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Physical Symptoms or Somatisation? Turkish Immigrants' Experiences and Understandings of Common Mental Health Difficulties: A Systematic Review (Thematic Synthesis)

Fiziksel Semptom mu yoksa Somatizasyon mu? Türk Göçmenlerin Yaygın Ruh Sağlığı Rahatsızlıklarına İlişkin Algıları ve Tecrübeleri: Bir Sistematik Derleme (Tematik Sentez) Çalışması

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ABSTRACT

There is scarce and conflicting information on how Turkish immigrants express, experience, and understand common mental health difficulties (CMHDs) as well as their preferences and needs. This conflict often emerges in the literature around symptom presentation and the causal attributions of CMHDs. Since inconsistent information may have real life consequences for Turkish immigrants it is important to investigate this area. The aim of this review was to explore the experiences and understandings of common mental health difficulties of Turkish immigrants. A systematic review using thematic synthesis adopted from Thomas & Harden (2008) was conducted to evaluate the existing literature. CINAHL, MEDLINE, PsycArticles and PsychInfo were searched. Only qualitative studies conducted with Turkish immigrants with lived experience were included (n = 10). The analysis was data-driven (inductive) leading to three themes with twelve subthemes being generated. Participants reported experiencing both emotional and physical symptoms. They linked their distress to significant life events and chronic adverse conditions, interpersonal conflict, immigration and discrimination related problems and problematic encounters with healthcare workers. Traditional/spiritual and biological understandings of mental health were also discussed. Family and social support, personal resources, and the utilisation of medical and traditional/spiritual resources were reported as coping strategies, though some were sceptical about the latter. This review found that Turkish immigrants experienced and expressed their distress in both emotional and physical terms, just like many other communities. Their understandings were mainly psychosocial but contained elements of biomedical and traditional models. Since research in this area is limited, further and better research is recommended. Policy makers and practitioners are also advised to provide meaningful and effective care for every community, including Turkish immigrants.

Keywords: Depression, anxiety, common mental health disorders, explanatory models, causal attributions, somatisation, culture

ÖZ

Türk göçmenlerin, yaygın ruh sağlığı rahatsızlıklarını nasıl ifade ettiği, deneyimlediği, algıladığı ve bu mevzudaki tercihleri ve ihtiyaçları hakkında literatürde az sayıda ve birbiriyle çelişen çalışma bulunmaktadır. Bu çelişki genellikle tecrübe edilen semptomların ve rahatsızlıkların nedenlerinin neye bağlandığıyla ilişkilidir. Literatürdeki bu tutarsızlık Türk göçmenlere sunulan ruh sağlığı hizmetlerinde istenmedik sonuçlara yol açabilir, bu sebeple bu mevzuyu araştırmak önem arz etmektedir. Bu çalışmanın amacı, Türk göçmenlerin yaygın ruh sağlığı rahatsızlıklarına ilişkin anlayışlarını/algılarını ve deneyimlerini incelemektir. Var olan literatürü değerlendirmek üzere sistematik bir derleme çalışması, Thomas ve Harden'den (2008) uyarlanan tematik sentez tekniği kullanılarak yapılmıştır. Bu amaçla, CINAHL, MEDLINE, PsycArticles ve PsychInfo veritabanları taranmıştır. Tarama sürecinde yalnızca yaygın ruh sağlığı rahatsızlığı yaşamış Türk göçmenlerle yapılan nitel araştırmalar mevcut çalışmaya dahil edilmiştir (n = 10). Analiz tümevarım tekniğiyle gerçekleştirilmiştir. On iki alt temalı üç ana tema oluşturulmuştur. Katılımcılar hem fiziksel hem de duygusal semptomlar yaşadıklarını ifade etmişlerdir. Psikolojik sıkıntılarını, yaşadıkları önemli olaylara ve kronikleşmiş kötü yaşam koşullarına, kişilerarası geçimsizliklere, göçmenliğe ve ayrımcılığa ilişkin problemlere ve sağlık hizmetleriyle yaşadıkları sorunlara bağladıkları görülmüştür. Gözden geçirmenin içinde, geleneksel/manevi ve biyolojik anlayışlar da ayrıca tartışılmıştır. Aile desteği ve sosyal destek, kişisel beceriler ve bazılarının şüpheleri olsa da geleneksel/manevi tedavilerden ve tıbbi kaynaklardan yararlanma başa çıkma stratejileri olarak belirtilmiştir. Bu derleme Türk göçmenlerin, tıpkı başka topluluklar gibi, psikolojik sıkıntılarını hem duygusal hem de fiziksel terimler kullanarak ifade ettiklerini bulmuştur. Psikolojik sıkıntıların kökenlerine ilişkin anlayışları genel olarak psikososyaldir ama biyolojik ve geleneksel/manevi modellerden de ögeler içermektedir. Bu alanda yapılan çalışmalar kısıtlı olduğu için daha fazla ve daha iyi kalitede araştırma yapılması ve politikacılar ile uygulamacılar Türk göçmenler de dahil olmak üzere her topluluk için anlamlı ve etkili olacak ruh sağlığı hizmetleri sağlamaları önerilmektedir.

Anahtar Kelimeler: Depresyon, kaygı, yaygın ruh sağlığı hastalıkları, ruh sağlığı hastalıklarının kökenleri, bedenselleştirme, kültür

Common Mental Health Disorders/Difficulties (CMHDs) include depression, anxiety, and anxiety-based disorders (National Collaborating Centre for Mental Health, 2011). There is research indicating that immigration can be a factor contributing to susceptibility to developing mental health difficulties including CMHDs such as depression and anxiety (Amiri, 2022; Bhugra, 2004; Foo et al., 2018). In particular, various studies have shown that Turkish immigrants[1] have worse mental health presentation in host countries in comparison to host populations and/or other immigrant groups (Beirens & Fontaine, 2011; Bengi-Arslan et al., 2002; Beutel et al., 2016; Britton et al., 2000; Deisenhammer et al., 2012; Fassaert et al., 2009; Janssen-Kallenberg et al., 2017; Knipscheer & Kleber, 2005a, 2005b; Lanzara et al., 2019; Levecque et al., 2007; Lien et al., 2010; Reich et al., 2015; Sariaslan et al., 2014; Schouler-Ocak et al., 2008; Schrier et al., 2010; Small et al., 2003a, 2003b; Strohmeier & Dogan, 2012; Tydecks et al., 2009; van Bergen et al., 2010; Velthorst et al., 2012).

Even though there are six and a half million Turkish immigrants with more than five million living in Europe (Republic of Türkiye Ministry of Foreign Affairs, n.d.), there is conflicting information about their mental health conditions, needs, preferences and understandings (Eylem et al., 2016; Latif, 2009), especially for CMHDs. This lack of consistency is present in the literature on symptom presentation (how Turkish immigrants experience CMHDs) and understandings (the causal attributions) of CMHDs. This inconsistent information may have real life consequences for Turkish immigrants, such as misunderstanding their distress and needs. Therefore it is important to investigate this subject matter.

Symptom Presentation

A distinction between psychological and physical symptoms of depression and anxiety is made in the literature (National Health Service [NHS], 2018, 2019), and a person can suffer from both. Additionally, a study conducted using data from several countries suggested that the physical presentation of depression is common regardless of the country's culture and is a core part of depression (Simon et al., 1999). However, some researchers and clinicians regard Turkish migrants to be more prone to *somatisation* in comparison to their Western counterparts (Balkir, 2013; de Bruyn, 1989; Nickel et al., 2006).

1 Turkish immigrants or migrants are defined as people who are originally from Türkiye, who immigrated to other countries. This definition includes all ethnicities of Türkiye, such as Turks, Kurds and Zazas.

Somatisation is described as bodily distress caused by emotional origins (Al Busaidi, 2010). This term is used in two circumstances. In the first, the person is unable to identify their emotions and is unable to realise that they suffer psychologically. Therefore, they use somatisation as an *alternative* to convey emotional distress (Kellner, 1990). Conversion disorder, which comes under the Somatic Symptom and Related Disorders diagnostic class in DSM-5 (American Psychiatric Association [APA], 2013), is a good example of this type. The second usage simply refers to the *physical symptoms* of mental health difficulties (Simon et al., 1999), which can be seen in depression and anxiety-based diagnoses in DSM-5 (APA, 2013), and which will be the focus of this study. It is suggested in the literature that people of non-Western cultures (Balkir, 2013; Bragazzi et al., 2014; de Bruyn, 1989; Kleinman, 1977; Leff, 1988; Nakkas et al., 2019) and/or people with lower socio-economic status (Crandell & Dohrenwend, 1967; Husemann, 1997; Singer, 1975) are more likely to communicate emotional distress through somatisation. Yet, some authors and clinicians claim that Turkish immigrants somatise more in comparison to host populations. However, it is not always clear to which of the two types of somatisation they refer.

