999). Various associations of workers, war victims or handicapped people which developed between the two World Wars also were based on the idea of self-help. The historical development of the sixties and seventies of the past
Theoretical Basis II

Chapter 2: Theoretical Basis II

The 20th century has brought numerous civic movements and initiatives like the women's movement, consumerism, environment protection, or the peace movement, to name only a few examples.

Among other sources, the self-help movement has its roots in companionships and trade unions. Insurance systems, including accident insurance, pension funds, as well as financial care for orphans and widows go back to self-help activities by the people concerned. During the past centuries, medical treatment (including medicine, nursing, and others) has been professionalized and medical knowledge has concentrated more and more within the medical professional and the official health system. During the 19th and the 20th century, a system of experts has developed within medicine, and medical knowledge about illnesses and their cures more and more was restricted to this system. Thus, lay-people and experts were strictly separated from each other.

It also must be emphasized that in the course of individualization relationships within families have changed. Households became smaller, women developed a growing sense of self-confidence and gender roles have changed. Thus, women today are less prepared to take over tasks of assistance and care as a matter of course (cf., Braun & Greiwe, 1989).

This is the basis which can explain how self-help associations developed. At the same time, the self-help movement can also be understood as a reaction to growing anonymity and heteronomy within the professional health system (Borgetto, 2004; von Ferber, 1983) and can be regarded a typical "post-modern" phenomenon (Kelleher, 2006). With respect to its most important prerequisites, Forster (2007) pointed to "the changing of predominant illness-related strain in modern society which is due to an increase of chronic illness" (p. 468). The latter have multiple consequences for the patients' self-images, for their concepts of life and for their relationships, often being subject to discrimination and rejection, with their lives depending more and more on a "management of illness". A second important causal complex is related to growing mechanization and specialization within medicine, leading to a lack of communication between medical experts and patients as well as to a neglect of their own experience and knowledge (Forster, 2007; Kelleher, 2006).

According to Trojan (1986; 2002) there are four approaches to the question, how self-help associations develop and why they are joined: the psychological and physical strain associated with a disease put excessive demands on close relatives, including the partner, the family and friends leading to feelings of hopelessness, thus suggesting associating in self-help groups. A second approach refers to feelings of hopelessness and dependency resulting from being in constant need of support by the social security system as a consequence of chronic psychological and physical strain. A third aspect of this theoretical
model suggests that a patient's chronic psychological and physical strain illustrates to him or her the shortcomings of the social security and the health system, leading to decreasing confidence into the efficacy of the official system of care. Again increasing hopelessness and despair may result and self-help may appear as a possible remedy. In a fourth approach, personal competency (also called empowerment, pro-activity, or personal initiative) is activated by psychological and physical strain and thus the individual is encouraged to become active towards his or her own recovery or towards the support of others similarly affected (cf., Kofahl, 2007).

The health related self-help movement can be traced back to the thirties, when groups like the Alcoholics Anonymous, Recovery Groups for people with mental and nervous diseases, and diabetics' associations were founded (Kelleher, 2006; Richter, 1984)\(^\text{10}\). On an international scale, in the sixties a continuous wave of founding self-help groups has begun which lasts unto today. At that time, also in Austria, there were first tentative attempts. Initially such groups frequently encountered hostility, discrimination, and rivalry as a consequence of unrealistic expectations on the part of some proponents of self-help but also resulting from simple lack of understanding on the part of many health professionals. Until today, fundamental change has occurred in this regard and self-help groups are widely recognized and respected (cf., Janig, 2002).

3. **FUNCTION**

3.1 **What do the People Concerned Say?**

What is the subjective function of self-help groups for their participants and what tasks do they accomplish from their point of view? Janig (2005) has summarized the function of self-help by the acronym **A-E-I-O-U**, which is formed by the five German concepts **Auffangen** (accepting), **Ermutigen** (encouraging), **Informieren** (informing), **Orientieren** (giving orientation) and **Unterhalten** (entertaining):

\[A \rightarrow \text{Auffangen (accepting)}:\]

New group members often feel depressed and lonely and they lack orientation. A group of people similarly affected offers them an opportunity to express their sorrow and distress and gives them a feeling of not being left alone:

\(^{10}\) See Borgetto (2002) for a summary of the development of self-help in Germany.
It is important to have the feeling, that there are other people who are equally concerned, who are suffering from the same disease and to share the feeling that there is sort of a community (Janig, 1999b, p. 86)\textsuperscript{11}.

...in the self-help group, there are the only people who can understand. You only understand what you have encountered yourself (p. 184).

...you feel understood in such a group. This is what it's all about, because I know that the other one knows exactly how I'm feeling. He knows what I feel now (p. 237).

And when I go there, ...there I'm in a place where I don't need to be afraid (p. 125).

\textit{E – Ermutigen (encouraging):}

Participants develop the confidence to be able to cope with their new situation.

Oh, in the first place, the self-help group should make it clear to the patient that he got to help himself, that one can really help each other (p. 139).

Once I felt extremely bad, ...and at that time I said: Whenever I'll be well again, I'm going to help the people who are feeling like I had felt at that time (p. 104).

\textit{I – Informieren (informing)}

Participants receive professional information, they hear lectures by experts, and literature or methods of treatment are recommended.

...and of course information was the most important thing, ...what you could do against it, what treatment options one could choose from, getting explanations in the first place (p. 85).

...as far as possible, I try to have a medical expert with us at any time, ...who can explain to us, what diagnoses are in each single case and what the chances are to stay alive (p. 99)

...it is just... ...that the self-help group offers a wealth of information (p. 40).

\textsuperscript{11} All the quotations have been taken from Janig 1999b, cf. also Miklautz, 2000
O – Orientieren (giving orientation)

Participants can orient their lives anew, they are offered role models and examples and they can redefine their expectations towards themselves, their fellow human beings and towards health professionals;

Alright, I have accepted my disease, ...you won't die of it, so I got to live with it... There are only two alternatives, either I say "yes" and accept the disease, then it's alright. But if you push it away from you... depression will result (p. 145).

You try again and again to come to an end with new power (p. 191).

By the example of others, you can see, how others have succeeded... (p. 83).

...so we can help ourselves by our activities and we can enhance our quality of life... (p. 172).

U – Unterhalten (entertaining)

Beyond the technical aspect of the contact in the self-help group, social activities and friendships develop which have an important supportive function.

Yes, I have gained a lot of friends by attending the group and this has positive psychological consequences and I'm feeling better then (p. 39).

People get along with each other well (p. 207).

3.2 Individual and Societal Effects

One of the most important questions, both for the participants as well as for the health system, appears to be the question of the self-help groups' effects. According to judgment by the general population, self-help groups may supplement medical treatment in a sensible way (Trojan et al., 2006).

According to Matzat (2003a), involvement in self-help groups has a threefold effect on their members: they affect a participant's relation to the disease as well as to his or her fate (by integrating illness, coping, and insight), but also his or her relation towards health professionals (medical doctors, nurses, and therapists); finally, self-help groups influence the relation which a recipient of care has to the health care system (quality assurance, patients' rights as well as economic aspects).
Traditional psychotherapy groups have frequently been subject of scientific investigation with respect to their efficiency, but this is not yet true of self-help groups. More and more frequently, however, such groups use to be seen as a possible alternative or at least as a convenient supplement to professional treatment. Empirical results are scarce, although the amount of sound evidence has increased during the past years. Review articles and meta-analyses (Barlow et al., 1999; Borgetto, 2004; Franzoni, 1992; Katz, 1981; Klytta & Wilz, 2007; Kyrouz et al., 2002) have revealed more or less positive effects of self-help groups on their participants. Although, as compared to other health related questions, the amount of evidence suffices neither quantitatively nor qualitatively, more and more interesting studies continue to be published which emphasize the growing importance of self-help groups and their effects.

For single participants, it could be shown that self-help generally promotes health, but also effects with respect to secondary and tertiary prevention have been found empirically. Engaging in self-help groups leads to an increase of information which is important both for the participants and for health care at large. From an economic point of view, the evidence points to the cost reducing properties of self-help groups. Some examples shall illustrate these effects:

### 3.2.1 Augmenting Information

According to the experiences reported by participants of self-help groups, the most prominent changes pertain to an increased knowledge about the disease and about treatment options. The amount of change will increase, if participants join the group as early as possible after being diagnosed with the disease, if they feel accepted by the group, and if they attend the group meetings regularly (Janig, 1999a). Knowledge from one's own experience being offered by fellow participants as well as the flow of information by invited experts seem to be the most important offer self-help groups can make. This composition of knowledge leads to a differentiated, complex, and comprehensive view of diagnoses, treatment options, recent scientific results, and realistic descriptions of living conditions which could not be achieved by other settings (cf., Hey & Stötzner, 2003).

As compared to non-participants, members of self-help groups possess a more thorough knowledge about their disease, about prevention and aftercare, as could be shown in a study of patients suffering from breast cancer (Kühner et al., 2006). In addition, participants were more open to new experience (Höflich et al., 2007).
3.2.2 Health Promotion and Salutogenesis

Health promotion aspires to integrated well-being for everybody by aiming at changes of behavior (in German: Verhalten) as well as of living conditions (in German: Verhältnisse). Self-help groups possess a variety of health promoting resources, for example by providing a stable environment recognized by society and by offering to each group member a high amount of recognition, assistance, and reassurance. Participants perceive self-help groups as equally important for their well-being and quality of life as their own children or their spouses. By far, these three groups of attachment figures are the most important ones for the participants (Janig, 2005).

From a salutogenetic point of view, the most important protective factors are transparency, activation, and participation, and all three of them are being addressed by self-help groups in a very pronounced way. By exchanging mutual personal experiences, by a relationship of trust within the group and by the openness of mutually disclosing personal conditions of the disease, ones own circumstances of life can be made clear and understandable. Group dynamics motivate participants towards getting involved with their own affairs and "empowerment" is an element of utmost importance in the work of the groups. Finally, group members are motivated not only to participate in their own development but also, in an indirect way, in their fellow members' personal change.

Members of a self-help group for unemployed persons, even months after participating reported significant improvements of their subjective quality of life and of self-assurance with respect to social phobia (Kager & Haslinger-Baumann, 2003). Patients with anxiety disorders, who had participated in self-help groups, perceived them as helpful too. At the same time, symptoms of anxiety and aggression as well as obsessive-compulsive symptoms were reduced (Taubmann & Wietersheim, 2008).

A content analysis of interviews with the heads of self-help groups pointed to a change of attitudes towards themselves and towards other people as well as towards activating resources, enabling them to get involved into their own concerns. Thus, "empowerment" has been promoted and in some cases even changes of personality resulted. In spite of their chronic diseases, a higher quality of life had been attained, leading to enhanced contentedness in their lives (Miklautz, 2000).

By getting involved, self-help participants feel less isolated and are convinced that they are able to deal with their diseases better than others. They are enabled to enjoy their lives more than before, they gain courage to face life and their anxiety towards illness is reduced (Janig, 2000). Following a by-pass operation
or myocardial infarction patients were granted the opportunity to visit a self-help support group over a period of three years. Patients who had accepted this offer reduced smoking, increased exercise, had tighter social networks, and received more social support than those patients who had declined the offer (Hildingh & Friedlund, 2004).

### 3.2.3 Effects on Secondary and Tertiary Prevention

In members of a guided self-help group for women with bulimia, after 15 months Rathner et al. (1993) found significant improvements of their eating behavior and reduced interpersonal distrust and depression as well as increased social adaptation as compared to the untreated control group.

A web-based self-help intervention has been examined with respect to its effects on depression and anxiety disorders (van Straten et al., 2008). These interventions yielded significant and clinically relevant effects, especially in those participants whose test-scores initially were poor and who took part in the intervention on a regular basis. Similar results were obtained in a study of web-based support groups for patients suffering from breast cancer: depression scores were reduced and stress as well cancer-related traumatic experiences had been integrated more successfully (Winzelberg et al., 2003).

Grimsmo et al. (1981) have shown successfully the short- and long-term effectiveness of self-help groups towards weight reduction. Participating in the groups not only had a direct effect on weight reduction, but group members also had learned to change their lifestyle and their eating habits, to reduce alcohol consumption and to increase exercise.

As compared to a control group receiving regular treatment only, patients with alcohol or drug abuse who took part in self-help groups regularly, in the long term had lower rates of abuse (Kissin et al., 2003). In another study it could be shown that participants of self-help groups, as compared to non-participants had a sevenfold probability of remaining abstinent (Bottlender & Soyka, 2005). According to Ferri et al. (2008), however, there are no experimental studies which would proof the effectiveness of the self-help groups offered by Alcoholics Anonymous. On the other hand, taking part in these groups can motivate patients to accept treatment and to maintain it for a longer period of time.

As opposed to these findings, the results of a meta-analysis by Kaskutas (2009) point to the effectiveness of the self-help groups by Alcoholics Anonymous: abstinence rates in these groups have been reported to be twice as high as compared to non-participants and a longer period of membership leads to higher...
abstinence rates. In their "experts consensus statement" (Humphreys et al., 2004), the authors point to reduced drug consumption, enhanced psychological health status as well as reduced health related costs as an effect of taking part in self-help groups for alcohol or drug addiction. Many patients decide to make use of both, self-help group and professional treatment and in no case should professional treatment be reduced or even terminated because of taking part in a self-help group.

4. THE RELATIONSHIP BETWEEN SELF-HELP AND PROFESSIONALS

Growing mechanization und specialization in modern medicine, the discrepancy between professionals and lay-people as well as the speechlessness and the communication gap between patients and health professionals were identified as the prerequisites which allowed self-help groups to develop. Against this background, patients find contact persons in the self-help groups with whom they can exchange their experience and their knowledge in order to compensate the shortcomings encountered at other places.

Self-reports and test scores obtained from participants with anxiety disorders revealed that, within one year, self-help led to an improvement and participation in most cases was described as helpful. A reduction was reported with respect to obsessive-compulsive symptoms, Phobic Anxiety, Aggressiveness, and Psychoticism. At the same time, the patients' psychotherapists were interviewed and 80% of them indicated that self-help may have had a supportive effect on psychotherapy (Taubmann & von Wietersheim, 2008).

By engaging in the group, self-help participants learn to deal more self-confidently with medical doctors and other health professionals. The doctors' competencies on the one hand and their professional relationships to their patients on the other hand, use to be judged quite differently. In most cases, self-help participants place a high value on the medical experts' knowledge and use to consult them with respect to diagnoses, to questions related to the disease and its treatment, and regarding possible coping strategies. Participants frequently are annoyed, however, by a lack of culture of dialog and empathy on the part of their doctors and also by missing experience in more specific questions. Feeling accepted and understood by the group promotes a persons' ability to deal with his or her disease and his or her strength and self-confidence when speaking to doctors (Janig, 1999a).

Medical experts appreciate the self-help groups' potential to supplement medical treatment and to enable patients to deal with and to accept their disease. Medical doctors experienced in co-operating with self-help groups are familiar with their
potential to promote quality of life, health, and mutual support (Janig, 1996). Bogenschütz (2006) interviewed the moderators of medical quality circles and found that the achievements of self-help groups were judged very positively. Out of the persons interviewed, 96% were familiar with self-help groups and 88% said that they appreciated that participants had an enhanced knowledge base, that information was gathered by the group which was of potential interest also to professionals and that groups gave competent advice to the people concerned. Group activities were found helpful towards compensating concomitant psycho-social distress and towards strengthening the patients' competence in dealing with their disease and they were judged to act as meaningful supplements to professional therapy.

With increasing duration of participating in self-help groups, the respective relative importance of medical doctors and of other health professionals change. Activities by medical practitioners and medical experts in general are appreciated highly and remain equally important in the case of longer duration of illness. On the other hand, less importance is attributed to hospitals, counseling centers, psychologists, and psychotherapists and their importance still decreases with longer duration of illness (Janig, 1999a, 2000).

According to Stark (2001), in future a co-operation between self-help and professionals will not be accomplished in a "simple technical-organizational" (p. 63) way. Rather, their relationships will have to be shaped on the personal and on the cultural level in order to combine successfully the patients' experience based knowledge with the health professionals' theory based knowledge. Thus, learning communities shall develop which will be able to add a new quality to public health.

5. SELF-HELP GROUPS FOR PEOPLE WITH A MIGRATION BACKGROUND

There are good reasons for the fact that a growing number of studies deal with health related questions of people with a migration background (Wyssmüller & Kaya, 2010). Apart from the reasons and conditions of migration, their socio-economic status in most cases is low, forcing them to do jobs which pose a risk to their health. Many migrants are unemployed, or they are living under dire housing conditions. Various such factors acting together may influence their health in a negative way and, according to a study by the Robert Koch Institute (Razum, 2008), migrants frequently suffer from posture and movement disorders, of heart and circulatory disorders, or from diabetes and respiratory diseases. Moreover, their accident rate is higher and they also run an increased risk to develop diseases like for example tuberculosis or to be subjected to psycho-social strain.
As far as migrants have sufficient command of their host country's language, they are equally active in self-help groups as the nationals. Migrants not integrated with respect to their knowledge of language, however, hardly have access to self-help offers (Kofahl et al., 2009). According to the authors, for this target group there are the following barriers towards founding or participating in self-help groups:

=> in many languages, **no such concept** as "self-help" exists;
=> many health related problems – e.g., psychological problems, addiction – are **associated with shame** and thus cannot be addressed in a group;
=> as migrants often are **highly associated** with each other, the groups would be unable to guarantee the necessary degree of anonymity;
=> according to cultural preconceptions, health frequently is seen as a phenomenon determined by **external factors**;
=> potential **group leaders** often are unavailable;
=> a small degree of reading proficiency or even **illiteracy**;
=> for cultural reasons, **men** and **women** would be unable to discuss health-related questions in the same group.

Still, health related self-help has a high potential for health promotion and prevention in migrants. Kofahl et al. (2009) have formulated a number of suggestions towards spreading the idea of self-help, like collecting and promulgating of positive experiences with self-help, approaching opinion leaders and authority figures with a migration background as well as promoting self-help contact points and organizations.

