Aus der Klinik für Psychiatrie und Psychotherapie, Campus Benjamin Franklin
der Medizinischen Fakultät Charité-Universitätsmedizin Berlin

DISSERTATION

"The relationship between cultural and migration-related factors, depressive symptoms and emotional distress among Vietnamese outpatients with depression in Germany"

zur Erlangung des akademischen Grades
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Table of Contents

1. Abstrakt (Deutsch)

Ziele. Vietnamesische Migrant*innen stellen die größte südostasiatische Bevölkerungsgruppe in Deutschland dar. Studien zeigten, dass bei dieser Gruppe nur eine geringe Inanspruchnahme der psychiatrischen Angebote vorliegt. Faktoren wie migrationsbedingte Stressoren, Akkulturation, und die subjektive Wahrnehmung von emotionalen Belastungen beeinflussen die psychiatrische Inanspruchnahme sowie die Psychopathologie der Patient*innen. Daher muss das Verständnis für solche Faktoren vertieft werden, um die kultursensible psychiatrische-psychotherapeutische Versorgung für vietnamesische Migrant*innen zu verbessern. Studie 1 der vorliegenden Dissertation untersuchte den Zusammenhang zwischen migrationsbedingten Stressoren und dem Schweregrad und der Symptompräsentation der Depression. Studie 2 untersuchte den Zusammenhang zwischen Akkulturationsgrad und Schweregrad der Depression. Studie 3 untersuchte emotionale Belastungsthemen von vietnamesischen Migrant*innen.

Methoden. Die Stichprobe besteht aus Patient*innen mit vietnamesischem Migrationshintergrund aus der psychiatrischen Ambulanz für vietnamesische Migranten an der Charité-Universitätsmedizin Berlin, CBF und der psychiatrischen Ambulanz am Evangelischen Krankenhaus Königin Elisabeth Herzberge in Berlin. Die Studien 1 und 2 waren quantitative, fragebogenbasierte Studien. In Studie 3 wurde ein interdisziplinäres, mixed-methods Studiendesign angewendet, bei dem zunächst emotionale Belastungsthemen zwischen vietnamesischen und deutschen Patient*innen quantifiziert wurden. Basierend auf den berichteten Ergebnissen wurden semistrukturierte, ethnographisch Interviews mit Patient*innen mit vietnamesischem Migrationshintergrund durchgeführt.

Ergebnisse. Studie 1 konnte zeigen, dass eine höhere Anzahl von migrationsbedingten Stressoren mit einem höheren depressiven Schweregrad assoziiert war, besonders bezüglich kognitiver Symptome. Studie 2 zeigte, dass Patient*innen, die eine höhere Orientierung zur deutschen Mehrheitsgesellschaft und zur vietnamesischen Herkunftsgesellschaft zeigten, mit leichteren depressiven Symptomen assoziiert waren. Bezüglich der Akkulturationsstrategien berichteten integrierte Patient*innen den niedrigsten depressiven Schweregrad, während marginalisierte Patienten den höchsten depressiven Schweregrad berichteten. Studie 3 zeigte quantitative Unterschiede in den berichteten Belastungsthemen zwischen vietnamesischen und deutschen Patienten. Im qualitativen Teil konnten in den Interviews kontextbezogene Informationen und zusätzliche Belastungsthemen wie Arbeit, Finanzen, Partnerschaft und Kinder erhoben werden. Darüber hinaus wurde ein zentrales, affektiv geladenes Thema berichtet, das als "Momente der

Sprachlosigkeit" ausgedrückt wurde und Patienten in verschiedenen Lebensbereichen belastet. **Fazit.** Die Ergebnisse dieser Dissertation tragen zu einem tieferen Verständnis über kulturell geprägte Faktoren bei, die die Psychopathologie von psychiatrischen Angeboten bei vietnamesischen Migranten beeinflussen. Darüber hinaus liefern die Studienergebnisse wichtige klinische Implikationen für kultursensible Diagnostik sowie Empfehlungen zur Weiterentwicklung therapeutischer Interventionen und gesundheitspolitischen Richtlinien.