A systematic review conducted by Sempértegui and colleagues (2019) of thirteen studies with Turkish migrants regarding symptom manifestation concluded that Turkish people presented both emotional and physical symptoms of depression, and higher symptom severity, in comparison with the host population. Similar results for depression and/or anxiety were reported from the UK, Sweden, Germany and Australia (Britton et al., 2000; Hjörleifsdottir Steiner et al., 2007; Morawa et al., 2017; Small et al., 2003a). Additionally, in Switzerland, immigrants from Türkiye and Bosnia presented more psychological and psycho-social difficulties than somatic symptoms (Gilgen et al., 2005). Thus, when taking physical symptoms of CMHDs into consideration, higher somatisation rates might be explained by higher rates of depression and anxiety rather than an inability to identify and express emotions due to the cultural background.

To the researcher's knowledge, the only study which evidenced higher somatisation symptoms of CMHDs in Turkish immigrants in comparison with a Western population with empirical results was that conducted by Uluşahin and colleagues (1994). This was a comparative study carried out with British participants in Britain and Turkish people in Türkiye. The results suggested that both the British and Turkish populations reported core depression and somatisation symptoms. However, the mean rates for 'core depres-

sion' symptoms were higher in the British population, and 'somatisation' symptoms were higher in the Turkish population (Uluşahin et al., 1994). The authors commented on some characteristics of socio-economic differences between the British and Turkish samples (lower formal education rates in the Turkish sample and higher socio-economic status in the British sample), but they did not control their results using these variables (Uluşahin et al., 1994). It might therefore be possible that the difference occurred due to education levels or other socio-economic factors rather than purely due to the difference in ethnicity.

Understandings of Common Mental Health Difficulties

It has been suggested that Turkish people attribute CMHDs to socio-economic conditions, life events, personal characteristics and interpersonal conflicts (Balkir, 2013; Balkir Neftçi & Barnow, 2016; Karanci, 1986, 1993; Latif, 2009; Minas et al., 2007; Vardar et al., 2012). This is in line with a psychosocial model of understanding mental health (Beresford et al., 2016; Johnstone et al., 2018; Kinderman, 2005; Lehman et al., 2017), and biomedical understandings (Huda, 2019; Shah & Mountain, 2007) such as heredity (Leavey et al., 2007) are also reported by this population.

Previous studies have suggested that Turkish people might also adopt a traditional/spiritual model of understanding mental health difficulties (Ghane et al., 2010; Ozturk & Volkan, 1971), even if they sometimes feel sceptical about them (Bäärnhielm & Ekblad, 2000; Leavey et al., 2007). This can include *jinn* possession[2], *nazar*[3], and black magic[4] (Borra, 2011; Leavey et al., 2007; Ozturk & Volkan, 1971). However, traditional/spiritual attributions were reported much less than psychosocial and medical causes

2 In Islamic teaching, *jinn* are described as intelligent supernatural creatures which cannot be seen by the human eye. They are believed to have free will and the capacity to make ethical decisions, and are therefore seen as responsible for their actions just like humans. Some *jinn*, like humans, can choose to adopt unethical ways of living. Some Muslims believe that these immoral *jinn* can possess humans, and severe mental health difficulties, such as psychosis (Leavey et al., 2007), are sometimes understood to be a product of *jinn* possession. This understanding might be similar to a spirit-possession condition called *'zar'*, which is reported in DSM-IV as a culture-bound syndrome seen in some parts of Africa, Asia and Middle East (APA, 1998, p. 849).

3 Literally: 'the stare', which is also known as the 'evil eye'. *Nazar* means that if a person envies another person, they might unwittingly cause misfortune for the person envied. Unfortunate events, accidents, medically unexplained illnesses can sometimes be explained as the result of *nazar*. A concept called '*mal de ojo'*, which is recorded as a culture-bound syndrome in the Mediterranean countries, seems to bear a similar meaning (APA, 1998, p. 847).

4 Black magic is intentionally cast by an envious person on the victim, and this is believed to cause difficulties in the recipient's life and health. A similar understanding called '*rootwork'* in DSM-IV is reported to be seen in many countries all around the world (APA, 1998, p. 847).

amongst Turkish immigrants in Australia (Minas et al., 2007). Additionally, a study conducted with Turkish immigrants in Switzerland and Switzerland-born Swiss people showed that the Turkish migrants only agreed to the possibility of supernatural attributions when prompted (Gilgen et al., 2005). Curiously, in that study, nearly the same number of Swiss nationals (14%) as Turkish immigrants (13%) thought supernatural causes could be responsible for mental health difficulties.

People's understandings of their mental health difficulties might be fundamental in regard to engaging them with interventions (Stolzenburg et al., 2019). The model of understanding what people use to make sense of their psychological distress potentially leads them to seek treatment in accordance with the perceived causes of distress. For example, if they perceive that the cause of their illness is supernatural, they might seek help from a spiritual healer.

Even though the literature suggests that Turkish immigrants potentially have higher rates of CMHDs in comparison with host populations, how this community experiences and expresses CMHDs and what they make of these experiences have not been explored systematically. Furthermore, there are controversial arguments and findings regarding Turkish migrants' mental health. This inconsistent information may have real life consequences for Turkish immigrants such as poor or incompatible provision of service. Therefore, it is important to investigate this subject matter systematically in order to evaluate the existing literature on experiences, expressions and understandings of CMHDs, namely depression and anxiety, in Turkish immigrants from first-hand accounts. In this context, 'experiences' include not only the presentation of symptoms and how they expressed these difficulties, but also how they coped with such difficulties including help-seeking behaviours. What is meant by 'understandings' has to do with what these immigrants thought about the difficulties they encountered as well as what caused them. The study also addresses the clinical implications of the existing literature and identifies possible gaps to guide further research.

Method

Design

Thematic synthesis is used to synthesise qualitative studies in order to create an evidence base to support better quality care in healthcare research (Thomas & Harden, 2008). In this current study, the process of thematic synthesis was based on that put for-

ward by Thomas and Harden (2008) and thematic analysis (Braun & Clarke, 2006) was employed as the analytical approach.

Procedure

Systematic Literature Search

Four online databases, CINAHL Complete, MEDLINE, PsycArticles and Psych Info, were searched on the EBSCO platform. The search steps can be investigated in Table 1.

Table 1
Systematic Literature Search Steps

Databases searched	CINAHL Complete, MEDLINE with Full Text, PsycArticles and Psych Info
Dates Searched	All years (– 31 Dec 2019) Latest Search Date: 10th Jan 2020

Step no.	Search Term	Results
S1	migrant* OR immigrant* OR immigration OR migration OR minorit*	570,842
S2	Turk* OR Kurd* OR Zaza*	358,570
S3	mental AND health	1,156,058
S4	mental* AND ill*	339,927
S5	distress* OR psych* OR depress* OR anxiety* OR "obsessive compulsive disorder*" OR "OCD" OR "panic disorder*" or "generalized anxiety disorder*" OR "social anxiety disorder*" OR "social phob*" OR "low mood" OR melanchol* OR dysthm* OR "mood disorder*"	7,159,165
S6	understanding* OR perception* OR comprehension* OR apprehension* OR interpretation* OR idea* OR concept* OR experience* OR involvement OR attitude* OR view* OR narrative* OR representation* OR meaning* OR discours* OR idiom*	7,729,024
S7	S3 OR S4 OR S5	7,469,694
S8	(S3 OR S4 OR S5) AND (S1 AND S2 AND S6 AND S7)	1,524*
S9	Limit to Turkish	32
S10	Limit to English	1345
S11	Duplicates were removed on the EBSCOHOST by clicking on the last page of 'Search Results'. The remaining papers were extracted in RIS format and exported to Mendeley (Elsevier, 2019).	Tr: 32 Eng: 946
S12	Remaining duplicates were removed by hand using Mendeley	Tr: 27 Eng: 912

*147 papers were in other languages

As seen in Table 1, a systematic literature search was conducted to access all relevant published literature. For this purpose, different variations of the search terms were used, utilising the wildcard character '*' and Boolean operators 'AND' and 'OR'. Finally, the search results were limited to the languages of Turkish and English , and duplicate results were removed.

Inclusion and Exclusion Criteria

The inclusion and exclusion criteria can be examined in Table 2.