### 6. Economic Gain

Taking into account the over-all importance of economic factors, these must also be considered with respect to self-help groups. The current political discussion on financial support of self-help groups also depends on the economic evaluation of their activities. According to Engelhardt et al. (2009), common parameters of health economy (like for example, Quality-Adjusted Life Years, QALYS, cf., Mullahy, 2001; Scharff & Jessup, 2007) cannot be applied to self-help groups for the following reasons: Firstly, the additional gain of life years that could be attributed to the effect that self-help adds to conventional treatment cannot be determined; secondly, QALYS does not sufficiently take into account that there may be an increase of quality of life in spite of a low "objective" degree of health; thirdly, the expenses per self-help participant cannot be determined (Engelhardt et al., 2009).
Humphreys and Moos (1996) have shown that treatment costs caused by group participants of Alcoholics Anonymous were 45% lower than those of alcoholics who underwent regular outpatient treatment. Apart from lower costs, self-help participants experienced a marked reduction of alcohol consumption, of negative side-effects, and of depressive symptoms and in this respect did not differ from patients who had received professional treatment. According to a study with self-help groups for patients with anxiety disorders by Engelhardt et al. (1995), as a consequence of reduced consultations and emergency visits, treatment costs were lower as compared to those of patients who were not affiliated to a self-help group. Concomitantly, the group members participated in telephone-chains, their duration of stay in psycho-somatic clinics was reduced, and they appraised the use of medication more critically. From a monetary point of view, the financial gain achieved by the self-help groups was a multiple of their funding by public authorities (Engelhardt et al., 1995).

Engelhardt et al. (1995) analyzed and evaluated four studies of the monetary value of self-help work (cf., also Trojan et al., 2008). They concluded that the work in self-help groups not only pays for their members by the health related advantages achieved, but also by their monetary benefit. This seems to be especially true for self-help groups and initiatives in the area of social security, which up to now have only rarely been investigated in a systematic way. Frequently, their activities seem to be highly innovative and seem to replace professional work, yielding substantial economic effects.

Engelhardt et al. (1995) concluded from the four German studies analyzed that the value of the work achieved by each member of a self-help group was between approximately € 700.00 and € 900.00 per year. Applying this only to the self-help groups of the region of Hamburg (Germany), a productive performance of over 20 million Euro per year results (Trojan et al., 2008). Being able to estimate the economic benefit of self-help activities in some cases, should not induce us, however, to underestimate the value of other self-help groups which cannot be assessed economically in a similar way (Rosenbrock, 2001).

7. FUTURE PERSPECTIVES

Against the background of attempting to shift the focus of health systems from medical intervention to health promotion, the self-help idea and self-help groups are gaining special importance. The health system will develop towards a basic philosophy of salutogenesis, emphasizing the patients' personal initiative. Thus, Matzat's (1999) vision, who had formulated that self-help groups might establish themselves as the fourth column of health care – besides hospitals, medical practitioners and the public health system – is moving a step closer.
Chapter 2: Theoretical Basis II

8. REFERENCES


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CHAPTER 3

HOW THE RANDOMIZED, CONTROLLED STUDY HAS BEEN PLANNED, ORGANIZED, AND CONDUCTED\textsuperscript{12}

WALTER RENNER\textsuperscript{13}

1. OUTLINE OF THE STUDY: PROJECT AIMS AND HYPOTHESES

According to the experiences of the Innsbruck based Psychiatric University Hospital, the most frequent diagnosis among Turkish migrant women is Recurrent Depressive Disorder (ICD-10 F33), and thus the study was designed towards this diagnostic category.

When addressing women with a Turkish migration background, it should be considered that a sufficient number of clinical psychologists/psychotherapists of Turkish descent, who could communicate with them in their mother tongue, currently are not available in Austria. Apart from the obvious practical value of testing a community based intervention for women of Turkish descent suffering from recurrent depression, however, the central aims of the proposed project referred to basic research in clinical and cultural psychology.

From the considerations outlined in Chapter 1 with respect to the cultural background and in Chapter 2 regarding the working mechanisms of self-help groups, we expected that participants would benefit from a community based self-help approach.

=> By psychometric (quantitative) methods (cf. Chapter 5 for results), we intended to test the effectiveness of guided self-help groups for Turkish women with Recurrent Depressive Disorder;

=> By qualitative methods (cf. Chapter 6 for results), we wanted to gain new insights into the working mechanisms of the groups;

\textsuperscript{12} Parts of this text have been taken from a grant application submitted by the author to the Austrian Science Fund (FWF) in 2008 (FWF-Research Grant Nr. P20523-G14).

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Guided self-help groups for Turkish women with Recurrent Depressive Disorder could serve as an example of a culturally sensitive, community-based intervention offered to an ethnic group in Austria and thus most importantly, from this approach, new insights about the effectiveness and the working mechanisms of community-based, culturally sensitive interventions in general were expected. Thus, we expected to be able to (cautiously) generalize the findings of the present research to interventions for other ethnic groups (like for example refugees and asylum seekers), both in Austria and abroad (cf., Chapter 10 for discussion of results and recommendations).

According to the experiences reported by Lara, Navarro, Rubi, and Mondragon (2003) and by Laitinen, Ettore, and Sutton (2006) for patients with depression, and according to our own previous experience in a study with Chechen asylum seekers and refugees in Austria (cf., Chapter 1), it seemed important that self-help activities would be guided by indigenous same-gender paraprofessionals. Without such guidance, meetings would have tended to be unorganized and without obligation. It was also obvious that in the work with depressed patients, it would be important to organize immediate professional help in cases of severely depressed mood and/or suicidal tendencies.

The guided self-help groups were expected to promote autonomy, empowerment, and self-management skills in the participants, with special emphasis on culturally specific, indigenous aspects. Although group leaders were trained beforehand towards their task, they were by no means obliged to follow a "western" rationale of coping and healing and rather were encouraged to follow their own ethnic health belief model.

We intended to test the effectiveness of the self-help groups as compared to Cognitive Behavior Therapy (CBT) in a group setting and to a Wait-List Control Group (the latter would receive the self-help intervention after completing the waiting time of approximately four months). To this author's knowledge, self-help groups for Turkish women suffering from recurrent depression have not yet been subjected to a randomized controlled trial. The design encompassed pre-, post, and two follow-up measurements of various clinical symptoms (for details see Point 6. below).

These were our hypotheses:

1. In terms of a pre/post comparison of clinical symptoms, we expected the guided self-help groups to be significantly more effective than a Wait-List control condition.
(2) In terms of a pre/post/follow-comparison of clinical symptoms, we expected that the outcome of the guided self-help groups would not differ significantly from the outcome of group Cognitive Behavior Therapy (CBT).

(3) We expected the guided self-help groups to yield an effect size of at least 1.00 (in terms of a comparison of clinical symptoms between the self-help groups and the waiting-list control condition).

A total of N = 60 participants should be randomized to three conditions, namely the Self-Help Groups (SHG), the Cognitive Behavior Therapy (CBT) Groups and to the Wait-List (WL) Control Condition. Assuming a mean factual group size of N = 10 participants, overall the study comprised two SHG, two CBT-Groups and two WL Control groups, who received the Self-Help Interventions after having completed waiting time. The idealized timetable of the study as it was originally scheduled as well as the initial sample sizes actually included in the study can be seen from Figure 1.

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<td>N = 10 SHG 1</td>
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<td>N = 13</td>
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<td></td>
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<td>N = 10</td>
<td></td>
<td></td>
<td>N = 10 CBT 2</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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</tr>
</tbody>
</table>

Vertical Lines: Measurement occasions
Grey Bars: Duration of Interventions

Figure 1: Proposed timetable of interventions and measurements with initial group sizes

2. Human Resources

The research has been devised and initiated by Walter Renner at the University of Innsbruck (Department of Psychology). Whereas Walter Renner did not participate actively in realizing the research, he was responsible for publication and dissemination of results during the final period of the research. As Walter Renner at that time had temporarily accepted an appointment as an Associate
Chapter 3: How the Study has been Planned, Organized, and Conducted

Professor at Private University UMIT\textsuperscript{14}, during its final phase, the research was carried out on behalf of this institution.

As a female representative as a contact person for the migrant women seemed advisable, practical work was headed on a 20 hours-per-week basis by Eveline Frenademetz, a doctor of educational science and psychotherapist-in-training. From month 1 to 16 Mrs. Frenademetz was assisted by Birsen Sladky on a 20 hours-a-week basis, a female doctoral student of Psychology who is of Turkish descent and speaks Turkish as a second language. A number of experts assisted us in conducting the workshops for training the group facilitators (see Point 3. below) and a female clinical psychologist was employed on an hourly basis towards conducting the CBT groups with the help of a female interpreter. A female psychiatrist-in-training screened the prospective participants from a clinical point of view. Barbara Juen, an Associate Professor of Psychology at the University of Innsbruck, who co-authored Chapter 6 in this volume, supervised the group facilitators on a monthly basis.

For the task of group leaders, we were looking for women of Turkish descent who did not need to have a psycho-social education but should have a background in dealing with other people's concerns. In addition they should be self-confident enough to fulfill the task of a group leader. The potential group leaders were recruited by personal contacts of lay interpreters of Turkish descent who had worked for us previously on a part-time basis in psychotherapy. Initially eight women had expressed their interest, but after some consideration, four second generation Turkish migrants remained. Three of them were studying Medicine and one of them Law at the University of Innsbruck. Several weeks after the potential group leaders' training had commenced, one of the medical students discontinued her training because of moving to Germany. Thus, one of the medical students headed the first Self-Help Group and the second Wait-List Control Group, whereas the other medical student was in charge of the first Wait-List Control Group and the Law student headed the second Self-Help Group.

3. \textbf{PRELIMINARY PHASE}

As can be seen from Figure 1, there was a preliminary phase of approximately six months during which the group leaders were trained.

The group leaders were prepared for their tasks by a series of five workshops of 15 units (per 45 minutes) each (plus homework)
The workshops comprised the following themes:

\textsuperscript{14} Private University of Health Sciences, Medical Informatics and Technology at Hall near Innsbruck
Workshop 1 (Walter Renner\textsuperscript{15}): Introduction to clinical psychology and basic intervention techniques with special reference to depression and possible suicidal tendencies;

Workshop 2 (Vedat Sar\textsuperscript{16}): Cultural aspects of depression in female Turkish migrants;

Workshop 3 (Karl Peltzer\textsuperscript{17}, project consultant): Lay counseling;

Workshop 4 (Eva Bänninger-Huber\textsuperscript{18}): Coping with depression;

Workshop 5 (Barbara Juen\textsuperscript{19}): Developmental and educational psychology, children's concerns, and guidelines for practical group work.

Workshops 1, 3, 4 and 5 were conducted by local experts of cultural, clinical, and developmental psychology, whereas Workshop 2 was held by Professor Vedat Sar of the Psychiatric Medical Hospital, Istanbul, who acted as a guest speaker.

4. HOW PATIENTS WERE RECRUITED, SELECTED, AND ALLOCATED TO EXPERIMENTAL CONDITIONS - DESCRIPTIVE STATISTICS OF FINAL SAMPLE

From anecdotal evidence which we collected while the present research had been designed, and according to the literature which we referred to in Chapter 1 of this volume, we assumed that there would be an urgent need for culturally specific interventions that might be helpful for depressed women of Turkish descent living in Austria. Moreover, this need for interventions had been stressed by psychiatric experts, psychotherapists, and social workers from the area of Innsbruck who are familiar with the psycho-social conditions as well as with the specific needs of Turkish people living in Austria.

\textsuperscript{15} Walter Renner, Ph.D., editor of this volume

\textsuperscript{16} Professor Vedat Sar, MD, author of Chapter 8 of this volume

\textsuperscript{17} Professor Karl Peltzer, Ph.D., Research Director, Social Aspects of HIV/AIDS and Health, Human Sciences Research Council, Pretoria, South Africa

\textsuperscript{18} Professor Eva Bänninger-Huber, Ph.D., psychotherapist and head of a working group on emotion, cognition, and interaction at the Dept. of Psychology, University of Innsbruck

\textsuperscript{19} Professor Barbara Juen, Ph.D., co-author of Chapter 6 of this volume
During Professor Vedat Sar's visit to the University of Innsbruck we took the opportunity to introduce him to the Turkish community in Innsbruck at a local mosque and cultural club, where he also gave a lecture to the public. At this occasion, a considerable number of women with a Turkish migration background had expressed their interest to participate in the research. In due course, our contact to the Turkish community was helpful towards further networking with a number of additional Turkish cultural clubs in the area of Innsbruck. Thus participants in the first place were recruited by spreading the word of mouth among Turkish migrants. Additional participants were referred by the outpatient department of the Psychiatric University Clinic and by medical practitioners and psychotherapists in free practice. In addition, we had placed an advertisement in a local Turkish newspaper.

All prospective participants were invited to a first meeting with the research assistants, who explained to them in detail the aims of the project. The first interview also was aimed at screening prospective participants for clinical symptoms and with respect to their suitability to the project. Approximately 130 women at first expressed their interest, many of whom lost interest shortly afterwards or rejected to participate because of family obligations, because their husbands had objected, or because access routes were too far. Still others could not be accepted because they did not fulfill clinical criteria for participation. Finally, \( N = 66 \) had agreed to participate and also were accepted according to the psychiatric screening.

As a consequence of many women staying away after their first contact to the research team, recruitment of participants turned out to be much more difficult than expected. In fact, numerous women had contacted us initially in order to be informed about what we could offer, but only a comparatively small member of them finally participated in the group programs. Although in the area of Innsbruck a considerable number of inhabitants are of Turkish descent and although we had made every effort to contact prospective participants, the recruitment procedure was much more difficult than initially expected. Thus the time plan of the study had to be adapted in order to reach the required number of participants. Whereas the first Self-Help Group and the first CBT-Group started in October 2008, the second Self-Help and the second CBT-Group had to be postponed and started in late January and early February 2009 respectively. Similarly, the first Wait-List group started in February 2009 as scheduled, while the second Wait-List group first was postponed until May and finally, due to summer vacations, had to be postponed till October 2009 because of a lack of participants.

When asking for the reasons for staying away many women informed us that they had expected rather single therapy by a "renowned" therapist as opposed to group treatment, or even "worse", a self-help group. This finding corresponds
quite well with the experiences reported by Wössmer and Sleptsova (2006) with respect to pain management in women of Turkish descent living in Switzerland (cf., Chapter 10 of this book for details).

The participants' biographic background will be given in Chapter 4 and the descriptive statistics of the sample will be summarized in Chapter 5.

5. RATIONALE OF GROUP INTERVENTIONS

5.1 Self-Help-Groups

In the course of their training, the rationale of self-help groups had been explained to the prospective group leaders. According to the nature of self-help, there was no given structure the group leaders would have been required to adhere to. Rather, they had been prepared to leave it to the group members, which issues they would like to raise.

Group leaders had been instructed, however, to promote empowerment, and self-confidence in the group members as required by the basic philosophy of self-help groups (cf., Chapter 2). In addition, it was the group leaders' task to insure that confidentiality was agreed upon by the group members and that basic rules of discussion (giving participants a feeling of being accepted, promoting trust, only one person should talk at a time, no sudden switching of topics, etc.) were adhered to.

The self-help interventions comprised 15 sessions per 90 minutes, plus two follow-up meetings (one and six month after the last meeting) which also served for administering the follow-up measurements (cf., Figure 1). Details of how the self-help groups had been conducted have been collected in the course of the group leaders' supervision and will be summarized in Chapter 6.

5.2 Cognitive Behavior Therapy Control Groups

Cognitive Behavior Therapy has been selected as a control condition because has been shown to be well-founded psychotherapeutic method with a sound theoretical and empirical basis (Blöschl, 1998). Most frequently, CBT approaches to depressive disorders are based on Lewinsohn's (1975) method of restoring positive reinforcement and on Beck, Rush, Shaw, and Emery's (1979) cognitive therapy of depression.
De Jong-Meyer and Hautzinger (1996) summarizing two German multi-center studies, indicated that CBT was equally effective as pharmacotherapy in patients with non-endogenous depression. They also emphasized that CBT was highly effective in outpatients regardless of the type of depression they were suffering from, especially with respect to long-term maintenance of symptom reduction after the treatment had been terminated (cf. also de Jong-Meyer, Hautzinger, Kühner and Schramm, 2007). On the basis of previous studies the same authors reported that in cases of mild and moderate depression, CBT yielded less drop-outs than pharmacotherapy did, while otherwise, both interventions were equally effective.

Feldman (2007) summarized the comprehensive meta-analysis by Gloaguen, Cottraux, Cucherat, and Blackburn (1998), who found cognitive therapy to be slightly superior to pharmacotherapy with milder forms of depression, while the opposite was true in the NIMH-funded large scale study by Elkin et al. (1989), as far as patients with severe forms of depression were concerned. Thus, current guidelines by the American Psychiatric Association (2000) recommend pharmacotherapy as the primary treatment for severe cases of depression and to combine it with psychotherapy if psychosocial or interpersonal problems exist or if preferred by the patient (cf. also de Jong-Meyer et al., 2007).

Still other studies questioned Elkin et al's (1989) results, suggesting that also in cases of severe depression CBT yields effects superior to medication. In addition, Feldman (2007) pointed out, however, that (in accordance with de Jong-Meyer and Hautzinger's, 1996 above mentioned German results and Gloaguen et al's, 1998 meta-analysis) "although acute outcomes of CT and medication may be largely comparable, CT has been shown consistently to protect better against relapse" (Feldman, 2007, p. 42).

Various studies with group CBT of depression have been conducted, suggesting that group therapy is equally effective as individual CBT or pharmacotherapy (cf. for example de Jong-Meyer et al., 2007; Herrle & Kühner, 1994; Miranda et al., 2006; Misri, Rebye, Corral, & Mills, 2004). The author of this chapter in a previous study found that group CBT in a psychotherapeutic outpatient department yielded effect sizes above 1.00 in patients with depressive disorders (Renner & Platz, 1999).

In the present study, group CBT followed a clear structure, adapted from treatment manuals of cognitive-behavioral treatment of depression (Hautzinger, Stark, & Treiber, 2003; Herrle & Kühner; 1994). Just like the self-help groups, CBT comprised 15 sessions per 90 minutes, plus two follow-up meetings (one and six months after completion), which also served for administering the follow-up measurements (cf., Figure 1). For details, how group therapy has been implemented, see Chapter 6 of this book.
6. REFERENCES


Chapter 3: How the Study has been Planned, Organized, and Conducted


As outlined in Chapter 3, all participants were screened with respect to their biography and their psychiatric diagnoses in order to assess, whether they would meet the diagnostic criteria of the present research, i.e., only women with recurrent depressive disorders (ICD-10 F33) were included.