2. Abstract (English)

Objectives. Vietnamese migrants constitute the largest South-East Asian population in Germany. Studies showed that there is a low level of utilization of mental health services among this group. Factors such as migration-related stressors, acculturation, and the patients' perception of emotional distress influence mental health care utilization and patients' psychopathological symptom presentation. Thus, there is a growing need to gain an in-depth understanding of such factors in order to improve mental health services for Vietnamese migrants. Study 1 of this dissertation examined the association between migration-related stressors and severity and symptom presentation of depression. Study 2 investigated the relationship between acculturation level and severity of depression. Study 3 examined emic themes of emotional distress among patients.

Methods. The sample consists of first-generation Vietnamese patients living in Germany from a psychiatric outpatient clinic for Vietnamese migrants at Charité-Universitätsmedizin Berlin, CBF and the psychiatric outpatient clinic at Evangelic Hospital Königin Elisabeth Herzberge in Berlin. Study 1 and 2 were quantitative, questionnaire-based studies. Study 3 applied an interdisciplinary mixed-methods design, in which themes of emotional distress between Vietnamese and German patients were investigated. Based on the reported differences, semi-structured ethnographic interviews were conducted with Vietnamese patients.

Results. Study 1 showed that a higher number of migration-related stressors was associated with a higher severity of depression, specifically cognitive symptoms. Study 2 showed that patients, who reported higher orientation towards the German and the Vietnamese society were associated with less severe depressive symptoms. Concerning acculturation strategy, integrated patients reported the lowest severity of depression, whereas marginalized patients reported the highest severity of depression. Study 3 revealed quantitative differences in themes of distress between Vietnamese and German patients. The qualitative part elicited contextualizing information and additional themes of distress such as work, finances, partnership, and children. Moreover, a central, affectively charged theme expressed as "moments of speechlessness" was reported, which poses an additional challenge in various life domains.

Conclusion. This dissertation contributes to a more in-depth understanding of migration-related and culturally shaped factors, which influence the psychopathology of Vietnamese migrants. Moreover, the studies' results provide important clinical implications regarding culture-sensitive diagnostic and suggestions for therapeutic interventions and healthcare guidelines.

3. Introduction

Global migration and the threat of mental illnesses (World Health Organization, 2013) challenge mental health care systems to consider the critical influence of migration-related factors and culture on mental health. Migration status has been associated with lower access to and use of mental health services (Kirmayer et al., 2007) and a higher psychopathological burden at the beginning of treatment (Mösko, Pradel, & Schulz, 2011; Ta et al., 2015). Moreover, access to mental health institutions is also influenced by migration-related factors such as perceived stigmatization, language barriers, or insufficient knowledge about services (Augsberger et al., 2015; Lindert, Schouler-Ocak, Heinz & Priebe, 2008). There is a rapid increase in migration worldwide (Abel & Sander, 2014; United Nations, 2019). Therefore, mental health research needs to develop an in-depth understanding of culturally related mental health factors among individuals with a migration background to provide culture-sensitive mental health care for migrants. These factors also include acculturation, migration-related stressors, and perceived emotional distress.

3.1 Migration-related Stressors and Mental Health

During the complex migration process, migrants are exposed to numerous pre-and post-migration stressors associated with distress and mental illness (Bhugra, 2004; Chen et al., 2017; Jurado et al., 2017). Pre-migration stressors include war, political or religious persecution, natural disasters, poverty, or violence (Chen et al., 2017). These stressors are often decisive in motivating individuals to migrate and are also referred to as push factors (Bhugra, 2004). Once migrants arrive in the host country, they often face a complex asylum process and uncertain residence status (Chou, 2007; Müller, Zink, & Koch, 2018). Moreover, many experience post-migration stressors such as unemployment, low financial status, social isolation, loneliness, partner conflicts, discrimination, racism, and language barriers (Chen et al., 2017; Pantelidou & Craig, 2006; Sangalang et al., 2019).