Table 2

Thematic Synthesis Inclusion and Exclusion Criteria

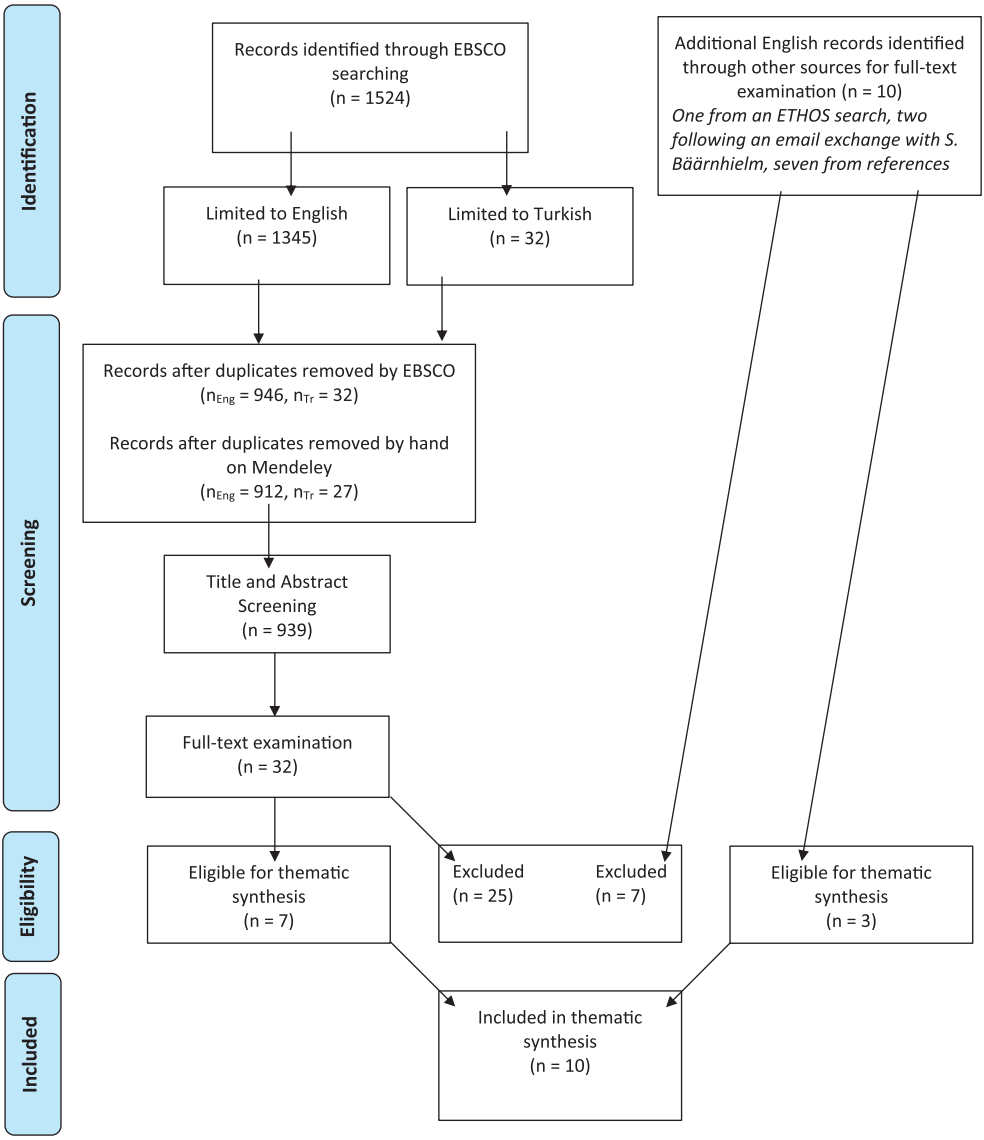
	Inclusion	Exclusion
Publication Language	English or Turkish	Published in languages other than English and Turkish
Method	Qualitative Original study Main focus is CMHDs	Quantitative Study reported in other publications Main focus isn't CMHDs
Population	Turkish immigrants with lived experience of CMHDs	Sample was Turkish people living in Türkiye In comparative study between Turkish immigrants and Turkish people living in Türkiye, the results were not reported separately Sample was migrants but not from Türkiye In studies conducted with more than one ethnic group, the results were not reported separately

Only qualitative studies conducted with Turkish-speaking immigrants who had a lived experience of CMHDs were included to ensure that rich and authentic narratives were accessed. In this context, 'lived experience' refers to people identifying themselves as having had difficulties similar to some symptoms of a common mental health disorder. A clinical assessment or diagnosis was not required; however, the interview schedules were examined to determine whether the participants had only been asked about their own difficulties. Additionally, if a study had been conducted with a different aim other than exploring the understandings and experiences of CMHDs but still included views and experiences on CMHDs, it was partially included.

Abstract and Full-Text Screening

The process of article selection can be followed in Figure 1.

Figure 1
Literature Search Flow Diagram



As depicted in Figure 1, after conducting the literature search on the EBSCO platform, the resulting records were imported into the Mendeley program. The records underwent Title & Abstract screening, followed by full-text examinations. Additionally, other potential sources were identified during this process, including papers obtained

through an ETHOS search following an email exchange with S. Bäärnhielm, and from the references of previously identified papers. Ultimately, a total of ten papers met the inclusion and exclusion criteria and were selected for thematic synthesis. An overview of these selected papers can be explored in Table 3.

Table 3

Details of Included Studies in Thematic Synthesis

Author(s) and Year	Type	Country	Analysis Method
Bäärnhielm et al., 2000	Journal Article	Sweden	Grounded theory
Bäärnhielm, 2004	Journal Article	Sweden	Grounded theory
Borra, 2011	Journal Article	Netherlands	Qualitative, no other information
Christodoulou et al., 2018	Journal Article	UK	Thematic analysis
Leavey et al., 2007	Journal Article	UK	Qualitative analysis with thematic coding
Mirdal, 1984	Journal Article	Denmark	Qualitative, no other information
Mirdal, 2006	Journal Article	Denmark	Qualitative, no other information
Sohtorik et al., 2011	Journal Article	US	Grounded theory
Taloyan et al., 2011	Journal Article	Sweden	Grounded theory
Yilmaz et al., 2000	Journal Article	Switzerland	Case formulation

Six of the studies included in the analysis had recruited participants through clinics (Bäärnhielm, 2004; Bäärnhielm & Ekblad, 2000; Borra, 2011; Christodoulou et al., 2018; Leavey et al., 2007; Yilmaz & Weiss, 2000), while the remaining four recruited participants had come from the community (Mirdal, 1984, 2006; Sohtorik & McWilliams, 2011; Yilmaz & Weiss, 2000). Two of the studies were follow-up papers conducted with the original participants (Bäärnhielm, 2004; Mirdal, 2006). The article by Christodoulou and colleagues (2018) was only partially included as it also contained a section on service evaluation. Although the participants in Leavey and colleagues (2007) were in remission from psychosis, as they had CMHDs and discussed them, the study was included in the analysis.

Quality Assessment

The quality of the selected papers was assessed using the Critical Appraisal Skills Programme (CASP) Qualitative Checklist (CASP, 2018). A table of the CASP results can be examined in Appendix A. The researcher, who is a Turkish national and a native Turkish speaker, also made quality checks on the accuracy of translations when they were reported.

The methodology of the papers was not appropriately reported in many instances, so it was not possible to identify the actual research design of half of the studies, which made evaluation of them difficult. Three of the ten articles did not report their recruitment strat-

egy and four did not report the procedure of data collection. Three did not include separate results and discussion sections and only provided minimal participant quotations. The data analysis process itself was reported in only three studies, and four did not name a specific analysis method but just reported conducting qualitative analysis (see Table 3).

Additionally, ethical issues and relationships between the researcher(s) and the participants were rarely reported rigorously (in three and two of the ten studies respectively). Almost none of them mentioned contradictory data.

Since the majority of the Turkish immigrant participants required an interpreter to participate in the studies, the accuracy of the translations was another concern. Most studies did not provide translation samples and did not detail their translation process. However, where samples were provided, many translation mistakes were easily identified by the first author of this study, who is a native Turkish speaker. This topic will be further discussed in the Discussion section.

Despite some methodological problems, the studies offered rich information. To manage the methodological shortcomings, the researcher evaluated the results of the studies and the interpretation of the authors with caution.