After initial screening by the research team, a total of N = 71 prospective participants underwent psychiatric screening, N = 66 of whom met the criteria and were accepted for participating. In the course of taking medical history, apart from demographic details, current psychiatric symptomatology as well as current and past stress factors and personal resources, with special regard to social support have been assessed. Moreover, the participants' living situation and previous psychiatric treatments, both as an inpatient or as an outpatient, were assessed. Special care was taken towards assessing suicidal tendencies as well as past suicide attempts. In addition, the prospective participant's family background was taken down in the form of a genogramm.

In the course of administering the psychometric questionnaires at the first measurement occasion, the participants also received the Life Events Check-List (LEC) (Blake et al., 1990) in order to assess possible traumatic events they might have experienced or witnessed or about which they might have heard from others. The LEC had been adapted and translated to Turkish from the Clinician Administered PTSD-Scale (CAPS-I).

1. Traumatic Events

Before turning to the results of the psychiatric screening with respect to current stressful living conditions, symptoms spontaneously reported, and the participants' personal resources, in Table 1 we wish to summarize the
participants' questionnaire responses with respect to traumatic events encountered in the past.

<table>
<thead>
<tr>
<th>Event</th>
<th>Happened to me</th>
<th>Witnessed it</th>
<th>Learned about it</th>
<th>Not sure</th>
<th>Doesn't apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Natural disaster</td>
<td>21</td>
<td>10</td>
<td>3</td>
<td>2</td>
<td>30</td>
</tr>
<tr>
<td>2. Fire or explosion</td>
<td>10</td>
<td>4</td>
<td>5</td>
<td>2</td>
<td>45</td>
</tr>
<tr>
<td>3. Transportation accident</td>
<td>24</td>
<td>5</td>
<td>7</td>
<td>0</td>
<td>30</td>
</tr>
<tr>
<td>4. Serious accident</td>
<td>14</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>42</td>
</tr>
<tr>
<td>5. Exposure to toxic substance(^{21})</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>55</td>
</tr>
<tr>
<td>6. Physical assault</td>
<td>23</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>38</td>
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<td>7. Assault with a weapon</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>55</td>
</tr>
<tr>
<td>8. Sexual assault</td>
<td>9</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>53</td>
</tr>
<tr>
<td>9. Other unwanted or uncomfortable sexual experience</td>
<td>11</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>50</td>
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<td>10. Combat or exposure to a war-zone</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>59</td>
</tr>
<tr>
<td>11. Captivity</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>57</td>
</tr>
<tr>
<td>12. Life threatening illness or injury</td>
<td>17</td>
<td>1</td>
<td>5</td>
<td>0</td>
<td>43</td>
</tr>
<tr>
<td>13. Severe human suffering(^{22})</td>
<td>32</td>
<td>2</td>
<td>0</td>
<td>4</td>
<td>26</td>
</tr>
<tr>
<td>14. Sudden, violent death(^{2})</td>
<td>15</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>40</td>
</tr>
<tr>
<td>15. Sudden, unexpected death of someone close to you</td>
<td>26</td>
<td>6</td>
<td>2</td>
<td>0</td>
<td>32</td>
</tr>
<tr>
<td>16. Serious injury, harm or death you caused to someone else</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>62</td>
</tr>
<tr>
<td>17. Any other very stressful event or experience(^{23})</td>
<td>43</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>14</td>
</tr>
</tbody>
</table>

Table 1: Traumatic events reported on the Live Events Check-List (Blake, 1990) by N = 66 participants

From the LEC it can be seen that a high number of traumatic events had happened to the participants personally, with an especially high rate of natural disasters, accidents, physical or sexual assaults, life threatening illnesses and the sudden death of beloved others. The number of events witnessed or learned about is comparatively low.

\(^{21}\) One answer missing  
\(^{22}\) Two answers missing  
\(^{23}\) Three answers missing
Chapter 4: Biographic Background

2. THE PARTICIPANTS' SPONTANEOUS REPORTS

2.1 Current and Past Stressors

Table 2 summarizes the current and past stressors which had been addressed by N = 71 prospective participants in the course of their psychiatric screenings. It can be seen that marriage and family problems were the most frequent concerns among the women interviewed. It should also be noted that conflict between the traditional values of the Turkish society of origin and the liberal ones of Austrian society posed a frequent source of distress. For example, many respondents expressed that they wished to be divorced from their husbands but were reluctant to do so because of fearing the consequences.

<table>
<thead>
<tr>
<th>Stressor</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Marriage crisis</td>
<td>39</td>
</tr>
<tr>
<td>2. Behavioral problems of sons and daughters</td>
<td>24</td>
</tr>
<tr>
<td>3. Own somatic illness or accident</td>
<td>16</td>
</tr>
<tr>
<td>4. Social isolation</td>
<td>9</td>
</tr>
<tr>
<td>5. Family member's somatic illness or accident</td>
<td>9</td>
</tr>
<tr>
<td>6. Death of family member</td>
<td>9</td>
</tr>
<tr>
<td>7. Domestic violence</td>
<td>7</td>
</tr>
<tr>
<td>8. Conflict with extended family, mostly mothers-in-law</td>
<td>7</td>
</tr>
<tr>
<td>9. Financial problems</td>
<td>5</td>
</tr>
<tr>
<td>10. Being cheated on by husband</td>
<td>5</td>
</tr>
<tr>
<td>11. Husband's drinking problem</td>
<td>4</td>
</tr>
<tr>
<td>12. Stress at work</td>
<td>3</td>
</tr>
<tr>
<td>13. Political persecution (Turkey)</td>
<td>2</td>
</tr>
<tr>
<td>14. Difficulties speaking German</td>
<td>2</td>
</tr>
<tr>
<td>15. Children left home</td>
<td>2</td>
</tr>
<tr>
<td>16. Being separated from her mother</td>
<td>2</td>
</tr>
<tr>
<td>17. Abortions enforced by husband</td>
<td>1</td>
</tr>
<tr>
<td>18. Social decline</td>
<td>1</td>
</tr>
<tr>
<td>19. Living in refugee home</td>
<td>1</td>
</tr>
<tr>
<td>20. Having been abducted (for marriage)</td>
<td>1</td>
</tr>
<tr>
<td>21. Childhood abuse</td>
<td>1</td>
</tr>
<tr>
<td>22. Being second, &quot;unofficial&quot; wife</td>
<td>1</td>
</tr>
<tr>
<td>23. Being bullied</td>
<td>1</td>
</tr>
<tr>
<td>24. Unfulfilled desire for a child</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 2: Current and past stressors reported spontaneously
2.2 Clinical Symptoms

In Table 3, the clinical symptoms, which the participants reported spontaneously in the course of the psychiatric interviews, are listed in the order of their frequency. Apart from depressed mood, reduced incentive, feeling anxious and worrying, somatic symptoms, especially pain without a physical cause, prevailed. Interestingly, feelings of guilt or difficulties concentrating only in rare cases were reported spontaneously.

<table>
<thead>
<tr>
<th>Symptom</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Depressed mood</td>
<td>31</td>
</tr>
<tr>
<td>2. Pain</td>
<td>19</td>
</tr>
<tr>
<td>3. Feeling weak and tired</td>
<td>17</td>
</tr>
<tr>
<td>4. Sleeping problems</td>
<td>15</td>
</tr>
<tr>
<td>5. Anxiety, panic attacks</td>
<td>15</td>
</tr>
<tr>
<td>6. Feeling irritable and aggressive</td>
<td>12</td>
</tr>
<tr>
<td>7. Feeling lonely</td>
<td>10</td>
</tr>
<tr>
<td>8. Withdrawal</td>
<td>5</td>
</tr>
<tr>
<td>9. Suicidal ideation</td>
<td>5</td>
</tr>
<tr>
<td>10. Fainting</td>
<td>5</td>
</tr>
<tr>
<td>11. Trembling, dizziness, nausea</td>
<td>4</td>
</tr>
<tr>
<td>12. Worrying</td>
<td>3</td>
</tr>
<tr>
<td>13. Tachycardia, hot flashes, hyperventilation</td>
<td>3</td>
</tr>
<tr>
<td>14. Numbness, pins and needles</td>
<td>3</td>
</tr>
<tr>
<td>15. Loss of appetite</td>
<td>3</td>
</tr>
<tr>
<td>16. Hallucinations</td>
<td>3</td>
</tr>
<tr>
<td>17. Feelings of guilt</td>
<td>1</td>
</tr>
<tr>
<td>18. Feeling worst in the morning</td>
<td>1</td>
</tr>
<tr>
<td>19. Difficulties concentrating</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 3: Clinical symptoms reported spontaneously

2.3 Resources

From the psychiatric interviews, we also attempted to get an impression of the most frequent resources employed by the participants. Table 4 summarizes what the participants mentioned spontaneously in this respect.

As far as resources are concerned, social support received from the participants' families, in some cases from their husbands, in other cases from their children or relatives is of utmost importance. In addition, in some cases, religious resources as well as help experienced by medical treatment have been mentioned.
### Table 4: Coping strategies reported spontaneously

<table>
<thead>
<tr>
<th>Resource</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support by family</td>
<td>16</td>
</tr>
<tr>
<td>Activities like walking, cooking, hearing music...)</td>
<td>4</td>
</tr>
<tr>
<td>Medication</td>
<td>3</td>
</tr>
<tr>
<td>Reading the Qur'an or praying</td>
<td>3</td>
</tr>
<tr>
<td>Support by social club</td>
<td>1</td>
</tr>
<tr>
<td>Being well-off financially</td>
<td>1</td>
</tr>
</tbody>
</table>

### 3. SUMMARY AND CONCLUSIONS

Stressors, clinical symptoms, and resources spontaneously reported agree with the theoretical assumptions put forward in Chapter 1 of this book. Turkish migrant women continue to live according to the collectivist values of their society of origin which are also upheld by their husbands and their husbands' extended families. Therefore, family life is a main source of conflict and strain, but at the same time has been addressed as a major resource by many respondents. The prospective participants' spontaneous reports also confirmed that clinical symptomatology differs between cultures. Whereas a "western" model of depression in the first place emphasizes depressed mood and cognitive distortions, accompanied by sleeplessness as well as loss of appetite and incentive, the present respondents in many cases complained about physical symptoms being their main source of distress.

### 4. REFERENCES

The present chapter will give a short account about how the quantitative part of the research has been conducted by briefly describing the sample and by giving some details about the instruments employed towards testing our hypotheses. Results will be only be summarized here, however, as they will be given in detail in a forthcoming journal article which also will be available from the first author upon request (Renner & Berry, accepted)\textsuperscript{25}.

1. **The Participants' Descriptive Statistics**

The mean age of the $N = 66$ participants was 42.7 years ($SD = 8.7$, Range 28 to 61 years) and 62 of them were migrants of the first, four of them of the second generation. They had an average of 5.9 years of schooling ($SD = 3.1$, Range 0 to 13 years) and their mean duration of stay in Austria was 18.6 years ($SD = 8.2$, Range 1 to 34 years). They had an average of 2.4 children ($SD = 0.9$, Range 0 to 5). Fifty-five women were married, seven divorced, three widowed, and one woman was single. Details of the participants' biographic background have been summarized on the basis of the psychiatric screenings in Chapter 4.

A total of $N = 66$ women have participated in the study and filled in the questionnaires at $t_1$ (for measurement occasions see Figure 1 in Chapter 3). For the purpose of data analysis, data from both Self-Help groups, both CBT groups and both Wait-List groups have been combined. Table 1 gives a summary of the sample sizes at the various measurement occasions.

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\textsuperscript{25} Open access via http://www.uibk.ac.at/psychologie/mitarbeiter/renner/
Table 1: Sample sizes at the five measurement occasions

<table>
<thead>
<tr>
<th></th>
<th>(t_1)</th>
<th>(t_2)</th>
<th>(t_3)</th>
<th>(t_4)</th>
<th>(t_5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Help</td>
<td>21</td>
<td>15</td>
<td>14</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>CBT</td>
<td>23</td>
<td>11</td>
<td>11</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Wait-List</td>
<td>22</td>
<td>12</td>
<td>8</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Total N</td>
<td>66</td>
<td>38</td>
<td>33</td>
<td>32</td>
<td>7</td>
</tr>
</tbody>
</table>

2. MEASURES

Depressive symptoms were measured by the Turkish version of the Center for Epidemiologic Studies Depression Scale (CES-D, Radloff, 1977), which has been found to be a reliable and valid measure of depressive symptoms in Turkish migrants in the Netherlands (Spijker et al., 2004). Although this study was conducted with geriatric patients, the instrument can be regarded to be useful with younger Turkish respondents as well. The scale comprises 20 items addressing clinical symptoms of depression which are to be rated on a four-point Likert type scale with respect to their frequency of occurrence during the past week.

Although depressive and somatic symptoms were expected to prevail, in addition, general psychopathology was assessed by a Turkish version of the Brief Symptom Inventory (BSI) (Derogatis, 1993). The BSI comprises 53 items to be rated with respect to symptom intensity during the past week on a five-point Likert type scale. The instrument measures with sufficient reliability nine types of clinical symptoms (somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism) and provides three global indices which indicate overall symptom strain. As an indicator of general symptomatology, in the present study, the Global Severity Index (GSI), i.e., the arithmetic mean of all responses, has been used.

As in the present study somatic symptoms were expected to be common, the Turkish version (Schwab & Tercanli, 1987) of von Zerssen's (1976) List of (Psychosomatic) Complaints ("Beschwerdenliste" - BL) has been used. This list consists of 24 items addressing somatic symptoms like weakness, sweating, back pain, sleeping problems, trembling, loosing weight, etc. which are to be rated with respect to their intensity on a four-point Likert type scale.

Following a reviewer's suggestion, symptoms of post-traumatic stress were measured separately. Towards this goal, the items 1 to 16 of the Harvard...
Chapter 5: Quantitative Study

**Trauma Questionnaire (HTQ),** Part IV (Mollica et al., 1992) had been found to be a reliable and cross-culturally valid measure (Renner, Salem, & Ottomeyer, 2006 in accordance with previous findings by Keane, Kaloupek, and Weathers, 1996). By the HTQ, post-traumatic symptoms are measured on a four-point Likert type scale. In addition, also following the reviewer's suggestion, traumatic life events were assessed by a Turkish translation of the **Life Events Check-List** (Blake et al., 1990).

We also followed a reviewer's suggestion by including the Turkish version of the **Patient Health Questionnaire (PHQ)**26 (Uzuner Özer, 2004) as an additional scale measuring various aspects of clinical symptoms. **Part 1** consists of 13 items measuring somatic complaints on a three-point scale and **Part 2** comprises nine depressive symptoms, to be rated on a four-point scale. **Part 3** of the PHQ is made up by five questions with respect to symptoms of anxiety. In the present book, data analysis will only pertain to the first question ("Did you experience a panic attack during the last four weeks?"). Finally, in **Part 4** of the PHQ, the overall degree of impairment by clinical symptoms has to be rated on a four-point scale.

With the only exception of the Life Events Checklist, which only was administered at the first measurement occasion, all the other measures had been administered at pre-, post-, and both follow-up measurement occasions.

To illiterate participants the items of the questionnaires were read and, if necessary their meaning was explained to them.

**3. OVERVIEW OF RESULTS OBTAINED BY THE QUESTIONNAIRES**

The following outcome variables have been used in data analysis:

=> Total scores of CES-D, BL, and HTQ (Part IV, Items 1 to 16)

=> **BSI:** Nine subscales and total score GSI

=> **PHQ:** Sub-score of Parts 1, 2, and 4 and the participants' answer to Part 3 (Panic Attacks: Yes or No?)

---

3.1 What the Self-Help Groups (SHG) Achieved as Compared to CBT and the Wait-List (WL) Control Group

For an overview of the measurement occasions see Figure 1 in Chapter 3. As can be seen from Table 1 of the present chapter, at t2 N = 15 participants in the Self-Help Group, N = 12 in the Wait List, and N = 11 in the CBT Group still were present and thus could be included in the data analysis. Taking the small sample sizes into account, the assumptions of Analysis of Variance were not fulfilled and thus non-parametric statistical methods were employed.

Renner and Berry (accepted) reported, that, according to Wilcoxon Tests, neither SHG nor WL had attained significant changes on any of the above mentioned scales between t1 and t2. In the CBT Group, participants had improved significantly with respect to depressive symptoms as measured by Sub-Scale 4 of BSI (M = 2.24, SD = 1.20 at t1 vs. M = 1.67, SD = 1.03 at t2, Wilcoxon p = .007), whereas on all the other scales, also in this condition no significant symptom change had been reached.

An example of the non-significant results attained between t1 and t2 is given in Figure 1 on the next page.

3.2 What the Wait-List (WL) Control Group Achieved in the Course of Its Time-Delayed Intervention

As could be seen from Figure 1 in Chapter 3, between t2 and t3, the WL Group received a time delayed self-help intervention after completing waiting time. Again, Wilcoxon Tests were employed in order to assess symptom change in the course of this intervention. As reported in detail by Renner and Berry (accepted), participants showed significantly reduced depressive symptoms as measured by the CES-D from M = 1.76 (SD = 0.52) at t2 to M = 1.28 (SD = 0.36) at t3 (Wilcoxon p = .012), whereas on all the other scales, no significant changes had been attained.

3.3 Follow-Up Measurements

Again consulting the timetable in Chapter 3, it can be seen that for all the interventions one- and six-months follow-up measurements had been carried out. In the case of SHG and CBT Groups, these follow-ups had been carried out at t3 and t4, whereas for the WL Control Group, the follow ups had taken place at t4 and t5 respectively. As reported by Renner and Berry (accepted), there were no significant changes with respect to the follow-up measurements for the SHG and the WL conditions, while the CBT-Group had deteriorated significantly on three
of the BSI sub-scales (BSI Sub-Scale "Depression": $t_2$: $M = 1.60, s = 1.06, t_3$: $M = 1.77, s = 0.85, t_4$: $M = 2.48, s = 1.20$; Friedman $p = .002$; BSI Sub-Scale 6 "Hostility": $t_2$: $M = 0.98, s = 0.73, t_3$: $M = 1.04, s = 1.01, t_4$: $M = 1.78, s = 1.17$; Friedman $p = .015$; BSI Sub-Scale 8 "Paranoid Ideation": $M = 1.44, s = 0.69, t_3$: $M = 1.60, s = 0.79, t_4$: $M = 1.98, s = 0.97$; Friedman $p = .046$).

![Figure 1](image.png)

**Figure 1:** Neither the SHG (N = 15; p = .125), nor the CBT-Group (N = 11; p = .838) or the WL Control Group (N = 12; p = .638) attained significant change on the CES-D from t1 to t2.