The majority of studies on migration-related stressors and mental health among Asians were conducted in the US, Canada, or the UK (Dutt & Webber, 2010; Huey & Tilley, 2018; Tiwari & Wang, 2008). For example, English language proficiency has been associated with psychological distress and psychopathology among Asian Americans (Takeuchi et al., 2007; Zhang et al., 2012). This observed relationship can lead to a vicious circle: symptoms of mental illness (e.g., cognitive symptoms, avolition) can be an additional barrier to learn the language (Eamer et al., 2017). Some studies also investigated Vietnamese migrants (Q. C. X. Nguyen & Anderson, 2005; Tran, Manalo

& V.T. Nguyen; 2007). One study surveyed 572 Vietnamese migrants, who have, on average, lived in the United States for about 20 years (Leung, Cheung & Cheung, 2010). The authors found that factors such as female gender, being unmarried, unemployed, or having family issues or health-related issues were associated with depressive symptoms.

However, the results mentioned above cannot be fully applied to Vietnamese migrants living in Germany. Previous research on the relationship between migration-related stressors and the level of depression in Asian migrants has mainly used different heterogeneous samples of migrants. In these studies, diverse Asian migrants were often grouped as "other migrants" or "Asian migrants" (Kalibatseva & Leong, 2011). Nevertheless, this approach does not take sufficient account of the very different socialization and migration experiences of each individual migrant group (Bhugra & Ayonrinde, 2004; Kerkenaar et al., 2013). In addition, there are differences in arrival conditions between countries, and these also have different effects on migrants' mental health; thus, generalizations cannot be made. For example, studies on the mental health of Vietnamese migrants in the United States can only be applied to a limited extent for Vietnamese migrants in Germany due to different arrival conditions and migration pathways (please find a more detailed description below). Therefore, it is necessary to investigate the relationship between migration-related stressors and the severity of depression in a more homogenous sample, for instance, Vietnamese migrants living in Germany, to make specific implications for improving the mental health care of specific migrant groups.

3.2 Acculturation and Mental Health

Migration entails acculturation processes, which have also been linked with mental health outcomes and attitudes towards mental health services (Gupta et al., 2013; Yoon et al., 2013). Acculturation has been defined as "those phenomena, which result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original cultural patterns of either or both groups" (Redfield et al., 1936, p. 149). Early acculturation research predominantly used unidimensional conceptualizations, which assumed that individuals are either oriented to the *mainstream society* (e.g., adopt its' attitudes and behaviors) or retain orientation towards their *heritage society* (e.g., cultural traditions and practices) (Sam, 2006). Due to this approach's inflexibility, Berry (1997) proposed a bi-dimensional conceptualization that considers the co-existence of both cultural orientations (Berry, 2005). According to Berry (1997), there are four possible acculturation strategies: integration, assimilation, separation, and marginalization. *Integration* involves participating in the mainstream

and the heritage society, whereas *assimilation* involves participation in the mainstream society and rejection of the heritage society. S*eparation* involves rejecting the mainstream society and orientation towards the heritage society. *Marginalization* describes the rejection of both cultural societies (Berry, 2005; M. H. Nguyen et al., 2017).

Previous findings on the relationship between acculturation and the psychopathology of migrants are inconsistent (Beirens & Fontaine, 2011; Yoon et al., 2013). Some suggest that adopting mainstream society's behaviors have beneficial effects (Cho et al., 2018; L. Nguyen & Peterson, 1993). For instance, a higher level of orientation towards American society among a sample of 210 Vietnamese Americans was associated with more favorable attitudes towards seeking mental health services (Luu, Leung, & Nash, 2009). A meta-analysis by Gupta et al., (2013) among Asian Americans found a relationship between orientation towards the mainstream society and depressive symptoms. The majority of these studies were conducted among heterogeneous groups of Asian migrants living in the US, who experienced different socialization and arrival conditions (Bulut & Gayman, 2016; Hwang & Ting, 2008). Thus, there is a need to investigate distinct migrant populations, such as Vietnamese migrants living in Germany.