Data Analysis

The included papers were exported to the NVivo 12 software. In line with the recommendations of Thomas and Harden (2008), the researcher familiarized herself with the data by reading and re-reading the studies. The data were considered as the 'results' or 'findings' of the studies, including participant quotations and author interpretations. If there was no section labelled 'results', the researcher collected the data from the sections in which the participants' narratives were presented. Initial coding of the data was carried out inductively. Subsequently, the codes were synthesized into sub-themes, then from sub-themes into broader, analytical themes using thematic analysis (Braun & Clarke, 2006) as the analytical approach. These themes were then presented in the Results section in a narrative format. Since the study is a thematic synthesis, direct source material was not presented in the report with the exception of a few very striking illustrative quotes.

Results

Demographics

In the ten studies, 203 interviews were conducted with 147 participants; 56 interviews were from two follow-up studies (Bäärnhielm, 2004; Mirdal, 2006). Authors re-

ferred to participants as 'Turkish and Kurdish' and did not report specific ethnicity, apart from Taloyan and colleagues (2011) who exclusively interviewed Kurdish men. Table 4 summarises other demographic information about the sample.

Table 4
Thematic Synthesis Sample Information

		Number (percent)
Gender	Female	114 (78.6%)
	Male	33 (22.4%)
Sampling	Community	101 (68.7%)
	Clinics	46 (31.3%)
Residence	Denmark (1 study, 1 follow-up)	72 (48.9%)
	Sweden (2 original studies, 1 follow up)	27 (18.4%)
	Netherlands (1 study)	20 (13.6%)
	UK (2 studies)	15 (10.2%)
	US (1 study)	12 (8.1%)
	Switzerland (1 case report)	1 (0.6%)
Total		147 (100%)

As shown in Table 4, the majority of the participants were female who had been recruited from the community and who resided in Denmark. This was mainly due to the fact that Mirdal's (1984) original study recruited 72 women, which is a significantly larger number of participants compared to the other studies.

Thematic Synthesis

Three themes were identified incorporating twelve sub-themes. Table 5 below offers a summary of the themes and sub-themes.

Table 5
Thematic Synthesis Themes and Sub-Themes

Themes	Sub-Themes
Symptom Presentation	Physical
	Emotional
	Unusual
Causes and Sources	Life events and situational circumstances
	Family and social life
	Immigration and the host country
	Problematic encounters with healthcare
	Traditional and medical understandings of causes
Coping	Family and social support
	Personal resources
	Traditional resources
	Help from healthcare

Table 6

Comparison of Included Studies by Sub-Themes

	Bäärnhielm et al., 2000	Bäärnhielm, 2004	Borra, 2011	Christodoulou et al., 2018	Leavey et al., 2007	Mirdal, 1984	Mirdal, 2006	Sohtorik et al., 2011	Taloyan et al., 2011	Yilmaz et al., 2000
Presentation										
Physical	*	*	*	*	*	*	*			*
Emotional	*	*	*	*	*	*	*	*	*	*
Unusual	*		*		*	*	*			
Causes and Sources										
Life Events and Situational Circumstances	*		*		*	*	*	*		*
Family and Social Life	*	*		*	*	*	*	*		*
Immigration and Host Country		*			*	*	*	*	*	*
Problematic Encounters with Healthcare	*	*		*	*			*		*
Traditional and Medical Understandings	*	*	*		*		*			*
Coping										
Family and Social Support	*	*		*	*	*	*	*	*	*
Personal Resources	*	*		*	*	*	*	*	*	
Traditional Resources	*				*					*
Help from Healthcare	*	*		*	*		*	*		

As the aims and research questions of the studies were diverse, not every paper contributed to each theme or sub-theme. Table 6 shows which papers contributed to which sub-themes in a graphic format and can be investigated for further information.

Theme 1: Symptom Presentation

Studies extensively reported physical and emotional difficulties. Mirdal (1984) reported that participants adopted imaginative methods for explaining their distress. For example a Kurdish woman told her life story in a song which she had written. Christodoulou and colleagues (2018) suggested that participant narratives did not necessarily differentiate between different types of symptom presentations. See Appendix B to investigate a cross-comparison of the reported presenting difficulties in detail.

Physical. Physical difficulties were extensively reported except by Sohtorik and McWilliams (2011) and Taloyan and colleagues (2011). Some participants framed their difficulties as "[the] body is protesting" (Bäärnhielm & Ekblad, 2000, p. 445) or "failure of the body" (Leavey et al., 2007, p. 268).

> *The body has certain limits of endurance. For example, the human being is long-suffering with her wisdom and ideas, but the body cannot endure. We have this problem that the body cannot cope* (Bäärnhielm & Ekblad, 2000, p. 439, participant quote).

Bäärnhielm (2004) suggested that anxiety carried more of a somatic meaning for participants before they received support from psychiatric clinics. Mirdal (2006), who conducted a follow-up study with the same participants twenty years after the original research (61% of the initial cohort attended), suggested that fewer somatic complaints were reported in the second study. Mirdal (2006) interpreted this as a result of major improvements in social, psychological and physical aspects of their lives as well as how they utilised help from health and social care systems, including understanding their symptoms and effectively managing them. Mirdal (2006) also stated that the participants presented as being more depressed than anxious in the follow-up study.

It was reported that participants talked about bodily sensations such as pain (Bäärnhielm, 2004; Bäärnhielm & Ekblad, 2000; Borra, 2011; Christodoulou et al., 2018; Leavey et al., 2007; Mirdal, 1984, 2006; Yilmaz & Weiss, 2000), tingling (Borra, 2011), sweating (Leavey et al., 2007), trembling (Mirdal, 1984), and feeling cold (Mirdal, 1984, 2006).

Symptoms related to heart (Bäärnhielm & Ekblad, 2000; Borra, 2011; Leavey et al., 2007; Mirdal, 1984), fatigue (Bäärnhielm, 2004; Bäärnhielm & Ekblad, 2000; Leavey et al., 2007; Mirdal, 2006; Yilmaz & Weiss, 2000), sleep difficulties (Bäärnhielm, 2004; Leavey et al., 2007; Mirdal, 2006; Yilmaz & Weiss, 2000) including bad dreams (Mirdal, 2006), and forgetfulness (Bäärnhielm & Ekblad, 2000; Christodoulou et al., 2018) were also reported.

Additionally, some participants attributed the physical difficulties which they were experiencing to physical illnesses, such as hypertension (Bäärnhielm & Ekblad, 2000), rheumatoid arthritis (Borra, 2011; Mirdal, 2006), and taking psychotropic medication (Leavey et al., 2007).

Emotional. All the included studies reported an extensive range of emotional difficulties, involving feeling low and anxious in differing severities. Experiences which are labelled in DSM-5 as 'symptoms of depression' (APA, 2013), such as lack of interest or pleasure and feelings of emptiness (Leavey et al., 2007; Mirdal, 2006; Yilmaz & Weiss, 2000), deprecating thoughts about self and capabilities such as feelings of uselessness and worthlessness, shame and guilt, and suicidal thoughts were reported (Bäärnhielm & Ekblad, 2000; Borra, 2011; Christodoulou et al., 2018; Leavey et al., 2007; Mirdal, 1984, 2006; Sohtorik & McWilliams, 2011; Taloyan et al., 2011; Yilmaz & Weiss, 2000). Other unpleasant emotions, such as disappointment, resentment, regret, frustration, and loneliness were also mentioned (Bäärnhielm & Ekblad, 2000; Leavey et al., 2007; Mirdal, 1984, 2006; Sohtorik & McWilliams, 2011). Some studies also reported low amounts of tolerance, and subsequently becoming angry, tearful or easily overwhelmed (Bäärnhielm, 2004; Bäärnhielm & Ekblad, 2000; Borra, 2011; Christodoulou et al., 2018).

Additionally, two different kinds of experience with their own specific names were mentioned. First, Mirdal (1984, 2006) gave a long account of *sıkıntı*[5] which was brought up by participants several times and translated as 'tightness'[6], and Borra (2011) also briefly mentioned it. Mirdal (1984) reported that it also had connotations in somatic experiences, such as tightness in the chest, feeling cold and a pounding heart.

5 The Turkish word *sıkıntı*, which means 'psychological distress', comes from the word *sık-mak*, which means 'tightening' and 'squeezing' (Türk Dil Kurumu, 2019a, 2019b). *Sıkıntı* refers to the condition of being emotionally unwell; a continuous tiredness and trouble which goes hand-in-hand with feelings of boredom, suffering and torment (Türk Dil Kurumu, 2019a). This word is also used in different formats to describe one's emotional state in the Turkish language.

6 The researcher considers 'distress' to be a better counterpart for what *sıkıntı* stands for.

The second condition, *yurek kalkinmasi*, was reported by Bäärnhielm and Ekblad (2000) from a participant who explained how the words 'stress' and 'anxiety' which she had heard from a doctor did not really fit her experience, but this term did. This condition (under the name of *yürek kalkması*[7]) is known in Türkiye, although its use is not as widespread as *sıkıntı* (PempeeMavii, 2016; Ucaolimbera, 2011).