### 3.4 Analysis of Responders and of Predictors of Outcome

Taking into account that depressive symptoms had been the main goal of the interventions, Renner and Berry (accepted) employed the score on the CES-D as the criterion for their responders' analysis. On the basis on those $N = 34$ participants who had completed either SHG, CBT, or the time delayed self-help intervention of the WL, the Reliable Change Index according to Jacobson, Follette, and Revenstorf (1984) had been computed. According to this criterion, on the 5% level of significance, for $N = 12$ (or 35.3%) participants significant improvement could be assessed. $N = 1$ (2.9%) participant had deteriorated
significantly, whereas for the remaining sample no significant change could be assessed.

By regression analysis, Renner and Berry (accepted) investigated the role of socio-demographic variables as possible predictors of outcome. They found, that a younger age \((p = .004)\), a longer duration of stay in Austria \((p = .034)\) and a higher number of traumatic events experienced personally \((p = .004)\) were predictive of the amount of change assessed by the CES-D. Neither the type of group in which one participated, the generation of migration, the number of years of schooling, the number of children, nor the number of traumatic events witnessed were significant predictors.

The detailed reports on the Life-Events Checklist have been summarized in Chapter 4 of this book.

4. SUMMARY

Contrary to our hypotheses, self-help groups have not been effective in reducing symptoms of depression, somatic complaints or other clinical symptoms in Turkish migrant women with recurrent depression. Moreover, although a well-established intervention method, Cognitive Behavior Therapy only led to improvement on one of the measures employed and, in this case, the participants reported significant deterioration after the interventions had ended. Although in single cases significant improvement had been attained, on a larger scale, group interventions as employed in the present study do not pose a promising alternative to conventional treatment for Turkish migrants with recurrent depression.

5. REFERENCES


Renner, W. & Berry, J. (accepted). Group Interventions were not Effective for Female Turkish Migrants with Recurrent Depression – Recommendations from a Randomized Controlled Study. Social Behavior & Personality.


In the following chapter we will focus on a qualitative approach to the outcome of Self-Help Groups and Cognitive Behavior Therapy (CBT) groups. We analyzed the group leaders' summaries of sessions, the transcripts of the Self-Help group leaders' supervision and the interviews conducted with Self-Help and CBT-Group participants after their interventions had ended. Thereby we have tried to find out details about the group process as well as about the experiences shared by the group leaders and the group participants. We wished to distinguish helpful from less helpful aspects of group work and to form hypotheses about the causes for possible discrepancies between the qualitative and the quantitative results.

1. Method

Based on the summaries of Self-Help and CBT group sessions as well as on summaries of Self-Help group supervisions and interviews with group-members, a qualitative content analysis has been conducted (Mayring, 2008). The data were systematically reduced using the techniques of selective paraphrasing, generalizing, and reduction. From the various steps of qualitative analysis, we have derived the categories summarized in Table 1.

2. The Group Leaders' Summaries: How Self-Help and CBT Groups Have Been Conducted

In total, two Self-Help Groups from the Intervention condition and two time delayed Self-Help Groups from the Control condition as well as two CBT groups have been analyzed (cf., Figure 1 in Chapter 3). From this figure the initial group sizes and the approximate durations of the interventions can be seen as well.
# Chapter 6: Qualitative Study

<table>
<thead>
<tr>
<th>Category</th>
<th>For details see sub-chapter:</th>
<th>Applies to</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How groups have been conducted</strong> (Source: Group leaders' summaries)</td>
<td></td>
<td>SHG &amp; CBT</td>
</tr>
<tr>
<td>Topics</td>
<td>2.1</td>
<td></td>
</tr>
<tr>
<td>Structure</td>
<td>2.2</td>
<td></td>
</tr>
<tr>
<td>Aims</td>
<td>2.3</td>
<td></td>
</tr>
<tr>
<td>Subjective outcome</td>
<td>2.4</td>
<td></td>
</tr>
<tr>
<td><strong>Group process in self-help groups</strong> (Source: Group leaders' supervision)</td>
<td></td>
<td>SHG</td>
</tr>
<tr>
<td>The beginning</td>
<td>3.1</td>
<td></td>
</tr>
<tr>
<td>Testing out phase</td>
<td>3.2</td>
<td></td>
</tr>
<tr>
<td>Becoming a group</td>
<td>3.3</td>
<td></td>
</tr>
<tr>
<td>Finding a topic</td>
<td>3.4</td>
<td></td>
</tr>
<tr>
<td>Gaining trust and group cohesion</td>
<td>3.5</td>
<td></td>
</tr>
<tr>
<td><strong>Subjective outcome</strong> (Source: Interviews with participants)</td>
<td></td>
<td>SHG &amp; CBT</td>
</tr>
<tr>
<td>Complaints prior to interventions</td>
<td>4.1.1, 4.2.1</td>
<td></td>
</tr>
<tr>
<td>Behavior during interventions</td>
<td>4.1.2, 4.2.2</td>
<td></td>
</tr>
<tr>
<td>Changes in the course of interventions</td>
<td>4.1.3, 4.2.3</td>
<td></td>
</tr>
<tr>
<td>Generalizing Self-Help behavior</td>
<td>4.1.4, 4.2.4</td>
<td></td>
</tr>
<tr>
<td><strong>Discrepancy between subjective and objective outcome</strong> (Source: All of the above)</td>
<td></td>
<td>SHG &amp; CBT</td>
</tr>
<tr>
<td>Subjective outcome</td>
<td>5.1</td>
<td></td>
</tr>
<tr>
<td>Problematic aspects</td>
<td>5.2</td>
<td></td>
</tr>
<tr>
<td>Traumatic experiences</td>
<td>5.3</td>
<td></td>
</tr>
<tr>
<td>The role of the environment</td>
<td>5.4</td>
<td></td>
</tr>
</tbody>
</table>

**Table 1:** Summary of categories

The self-help groups only followed a rough structure, not defined in any detail. In the first couple of sessions, participants introduced themselves and agreed upon basic rules of conversation, like for example, discretion, trust, or talking in turns. In sessions four to 13, different topics were discussed, giving the participants the opportunity to share themes related to illness, daily hassles, or
concerns of their family lives. These topics were either introduced by the participants themselves or by the group leaders. In the final sessions, the group leaders summarized the most important topics and the meetings were finished with a little festival.

The CBT groups had a structure strictly defined and aiming at enhancing knowledge about depression. Participants were trained in relaxing and other behavioral procedures to tackle the effects of depressive symptoms and were encouraged to practice at home what they had learned. During consecutive sessions they exchanged their experiences and talked about progress in reducing depressive symptoms. Table 2 gives an overview of the CBT and the Self-Help group sessions.

<table>
<thead>
<tr>
<th>Group type</th>
<th>Self-Help</th>
<th>CBT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Topic</td>
<td>Family violence and other family problems; clinical symptoms</td>
<td>Self awareness, new strategies in dealing with depression</td>
</tr>
<tr>
<td>Structure</td>
<td>Defined</td>
<td>Not defined</td>
</tr>
<tr>
<td>Aims</td>
<td>Experience sharing, learning to cope with aggression and problems in the family</td>
<td>Increase of self awareness and reduction of symptoms</td>
</tr>
<tr>
<td>Subjective outcome</td>
<td>Increased self confidence and being able to stand in for one's own needs, good group cohesion and well-being within the group</td>
<td>Increased self confidence and being able to stand in for one's own needs</td>
</tr>
</tbody>
</table>

Table 2: Overview of Self-Help vs. CBT Groups

2.1 Topics Pursued in the Group Sessions

In the Self-Help Groups, the topics were as follows: rules, safety, violence in the family, problems with husbands and children, aims of group, symptoms, patience, death and grief, anxiety, role of women, metaphors about self and others, homesickness, summary and positive outcome.
On the other hand, according to our analysis of the group protocols, in the CBT groups the most frequent themes were: rules, mood diaries, strategies to deal with depression, self modification, relaxation, positive activities, (de)constructive thinking, depression and somatic complaints, self comments, working with metaphors, summary of therapeutic process and outcome.

2.2 Structure of the Groups

Whereas in the CBT groups each session had a given topic which was followed, in the Self-Help Groups the group leaders only partly suggested themes for the sessions and the group members not always were willing to accept a given topic. Thus, the Self-Help sessions were much less structured than the CBT sessions and much more experience sharing especially about symptoms and about problems with husbands and children took place.

2.3 Aims

In the beginning, participants of the Self-Help Groups had certain goals and expectations they tried to reach. These were related to alleviating depressive symptoms (e.g., aggression, sleeping disorders) or towards meeting other women and being distracted from everyday life.

Example of aims and expectations: She (participant) participates in the self-help group to get to know other women, to have a change and especially because she is scared when she is alone at home. Hope to get better.

2.4 Subjective Outcome

Whereas in Chapter 5 we reported that on the level of objective psychometric measures, no symptom change has occurred on average, the group leaders' summaries were a first indicator of the participants' subjective experiences: all women, both in the Self-Help and in the CBT condition, said that the interventions had helped them becoming more self confident and more able to stand in for their needs. In one case, the participant's husband had threatened with violence because his wife had become more self-assertive.

After the final sessions most participants had reported positive changes to the group leaders. They indicated that they had gained trust and power to fight for positive changes and that they felt isolated to a lesser degree.

Example of subjective change: Now I can trust myself, I have regained strength and started to fight.
3. THE GROUP LEADERS' SUPERVISION: THE GROUP PROCESS IN THE SELF-HELP GROUPS

With respect to the Self-Help Groups we could have a closer look on the group process because in addition to the group sessions' summaries we also had the supervision protocols to analyze. Table 3 gives an overview of the categories derived from these protocols:

<table>
<thead>
<tr>
<th>Sub-Category 1</th>
<th>Sub-Category 2</th>
<th>Sub-Category 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) The beginning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Struggle for leadership role</td>
<td>Appreciation of language</td>
<td>Concerns about discretion</td>
</tr>
<tr>
<td>(2) Testing phase</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contributing difficult topics</td>
<td>Taking on the leader's role</td>
<td>Confronting leaders directly</td>
</tr>
<tr>
<td>(3) Becoming a group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provoking quiet participants</td>
<td>Leading the group process</td>
<td></td>
</tr>
<tr>
<td>(4) Finding a topic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easier topics: experiences with husbands and children</td>
<td>Topic brought in by group: how to bring about change</td>
<td>More difficult topics: depression and self-awareness</td>
</tr>
<tr>
<td>(5) Gaining trust and group cohesion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sharing difficult topics</td>
<td>Teasing and humor</td>
<td>External meetings and support</td>
</tr>
</tbody>
</table>

Table 3: The categories derived from supervision protocols with respect to the group process

3.1 The Beginning

In some of the groups, until the second or third session, new members had arrived or others had left and thus group leaders reported initial difficulties. Furthermore the group leaders, young and academically highly achieved Turkish women had to be accepted by the mostly older and less educated participants.

All of them were very glad about being able to speak in their own language. Trust and discretion demanded special attention and had to be debated in several sessions. Many participants feared that their stories would reach their mothers-in-law, neighbors, or family members. Group leaders had to be very sensitive to gain the participants' trust when continuing the group sessions.
3.2 Testing the Leaders

In the Self-Help Groups the first sessions were especially important for the group leaders to establish their position within the group, although sustaining their position remained substantial during consecutive sessions too.

The group leaders had to convince the participants that they were able to cope with difficult topics, when the women reported their experiences of family violence as well as other traumatic experiences and thus, the group leaders sometimes had the impression of being tested. In one group, participants explicitly asked the group leader about her life experience. Occasionally, the group leaders were devaluated because, as compared to most group members they did not have as many children or because they had married for love, so they would not understand the participants' problems. Sometimes older participants explicitly tried to take over leadership.

3.3 Becoming a Group

In the beginning, the more quiet participants were often provoked by the more expressive ones to share their experiences and the group leaders had to be careful to guide this process in a democratic way.

*Example of the group as a social network:* ...she really enjoys participating in the group, the younger participants are like daughters and the older ones like friends to her.

The group sessions also posed the chance to join a social network. After initial distrust, the participants were able to get in contact with each other and to share their experiences, to reduce their isolation and their feelings of being left alone with being diagnosed as depressive.

*Example of reducing feelings of loneliness:* ... different perspective, (thought she is) the only one who suffers, it is an important experience for her that others have problems too, that she is not the only one...

3.4 Finding a Topic

Initially, the most important topics had been trust and discretion. The group members needed many rituals to ensure this. Furthermore, group leaders experienced it as difficult to keep the participants engaged in one theme, as participants kept switching from one topic to another within one session. The women did not know much about depression, but at the same time they did not
Chapter 6: Qualitative Study

seem to be really interested in the more technical aspects of the topic. On the contrary, their main concerns pertained to their family lives and possible remedies.

3.5 Gaining Trust and Group Cohesion

According to the group leaders, in the Self-Help Groups a trustful relationship between group participants and group leaders has been achieved. This had been indicated for example by the degree of sharing also difficult topics and by the amount of positive feedback that had been given to the group leaders. Group leaders estimated the amount of group cohesion by the degree of support the participants gave each other, by the degree of teasing and good humor, by occasional meetings of group members between group sessions, as well as by feelings of well-being in the group spontaneously addressed by the participants.

Example of group cohesion: The group leader described it as wonderful that every participant had been absolutely empathic towards the others, no matter what small or big problems had been described, everybody being sensitive, without critic or bad mouthing.

4. THE INTERVIEWS WITH PARTICIPANTS: SUBJECTIVE OUTCOME

At the end of the interventions we have asked participants of the Self-Help and the CBT Groups about subjective changes they had experienced, both with regard to their living conditions and to symptoms of depression as well as to any problems in addition to depressive symptoms. These interviews also addressed the participants' experiences in the course of the group sessions. Twenty women from the Self-Help Groups (including those participating in the delayed Self-Help Groups of the Wait List condition) and ten women from the CBT groups were interviewed. On average, these women were 42 years of age and had lived in Austria for approximately 20 years. Independent raters analyzed the interviews and inter-rater concordance was assessed by Cohen's kappa.

We will first present the results obtained for those sub-categories, which achieved satisfactory inter-rater agreement as measured by Cohens's kappa. Consecutively, we will report the results found be the remaining sub-categories. Towards interpreting kappa values, we have used the criteria given in Table 4 (see Grouven, Bender, Ziegler, & Lange, 2007; Viera & Garrett, 2005). The best kappa values presented below reached substantial to perfect agreement, whereas the worst kappa values had indicated only slight or nearly no agreement at all.
Chapter 6: Qualitative Study

<table>
<thead>
<tr>
<th>kappa</th>
<th>Degree of Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 0</td>
<td>Less than chance agreement</td>
</tr>
<tr>
<td>0.01 - 0.20</td>
<td>Slight agreement</td>
</tr>
<tr>
<td>0.21 - 0.40</td>
<td>Fair agreement</td>
</tr>
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Table 4: Approximate values for interpreting kappa

4.1 Sub-Categories with Sufficient Inter-Rater Agreement

In Table 5 we have summarized the sub-categories for which optimal kappa values\(^{27}\) have been achieved.

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<tr>
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<td>Palliative coping</td>
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<td>Anxiety and lack of trust</td>
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<td>(3) Changes in the course of the interventions</td>
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<td>Reflecting one's own behavior and thoughts</td>
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Table 5: Sub-categories for which optimal kappa values have been achieved

We will now give a more detailed account of the categories summarized in Table 5.

\(^{27}\) See Appendix of this chapter for details.
4.1.1 Category 1: Complaints Prior to Interventions

The interviewees had been asked to describe their problems and symptoms they had experienced before the interventions had commenced.

Sub-category: Depressive Symptoms

Category 1 ("Complaints Prior to Interventions") comprised various symptoms that had been distinguished (e.g., physical pain and physical complaints, feelings of numbness, exhaustion, loss of joy, panic attacks). One sub-category has been labeled "depressive symptoms" and achieved a high inter-rater agreement (see Table 5). It comprised depressive symptoms on an affective level as opposed to physical complaints. Ninety-seven percent of the women (29 out of 30) interviewed retrospectively complained about symptoms of depression.

Example of depressive symptoms: I burst into tears quickly. I also become angry very quickly.

4.1.2 Category 2: Behavior During Interventions

This category "Behavior During Interventions" comprised seven sub-categories. For four of these components, good or very good inter-rater agreements were achieved. This assessment involved all kinds of behavior that appeared during group sessions and could either be positive or negative. It pertained to helpful and comforting behavior experienced from other participants or from the group leaders, to strategies having been learnt (e.g., exercises for relaxing, gaining strength, patience, or both) but also to disturbing behavior (e.g., feeling distracted by other women's stories).

Sub-Category: Palliative Coping

This label has been applied to all statements with respect to emotions about the group and the level of well-being as a member of the group. Ninety percent of the women (27 out of 30) had engaged in some kind of palliative coping. In the interviews the women reported positive effects most of them had experienced. Some of them indicated that group attendance was the only occasion for them of leaving their homes in the course of the week.

These women perceived group meetings as comforting and supportive and there was a very high degree of solidarity and support among group members. Most of them reported that they had made friends with other participants.

Example of relaxing: You could just relax. Talk to like-minded people.
Sub-Category: Providing and Accepting Advice

The participants often discussed how to change their living conditions or to solve specific problems. In the CBT groups, this was done by practicing strategies towards ameliorating depressive symptoms, and in the Self-Help Groups by discussing current problems encountered for example with families or husbands. The women gave advice to each other and it was very important for them to meet others suffering from similar problems.

Thus, perceived stigmata and isolation could be reduced, as participants felt less alone with their everyday problems and symptoms of depression. Before the interventions, some of the women even were afraid of losing their mind, because they could not connect the symptoms and feelings to their illness. Therefore it was a major help for all participants to meet other people with a similar (cultural) background and similar struggles. Twenty-seven out of 30 (90%) women reported to have accepted or given advice.

*Example of reduced isolation and stigmata:* It felt good to listen to the troubles reported by other participants. You notice that you are not the only one with problems.

Sub-Category: Feeling Disturbed by Others

There were only two participants (7%) who complained that others were talking too loud or that they had troubles listening to the stories of others. By such experiences, these women had been reminded of their own (sometimes already past) problems or had difficulties coping with the emotional aspects of the stories told by others. So, occasionally, they burst into tears after leaving the group and could not calm themselves.

*Example of being upset by the other women's stories:* Why can’t these women say no? I had the feeling that everything is the same as always. I thought something has changed but I noticed that everything is still the same. That upset me very much. It reminded me of my years of being married, when I was weak and could not say no.

