

Somatization and psychological awareness of ethnic minority clients in Western-European mental health care: A pilot study

Marrie H.J. Bekker, PhD
Roel Schepman, MSc

Faculty of Social and Behavioural Sciences
Department of Developmental, Clinical and
Cross-Cultural Psychology
Tilburg University
Tilburg

THE NETHERLANDS

Somatization, expressing psychological distress through physical symptoms that cannot be attributed to medical illnesses^{1,2}, is a core symptom of somatoform disorders³ and presents a significant problem to clinicians^{4,5}. Prevalence rates range from 0.03%⁶ to 19.7%⁷. Immigrants, especially from less industrialized countries, are often assumed to express distress more through somatization, people from “Western” countries through psychological symptoms⁸⁻¹⁰. Such differences could seriously complicate Western health care for immigrants that usually focus on either physical or psychological health¹¹. Moreover, medically unexplained somatic symptoms are often resistant to medical treatment, and somatizing clients’ attitude towards psychosocial treatment can result in unfavourable therapy outcome¹²⁻¹⁴.

Most studies on somatization did not show significant differences between “Western” and “non-Western” clients^{2,7,15}, but others did^{16,17}, maybe due to varying ethnic groups. Moreover, most ethnic U.S.-minorities are Asian, Hispanic, or African-American, whereas those in Western Europe come from Mediterranean countries like Turkey

and Morocco¹⁸. The present pilot-study provides a first comparative indication of somatization tendencies between native clients and those belonging to European minorities.

Also, we examined the relationship of somatization in these groups with psychological mindedness (PM) and autonomy-connectedness. PM, assumed to be lacking in somatizing clients¹⁹, is the motivation and ability to explore and understand psychological processes within one-self and others²⁰, which seems relevant for successful psychological treatment²¹⁻²³. We therefore expected higher PM-levels to be positively related to higher levels of attributing symptoms to psychological causes, and lower PM to more somatic attributions. In Western-Europe and North-America, becoming an autonomous individual might be more important for personal development (and treatment) than in more “collectivistic” cultures. Autonomy-connectedness, the need and capacity for self-reliance and independence, as well as for intimacy and functioning satisfactorily in intimate relationships²⁴⁻²⁶, has three components^{24,25,27}: Self-awareness (SA; awareness of ones feelings, wishes and opinions), Sen-

sitivity of Others (SO; sensitivity of others' needs and opinions, the ability of empathy, intimacy and separation), and Capacity for Managing New Situations (CMNS; the ability to feel at ease in new situations). We expected individuals with low SA to be less inclined explaining their symptoms psychologically. As Korean, more other-directed immigrants were found to have elevated somatization levels, and those more self-directed to psychologize more²², we expected that the higher one's SO would be, the more one might somatize. This expectation was also prompted by stigma: physical illnesses seem less stigmatizing than psychiatric illnesses, and SO might also include (sensitivity to) stigma^{2,28,29}.

We tested all hypotheses in 2 patient samples (32 native Dutch, 24 ethnic minority Dutch; age 18-61) scheduled for standard intake procedures at an ambulatory mental health care institution in the South of the Netherlands. All clients presented predominantly with mood-, anxiety-, and adjustment disorders (additionally presented, e.g. somatoform, complaints were not recorded). Included in the ethnic minority group (mostly from Turkey or Morocco) were clients who, themselves and/or (one of) their parents, had not been born in the Netherlands and understood the Dutch language. They appeared lower-level educated than the native Dutch respondent; no other socio-demographic differences were found.

We measured somatization with the 13-item Symptom Interpretation Questionnaire (SIQ; subscales Psychological-, Somatic-, and Externalizing Attribution Style)^{30,31} and psychological mindedness with the 24-item Tilburg Psychological Mindedness Scale (TPMS-24; subscales: Lack of Monitoring

and Insight; Avoidance of Feelings; and Positive Attitude towards Feelings)³². Autonomy-connectedness was assessed with the Autonomy-Connectedness Scale (ACS-30; subscales SA, SO, and CMNS definitions see before)^{24,25,27,33,34}. Reliability of all scales was satisfactory, except for CMNS (ethnic minority sample), which we excluded from further analyses*.

ANCOVA on all dependent variables, controlled for education and gender, did not reveal any between-group difference (see Table I). Women compared with men scored significantly higher on SO, and a significant gender x ethnicity interaction effect appeared; with higher SO in native than in ethnic minority women, and similar SO in men of both groups.

Correlational analyses, for both samples separately (Table I), revealed positive correlations between somatic- and psychological attribution for both the native and the ethnic minority sample; both were un-correlated with externalising. PM correlated negatively with somatic attribution (both samples), but only significantly for ethnic minority clients. In native clients psychological attribution correlated negatively with SA but positively with SO. For native clients, PM was positively correlated with SA and SO; these correlations were non-significant in the ethnic minority sample.