Unusual Experiences. Four studies reported some unusual presentations even though only one of them had a sample with psychosis in remission (Leavey et al., 2007). Hearing and seeing things which other people cannot, tactile experiences and feelings of persecution were reported (Borra, 2011; Leavey et al., 2007; Mirdal, 1984, 2006).

In addition to the above, two particularly unusual experiences were conveyed. Bäärnhielm and Ekblad (2000) described a woman having an attack, which could have been interpreted as a dissociative experience. Additionally, Borra (2011) reported a woman's account of feeling that she was being pushed down by a goblin-like creature while falling asleep, making breathing extremely difficult. This experience is sometimes called *karabasan* in Turkish communities.

Theme 2: Causes and Sources

Participant narratives reported in the studies did not necessarily identify one single traumatic event or condition as the only cause. Instead, their difficulties were reported as related to or caused by an accumulation of adverse events (Bäärnhielm & Ekblad, 2000; Borra, 2011; Leavey et al., 2007; Mirdal, 1984). For example, Bäärnhielm and Ekblad (2000) stated that the onset of symptoms was often reported parallel to life events and distressing circumstances. However, they also argued that the causal attributions remained 'poor' as direct connections between causes and their illness were rare.

> *I don't know what caused the pain. I cannot say anything about that, if it is the weather here in Sweden, or if it is the air, or if it is because we have worked all the time? I don't understand why it has got this way. I have worked, I have six children, I have worked the whole time, if that is the reason, I don't know?* (Bäärnhielm & Ekblad, 2000, p. 440, participant quote).

Life Events and Situational Circumstances. Even though the participants formulated their psychological difficulties in terms of resulting from multiple factors, many participants linked the onset of their difficulties with single life events or chronic unfavourable situational circumstances. Adverse life experiences, such as unmet needs

7 Literal translation: 'rising of the heart'

during childhood (Leavey et al., 2007), accidents and traumatic childbirths (Bäärnhielm & Ekblad, 2000), separations and bereavements including the loss of loved ones (Bäärnhielm & Ekblad, 2000; Borra, 2011; Leavey et al., 2007), being subjected to physical abuse by others (Borra, 2011; Leavey et al., 2007) and witnessing violence (Leavey et al., 2007) were reported.

Chronic adverse conditions such as employment and workplace problems (Bäärnhielm & Ekblad, 2000; Leavey et al., 2007; Mirdal, 1984, 2006; Sohtorik & McWilliams, 2011; Yilmaz & Weiss, 2000) and poor living conditions such as inadequate housing (Bäärnhielm & Ekblad, 2000; Mirdal, 1984) were also reported in some of the studies. Social demands, like the double burden of responsibilities on women who had both domestic and work-related tasks to fulfil (Bäärnhielm & Ekblad, 2000; Mirdal, 1984) and ill health were also mentioned as possible initiators of emotional difficulties (Bäärnhielm & Ekblad, 2000; Mirdal, 1984, 2006).

Family and Social Life. Difficult relationships or the lack of family support or social connections were another source of distress cited by the studies. Marital problems (Bäärnhielm & Ekblad, 2000; Leavey et al., 2007; Mirdal, 1984, 2006; Sohtorik & McWilliams, 2011), inter-generational conflicts (Mirdal, 1984, 2006), concern about meeting the expectations of the family and community (Bäärnhielm & Ekblad, 2000; Mirdal, 2006; Yilmaz & Weiss, 2000) and worries about children and childcare were often reported (Bäärnhielm & Ekblad, 2000; Mirdal, 2006).

Family members' poor understanding of a participant's difficulties was another source of conflict (Christodoulou et al., 2018; Leavey et al., 2007; Yilmaz & Weiss, 2000). Some people were reported to have chosen to conceal their difficulties from people outside the immediate family (Bäärnhielm & Ekblad, 2000; Borra, 2011; Christodoulou et al., 2018) or in some cases from the immediate family as well (Bäärnhielm & Ekblad, 2000; Leavey et al., 2007). Some socially isolated themselves so that others would not know their mental health difficulties (Bäärnhielm & Ekblad, 2000; Christodoulou et al., 2018) whilst others were actively rejected and ostracized by their social networks when they shared their problems (Bäärnhielm, 2004).

Other within-community difficulties, such as gossip and unfair treatment by Turkish bosses and Turkish landlords, reportedly caused a lack of trust between Turkish immigrants (Bäärnhielm, 2004; Mirdal, 1984; Sohtorik & McWilliams, 2011). Cultural dif-

ferences between different Turkish communities were also highlighted (Sohtorik & McWilliams, 2011). It seemed that balancing the relationship with the Turkish community was quite important as having less contact with other Turkish immigrants caused more isolation, but also less gossip leading to less harm (Mirdal, 1984).

Immigration and the Host Country. Many studies reported adjustment and acculturation difficulties for the Turkish immigrants (Mirdal, 1984, 2006; Sohtorik & McWilliams, 2011). Alienation and the feeling of not belonging to either country (Taloyan et al., 2011), homesickness and second thoughts about immigration (Sohtorik & McWilliams, 2011) were highlighted. Regarding the latter, there were reports of not wishing to invest in, or adjust too much to, the resident country as they were uncertain about living there permanently (Sohtorik & McWilliams, 2011). For instance, some did not learn the language of the host country (Taloyan et al., 2011). On the other hand, others felt as if they were not wanted and not valued, and felt insecure in the host country (Mirdal, 1984, 2006; Taloyan et al., 2011; Yilmaz & Weiss, 2000). Confusion around the social cues of host societies was reported. Mirdal (1984) explained how these immigrants had to learn the implicit structures of the new society in which they found themselves.

> *You never know the meaning of a smile on Danish lips* (Mirdal, 1984, p. 994, participant quote).

Racism and discrimination in housing and job-seeking, prejudice against their ethnicity, and how the host country's media depicted their ethnicity were among the other problems which created psychological distress (Mirdal, 1984; Taloyan et al., 2011). The narratives suggested that some participants internalised racism and tried to keep a low profile (Mirdal, 1984).

Practical life challenges which were brought by immigration were among the other sources of distress. These included language problems and related job-finding difficulties, difficulty in establishing new relations, restrictions caused by being an undocumented immigrant such as access to healthcare, obtaining a driving license and travel restrictions (Bäärnhielm, 2004; Leavey et al., 2007; Mirdal, 1984; Sohtorik & McWilliams, 2011; Yilmaz & Weiss, 2000).

The difference between the climate of Türkiye and that of the host country, often from a warm to a cold climate, was another concern reported (Bäärnhielm & Ekblad,

2000; Yilmaz & Weiss, 2000). Additionally, the lack of food which suited their taste was at times referred to as a possible cause for psychologically feeling unwell (Yilmaz & Weiss, 2000). It was also reported that the psychological symptoms either started or worsened after immigration (Mirdal, 1984; Yilmaz & Weiss, 2000).

Problematic Encounters with Medical Systems. Challenges with healthcare systems were reported as a source of distress (Bäärnhielm, 2004; Bäärnhielm & Ekblad, 2000; Christodoulou et al., 2018; Leavey et al., 2007). Participants described practical challenges such as confusion around how the services work (Christodoulou et al., 2018), long waiting lists (Bäärnhielm, 2004; Christodoulou et al., 2018), finding the jargon of the health system hard to understand (Bäärnhielm & Ekblad, 2000) and not having access to Turkish-speaking therapists (Sohtorik & McWilliams, 2011). For people in the USA, medical help either did not exist or was too expensive (Sohtorik & McWilliams, 2011).

Medication-related problems (Bäärnhielm, 2004; Leavey et al., 2007) and problems related to psychological therapies (Christodoulou et al., 2018) were also raised. Participants criticized short-term (six sessions) Cognitive Behavioural Therapy as too structured to be meaningful and too short to be effective. They also reported that they sometimes felt abandoned after discharge (Christodoulou et al., 2018).

Another major point was that participants felt that Health Care Professionals (HCPs) did not collaborate with them (Bäärnhielm, 2004; Christodoulou et al., 2018; Leavey et al., 2007; Yilmaz & Weiss, 2000). In Bäärnhielm's (2004) study, participants described how they were sent to psychiatry by the GP without any explanation, were prescribed psychotropic medication without any consultation, were not listened to when they raised concerns regarding medication, and in some cases, were forced to receive psychiatric intervention. Participants also reported that patients' understandings of the illness were not taken into account regarding their treatment (Bäärnhielm, 2004; Leavey et al., 2007; Yilmaz & Weiss, 2000).