Sub-Category: Anxiety and Lack of Trust

As already mentioned above, almost all of the women needed repeated confirmation of confidentiality. The women were afraid that their families, friends, or acquaintances would get knowledge about their sorrows and problems. Most women were able to trust the group after repeated rituals
confirming discretion. Four women (13%), however, stated in the interviews that they could not trust the others because they knew one of the group members personally.

*Example of lack of trust:* Yes, to meet others was really nice. But I would have preferred not being in a group, because then you could talk more openly. You have to be careful about what you are saying because there are also acquaintances in the group. That was not so good. There will be gossip.

### 4.1.3 Category 3: Changes in the Course of the Interventions

We also asked interviewees whether they had perceived any changes in their everyday actions or thoughts. Thus we learned how participating in the groups had influenced their behavior and what the reactions of their social environment had been.

**Sub-Category: Improved Reflection of One's Own Behavior and Thoughts**

Twenty out of 30 women (67%) reported that at the end of the interventions they had been able to reflect their behavior better than before. Similarly, they indicated that they had improved their understanding of how their symptoms and their behavior were connected to each other. They also were better able to reflect why they acted in a certain way (e.g., being angry at their husbands for going to a bar without them). They had learned to change their views by focusing rather on their own needs than on their children's and their husbands' expectations. Now, the women were explicitly taking time to do themselves some good.

*Example of taking time for themselves:* At least once a day I try to do something just for myself - not for my family, not for my husband, just for myself...

### 4.1.4 Category 4: Generalizing Self-Help Behavior

When we asked participants whether they could think of anything that might help them cope with difficulties in future, they named a variety of strategies they had learnt. They also discussed how they could use these strategies in difficult times to cope with their emotions.
Sub-Category: Other People

An important resource towards coping with negative emotions and everyday difficulties was being assisted by other people. Twenty-two out of 30 (73%) women were convinced that they would be more likely to cope with depression if other people would render them a higher degree of social support.

Example of support by others as a resource: If my partner was a good husband, I would be a good wife.

Sub-Category: Reflecting One's Own Behavior and Thoughts

Fifty-seven percent of the women (17 out of 30) have tried to apply the strategies they had discussed or practiced in the group sessions, for example, how to relax or how to cope with aggression. Prior to the interventions, women quickly were angry with their children, though knowing that it had not been their children's fault; on the contrary, after the sessions had been finished, the women tried to avoid being aggressive towards their children, or whenever they noticed becoming angry they tried to reflect their behavior and thoughts.

Example of behavior change: I do not shout as much as before. And I also do not beat my children so quickly.

4.2 Sub-Categories with Non-Sufficient Inter-Rater Agreement

As outlined above, some sub-categories were found which needed improvement. Most categories that did not meet expected kappa values pertained to "remaining" categories of complaints, strategies, or perceived changes. Such categories comprised a broad variety of responses presented by only one single woman but not by any others, making it difficult to sort them into specific categories or sub-categories.

Furthermore, most women perceived group meetings in a distinctly positive way, whereas only a few others commented critically on them. Whereas the women hardly noticed any improvements with respect to clinical symptoms, they also reported positive changes in being able to control their behavior (e.g., getting angry less frequently with their children) or having improved their ability of reflecting their behavior and thoughts. The sub-categories for which unsatisfactory inter-rater agreement has been reached, as well as the respective kappa values are given in Table 6\textsuperscript{28}. Next, we will have a more detailed look at the content of the sub-categories concerned.

\textsuperscript{28} See Appendix of this chapter for details.
Chapter 6: Qualitative Study

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<thead>
<tr>
<th>Categories</th>
<th>Sub-categories</th>
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<td>(2) Behavior during interventions</td>
<td>Diffuse negative (did not deliver the expected outcome)</td>
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<td>(3) Changes in the course of the interventions</td>
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<td></td>
<td>Reduced pain or physical complaints</td>
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<td></td>
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<td>(4) Generalizing Self-Help behavior</td>
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<td>.194</td>
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Table 6: Categories for which the poorest kappa values have been achieved

4.2.1 Category 1: Complaints Prior to Interventions

Sub-Category: Other Problems

Participants also named a great variety of problems that could not be sorted into any of the other sub-categories. One woman had to flee from her country of origin, because she and her family had been considered terrorists. Others lived in an asylum seekers' home, were not able to work, had lost their work or had reported troubles with their employers.

4.2.2 Category 2: Behavior During Interventions

Sub-Category: Diffuse Negative

Under this sub-category, diffuse negative statements, pertaining to an unexpected outcome have been summarized. Just one woman said that she was glad that no more sessions would take place. She said that she had been unable to enjoy the sessions and to relate to the other women. Some women had come with different expectations (e.g., single therapy) when assigning for the interventions and subsequently were unable to adapt their expectations. In such cases, participants tended to perceive the other women as a burden and consequently were reluctant to present themselves openly to the group leaders and to their fellow participants.
4.2.3 Category 3: Changes in the Course of the Interventions

Sub-Category 1: Reduced (Subjective) Symptoms of Depression

Some women reported reduced depressive symptoms whereas others reported an increase. However, not all of the respondents gave details about their symptoms or their difficulties in expressing their emotions or thoughts. Some of the women did not mention clearly, whether there had been any changes, or what the nature of the changes had been. One woman did not report her symptoms but only her husband's complaints.

Sub-Category 2: Reduced Pain or Physical Complaints

Retrospectively, only few women mentioned initial physical complaints or pain in their interviews and only in single cases, any changes regarding these symptoms had been perceived.

Sub-Category 3: Reduced Other Complaints

There were a few participants who had difficulties to trust other people. They reported that they had lost trust in general and that they were unable to re-establish trust in other people.

4.2.4 Category 4: Generalizing Self-Help behavior

Sub-Category: Other Aspects

In their interviews, a few women complained of being unable to cope with their emotions when necessary. As possible coping strategies, some of them mentioned taking medication and others going to sleep.

4.3 Responders vs. Non-Responders

We compared the results of the psychometric analysis regarding a significant reduction of clinical symptoms in single cases (cf., Chapter 5 on "Responders" vs. "Non-Responders") with the qualitative results presented in this chapter. We found that, according to single case analyses, nine of the women interviewed had reported significantly improved results on the score of the CESD Depression Scale, whereas in 20 of the women interviewed no significant
difference had been found. Only in one case, significant deterioration had occurred. By Fisher's exact test we found no differences with respect to the qualitative data of these two groups.

We also compared responders and non-responders with respect to the content of their statements in the interviews, but found no difference. All of the women had given advice and had accepted advice from each other and most of them had reported an improved ability of reflecting their behavior and had applied strategies learnt in the Self-Help or CBT Groups to real-life situations. Interview reports of problems and symptoms of depression did not differ between responders and non-responders.

5. DISCREPANCY BETWEEN SUBJECTIVE AND OBJECTIVE OUTCOME

The marked discrepancy between subjective and objective outcome (cf., Chapter 5) may be due to several aspects. As will be pointed out in Chapter 10 in more detail, secondary gain of illness may have prevented symptom reduction. Almost no change seemed possible with respect to the women's family background. The group sessions were seen as an opportunity to share experiences and to become a bit more self-confident. In the group leaders' view, real change would bring about conflict within the families, preventing the women from fitting into their traditional role. As pointed out in Chapter 1, Turkish women in Austria use to live in a very traditional culture which conflicts with liberal Austrian society.

They live between two worlds, the western modernized one and the traditional Turkish one, in the first place represented by their husbands and their husbands' extended families and their illness seems to be their only way towards a little bit of autonomy and space for themselves. Another point to be addressed in more detail in Chapter 10, is comorbidity of depression with trauma related symptoms. Towards attempting to explain the discrepancy between objective and subjective outcome, we have derived the categories presented in Table 7 from the qualitative material.

5.1 Subjective Outcome

The women appreciated the process of being able to share their experiences with others in a safe environment, they learned that depression can have many faces, they learned to stand in for themselves and to be more self-confident. They
enjoyed being in the group and wanted to have more sessions and to continue the group work.

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<th>Sub-Category 1</th>
<th>Sub-Category 2</th>
<th>Sub-Category 3</th>
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<td>Depression has many faces</td>
</tr>
<tr>
<td>(2) Problematic aspects</td>
<td>Fighting for leadership</td>
<td>No ability to continue</td>
</tr>
<tr>
<td>(3) Traumatic experiences</td>
<td>Violence and death in the family</td>
<td>Guilt and shame, problems</td>
</tr>
<tr>
<td></td>
<td>Symptoms of intrusions, isolation,</td>
<td>concentrating and sleeping, aggressive</td>
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<tr>
<td></td>
<td>numbing and lack of trust in</td>
<td>feelings and anger</td>
</tr>
<tr>
<td></td>
<td>others and positive future</td>
<td></td>
</tr>
<tr>
<td>(4) The role of the</td>
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<td>Illness gain</td>
</tr>
<tr>
<td>environment</td>
<td>Role orientation</td>
<td></td>
</tr>
</tbody>
</table>

Table 7: The categories derived from supervision protocols with respect to differential outcome

5.2 Problematic Aspects

It was substantial for the group leaders in the Self-Help Groups to speak Turkish fluently, as otherwise the participants would not have taken them seriously. Some women needed much attention so that the group leaders had difficulties to give enough space to all the participants. Furthermore the group leaders had the impression that they had to fight for their roles more than once. The group members did not accept some of the topics the group leaders had wished to address. The young group leaders had to convince older participants that they were able to cope with the topics like violence experienced from husbands or mothers-in-law. Participants needed repeated reminders that the group leaders would not be intimidated or overcharged by their stories. These difficulties may have contributed to the negative outcome on the objective level of clinical symptoms being measured by questionnaires.

Even though the wish to continue had been expressed and telephone numbers had been exchanged, the group participants did not seem to be able to continue the group meetings without the group leaders' help.
5.3 Traumatic Experiences

Many participants reported various traumatic experiences. Besides family violence, group leaders also reported that more than half of their participants had experienced rape, forced isolation, or involuntary separation from family members or friends. Details on traumatic events have been reported in Chapter 4.

*Example of violent assault from the family of origin:* I had a horrible childhood. My father was an alcoholic and he came into my room every night to hit me. I am 38 and I cannot say that I ever slept a night through. My father has beaten me black and blue.

*Example of violent assault from the parents-in-law:* How should one act against it when you are all alone. I worked and my parents-in-law took my money... he never called me by my name, he always named me a "whore".

Looking at the symptoms recorded by the group leaders, participants still had troubles with recurrent thoughts or memories of painful and shocking events, difficulties to concentrate, sleeping problems, or being irritable. Other frequent symptoms pertained to avoiding actions that reminded the group members of traumatic and painful events, feelings that people did not understand what had happened, hopelessness, ruminating why these events had happened to them and to the feeling that they were the only ones who had experienced such events.

5.4 The Role of the Environment

Participants often discussed the effects of being separated from their families of origin and having difficulties in a foreign country. Being in Austria was partly reported as the reason for suffering from depression. Not being able to understand the language and to communicate with others, forced them into isolation. The Austrian and the Turkish culture were seen as entirely different and incompatible. As already mentioned above, the women tried to fulfill the traditional roles as wives and mothers, but these roles were confronted with the experiences they had made in Austria.

The participants described two aspects of traditional roles: one of them pertained to differential role expectations for women and men, whereas the other aspect addressed specific tasks women and men were allowed or prohibited to do. While the women took on the role as caregivers for their children and their husbands, the latter had a superior role in their families.

*Example of family hierarchy:* …the most significant bit is the husband. I.e., the participant's husband comes first, then the children and the remaining family.
Some women emphasized that some tasks, like taking out the garbage would not suit a man according to traditional role orientations. This point of view was challenged by other participants with a more egalitarian role orientation:

Example of different role orientations: A: … so I told him (husband) to clean the toilet because he is using the toilet too. B: But you cannot tell your husband to do this!

The women's extended families also supported the strict role allocation and sanctioned the violation of rules with devaluation. One woman reported about having been insulted after getting her driver's license. Some women said that their husbands used to protected them against their mothers-in-law, whereas in other cases the husbands even physically abused their wives on their mothers' order.

Most of the women complained about problems in their partnerships. Discussing them with the other participants and giving advice to each other was an important topic in almost all the sessions of all the groups. Some participants told how they had managed to positively influence their relationships. Many of them suffered from not being noticed by their husbands, being taken for granted and being treated like a servant. Although some participants also had endured violent acts from members of their own, their family of origin mostly was seen as resource to gain strength. Participants were physically assaulted by their fathers, but their fathers also were loving and beloved figures in their lives.

Even though participants suffered from depressive symptoms and aimed at getting better, they also gained from their illness. Being depressed also could be seen as a chance for the women to receive attention from their husbands, for being assisted in the household and for being cared for and in some cases, intense states of anxiety when being alone gave them the opportunity of being with their adolescent sons and daughters.

6. SUMMARY

Our qualitative analysis has pointed to a substantial subjective benefit of the Self-Help as well as the CBT Groups. Issues discussed in the groups have focused on problems with the participants' husbands and children, on how to positively change their marital relationship and on how to gain a social network. Being isolated from others (e.g., due to the language barrier), feeling alone with symptoms of depression and being overcharged with family issues had discouraged them to engage in social activities previously.
After the interventions had been completed, participants experienced more trust in others, more power to change and increased competence in using the strategies learnt in the sessions. Participants in the Self-Help Groups wished for permanent groups to interact and to discuss problems and daily hassles. The group leaders tried to motivate participants to arrange consecutive meetings independently, without needing the leaders' presence. Group members were unable, however, to accomplish this task. Having a group leader seems to provide a professional frame to the meetings and to strengthen the participants' trust in confidentiality.

Overall, the qualitative results point to the participants' subjective satisfaction. An important limitation of this result pertains to the high number of drop-outs which, in part may be due to the participants' difficult living conditions, and only 30 out of 24 women who had completed the interventions had been willing to give final interviews.

With respect to a high number of traumatic events experienced, the results of the final interviews reported above converge with both, the psychiatric screenings and the results obtained on the Life Events Checklist (cf., Chapter 4). The interviews also converged with the psychometric questionnaire with respect to the fact that on average no improvement had been obtained on the level of clinical symptoms. In Chapter 10 of this book we are going to discuss in more detail why the positive subjective outcome reported in this chapter might contrast with the negative one on the basis of objective, psychometric measures.

7. REFERENCES


# APPENDIX

## DETAILS FOR CATEGORIES WITH SUFFICIENT INTER-RATER AGREEMENT

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### Chapter 6: Qualitative Study

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### DETAILS FOR CATEGORIES WITH NON-SUFFICIENT INTER-RATER AGREEMENT

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### Chapter 6: Qualitative Study

#### (3) Changes in the course of the interventions

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#### Less pain or physical complaints

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#### Less other complaints

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#### (4) Generalizing self-help behavior

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CHAPTER 7

AN UNINTENDED CONTROL GROUP: PSYCHODRAMA IN SUPPORT OF TURKISH MIGRANT WOMEN

ASTRID LAMPE & MARIA-THERESA BARBIST

1. BACKGROUND

At the same time when Walter Renner and his collaborators have been carrying out the research presented in this book, Astrid Lampe and Maria-Theresa Barbist, who have authored the present chapter carried out a similar study at the Innsbruck based University Clinic of Medical Psychology. Although both were operating in the same small city of Innsbruck, the two research teams were unaware of each other's activities. They have achieved similar results, however, and drew comparable conclusions from what they had found. In this sense, both studies have served as "unintended control groups" to each other and could be instrumental in interpreting their respective outcome.

The basic assumptions made by the authors of the present chapter were similar to the ones put forward by Walter Renner in Chapter 1 of this book: People from Turkey are the third largest group among migrants in the political district of Tyrol where they pose over three per-cent of the total population, with much higher numbers living in the metropolitan area of Innsbruck. Migrants are known to be disadvantaged economically and psycho-socially and are subjected to multiple stressors in the course of acculturation (Leyer, 1991), with about one third of them being in need of psychiatric or psychotherapeutic treatment (Machleidt et al., 2006). After initial euphoria, in a later phase disappointment, a lost sense of security, homesickness, anger, hostility, frustration, and sorrow are frequent phenomena among them. Women are especially affected and frequently suffer from unexplained gastro-intestinal disorders, chronic pain in the lower body or in the back as well as from chronic headache. At the same time, massive cultural barriers pose an obstacle to effective medical or psychological treatment (Becker, Wunderer et al., 2001). Moreover, offers of psychotherapy for migrants at low-cost are extremely scarce.

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We have therefore decided to develop an alternative intervention which could be offered to Turkish migrant women at the University Clinic of Medical Psychology free of charge.

2. THERAPEUTIC CONCEPT

2.1 Group Treatment

Therapy had been based on the theoretical assumptions of psychodrama and patients were free to join or to leave therapy at any time ("open group"). Sessions were designed as support groups providing structured illness related information ("psychoeducation") and towards encouraging patients to put forward and to work on themes of concern.

Group therapy was headed by two therapists, was assisted by female interpreters and comprised ten sessions which were offered twice a month, in order grant support to the women for a time period as long as possible. Eight to 13 female Turkish migrants participated, each of whom had been interviewed by one of the therapists prior to group participation.

Primarily, group therapy aimed at stabilizing and advancing the participants' mental state by activating resources in the course of psychoeducation and group participation. Thus, the participants should be encouraged and enabled to act responsibly on their own. Whereas the women were not encouraged to speak about traumatic experiences (which might have put too much strain on them in the group setting), by the appreciative contact within the group, self-esteem should be instigated and the participants should be guided towards developing meaning in their lives and to towards regaining trust in other people step by step.

2.2 Individual Treatment

Treatment in an individual setting had been designed as a control condition to the group interventions. Due to limited resources, a number of patients could not be admitted to group treatment and thus received psychodrama therapy in an individual setting. For the purpose of the present study, these patients served as a control group receiving "Treatment as Usual".

Individual treatment comprised ten sessions (50 minutes each) over a period of six months. This type of intervention had been provided by female Austrian therapists assisted by interpreters.
3. **METHOD**

3.1 **Sample**

3.1.1 **Group Treatment**

A total of $N = 25$ Turkish women participated in group treatment. Their mean age was 41.3 years ($s = 9.10$). Nine of them, or 36% had discontinued treatment for various reasons and one participant provided incomplete data. Thus, we analyzed the data sets provided by the remaining $N = 15$ participants.