In short, ethnic minority clients did not use a somatic, psychological, or externalising attribution style more frequently, neither showed any differences on PM, SA, and SO. The assumption that ethnic minority clients attribute somatically more often, possess less introspective ability, and tend to be more led by the expectations of other people, had to be rejected.

* All analyses were executed using SPSS (version 12.0, 2004, SPSS Inc., Chicago, Illinois).

Table I
Between Group Differences and Pearson Correlations of the Dependent Variables

	M (SD)	F Ethnicity (df)	F Gender (df)	F Ethnicity x Gender (df)	1	2	3	4	5	6
1. Somatic attribution style										
Native	1.71 (0.56)	2.46 (1.47)	3.66 (1.47)	0.12 (1.47)	1.00	0.46*	0.24	-0.23	-0.15	0.13
Ethnic minority	1.85 (0.60)				1.00	0.54*	0.35	-0.69**	-0.25	-0.37
2. Psychological attribution style										
Native	2.57 (0.67)	0.51 (1.49)	0.19 (1.49)	0.45 (1.49)	1.00	1.00	0.04	-0.05	-0.40*	0.42*
Ethnic minority	2.74 (0.63)				1.00	1.00	0.25	-0.10	0.24	-0.01
3. Externalising attribution style										
Native	2.32 (0.49)	0.03 (1.48)	0.01 (1.48)	0.10 (1.48)	1.00	1.00	1.00	0.37	0.24	0.18
Ethnic minority	2.24 (0.55)				1.00	1.00	1.00	-0.07	-0.30	0.03
4. Psychological mindedness										
Native	3.15 (0.74)	2.66 (1.48)	0.75 (1.48)	0.18 (1.48)	1.00	0.46*	0.40*	1.00	0.40	0.28
Ethnic minority	3.42 (0.47)				1.00	1.00	1.00	1.00	1.00	0.24
5. Self-awareness										
Native	3.40 (0.89)	0.32 (1.50)	0.17 (1.50)	0.18 (1.50)	1.00	1.00	1.00	1.00	1.00	1.00
Ethnic minority	3.48 (0.89)				1.00	1.00	1.00	1.00	1.00	1.00
6. Sensitivity to others										
Native	3.58 (0.83)	1.17 (1.50)	8.79 (1.50)**	4.48 (1.50)*	1.00	1.00	1.00	1.00	1.00	1.00
Ethnic minority	3.36 (0.52)				1.00	1.00	1.00	1.00	1.00	1.00

Note: means were computed if at least 75 % of the items of a subscale had a valid response. Means represent the mean score within the response range of a subscale (for variables 1 through 3 range = 1-4 and variables 4 through 6 range = 1-5).

* $p < 0.05$

** $p < 0.01$

For both the native and the ethnic minority sample, the use of somatic and psychological attribution styles were positively correlated, suggesting that for all clients somatic and psychological causes can both, simultaneously, explain the same symptoms. Maybe individuals do not differ that much in *what* causes they attribute but rather in their tendency to search for causes anyhow, regardless of their nature. Apparently, somatic and psychological attribution do not clearly represent two mutually exclusive categories of symptom presentation, supporting that somatization is dimensional rather than categorical^{35,36}.

Women's higher SO than men's agrees completely with previous findings^{24,27} as does the surprising finding of higher SO in native compared to ethnic minority Dutch women³⁴.

The remarkable correlational differences between both samples may indicate that PM, SA, and SO represent (partly) different concepts for native and ethnic minority Dutch clients. Further research with larger sample sizes should clarify these concepts' structural equivalence.

That the ethnic background of clients solely did not affect somatisation tendencies is also supported by other studies^{37,38} targeting other ethnic groups in other countries. Nevertheless, other cultural factors might influence somatisation, e.g. acculturation-related factors^{17,39}.

Study limitations hampering the generalizability of results are the rather small sample sizes, the inclusion of Dutch-speaking participants only, a rather limited ethnicity measure, and lacking information recorded on secondary diagnoses. Future research should therefore use larger, more diverse samples, and more checks and measures.

We conclude that the relationship between ethnicity and somatization is not as straightforward as commonly assumed. The dualistic vision on separate somatic and psychological health persisting also in Western-European health appeared not at all reflect clients' perspective of health; they used somatic and psychological attribution styles without one excluding the other. A priori assumptions regarding illness-representations of ethnic minority clients, understandable from possible uncertainty of therapists⁴⁰, should be avoided, e.g., by better training⁴¹.

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Address for correspondence:

Marrie H.J. Bekker, PhD
 Department of Clinical Psychology
 Tilburg University
 P.O. Box 90153
 5000 LE Tilburg
 The Netherlands
 Tel: 00-31-(0)13-4662366/2167
 Fax: 00-31-(0)13-4662370
 E-mail: m.h.j.bekker@uvt.nl