> *They (English doctors) are only interested in symptoms* (Leavey et al., 2007, p. 264, participant quote).

Negative experiences with HCPs prevented participants expressing themselves (Bäärnhielm, 2004; Bäärnhielm & Ekblad, 2000) and asking for help (Christodoulou et

al., 2018). It was also reported that when discussing their difficulties with HCPs, some participants refrained from using the words they would typically use to describe their difficulties, so as to prevent being misunderstood by the HCPs (Bäärnhielm & Ekblad, 2000; Leavey et al., 2007). Some felt that they were not trusted by HCPs because they were immigrants, and discriminatory views by HCPs towards minorities were noted (Bäärnhielm, 2004). Additionally, some struggled to trust the information given by HCPs, but it seemed like they did not have the epistemological power to challenge that.

> *They call it anxiety. I do not know. I believe that it is. As I do not have any other choice, I have to believe in what they say* (Bäärnhielm & Ekblad, 2000, p. 445, participant quote).

Traditional and Medical Understandings of Causes. In a number of studies, participants reported some traditional understandings of their difficulties (Bäärnhielm & Ekblad, 2000; Borra, 2011; Leavey et al., 2007; Mirdal, 2006; Yilmaz & Weiss, 2000). Spells/magic (Leavey et al., 2007; Yilmaz & Weiss, 2000), the evil eye (Bäärnhielm & Ekblad, 2000; Leavey et al., 2007; Yilmaz & Weiss, 2000), and *jinn* possession (Borra, 2011; Leavey et al., 2007; Mirdal, 2006) were stated as some of the possible explanations for ill health and psychological distress. However, the participants also reported being sceptical of traditional/spiritual explanations (Borra, 2011; Leavey et al., 2007; Mirdal, 2006) despite trying some remedies such as amulets suggested by *hocas*[8] (Borra, 2011; Leavey et al., 2007; Yilmaz & Weiss, 2000). Leavey and colleagues (2007) reported that some believed in black magic or the evil eye as concepts but did not think that their problems stemmed from them. Another important point highlighted in some studies was that many perceived their illness to be their fate, that it was sent by God and had to be accepted, and that a cure must be sought by the ill person (Bäärnhielm, 2004; Borra, 2011; Leavey et al., 2007; Yilmaz & Weiss, 2000).

> *Of course this is because of God. I mean, God gives you these problems but he also gives remedy. I now have these problems but there are also hospitals. I know that I have these problems as a result of stress, depression, accumulation, but I also know that they will make me feel better* (Leavey et al., 2007, p. 264, participant quote).

Additionally, heredity was highlighted by some participants in Leavey and colleagues' (2007) study. Some made links between their difficulties and their ancestors' experiences, for example saying their father also had 'weak nerves'. Furthermore, an-

8 *Hoca* means teacher in Turkish and can be used with or without Islamic connotation. Islamic *hoca*s, on top of their formal or informal teaching roles, can act as clergy and offer religious advice.

other participant used the absence of mental ill health in their lineage as evidence to underline the impact of traumatic and disruptive life events on their difficulties (Leavey et al., 2007). Unknown diseases and stress were also cited as possible explanations (Bäärnhielm & Ekblad, 2000).

The participants' narratives suggested that they did not hold one model of understanding over another, but instead they welcomed different explanations that made sense for them. For example, one participant who had initially thought that she was grieving for her deceased sister accepted the diagnosis of depression, but not anxiety (Bäärnhielm, 2004, p. 50).

Theme 3: Coping

This theme incorporates the narratives of survival. The studies indicated a variety of resources adopted by the participants, including support from family and social circles, personal resources such as self-management strategies, traditional/spiritual resources, and utilising healthcare in the host countries. These are detailed below.

Family and Social Support. In several studies, participants reported having support from family and friends. This constituted practical support, such as help with childcare (Bäärnhielm & Ekblad, 2000), taking the first steps of seeking medical help (Christodoulou et al., 2018; Leavey et al., 2007), help with finances (Yilmaz & Weiss, 2000), and emotional support (Bäärnhielm, 2004).

Additionally, participants reported that it helped them to cope better when they felt connected to the Turkish community in the host country (Mirdal, 1984, 2006; Sohtorik & McWilliams, 2011) and when they felt a part of the host country (Taloyan et al., 2011). Political refugees also talked about the positive effect of having 'a sense of freedom' to be themselves and of working for their own self and wellbeing (Taloyan et al., 2011).

Personal Resources. Acceptance (Bäärnhielm, 2004; Taloyan et al., 2011), taking responsibility for their own recovery (Bäärnhielm, 2004), positive thinking (Bäärnhielm & Ekblad, 2000; Christodoulou et al., 2018), giving less importance to bodily symptoms (Mirdal, 2006), self-soothing by talking to oneself (Bäärnhielm, 2004; Sohtorik & McWilliams, 2011), self-determination (Bäärnhielm, 2004; Bäärnhielm & Ekblad, 2000; Mirdal, 1984; Taloyan et al., 2011), having a meaningful identity (Taloyan et al., 2011), taking a break by resting and pursuing a calm life (Bäärnhielm & Ekblad, 2000) were all cited as

personal resources. Some participants reported contemplating their difficulties through their faith system, Islam, as an acceptance strategy (Leavey et al., 2007).

Activities which were meaningful to the participants, such as praying (Bäärnhielm & Ekblad, 2000), carrying out everyday chores (Christodoulou et al., 2018), and pleasurable activities (Bäärnhielm, 2004; Christodoulou et al., 2018) were also underlined. Some had adopted these activities on the recommendation of HCPs.

However, participants in Bäärnhielm and Ekblad's (2000) study considered personal resources to be of limited value and stated that if their external circumstances had not changed for the better, self-management strategies would have offered limited benefit.

Traditional Resources. Some studies reported participants encountering traditional/spiritual healing techniques. These were sought before (Bäärnhielm & Ekblad, 2000) Western medicine or as complementary to it (Bäärnhielm & Ekblad, 2000; Yilmaz & Weiss, 2000). Three different types of traditional/spiritual treatments were reported. First, those which were performed by *hoca*s to break a spell or the influence of the evil eye (Bäärnhielm & Ekblad, 2000; Leavey et al., 2007; Yilmaz & Weiss, 2000). They prayed for the participants, or sometimes prayed into water and gave it to participants to sprinkle onto themselves or to drink (Leavey et al., 2007). Preparing a *muska* (an amulet) for the participant to wear or keep under a pillow was also mentioned (Bäärnhielm & Ekblad, 2000; Leavey et al., 2007; Yilmaz & Weiss, 2000). Second, interventions such as cupping, massages and tractions conducted by folk healers or naturopaths were also reported (Bäärnhielm & Ekblad, 2000). Third, giving strength to the body by keeping it warm through going to Türkiye for warm weather or thermal springs were cited (Bäärnhielm & Ekblad, 2000). Participants reported different outcomes. Some said that this did not help (Leavey et al., 2007; Yilmaz & Weiss, 2000), but others found it helpful.

Help from Healthcare. Participants in two studies expressed mixed feelings about getting help from the local (Western) healthcare system (Bäärnhielm, 2004; Bäärnhielm & Ekblad, 2000; Christodoulou et al., 2018). Some were hopeful about help from statuary mental healthcare whereas others were doubtful about its efficacy (Bäärnhielm & Ekblad, 2000; Christodoulou et al., 2018). Nevertheless, some studies reported that participants benefitted from mental health care (Bäärnhielm, 2004; Bäärnhielm & Ekblad, 2000; Christodoulou et al., 2018; Mirdal, 2006). Bäärnhielm and Ekblad (2000) reported some change in participants' understandings of their difficulties when they had re-

ceived help from psychiatric services. According to the authors, this led to an increase in their self-esteem regarding dealing with their problem and subsequently to feeling less stigmatized. Participants also received psychoeducation which they regarded as positive learning. Medication was found helpful by those who adhered to it, but fears around dependence on medication were also raised (Bäärnhielm, 2004).

The importance of a good relationship with HCPs was often highlighted; trusting HCPs and feeling believed by them was suggested as an essential aspect of a good outcome. Participants appreciated when HCPs offered time and urgent appointments as needed and believed that they had pain (Bäärnhielm, 2004; Bäärnhielm & Ekblad, 2000). It seemed that participants felt included, valued and remembered by such HCPs, and the 'human' part of psychiatric care was stressed.

A similar concept was also present in the findings of Christodoulou and colleagues (2018) when former users of an Improving Access to Psychological Therapies service were interviewed. The participants stated feeling a sense of 'relief' following interactions with their therapists.