Most frequent diagnoses were Depressive Disorders ($N = 10$ or 67%), Somatoform Disorders ($N = 2$ or 13%), Personality Disorders ($N = 2$ or 13%), and Adjustment Disorders ($N = 1$ or 7%). All but one of the patients had reported traumatic experiences (e.g., being abused in childhood, forced marriage, family violence, etc.). Fifty-three percent ($N = 8$) of the participants were Turkish citizens, all the others were Austrian citizens. Seventy-three percent ($N = 11$) were married, $N = 4$ or 27% were divorced. The participants, on average, had given birth to 2.60 children ($s = 0.99$).

3.1.2 **Individual Treatment**

Thirteen patients had been admitted to the single treatment condition. Two of them, or 15% had discontinued treatment for various reasons and one participant provided incomplete data. Thus, we analyzed the data sets provided by the remaining $N = 10$ participants. Their mean age was 38.2 years ($s = 10.1$). Among them, the most common diagnoses were Depressive Disorders ($N = 7$ or 70%), Anxiety Disorders ($N = 2$ or 20%), and Posttraumatic Stress Disorder ($N = 1$ or 10%).

All of the patients had reported traumatic experiences such as severe childhood abuse, forced marriage and domestic violence. Nine patients or 90% held the Turkish and one patient the Austrian citizenship. Ninety percent (or $N = 9$) were married, one patient was divorced. In this subgroup, the average number of children was 2.50 ($s = 0.85$).

A statistical trend indicated that there were more Turkish citizens in the Single Treatment subgroup than in the Group Treatment subgroup ($\chi^2 = 3.71; df = 0.54; p < .10$).
3.2 Measures

3.2.1 Number of Hospital Contacts

In-patient and out-patient contacts to the University Hospital (not taking into account the University Clinic of Medical Psychology, were the study had been carried out) were assessed six months prior to admission to the present study as compared to the six-months period following admission.

3.2.2 Brief Symptom Inventory (BSI) (Derogatis & Melisaratos, 1983; Turkish version by Sahin & Durak, 1994)

Details of the BSI have been reported in Chapter 5 of the present book. The authors of this chapter have used the Global Severity Index (GSI) of the Brief Symptom Inventory as a measure of global clinical symptom strain.

4. RESULTS

4.1 Number of Hospital Contacts

During the six months period prior to admission, on average the participants had 3.00 ($s = 2.9$) hospital contacts, whereas during the six months period following admission, the average number of admissions was 3.07 ($s = 4.4$). There had been no significant change (Wilcoxon test: $z = -0.18; p > .05$) in the number of admissions.

Similarly, the patients participating in single treatment, had an average number of hospital contacts of 1.80 ($s = 2.8$) during the six months period prior to admission to the research, whereas during the six months period following admission, their average number of hospital contacts was 1.6 ($s = 2.2$). Again, there had been no significant change (Wilcoxon test: $z = -0.37; p > .05$) in the number of admissions.

4.2 Brief Symptom Inventory (BSI)

The descriptive statistics achieved are shown in Table 1. From the table it can be seen that there was no significant change with respect to the Global Symptomatic Index of the BSI in the group condition whereas the patients who had received individual treatment had improved significantly in this respect. When comparing both groups, and effect size of $d = -1.05$ has been found.
### Table 1: Scores assessed by the BSI prior and consecutive to the group and the single interventions

<table>
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<th>Post-treatment</th>
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</tr>
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<tbody>
<tr>
<td></td>
<td>$M$</td>
<td>$s$</td>
<td>$M$</td>
</tr>
<tr>
<td><strong>Group treatment</strong></td>
<td>2.16</td>
<td>0.96</td>
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</tr>
<tr>
<td><strong>Single treatment</strong></td>
<td>2.24</td>
<td>0.90</td>
<td>1.76</td>
</tr>
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</table>

5. **DISCUSSION**

Whereas the single interventions were effective in reducing symptom strain, the group intervention was not. Neither intervention has been effective in reducing the number of hospital admissions.

The group therapists reported that, in the course of therapy the participants had developed an increased ability to perceive their own feelings and resources. Psychoeducation had been instrumental in teaching them biological and psycho-social knowledge as well as treatment options with respect to their disorders. Participants had gained trust in each other and also had learned to talk openly during group sessions. Overall, the therapist perceived the participants as more vivid and – as they put it – "colorful" at the end of the interventions. The group interventions had been an opportunity of promoting the group members' mutual relationships and thus had contributed to developing psycho-social resources.

The group setting may have prevented some of the women from addressing personal themes, for example with respect to marital relations, whereas the single setting might have provided a higher degree of confidentiality. Whereas in the present study, group treatment had led to no significant change, it may still have been effective in preventing deterioration of symptoms. In order to clarify this point, future research should compare the effects of group treatment with a Wait-List (WL) control condition. In practice, for many patients group therapy is the only possible type of intervention while they are waiting for an opportunity to receive single treatment.

In the course of future research, we also intend to reduce the number of group members to six participants in order to promote an atmosphere of trust and mutual understanding. At the same time, the concept of an "open group" should be replaced by an alternative one comprising a stable number of participants over a prolonged period of one year. This concept should enable participants to...
focus on themes of their choice rather than being limited to a resource oriented procedure.

6. REFERENCES


Depression may occur as a common final pathway of various psychiatric disorders. While a group of patients enter depressive episodes in the context of a primary mood disorder (once called "endogenous" depression with a genetic component to its causation), a large group of subjects develop chronic ("dysthymic"), or episodic ("major") depression in relation to ongoing or past stressful life experiences ("reactive" depression) that, sometimes, are considered also a derivative of temperament, character, and/or personality ("neurotic" depression) having led to a long lasting maladaptive development. Whereas any overlap between these occurrences is possible, many patients go through a "double" depression (major depression episodes superposed on dysthymic depression) with fluctuations in severity and in terms of the disease's long-term course.

1. TREATMENT-RESISTANT DEPRESSION AND THE "TRAUMA MODEL" IN PSYCHIATRY

Whereas the common biologically based treatment approaches to depression as proposed by the medical model of psychiatry usually have a good to excellent outcome for "primary" depression, many "depressive" patients respond to well shaped medical treatment algorithms only poorly and must be considered as "treatment-resistant" in due course. A closer look at these "resistant" patients easily makes apparent that they have been living under lifelong environmental stress usually with an origin in early developmental years. Besides having grown up in dysfunctional or "apparently normal" families (Öztürk and Sar, 2005), many of these patients report various kinds of adverse experiences ("traumas") in childhood, not rarely in the scope of (sexual, emotional, or physical) abuse and/or (physical or emotional) neglect (Akyüz, Sar, Kugu, & Dogan, 2005). It is no wonder that they are patients who respond to psychotherapeutic interventions rather than to pharmacological treatment, provided that it is delivered on the

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basis of modalities oriented by psycho-traumatology. Thus, the problem of "treatment-resistant depression" is embedded in a larger context which can be better explained by a psychiatric "trauma model", as opposed to a mere "medical model" (Ross, 2000).

The medical model of psychiatry is based on diagnoses of well shaped syndromes called "disorders". Treatment algorithms designed to target psychiatric disorders try to rely on "evidence" derived from clinical research as largely as possible. However, studies conducted on "pure" diagnostic populations hardly reflect the "real" clinical situation in mental health, because co-morbidity is almost always the rule rather than the exception in psychiatry (Sar and Ross, 2006). In this sense, psychiatric research has lagged behind clinical practice and experience for decades. Moreover, high levels of co-morbidity for many psychiatric disorders cannot be simply an artifact of over-inclusive or imprecise diagnostic criteria; rather, they must reflect a multifactorial etiology of psychiatric disorders and a need for multimodal treatment strategies.

Nevertheless, co-morbidity in psychiatry is related to certain risk factors rather than being common to all patients. Accumulating research demonstrates that a history of traumatic childhood is associated with several mental health conditions in adulthood which are partly independent of the main diagnosis. One of them is a high degree of lifetime and current general psychiatric co-morbidity. Thus, unlike for biologically based psychiatric disorders, in traumatized populations, the medical model usually leads to nosological fragmentation which interferes with the standards of treatment planning within the scope of mainstream psychiatry.

2. "DISSOCIATIVE" DEPRESSION

Dissociation is defined as a disruption in and a fragmentation of the usually integrated functions of memory, consciousness, identity, body awareness, and perception of the self and the environment (American Psychiatric Association, 1994). Chronic complex dissociative disorders such as dissociative identity disorder and its more common milder forms (dissociative disorders not otherwise specified) are increasingly considered to be a post-traumatic syndrome closely related to childhood abuse and/or neglect. While most of the patients with chronic complex dissociative disorders report severe childhood trauma, a sizable proportion of these patients originate from "dysfunctional" families which seem to be "apparently normal" (Öztürk & Sar, 2005), being characterized by insecure attachment patterns, affect dysregulation, or narrow and rigid thinking styles without an overt history of severe childhood abuse. In
fact, in today's view, dysfunctional communication styles of families (like e. g., pseudomutuality, marital schism, schizophrenogenic mother, double bind) which were once proposed to be a factor in the psychogenesis of schizophrenia, are in fact descriptive of dissociative patients' families rather than of those suffering from schizophrenia. A smaller percentage of patients report diverse kinds of childhood traumas other than childhood abuse and/or neglect such as repetitive painful invasive medical/surgical procedures enforced in childhood (Diseth, 2006) or having grown up in extreme poverty.

Almost all of the patients with severe and chronic dissociative disorders, such as dissociative identity disorder and dissociative disorders not otherwise specified are chronically depressed (Sar et al., 1996; Sar, Tutkun et al., 2000). The opposite is also true to some extent. Unpublished data collected from a representative sample of women in the general population of a town in central Turkey (Sivas City), suggested that the lifetime prevalence of major depression was 31.7 % and current prevalence was 10.0 % (Sar et al., 2007). Sizable proportions of women with a lifetime diagnosis of major depression (39.2%) and current major depression (41.3%) had a lifetime history of DSM-IV (American Psychiatric Association, 1994) dissociative disorder. Thus, "dissociative depression" is an important public health issue in Turkey and may explain treatment-resistance for a considerable part of depressive patients. Given the larger prevalence of dissociative disorders among women compared to men, both in the community and in clinical settings (Akyüz et al., 1999; Tutkun et al., 1998; Sar et al., 2003), understanding trauma-related dissociative depression is of critical importance for women's mental health in particular.

One aspect of dissociation are medically unexplained or so-called "somatoform" symptoms (Sar, 2006; Lewis-Fernandez, et al., 2007; Martinez-Taboas, et al., 2009; Sar et al., 2009; Sar, 2010). In the case load of a psychiatric clinic in central Turkey, among patients with conversion symptoms (most of them had psychogenic non-epileptic seizures), 47.4 % met lifetime criteria of a dissociative disorder (Sar et al., 2004). As compared to patients with conversion symptoms without a dissociative disorder, those who also met criteria of a dissociative disorder had more comorbid psychiatric disorders, childhood trauma, suicide attempts, and self-mutilating behaviors. In a series of patients collected in a university clinic of a large metropolis (Istanbul) in Turkey, medically unexplained somatic symptoms differentiated patients with complex dissociative disorders from other psychiatric diagnostic groups (Sar, Kundakçı et al., 2000). As an evidence for universality of this phenomenon, there was no difference in somatic complaints between Turkish and Dutch patients with dissociative disorder except for the prevalence of psychogenic non-epileptic seizures (pseudo-seizures), which was higher among Turkish patients. Standing in for general severity of the clinical condition, somatic complaints were related to higher suicidality among Turkish dissociative patients (Öztürk and Sar, 2008).
Thus, treatment-resistant depressive conditions among Turkish women characterized by various kinds of "functional" somatic complaints require evaluation in terms of subtle dissociation and a history of childhood trauma.

3. THE PSYCHODYNAMICS OF "DISSOCIATIVE" DEPRESSION

Recovery from dissociative disorder instantly relieves the depressive façade. As a reason of this impairment, at least partly, re-integrated anger can be taken into consideration. This anger is absorbed in the fragmented or compartmentalized internal world (alter personalities) of these dissociative patients. The lack of sense of a healthy "self" and being confused due to continuous interruptions by mental intrusions and passive influence experiences originating from "within", cause these patients to be upset and undermines any hope for a better future for them, whereas their painful past intimidates their present consciousness. Difficulties in accessing memory beginning from daily mundane amnesias reaching to the scope of dissociative amnesia about large periods of past life (sometimes covering traumatic periods and events) additionally interfere with a healthy and integrated sense of self. Once denied of their autonomous existence as children by their caretakers, these individuals continue to be prevented from being in leading role of their own life throughout adulthood either, this time captive by their internal world.

For some of the patients, chronic depression may be even a façade which hides a chronic Post-Traumatic Stress Disorder (PTSD) with the classical symptom triad of numbing, intrusions, and hyperarousal. Others (including their family members) may suffer from affect dysregulation, creating unexpected mood fluctuations and disturbing subjective well-being and/or interpersonal relationships. Some individuals are rather prone to alexithymia, including difficulty in identifying or expressing feelings and leading to frequent somatic complaints or alcoholism (Evren et al., 2008). Some authors have described this composite syndrome as complex PTSD (as a variant of its classic form), which usually has an origin in a traumatic childhood like it might be the case for depressed patients with an underlying chronic dissociative disorder. Recently, some authors propose a dissociative subtype of PTSD associated with childhood adversity alongside the index traumatic event(s) of adulthood leading to the main diagnosis (Lanius et al., 2010).

Arieti and Bemporad (1980) underlined the role of the "dominant other" in the lives of depressive individuals. From the angle of view of psycho-traumatology, we may translate this concept to an "attachment to the perpetrator" and a "shift of locus of control" model (Ross, 1997; 2000). Insecure attachment has been reported as an etiological factor of dissociative disorders (Liotti, 1992; Lyons-
Chapter 8: Dissociative Depression

Ruth et al., 2006) as well as of somatization (Ciechanowski et al., 2002). Childhood adversity usually affects lifelong attachment patterns which go back to an individual beginning in early childhood. One hypothesis proposed about lifelong dysfunctional interpersonal relationships of traumatized subjects is based on attachment to the perpetrator and shift of locus of control (Ross, 1997; 2000). According to this model, the child is biologically determined to develop attachment to her primary caretakers. Even in an abusive and/or neglectful environment, the child must develop attachment to the caretaker, whereas the modules of the mind that maintain attachment behavior are disconnected from those taking in the traumatic information from the outside world. Paradoxically, the child only feels safe when the abusive "caretaker" (the perpetrator) is nearby. This problem of the attachment to the perpetrator can be acted out throughout life. The helpless child continues to identify with the aggressor and shifts locus of control inside his or her personality. The victim's rationalizations of the abuser's behavior as his or her own fault reinforce the shift of locus of control. While the illusion of control created in the child's mind is developmentally protective, it requires to be broken in adulthood in the face of outside reality.

Whereas this internal world composed like a ghetto leads to the experience of perpetuated abuse inside, it also facilitates and maintains abusive relationships in the external world. This situation does not only end up in a depressive condition but also undermines healthy intimacy, causes social withdrawal, leads to psychological stagnation, and interferes with any hope for psychological change, progress, and maturation necessary to break the circulus vitiosus.

4. FAMILY AS THE ORIGIN OF TRAUMA AND ATTACHMENT PROBLEMS

While childhood abuse and/or neglect are common among Turkish depressed dissociative patients as a universal phenomenon, certain types of family dynamics seem to be culturally specific. Special roles are ascribed to the child in his or her family of origin, differences in gender roles, shame-based blockage of communication, and enmeshment in the extended family environment being among them.

4.1 Complaisant Over-Adjustment

Some Turkish patients with somatic dissociative (conversion) disorder describe a special familial role granted by parents and adopted by the patient, such as being the most favorite child usually combined with "complaisant over-
adjustment" by the potential patient which continues throughout adulthood (Öztürk and Gögüs, 1973; Öztürk, 1976; Öztürk and Öztürk, 1981). Complaisant over-adjustment is defined as an enduring attitude aimed at pleasing others despite being overburdened by duties (e.g., being in the service of family members; self-sacrifice for others' interests). This attitude usually serves to maintain a given role in the family supposed to be for the subject's own good. The potential patient tries to please his or her family members by being "perfect" in his or her role. This submissive attitude may be conceptualized as a sequel of early traumatization that leads to a special attachment to the perpetrator. Research on children and adults with symptoms of conversion suggests the importance of early birth order as a risk factor in Turkish families (Öztürk, 1976; Sar and Sar, 1991).

4.2 "Apparently Normal" (Dissociative) Families

In accordance with the subtle dynamics described above, first-degree relatives of patients with complex dissociative disorders described a special type of family that may have predisposed them towards dissociative and trauma-laden psychopathology. These "apparently normal" families are characterized by affect dysregulation, leading to angry outbursts in some members with resulting chronic traumatization of their relatives. Members of this type of family reported childhood trauma more frequently than controls did, suggesting trans-generational transmission of trauma-related psychopathology (Öztürk and Sar, 2005).

4.3 Gender Roles

Although there has been tremendous social change within a few decades in Turkey, women still are in a disadvantaged position, especially in families with conservative attitudes in which women are restricted in their opportunities of self-expression. Arranged marriages during early adolescence, premature cessation of education, and quasi-religious gender-related oppression, due to limited interpretation of Islamic practices are common in rural areas, or in towns among social strata emerging from a rural or a semi-rural background.

4.4 Shame-Based Inhibition of Communication

Somatic symptoms of dissociation (conversion including pseudo-seizures) can be understood as an implicit form of communication, conditioned by cultural blocks towards more explicit one. These blocks are usually enforced by the family as the agent of culture by means of shame-based practices. For these
social groups, dissociative crises may be a way of taking some form of control in family, when a more direct channel for conflict expression and resolution has been blocked. The dramatic phenomenology of dissociative crises of either psychological or somatic type usually stops the family's hostility toward the patient and often creates a more supportive attitude among family members. A dissociative crisis may take the scope of a transient dissociative psychosis, which may serve as the last way of escape leading to psychological survival under otherwise unbearable conditions (Sar and Tutkun, 1997; Sar and Öztürk, 2009).