Discussion

Despite more than six million Turkish immigrants living outside their home country (Republic of Türkiye Ministry of Foreign Affairs, n.d.), the information about how they understand, experience and express CMHDs has been scarcely studied. Furthermore, the existing literature contains conflicting information, especially around how CMHD are experienced, expressed (symptom presentation), and understood (casual attributions). To systematically investigate the experiences and understandings of CMHDs of Turkish immigrants, this study included 10 original qualitative studies.

Three themes were generated with a total of twelve sub-themes. The first theme 'Presentation' covered how Turkish immigrants experience and express CMHDs. The results suggest that Turkish immigrants express psychological difficulties in both emotional and physical terms. In fact, as can be seen in Appendix B, Turkish immigrants frequently use emotive language. Considering that CMHDs affect both the physical and the emotional domains (APA, 2013; National Health Service [NHS], 2018, 2019; World Health Organization [WHO], 2019), it should not be a surprise that the Turkish immigrant population suffers from both. This finding is consistent with various quantitative

studies where Turkish immigrants were found to have not only higher rates of physical symptoms but also higher rates of emotive symptoms in comparison to native populations in the host countries (Britton et al., 2000; Hjörleifsdottir Steiner et al., 2007; Morawa et al., 2017; Sempértegui, 2017; Small et al., 2003a).

However, this finding is inconsistent with the other claim in the literature, the 'somatisation hypothesis' (Beirens & Fontaine, 2011; Bragazzi et al., 2014; Lanzara et al., 2019), which argues that people of non-Western cultures, including Turkish immigrants, tend to experience their psychological difficulties physically more than Western people. When one considers the reasons for the popularity of somatisation hypothesis (Balkir, 2013; de Bruyn, 1989; Morawa et al., 2017; Nakkas et al., 2019), despite the lack of empirical evidence, several possible reasons come to mind. First, it could be linked to a tendency to overgeneralise findings. For instance, Nickel and colleagues (2006) suggested that Turkish immigrants "rarely view(ed) ... linking bodily symptoms to emotional distress helpful" (p. 507-8) and they referenced this claim to Bäärnhielm and Ekblad (2000). However, Bäärnhielm and Ekblad's (2000) participant sample consisted of ten Turkish immigrant women who were diagnosed with a somatic disorder, so their experiences may not be representative of all Turkish immigrants. There were also other studies in which claims supporting the somatisation hypothesis were not verified by evidence (Balkir, 2013; de Bruyn, 1989), but they were still considered as being generally true of the entire population.

Second, the design of the studies might not have taken all the relevant factors into consideration. For example, there is strong evidence indicating that, in comparison to host populations and/or other immigrant groups, Turkish immigrants not only score higher on somatisation/physical symptoms, but also on emotional symptoms. Thus, the higher somatisation rates in Turkish communities could be a result of the severity of common mental health difficulties rather than being an indication of a greater tendency to somatise. If a study does not take emotional symptoms into consideration and focuses solely on the physical symptoms of CMHDs, the analysis and/or interpretation might not represent the whole picture. Additionally, not taking other factors, such as socio-economic circumstances, into consideration may also lead to incorrect interpretation.

Third, quality of translation could be a factor. Many of the studies conducted on Turkish immigrants relied on interpretation from Turkish into the host language, and

nuances might have been lost during translation and misunderstandings might have occurred. Even though it was not possible to fully assess the translation/interpretation quality of all studies as examples were not always provided, some authors helpfully offered samples from their translations. This allowed the first author of this study, who is a native Turkish speaker, to identify many translation mistakes. For example, interviewers in Borra's (2011) study were instructed to ask their participants a question in Turkish ("Ic dengen nasil?", p. 665), thinking this would mean "How are you feeling?" in Turkish. Unfortunately, this phrase is quite meaningless in daily Turkish. Bäärnhielm and Ekblad (2000) reported sharing similar concerns on translation accuracy. During the translation process of their research they realised that participants' emotional language had not always been translated accurately. They also wondered about the possibility of such errors in clinical appointments and whether this contributed to a somatisation diagnosis.

Fourth, the researchers might have held elitist/racist views against Turkish immigrants (Small et al., 2003a) which is linked to 'strategic ignorance' (Bailey, 2007). This concept relates to implementing wilful ignorance by making a conscious choice to overlook epistemological flaws to support and maintain particular social and political agendas (McPherson et al., 2020).

Additionally, the present review found that although low in frequency, unusual experiences known as hallucinations, delusions and dissociative experiences were also experienced by Turkish immigrants, and not just by those diagnosed with psychosis. This is consistent with the findings of previous studies in which psychotic-like difficulties were reported to be experienced by some non-clinical samples (Selten et al., 2020; van Os et al., 2009).

The second theme, 'Causes and Sources', included the understanding of CMHDs in terms of what the Turkish immigrants thought caused their psychological difficulties and what kept them going. The findings suggest that Turkish immigrants made links between their mental health difficulties and adverse life events, living conditions, difficult relationships, discrimination by the host country, the hereditary nature of CMHD related difficulties, and the effects of unknown diseases. This might suggest that they adopt and utilise the psychological, social, and medical models of understanding of mental distress. This finding is in line with the wider literature which indicates that

bio-psycho-social explanations of mental health difficulties (Herzog & Schmahl, 2018; Huda, 2019; Read et al., 2005; SAMHSA, 2014), including the impact of immigration, are adopted by several different communities (Kamperman et al., 2007; Moussaoui & Agoub, 2010; Thomas & Gideon, 2013).

The traditional/spiritual explanations of difficulties were also acknowledged, though generally with some scepticism. This finding seems to be in line with the results of two quantitative studies conducted in Australia (Minas et al., 2007) and Switzerland (Gilgen et al., 2005), in which Turkish individuals reported traditional attributions much less than natural ones.

Furthermore, suspicion was not reserved solely for traditional/spiritual methods. Encounters with mental health care systems also became a source of difficulty because participants complained about a lack of communication between the HCPs and themselves. This is consistent with the results of a qualitative study that was conducted with Turkish immigrants in London, UK (Latif, 2009) and a wider review which indicated that ethnic minority people are given poorer care than their "White British" counterparts in the UK (Bignall et al., 2019). Furthermore, there is research indicating that many service users, with or without ethnic minority backgrounds, report problematic behaviour towards patients by HCPs and call for better mental health services for all (Koschorke et al., 2021; Rogers & Pilgrim, 1993; Trevillion et al., 2022; Wallcraft & Bryant, 2003).

Lastly, the third theme, 'Coping', showed that Turkish immigrants reported a wide range of coping strategies including family and social support, personal resources, traditional/spiritual resources and help from formal healthcare settings. A systematic review by Leamy and colleagues (2011) found that in 75 out of 87 studies, people from black and other ethnic minority origins identified human relationships as part of their mental health recovery. The same article also identified personal resources, such as positive thinking, rebuilding a meaningful identity, finding meaning through spirituality, and taking actions as part of their recovery journey as coping strategies, which were also highlighted by the present study. Additionally, in line with the present study's findings, in their comparative quantitative study, Latif (2009) found that the Turkish immigrant sample showed no significant difference in terms of 'psychological openness' in comparison with the White-British participants. Additionally, the Turkish sample were found to be slightly more open to seeking help and being indifferent to mental health stigma.

Furthermore, a quantitative study conducted in Germany indicated that Turkish immigrants sought help from formal settings and found it as useful as the native population did (Vardar et al., 2012). A study in the Netherlands reported similar results and indicated that help-seeking behaviours in a Turkish migrant sample were more related to socio-economic status than ethnicity, and involving traditional healers in the treatment process was very rare (Knipscheer & Kleber, 2005a). Studies conducted in Iran, Switzerland and the Netherlands have also suggested that Turkish immigrants perceive formal mental health care as a strategy for dealing with mental health distress (Dejman et al., 2008; Gilgen et al., 2005; Kamperman et al., 2007). However, there is also evidence that Turkish migrants are often unwilling to seek help from formal resources (Balkir, 2013; Eylem et al., 2016; Flink et al., 2013, 2014; Mahintorabi et al., 2017) even when the support from social networks is absent or inadequate (Schoenmakers et al., 2017).

The current study has some limitations. A qualitative systematic review can be theory- or data-driven (Dixon-Woods et al., 2005) and the present review was a data-driven (inductive) one. Even though the reviewer made a conscious effort (by seeking regular supervision from her supervisors/co-authors) to adopt a reflexive approach, it might not have always been possible to overlook theories implemented by the authors of the papers (McPherson & Armstrong, 2012), and to put aside her own assumptions as a Turkish national.

The majority of the articles had methodological shortcomings as presented in Appendix A. The most common were around design, data analysis and ethical issues, as most of the studies did not report their design and data analysing strategies in sufficient detail and did not mention whether they had sought ethical approval for their studies. Furthermore, a minority of articles failed to offer clear findings or clearly report the recruitment strategy. Additionally, the papers had different research questions and aims, so not all the papers provided information applicable to all the aims of this review. They also used different qualitative methodologies. Finally, this systematic review is conducted with a small body of literature due to the scarcity of research in the area and focused only on CMHDs and no other mental health conditions, which may also impact the conclusions drawn.

Despite these limitations, several valuable points can be made based on the findings. Additionally, to the researcher's knowledge, this is first time that the question of how Turkish people express and understand their common mental health difficulties has been reviewed systematically by including all relevant literature.

Additional and improved research is necessary to gain a better understanding of CMHDs and other mental health conditions experienced by Turkish immigrants, as the current research in this field is quite limited. Furthermore, many of the studies conducted so far have methodological shortcomings. As the field of qualitative research methodology and ethics is continually evolving, it is crucial for researchers to remain updated and thorough in their study design, implementation, and reporting. Adopting robust strategies to ensure translation accuracy, such as using 'forward and back translation' technique and using localisations, is specifically recommended. Additionally, the material in translation could be reviewed by a 'layperson' to ensure comprehension by individuals without specific mental health backgrounds or education levels.

It is also important to contemplate the potential negative effects of somatisation theory on the mental health care of Turkish immigrants. People who make referrals to health care services and service providers should be aware that Turkish immigrants experience and express CMHDs both emotionally and physically. Otherwise, they might not refer Turkish immigrants to psychological therapies thinking individuals in this community are unlikely to benefit from them. Additionally, physical symptoms that are not linked to mental health conditions might be overlooked, and physical health conditions might be missed in this population.

The results also suggest that Turkish immigrants employ a range of models to understand their psychological difficulties. Consequently, they might adopt and use coping strategies and cures based on those understandings. Over time, their understandings and coping strategies might change, turning their model of mental health understanding regarding CMHDs into a dynamic, multi-model one rather than a uniform, static one. It is important for clinicians and researchers to take this possibility into consideration and to offer holistic and person-centred interventions rather than prescriptive ones based on singular understandings.

It is also critical to note that although they share many common characteristics, Turkish people, like most populations in the world, are not a homogenous group. Hence, different individuals might prioritise different understandings and values with regard to their mental health as this group uses and implements a wide variety of models of understanding. For instance, an individual might believe in *nazar*, but might not link their mental health difficulties to this concept and might not discuss it in a clinic. Thus, as with any client group, the clinician needs to be curious while exploring the presenta-

tions and history without personal bias, and to formulate, collaborate and agree on an intervention in line with the client's values. Furthermore, the clinicians are advised to implement a prejudice-free, culturally sensitive, person-centred approach where clients cultivate their already existent reflective skills.

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Appendices

Appendix A

Table A1

Quality Assessment of Included Papers Using CASP(2018) Framework

	Clear Aim	Appropriate Method	Appropriate Design	Appropriate Recruitment Strategy	Appropriate Data Collection	Relationship Between Researcher and Participants	Ethical Issues	Rigorous Data Analysis	Clear Findings
Bäärnhielm et al., 2000	2	2	2	2	2	2	2	2	2
Bäärnhielm, 2004	2	2	2	2	2	1	2	1	2
Borra, 2011	2	2	1	2	2	1	1	1	2
Christodoulou et al., 2018	2	2	2	2	2	2	1	1	2
Leavey et al. 2007	2	2	1	1	1	0	1	1	1
Mirdal, 1984	2	2	1	2	2	1	1	1	1
Mirdal, 2006	2	2	1	2	2	1	1	1	2
Sohtorik et al., 2011	2	2	2	1	1	1	1	2	1
Taloyan et al., 2011	2	2	2	2	2	1	2	2	2
Yilmaz et al., 2000	0	2	1	1	1	0	1	1	2

*0 = no, 1 = can't tell, 2 = yes

Appendix B

Table B1

A List of Presenting Difficulties and their Domains in Thematic-Synthesis

	Physical	Emotive	Unusual
Bäärnhielm et al., 2000	Anxiety as somatic Body can't cope Breathing difficulties Dizziness Fainting Fatigue Forgetfulness Heart symptoms Hypertension Pain in body Pain in the right side of the body Tightness in the chest (breast)	Anger Pain in heart Disappointment Feeling of being on verge of exploding Feeling dreams crushed Feeling fear Feeling shame Feeling weak Grief Lack of happiness Lack of self-confidence Loneliness Sadness Worrying "Rising of the heart" (*yurek kalkinmasi*)	*Ruh cikmasi* – disassociation?

Table B1

A List of Presenting Difficulties and their Domains in Thematic-Synthesis

	Physical	Emotive	Unusual
Bäärnhielm, 2004	Anxiety as somatic to mental Being tired Being worn-out Sleep difficulties Tensions in the body	Feeling nervous Having bad nerves Lack of patience Panicky feelings Shattered nerves	
Borra, 2011	Back pain Diabetes Loss of sensation Neck and shoulder pains Pounding of the heart Pre-menstrual symptoms Rheumatoid Arthritis Severe headaches Stomach-ache Swollen feet Tightness in the chest Tingling sensations in arms and legs	Attempting suicide Being edgy Sadness Being devastated (*bozukluk*) Depression (*bunalım*) Fear of something bad happening Feeling uncomfortable Feeling useless Feelings of worthlessness Feeling humiliated (*gururu kırılmak*) Lack of self-confidence Lack of self-esteem Picturing unlikely things (*kuruntu*) Tightness (*sıkıntı*) Thinking negatively (*karamsar*)	Feeling watched Hearing voices Before going to sleep a goblin pushing down you (*karabasan*?) Feeling a slap in the face Feeling hair being pulled Seeing shadows Seeing jinn
Christodoulou et al., 2018	Forgetfulness Having a full head Pain in the body	Brooding Emotional turmoil Emotional up and downs Feeling down Feeling overwhelmed Feeling low Feeling powerless Having a full head Overthinking Social withdrawal Tired of being strong	
Leavey et al., 2007	"Bodily sensations" Dizziness Failure of the body Feeling numb Heavy sweating Pain in bones Pain in nails Severe headaches Sleep difficulties Tightening heart Weakness Not being able to eat	Frustration Mood disturbances Severe stress Anxiety Depression Boredom Suicidal thoughts	Hearing voices Contact with angels and devils Feelings of persecution Seeing angels

Table B1

A List of Presenting Difficulties and their Domains in Thematic-Synthesis

	Physical	Emotive	Unusual
Mirdal, 1984	Chills running up and down	Anguish	
	Cold feet	Anxiety (about future)	
	Feeling chilly	Fear	
	Muscular pains	Helplessness	
	Pounding of the heart	Jealousy	
	Ring around the chest	Longing	
	Tightness in the chest	Lump in throat	
	Trembling	Regrets	
		Resentment	
		Sorrow	
		Thinking being a burden on loved ones	
		Thinking outside world is dangerous	
		Tightness (*sıkıntı*)	
		Worrying	
Mirdal, 2006	Bad dreams	Bad thoughts running in mind	Hearing voices
	Being tired	Constant sorrow	
	Dental problems	Crying	
	Dermatological problems	Feeling empty	
	Feeling cold	Feeling everything is meaningless	
	Less somatic complaints	Feeling like living dead	
	Poor health	Fidgeting	
	Rheumatoid arthritis	Having a death wish / thinking death	
	Severe headaches	Hopelessness	
	Shaking jaw	Loneliness	
	Sleep difficulties	Losing will to live	
	Stomach-ache	Moving around	
		Not being able to enjoy food	
		Regrets	
		Burning inside that smoke gets out of one's mouth	
		Tightness (*sıkıntı*)	
Sohtorik et al., 2011		Feeling isolated	
		Feeling shame	
		Feeling lonely	
		Feeling nervous	
		Feeling powerless	
		Feeling inadequate	
Taloyan et al., 2011		Feeling emotionally tortured	
		Feeling shame	
		Longing	

Table B1

A List of Presenting Difficulties and their Domains in Thematic-Synthesis

	Physical	Emotive	Unusual
Yilmaz et al., 2000	Insomnia Persistent pain Being tired	Feeling rejected Feeling guilt Feeling shame Feeling like a failure Lack of interest Lack of pleasure Low self-worth Self-blame Social withdrawal	