4.5 Interference as Chronic Interpersonal Trauma

The family is a highly valued sociological unit in Turkish culture, including relationships with members of the extended family. The age-related hierarchy in extended families in particular allows enmeshment and violations of boundaries between two generations (e.g., between the young bride entering the family and her mother in law), in countryside Turkey in particular. This may happen in the form of chronic, repetitive interference to functions in a spectrum beginning from daily mundane activities (e.g., cooking) to decisions important for the young couple's future (Karaaslan et al., 2004). This intrusive behavior may take an emotionally abusive form in terms of critics and belittling from time to time. The result is chronic PSTD with accompanying dysthymic mood and irritability, undermining marital relationship for a long period.

5. A NEW PARADIGM: FUNCTIONAL DISSOCIATION OF THE SELF

Sar and Öztürk (2006, 2007) have proposed a new model of understanding trauma-related dissociation both in terms of clinical conditions and psychopathology of everyday life. This new model, based on an assumption of "functional dissociation of the self", proposes that a certain level of differentiation of sociological self from psychological self is common to every human subject from the beginning of life. Whereas a harmonic relationship between two aspects of personality is a prerequisite of healthy life, chronic traumatization leads to their further detachment from each other. This condition causes a hypertrophied sociological self and a rather "frozen" psychological self, restricted in its developmental fate.

Whereas detachment may lead to further fragmentation of the sociological self (e.g., to the creation of altered personalities in the sense of a dissociative identity disorder), psychological self remains as a saved treasure. Thus, besides serving to the individual's adjustment to the society by buffering psychological trauma,
the main function of sociological self is to protect psychological self. **Table 1** demonstrates the properties of the sociological self and the psychological self.

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<td>Compassion</td>
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<td>Ownership</td>
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<td>Signs</td>
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<tr>
<td>Abuse and being abused</td>
<td>Recognition of boundaries</td>
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</table>

**Table 1:** Some Properties of Sociological and Psychological Selves

The resulting condition may lead to a clinical dissociative disorder but may also remain on the level of everyday dissociation. Subjects with a hypertrophied sociological self may find a niche in contemporary society (with its preference for individuals controlled from outside), which may benefit from their capacities in professional life and so the individual may adjust accordingly. For some of those affected, however, the condition may develop further to a clinical one with subjective distress, interpersonal disturbance, and dissociative crises. Beside
developmental traumas, the properties of the sociological self may also be prompted by family environment and society at large as the source of a “sociocognitive trauma” (Sar, 2008). In its extreme form, an individual with a hypertrophied sociological self (and consequently, with reversible personality) may become a malignant character.

Any successful psychotherapy of a dissociative individual requires a shift from sociological self to psychological self. In fact, both sociological and psychological selves provide a context to an other mental agent which takes contact with the outside world in frontline during crises and leads to clinical symptoms, namely the "Trauma-Self" (Sar and Öztürk, 2006; Sar and Öztürk, 2007). Whereas the adoption of the trauma-self by the sociological self will lead to a deterioration of the clinical condition, a return of the trauma-self into its original context in the psychological self will ameliorate symptoms and relieve the crisis. Hence, while working on the trauma-self, continuous nurturing of the psychological self in the context of psychotherapy creates positive change, as can be seen from Figure 1.

Mainstream psychiatry is hardly aware of these dynamics on the level of various selves. The medical model is interested in the functions of the "moderator" as a mental entity, which becomes overwhelmed secondarily due to the dysfunctional operations of sociological, psychological, and the trauma-selves in trauma-related conditions. Psychotherapeutic interventions establishing harmonic relationships between the selves are usually sufficient to restore the functions of the moderator rather than trying to restore any of its capacities through working on them. This is the vital strategic issue in effective psychotherapy of trauma-related conditions.

A return of the trauma-self into its original place in the psychological self requires effective management of the resistances pertaining to the trauma-self. They are composed of traumatic obsessions, a disruption of interpersonal mutuality (shown as diminished cooperation in psychotherapy), and, last but not least, of depressive symptoms (Sar and Öztürk, 2006).

Thus, in terms of the model of functional dissociation of the self, depression is considered as one of the resistances of the trauma-self under trauma-related conditions. Emotions are available to the players of this system, whereas the "natural" (the original one before development of the dual system) self remains as a rudimentary unit serving as a source of life energy only.
6. CONCLUSIONS

Chronic treatment-resistant depressive phenomena and the frequently accompanying medically unexplained physical symptoms may be conceptualized as post-traumatic conditions of diverse origin, usually going back to dissociation as the basic element of psychopathology. Notwithstanding its universality, understanding the trauma-related origin of depressive conditions...
is important for clinicians when treating depressive Turkish women with a
countryside background who continue their lives in towns including those of
several European countries. While not based on cultural assumptions per se, our
model of the "functional dissociation of the self" may serve as a tool in
overcoming the treatment-resistant and emotionally restricted "facade" of
individuals who usually keep an inner world hidden from themselves and from
the world.

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Chapter 8: Dissociative Depression


Chapter 8: Dissociative Depression


Gender role orientations are known to have a significant impact on everyday life. Gender can be viewed as a flexible and constantly reconstructed variable which is dependent on culture and society. We have ideas of how men and women should behave and which behavior can be expected to be typical of men and women.

In this study on Turkish migrant women with depression, we have analyzed how gender roles have changed in the course of migration and how different ideas of role allocation have been confronted with each other. In the following chapter we are going to discuss the impact of gender roles on symptoms of illness and disease.

1. GENDER ROLE ORIENTATION

West & Zimmerman (1987) stated that gender is reproduced through interaction in everyday life and should be conceived as flexible and changing constantly. Formerly gender had been seen as a stable construct that could not be changed (cf., Garfinkel, 1967).

Masculine and feminine aspects exist in each individual, suggesting that an individual can behave in either way depending on the demands put on him or her (Bem, 1974; Hyde, 2005; West & Zimmerman, 1987). Typical traits of men and women are also called masculinity and femininity. Men are described with traits associated with the role of a provider and protector (e.g., being aggressive, dominant, or protective), whereas women are often linked to nurturing and caring traits (e.g., being communal, worrying, sensitive, or emotional) (Seem & Clark, 2006). These concepts are strongly connected to gender role orientations, which comprise views, responsibilities, and behavior that society associates with
biological sex. These responsibilities and behavior are therefore highly influenced by those traits which are considered typical for men or women. Gender role beliefs describe the general perception of gender roles such as role allocation and power distribution (Van de Vijver, 2007).

Traditional gender roles can be distinguished from egalitarian ones. Traditional gender roles describe role allocations between men and women. Individuals with more traditional gender role orientations have stricter ideas about how men and women should behave and that certain tasks, such as household chores, caring for children or politics, as well as certain professions such as police officer, are linked to the female or male sex. Hence, a traditional gender role refers to the belief that men and women have different tasks to fulfill according to their sex and that separate gender roles exist. Therefore men and women take over different social roles. The social role of men and women in society is greatly influenced by culture. Studies have shown that a higher educational level is also related to a more egalitarian gender role belief (Athenstaedt, 2000; Van de Vijver, 2007).

With respect to the women's movement and to equal rights and treatment for men and women (e.g., maternity leave for men) it is assumed that gender roles have changed. Seem & Clark (2006) compared gender role stereotypes in the 21st century with those of the 1970s. They found that women are still associated with traditional stereotypes (i.e., to be nurturing, nice, and sensitive) but also with masculine traits (i.e., enjoying a challenge, being independent, and strong). However, men were not described with more feminine, but with traditional traits. Women are also supposed to hold more egalitarian gender role beliefs than men (Van de Vijver, 2007). It is supposed that gender roles and gender stereotypes are changing but not as much and as fast as assumed.

Hofstede (2001) differentiated countries according to four dimensions: Individualism - Collectivism, Power Distance, Uncertainty Avoidance and Masculinity - Femininity. It is assumed that Power Distance and Masculinity - Femininity are especially important with respect to gender role beliefs. A high Masculinity index stands for a larger gap between male and female values. The Masculinity index orientates by "male values", such as competitiveness and by "female values" such as caring. In countries with higher masculine values it is more important to be competitive, to show off with what one has, whereas in more feminine countries, the overall values rather pertain to being modest and caring. Female values, however, do not differ as much between countries as male values do. Furthermore, Power Distance describes the extent to which less powerful people in the country expect or accept an unequal distribution of power. Countries with high Masculinity indices typically have unequal gender role allocations and women have a weaker position in their families as compared to feminine countries (Van de Vijver, 2007). For example: northern European
countries such as the Netherlands would be classified as feminine countries, whereas an example of a more masculine country would be Austria, with more distinct professional fields and values of men and women. In the context of the present research it is important to note that Turkey's index of Power Distance is higher than its Masculinity index\(^{32}\).

### 2. IMMIGRATION

Espin (1997) stated "[…] when immigrants cross borders, they also cross emotional and behavioral boundaries. Becoming a member of a new society stretches the boundaries of what is possible because one's life and roles change, and with them, identities change as well" (p. 445).

Immigration can lead to loneliness, isolation and overstrain by the new culture and the expectations of the "new" society. On the one hand, the language barrier and different life styles may challenge the previous way of life and coming from a more traditional society may open up opportunities to immigrants, especially to women (Espin, 1997). Nevertheless, these opportunities are not accessible to everyone, as immigrants have to be accepted by the host society. Thereby, language plays an important role. Furthermore, the reactions of the immigrants' extended family to his or her behavior change will be of utmost importance.

Espin (1997) noted that women are less encouraged to acculturate quickly as compared to men. Women are supposed to sustain cultural continuity even when dislocated from their culture of origin. Women are expected to transmit traditional values to their children, even though these values may be different or inadaptable to the host society. Original values may be less functional in the "new" society than they were in the society of origin. Furthermore, as the culture of origin is being put on hold after immigration, migrants frequently are unable to experience the development and changes of the culture in their country of origin.

Moreover, feelings are being accepted and demonstrated in a culturally specific way. Schouler-Ocak et al. (2010) have argued that depressive symptoms may be expressed differently depending on culture. Thus, some cultures put more emphasis on physical symptoms and others on psychological complaints.

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3. **EMPIRICAL RESULTS FROM THE PRESENT STUDY**

Whereas in **Chapter 6** of the present book we presented qualitative results under a more general perspective, in the present chapter we will focus on topics of gender and gender roles. Also in this case, we have derived the qualitative material from the group protocols, the supervision protocols, and from the interviews with the participants. Details on how these materials had been obtained also were given in **Chapter 6**.

The data gathered by supervision on the one hand and those obtained from the interviews and group protocols on the other differed with respect to the categories of "gender" and "family". In the interviews and the group protocols, gender and gender role were of importance, whereas in supervision these topics were more related to violent acts within the family. **Table 1** gives the categories and sub-categories which we have found.

<table>
<thead>
<tr>
<th>Category</th>
<th>Sub-Category 1</th>
<th>Sub-Category 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Gender</td>
<td>Gender role orientation and role allocation</td>
<td>Gender-role belief</td>
</tr>
<tr>
<td>(2) Marital Relationship</td>
<td>Problematic aspects of relationships</td>
<td>Positive aspects of relationships</td>
</tr>
<tr>
<td>(3) Emancipation</td>
<td>Gaining strength</td>
<td>Emancipation within marital relationships</td>
</tr>
<tr>
<td>(4) Violence</td>
<td>Violence within the family</td>
<td>Violence from the family-in-law</td>
</tr>
<tr>
<td>(5) Immigration</td>
<td></td>
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<tr>
<td>(6) Subjective theories of the illness</td>
<td></td>
<td></td>
</tr>
</tbody>
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**Table 1:** Gender related categories found in the qualitative material

### 3.1 Gender

The participants mainly had traditional gender role orientations. They felt responsible for child-care and household chores. They were cooking and cleaning even when the husband came home late or when they had already eaten. Traditional gender roles are especially pronounced with respect to strict allocations of tasks. Women take over a nurturing and caring part whereas men mainly are regarded as breadwinners. In addition, the women repeatedly pointed to a strict hierarchy within the family. The participants especially focused on their children and reported that feeling happy as a mother was strongly linked to their children's happiness. At the same time the women pointed to their sorrow
and their anger because of feeling neglected by their husbands. Thus their children were their main focus and an alternative to receive attention. The participants also said that they were afraid of their children turning away from them or that the children preferred their fathers and some women reported that this fear already had come true.

**Example of children as the greatest good:** […] the participant cannot [live] without her children, she needs them. The children are the only source of support in her life.

Some women in the group warned the other mothers to distance from their partners. The women were called on focusing on their own needs because the children might turn against them in the end.

**Example of children turning against their mother:** The husband does not give a damn about her, she stands up for herself, but her children turned against her, her own flesh and blood turns against her.

The participants had clear preconceptions of behavior and task allocation. They value a clean and neat house or flat and it is important for them what others would be thinking or feeling. Some women reported that their children or mothers did not want them to separate from their husbands because they feared defamation. Also the women themselves eschewed a divorce.

**Example of fear of defamation:** I wanted to get a divorce but my children did not want me to. Sometimes I still want a divorce, but I don’t want other people to trash me.

### 3.2 Marital Relationships

As reported in Chapter 6, problematic aspects of relationships were a major discussion point in the groups. The women reported that their partners ignored them and that they could not reach their husbands emotionally. Often, husbands treated them like objects or servants and refused to show respect and appreciation for them. Thus, fights and discomfort resulted, often accompanied by negative comments or further ignorance.

**Example of negative comments:** My husband only says that my tongue has grown, she got too long [i.e. metaphor for talking too much] and that this is unbearable.

Some women reported that they were supported and protected by their husbands, with whom they experienced a positive relationship. In these cases, the husbands invited them to state their opinion, gave them attention and demonstrated their appreciation and love to their wives.
3.3 Emancipation

Almost all of the women reported that they had become emancipated. The support and encouraging advices of the other women or the group leaders had increased their self-confidence and their strength. They were able to shift their focus on their own instead of their husbands' well-being. The women tried to concentrate on their own needs or their children's needs and took time to relax.

**Example of shift of focus:** My point of view has changed. If my husband goes to the café I do not mind anymore. If he comes home late and wants something to eat, I will not make him dinner. I ignore him. In former times this was different. I got out of bed to cook dinner for him. That is over now. I learnt to say no. I could not do that before.

Some husbands noticed that their wives had begun to resist and tried to restrict this behavior. One husband tried to prohibit any further participation. Such reactions underlined that the women were able to adopt strategies learnt in the course of the interventions.

**Example of the husband's reaction:** My husband said that I have changed. He doesn't want me to participate in the group any longer as I have started to resist.

3.4 Violence

As outlined in Chapter 6, some women had experienced violence and repression from their families of origin. Other women, however, had a family background which enabled them to attain higher education or to marry a husband of their choice.

Some women got married during adolescence. They reported that they were of very young age and did not know how to sustain their position. They had to help in the house (e.g., cooking, taking care of the whole family) and were assaulted if they tried to resist. One woman reported that she was not allowed to eat the meals at the same table with the rest of the family and others were not allowed to caress their babies. The participants also reported violent assaults by their husbands which either had occurred spontaneously or on demand of their husbands' mothers. Only a few women stated that their husbands supported them and that they got protection from other violent family members.

**Example of violence from the mother-in-law:** [...] she married into his family and she was at their mercy. She had to do anything they wanted her to do… she had to take care of her husband's family. Her four sisters-in-law did not help her at all. Her husband served in the army and there was nobody to help her. Her mother-in-law even would beat her.
3.5 Immigration

Immigration was not always seen in a positive light. The women reported feeling isolated due to the language barrier, to cultural differences, as well as to general difficulties acculturating. Following migration, their scope of action suddenly had become restricted. In addition, many women had started to feel rejected or continuously suffered from family violence.

Example of difficulties after immigration: I had difficulties to adapt. Sixteen years ago I came to this new, foreign country. Everything was new. I had great difficulties to cope. I was not able to speak the [German] language. Everything was different. I had to adjust completely. I had to think through every detail, I could not take anything for granted anymore.

3.6 Subjective Theories of Illness

Most women did not seem to accept being diagnosed with depression. They had various subjective theories of their illness, attributing it to external causes in all of the cases. The reasons reported pertained to being treated unequally and neglected by their husbands and to negative experiences during immigration. Other alleged causes related to feeling isolated, in most cases because of the language barrier. They also reported that their limited scope of action and the loss of educational perspectives had instigated symptoms of depression.

Example of subjective theories of illness: Sometimes I think that if I had not been so suppressed, I would feel better today.

4. SUMMARY AND DISCUSSION

The participants strictly adhered to traditional gender role orientations and problems reported pertained to their husbands, children, or domestic tasks. Problems may have increased after migration and although many husbands tended to ignore their wives in everyday life, they reacted negatively to their attempts to emancipate.

Children, playing a major role in the participants' lives, sometimes tended to take over the part of an adult to support their mothers and depressive symptoms may function to receive increased support. The women's focus on their children may also be understood as a consequence of their husbands' lack of attention and thus, the idea of the children becoming detached from their mothers may lead to feelings of panic, implying the loss of attention and appreciation. In turn, increased symptoms of depression may result.
Just like Espin (1997) pointed out, immigration may imply being isolated from others. Under such conditions, one's family becomes the only source of reducing loneliness and providing safety and a secure environment. Women are trapped in their traditional gender role orientation as caring and nurturing women, which may not be suitable in the host society. Thus, further feelings of being rejected and increased difficulties in the course of acculturation may result. Therefore, women may feel even more isolated than the rest of the family does. Depression may be a means towards strengthening the women's position within their families as the relatives now have to take care of them.

The strategies learnt and discussed in the intervention may have led to an amelioration of aspects of the self (e.g., self-assurance, emancipation, gaining strength, etc.). In the absence of an effect on the symptom level (cf., Chapter 5), participating in the group has addressed both

$=>$ **social aspects** (meeting other women from the same culture, being able to talk in their native language, secure and confiding place to meet)

as well as

$=>$ **individual aspects** (problems with the partner, depression symptoms, living circumstances, discussion of strategies, exchange of advice)

and thus may have been a first step towards instigating emancipation and successful acculturation in the participants.

### 5. REFERENCES


CHAPTER 10
SYNOPSIS AND RECOMMENDATIONS
WALTER RENNER & HEIDI SILLER

1. SUMMARY OF RESULTS

The quantitative results as they were presented in Chapter 5 can be summarized as follows: Contrary to our hypotheses, there was no significant improvement of clinical symptoms in the Self-Help Groups as compared to the Wait List Control conditions. Similarly, neither the participants of the Wait List in the course of their time-delayed self-help interventions (there was a significant improvement on only one out of three scales measuring depression), nor those of the Cognitive Behavior Therapy (CBT) Groups achieved clear cut improvements.

When taking follow-up measurements into consideration, in the Self-Help interventions there was little change of symptomatology after the interventions had been completed. For the CBT-Groups, however, on various scales, symptoms deteriorated significantly after group sessions had ended.

In order to assess the amount of change, the scores on the CES-D Depression scale have been employed and about 35% of participants had reached significant improvement of depressive symptoms as measured by the CES-D on an individual level. According to linear regression, a higher number of traumatic events experienced, younger age, and a longer duration of stay in Austria were predictive of a more expressed reduction of symptoms.

The qualitative analysis revealed that the themes discussed in the groups had focused on those issues which already had been addressed most frequently and intensely in the course of the psychiatric assessments (cf., Chapter 4), namely the participants problems with their husbands and children and feeling isolated. In the course of the group meetings, participants had found trust in each other and felt that they had regained the power to bring about change in their lives. Participants expressed that during the group meetings they had learned problem
solving strategies, which they would be able to use in everyday life. From qualitative analysis the importance of group leaders became clear, as the participants indicated that they would feel unable to continue the meetings on their own, without their group leaders being present.

Although, according to the quantitative results, a significant reduction of symptoms has only been achieved in single cases, according to qualitative analyses the group members have gained from participation with respect to their personality development. In Chapter 2, Herbert Janig has summarized the effects of Self-Help Groups by the German acronym A-E-I-O-U, standing for Auffangen (accepting), Ermutigen (encouraging), Informieren (informing), Orientieren (giving orientation), and Unterhalten (entertaining). Quite clearly, especially the functions of "accepting", "encouraging", and "entertaining", and to a lesser degree, those of "informing" and "giving orientation" have been fulfilled by both, the Self-Help and the CBT groups, and in certain respects, advantages of Self-Help as compared to CBT have been found.

2. EFFECTS OF THERAPY WITH PATIENTS OF TURKISH DESCENT REPORTED BY OTHER RESEARCHERS

In the first place, the results reported in Chapter 7 by Astrid Lampe and Maria-Theresa Barbist with respect to an "unintended control group" should be taken into account. In this case, Turkish migrant women with a similar biographic background and with comparable living conditions and clinical symptomatology have been treated by a group psychotherapy program. It is important to note that the theoretical basis and therapeutic rationale in that case was quite different from our two approaches. Astrid Lampe had employed psychodrama, whereas in the present research we had used Self-Help and Cognitive Behavior Therapy. In a group setting, none of these approaches had instigated symptom reduction, whereas in Astrid Lampe and Maria Theresa Barbist's study, in an individual setting, therapy was effective in reducing clinical symptoms.

Results similar to the ones we have obtained in the present study also were reported by Sleptsova, Wössmer, and Langewitz (2009) with respect to a cognitive-behavioral group treatment (combined with physiotherapy) for Turkish and Kurdish migrants to Switzerland suffering from chronic pain. Twenty-five sessions of patient information, culturally specific topics, relaxation, and physiotherapy did not change the intensity of pain as measured by a Visual Analogue Scale, ranging from 0 to 10 (Pre: $M = 7.5, SD = 2.1$; Post: $M = 7.6, SD = 1.7$; 1 Year Follow-Up: $M = 7.6, SD = 2.0$). The patients did, however, report a significant improvement of their quality of life on two of eight scales of the SF-36 questionnaire.
Similar to our qualitative results, but from a psychodynamic point of view, according to Battegay (1997), participating in psychotherapy groups had increased Turkish men's and women's willingness to adapt to living conditions and demands of Swiss society and therapy groups had been a source of social support to their members.

Erim (2009a) reported her therapeutic experiences with psychoanalytic group treatment of female Turkish migrants in the patients' mother tongue. While no psychometric measures of symptoms have been applied, the author noted that "patients [...] were reluctant to abandon their symptoms, especially symptoms of pain" (translated from Erim, 2009a, p. 236). Towards the end of therapy, however, patients started aiming at changes in their lives (e.g., finding work). Finally, most patients reported that they had reached important goals. "Most of them had partly abandoned their symptoms and had developed willingness towards new experiences in their relationships" (translated from Erim, 2009a, p. 237).

Similar to Erim's (2009a) at least partly successful approach, there are reports about successfully applying "western" psychotherapeutic approaches to native Turkish born patients within Turkey. For example, Hisli (1987) found improvements on the symptom level in neurotic patients in the course of group psychotherapy at a clinic in Izmir (Turkey) and Bahar et al. (2008) successfully reduced depressive symptoms by problem based therapy and occupational therapy in the adolescent victims of an earthquake in Golcuk. According to an earlier study by Konuk et al. (2006), an estimated number of 1,500 survivors of the earthquake at Marmary (Turkey) in 1999 had been treated by Eye Movement Desensitization and Reprocessing (EMDR), out of whom a representative sample had been evaluated successfully with respect to a reduction of post-traumatic symptoms.

Hamamci (2006) reported that both Cognitive Behavior Therapy (CBT), and psychodrama, combined with CBT, both on a group basis, were effective in reducing symptoms of moderate depression in Turkish students. Also in a Turkish student sample, EMDR was effective in reducing symptoms of anxiety (Tutarel-Kislak, 2004) and Sertöz and Mete (2005) reported about a CBT group program achieving weight loss, as well as decreased pain and psychiatric symptomatology in Turkish patients suffering from obesity.
3. LIMITATIONS AND SHORTCOMINGS OF THE PRESENT RESEARCH

In a previous own study, a Self-Help approach had reduced symptoms of anxiety, depression, and post-traumatic stress significantly and to the same extent as CBT in a sample of traumatized asylum seekers and refugees from Chechnya (Renner, Bänninger-Huber, & Peltzer, accepted). On the contrary, in the present study no symptom change had occurred. Members of Self-Help and CBT Groups did report, however, an unspecific benefit in the sense of Janig (Chapter 2, this book). As an important result of the present study it should be noted that recommendations for culturally sensitive interventions must not be generalized but must differentiate between various ethnic groups and between asylum seekers and refugees on the one hand and working migrants on the other.

We had designed the present research along the lines of Wössmer and Sleptsova's (2006) recommendations for a culturally specific and congruent approach towards reducing clinical symptoms in Turkish migrant women. Although the group leaders were of Turkish descent, however, especially the older participants and those with a shorter duration of stay in Austria may have perceived both, the self-help intervention as well as CBT per se as too westernized to be helpful for them.

Whereas Erim (2009a), being of Turkish descent herself, had been partly successful in attaining symptom reduction by her group therapy in the patients' Turkish mother tongue, in the present case, the Turkish speaking Self-Help Groups lacked a professional therapeutic approach and the CBT groups lacked cultural congruence.

Especially the older participants may have been disappointed about not being offered what they perceived as "real therapy". The Self-Help Groups were conducted by students in their twenties, who may not have been taken seriously especially by older women because of their lack of life experience. Moreover, the group setting did not provide enough confidentiality towards enabling participants to express their feelings freely without being ashamed.

4. HYPOTHESES TOWARDS EXPLAINING THE OUTCOME

4.1 Cultural Differences

Migrants are living between two cultures, their culture of origin as opposed to the one of their host country. Moreover culture is linked to expectations of how men and women should behave, about the conditions of marriage and divorce, of
having children and educating them (Philips, 2008). Men and women are confronted with different expectations of masculinity and femininity, honor, and sexuality. Norms and rules (and the concept of honor) include regulations in a familial, sexual, and reproduction context. This is especially true for migrants of rural provenience, even though Turkish society is complex and heterogeneous. Therefore individuals who violate norms, expectations or rules of the religious or ethnic group they belong to, may face regimentation (Strasser, 2008).

In Chapter 2 of the present book, based on arguments put forward by Kofahl (2009), Herbert Janig had pointed to possible problems when applying the self-help paradigm to migrant populations: firstly, the self-help concept, addressing a person's ability to improve his or her own health status or living conditions is typical of western individualistic societies, whereas non-western cultures tend to attribute illness to external influences. Moreover, many people are reluctant to discuss health problems, which are associated with shame, in a group, where, considering the small ethnic communities, confidentiality cannot be guaranteed. Most of these arguments not only apply to the self-help approach, but similarly also must be considered for CBT in a group setting.

Similarly, with respect to their group intervention designed to instigate pain-management in women with a Turkish migration background, Wössmer and Sleptsova (2006) reported that many of them, especially those with poor educational level, had tended to see therapy in an extremely hierarchical manner, expected the therapist to be the all knowing expert and were quite unable to develop insight into their own feelings, let alone self-management skills: "Implicitly they expect of therapists, to take over a clear 'Führungsrolle' as they perceive therapists to be on a higher level of hierarchy. No matter if one likes or dislikes that personally, as a therapist one has to take over the patient's value system" (translated from p. 11). According to Wössmer and Sleptsova (2006), many Turkish women tend to be disappointed when these expectations are not met, to break off therapy and not to take part in evaluations. Although we tried to meet the culturally specific requirements of Turkish women as well as possible, they may very well have perceived our endeavors as too "westernized" or they may have been afraid to be unable to meet the group leaders' or the therapists' requirements. Wössmer and Sleptsova (2006) also mentioned language problems and a lack of education which made group work difficult. Callies, Schmid-Ott, Akguel, Jäger, & Ziegenbein (2007) compared the attitudes towards psychotherapy of 139 Turkish immigrants to Germany with those of 164 Germans. They found that overall respondents of Turkish descent were more skeptical towards psychotherapy than Germans were, especially when they had a more traditional cultural background. Eppink (1984) pointed to the need of adapting "western" therapeutic approaches to migrants' cultural needs and to include family members and the peer group in the course of diagnosis and treatment.
4.2 Dissociation

In Chapter 8 of this book, Vedat Sar has commented on the participants' resistance to symptom reduction from the standpoint of dissociation theory. According to Vedat Sar's arguments, chronic depression may "hide" the underlying symptoms of post-traumatic stress and thus may be resistant to treatment approaches which are solely addressing depressive symptomatology.

Numerous traumatic experiences have been reported on the Life Events Checklist and in the course of the psychiatric screenings (cf., Chapter 4) as well in the interviews conducted as part of qualitative evaluation (cf., Chapter 6). In addition, many participants' reports about their current dire living conditions, often involving frequent experiences of violence must be considered.

4.3 Negative Social Support

Self-Help Groups and, to a lesser extent, psychotherapy groups are expected to work by providing social support to the group members. It is important to note, however, that besides the positive effects of social support, negative aspects are known. Such effects of "negative social support" have been summarized by Laireiter, Fuchs, and Pichler (2007) in an extensive review of the literature. A factor analysis of a scale constructed by these authors towards measuring stressful aspects of support, yielded the following dimensions: (1) Critique and Derogation (e.g., demanding of the person, to make more effort), (2) Discrimination and Hostility (e.g., open aggression), (3) Disappointment and not Being Taken Seriously (e.g., feeling disappointed with respect to ones needs to be supported), (4) Interference and Excessive Care (e.g., being pitied).

In the present case, many participants expressed that they accepted neither the time limited nature of the intervention nor the fact that they did not receive treatment in an individual setting. This may have instigated feelings of not being understood, not being adequately cared for, or not being taken seriously with respect to the degree of clinical symptoms the participants were suffering from.

4.4 Contagion Effect and Co-Rumination

With special regard to cross-cultural experiences encountered by migrants and sojourners and to their psychological conditions, Adelman (1988) addressed other negative aspects of social relationships, namely a "Contagion Effect":

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139
Support systems that are undergoing similar cross-cultural stress can be hindered in providing adequate assistance to [...] members (Fontaine, 1986). The "contagion effect" refers to the ways stressed individuals can infect others who are vulnerable to similar stressors [...]. Contagion can occur at both the dyadic and network level. Highly interdependent, stressed, and threatened relationships or groups that remain fortressed from the outside social unit, may be ineffectual in active problem solving or providing relief [...].

Among compatriots and sojourners, the contagion effect can inadvertently arise as common experiences are shared. For example, feelings of homesickness can be easily stirred in a newcomer as others romanticize about home-sweet-home. (Adelman, 1988, p. 192).

Similarly, Rose (2002) has introduced the concept of "Co-Rumination", referring to "extensively discussing and re-visiting problems, speculating about problems, and focussing on negative feelings" (p. 1830), with girls reporting more co-rumination than boys. While self-disclosure promotes the quality of friendships, it may have a negative effect on effective coping (Rose, 2002). In girls, co-rumination not only was predictive of friendship quality, but also of anxiety and depression (Calmes & Roberts, 2008; Rose, Carlson, & Waller, 2007) and in women, co-rumination went along with increased levels of stress hormones (Byrd-Craven, Geary, Rose, & Ponzi, 2008).

A contagion effect, as a negative effect of social relationships is well-known with respect to suicidal persons (see for example van Heeringen, 2001; Joiner, 1999; Winkel, Grön, & Petermann, 2005), but has also been held responsible for social induction of burnout in employees (Bakker, Demerouti, & Schaufeli, 2003). In the present group setting, contagion and co-rumination may have contributed to the negative outcome on the symptom level, whereas, according to qualitative results, the group members had enjoyed the interpersonal experience of participating. This result is in line with the above mentioned findings by Calmes and Roberts (2008) and Rose et al. (2007) indicating that, in female participants co-rumination was not only associated with increased clinical symptoms but also with an improved quality of friendships.

4.5 Secondary Reinforcement

From their above mentioned results, Sleptsova et al. (2009) concluded:

It could be shown that the patients had accepted the treatment offered and that treatment to some extent had led to an improved quality of life. Admittedly, our study has made equally clear, however, that the therapeutic interventions had only reached certain aspects in these patients' lives. Their living conditions essentially depend on the social, socio-political, and economic
framework, which cannot be changed by interventions taking place solely within the medical system. (Translated from Sleptsova, Wössmer, & Langewitz, 2009, p. 320).

Going more into details, Erim (2009a) has pointed to the fact, that in her group psychotherapy which had been conducted in the patients' mother tongue, many women had complained about being maltreated by their husbands and their families. Being unable to change their living conditions, the women resorted to "a passive lamenting role, emphasizing the resistance of the suppressed, by trying to dominate their spouses and by troubling them with allegations and persistent somatic complaints. Thus, for the patients, their symptoms, most importantly their symptoms of pain, were regulating their relationships and as a consequence, they were reluctant to abandon them. The symptoms of pain were dominating the body as a last resort of self-determination and control, where the patients could retire to. This constellation of defense can be compared with anorectic patients' starvation by which they regain a limited part of their autonomy. (Translated from Erim, 2009a, p. 236f.).

Similarly, Erim (2009b), with respect to the women's role within their families, explained that older women use to attain an improved status within family hierarchy, being relieved from the burden of work in the household, while these tasks are being taken over by their daughters and daughters in law. In due course symptoms of pain may become a means of attracting the amount of attention from other family members, which the women expect according to their age.

According to Vedat Sar's contribution to the present book (Chapter 8), illness can be the only way out for women suffering from unendurable living conditions. He also pointed out that being ill can be a means of terminating the other family members' hostility towards the patient and can be instrumental towards eliciting their support. Along similar lines, Heidi Siller has argued in Chapter 9 of this book from a gender perspective.

Turkish migrant women's living conditions in Austria have been described in some detail in Chapter 1 of this book. In the course of the interviews, which we summarized in Chapter 6, many women indicated that their husbands were reluctant to accept household chores or to share domestic responsibilities. According to Copur, Erzal, Dogan, and Safak (2010), although social and economic conditions in Turkey have changed, women still hold the main responsibility for the household.

Moreover, in migration, the husbands, with the help of their extended families frequently use to adhere to extremely conservative values and gender roles which may have been abandoned long ago in their country of origin. Thus women feel patronized and their hopes about life in Austria have been
disappointed. For them, psychological and psychosomatic illness may be the only means of expressing their wishes and of drawing attention to their needs.

Thus symptoms may be reinforced and secondarily maintained by attracting a minimum of support and understanding, and by saving the women, at least temporarily from their husbands' excessive demands. In other words, symptoms may be the only instrument of power under otherwise hopeless living conditions. Therefore, symptoms cannot readily be given up by the patients, will become resistant to change and short term interventions which do not address more complex aspects of the patients' lives will be of no avail.

5. RECOMMENDATIONS

Neither the interventions in the course of the present research, nor the group interventions by various other "western" researchers, had led to a reduction of clinical symptoms in Turkish migrants. According to the results cited above however, western therapeutic techniques per se had worked satisfactorily with Turkish patients living and treated in Turkey. Thus, when taking cultural factors in working with Turkish migrants into account, there seems to be no need to adapt the therapeutic rationale or techniques. Rather, a number of non-specific factors, which contribute substantially to therapeutic outcome should be attended to carefully:

(1) Self-Help should be replaced by regular psychotherapy (as the typical western concept cannot be understood by many patients);

(2) Individual treatment should be preferred to group treatment (issues of confidentiality, conservative understanding of psychotherapy, themes eliciting shame can be discussed more openly, enhanced feelings, no contagion and co-rumination, possible dissociation can be dealt with more professionally than in individual treatment);

(3) Treatment should last for a longer period of time and should address not only the symptom level but the patient's entire living conditions (taking effects of secondary reinforcement especially into account), possibly with a social worker's assistance;

(4) Indigenous therapists should be employed and should be perceived as competent and experienced by the patients;
Chapter 10: Synopsis and Recommendations

(5) According to conservative gender roles, a same gender therapist is recommended;

(6) At least at its early stages, the rationale of treatment should meet the patients' expectation of being healed rather than addressing self-management (according to many patients' conservative view of therapy);

(7) Therapy should address especially traumatic events encountered, should include the concept of dissociation and should also address the possibility of post-traumatic symptoms being masked by depressive ones;

(8) As the patients' current living conditions can be expected to contribute to clinical symptomatology to a large extent, at least at the beginning of therapeutic intervention in-patient treatment should be considered.

Further research might address the differential findings of the present study. We have outlined above that younger women, who at the same time had spent a longer period of time in Austria, showed an increased response to the interventions. A younger age and a longer period of stay may both contribute to a more "westernized" worldview which may have enhanced the effect. Interestingly, also a higher number of traumatic events reported were predictive of an improved outcome. This may be an artefact and could be due to the fact that younger and more westernized women may have been less reluctant to report adverse life events. While this single result should not be over-estimated, group therapy for younger and better acculturated women from Turkey with a history of traumatic stress as a supplement to psychotherapy in an individual setting could be considered as a supplementary intervention. In addition, post-traumatic stress in female migrants from Turkey should receive increased attention by future research.

6. REFERENCES