3.3 Cultural Impact and Emotional Distress

Culture influences patient's perception and expression of emotional distress (Kirmayer & Young, 1998). Previous studies have reported that in comparison to Western patients, patients with an Asian ethnicity report somatic symptoms such as pain, dizziness, or insomnia more frequently than emotional symptoms (Dreher et al., 2017; Kleinman, 1982; Ryder et al., 2008). Various causes for these reported differences in symptom presentation have been critically discussed (e.g., Ryder & Chentsova-Dutton, 2012). For instance, stigma against mental illness is more widespread in Asian societies; therefore, somatic symptoms are socially more accepted than emotional symptoms, which are often associated with personal failure and weakness (Lauber & Rössler, 2007). Also, body and mind are perceived as one unit in Asian societies compared to the Eurocentric perspective, which tends to assume two separate entities (Ryder & Chentsova-Dutton, 2012). Moreover, responses to distress are also shaped by culture; for example, Hinton, L. Nguyen, and Pollack (2007) described the phenomenon of *orthostatic panic*, a specific response to traumatic events among Vietnamese patients involving sensations of dizziness and palpitations while standing up. The authors discuss the meaning of an upright posture, like a stable pillar, and the valued ability to adapt, like a flexible bamboo, to be rooted in the Vietnamese culture. Traumatic events may involve a cognitive and embodied loss of uprightness and flexibility, leading

to orthostatic panic (Hinton et al., 2007). These findings show the important influence that culture has on the perception and expression of emotional distress.

Nevertheless, knowledge of the subjective perspective of patients' emotional distress and the impact of these burdens on their lives are scarce. Mental health research predominantly applies an *etic* perspective, which comprises the researchers' viewpoint or frame of reference (Merriam-Webster, n.d.). For instance, most quantitative studies are based on diagnostical classification systems (e.g., DSM-5, ICD-10) and psychometric scales, developed in western societies, mostly reflecting western nosology. In contrast, the *emic* perspective aims to capture the research participant's subjective context and meaning (Merriam-Webster, n.d.). Therefore, comprehensive research on emic emotional themes of distress of patients with a migratory background is needed to improve mental health services for migrants further.

3.4 Mental health care for Vietnamese migrants in Germany

At present, about 188,000 individuals with a Vietnamese migration background live in Germany (Federal Office of Statistics of Germany, 2019). Thus, this group comprises the largest Southeast Asian migrant group in Germany. There are three main migration flows from Vietnam to Germany. After the Vietnam War in 1975, thousands of South Vietnamese people fled the country. The Federal Republic of Germany granted political asylum to approximately 40,000 South Vietnamese refugees, referred to as 'boat people.' Meanwhile, about 80,000 guest workers from North Vietnam were recruited as guest workers to the German Democratic Republic (Huwelmeier, 2013; Kocatürk-Schuster et al., 2017). The third ongoing migration flow proceeds since 1990 and encompasses Vietnamese migrants from former Eastern bloc countries, students, or economically challenged people from central Vietnam (GIZ, 2016).

To improve mental health care for Vietnamese migrants, the Department for Psychiatry and Psychotherapy at Charité-Universitätsmedizin Berlin, Campus Benjamin Franklin, opened a specialized outpatient clinic for Vietnamese migrants in 2010 (Ta et al., 2015). This outpatient clinic offers culture-sensitive psychiatric and psychotherapeutic treatment in the Vietnamese language, especially for patients with little German knowledge. These patients often fear contact with the German mental health care system. In 2012, a second outpatient clinic was opened in cooperation with the Department of Psychiatry, Psychotherapy, and Psychosomatics at Ev. Krankenhaus Königin Elisabeth Herzberge (KEH), which further integrates the psychiatric-psychotherapeutic treatment of Vietnamese migrants into the regular care system and offers locally available community-based mental health care for patients living in the eastern parts of Berlin.

Furthermore, since 2013 the network *Netzwerk für Seelische Gesundheit von vietnamesischen Migrant*innen* has been established (Ta et al., 2017), in which psychiatrists, psychologists, social workers, caregivers, employees of counseling centers, and scientists regularly exchange information and receive further training to improve mental health care for Vietnamese migrants.

At present, there are only a few studies on the mental health of Vietnamese migrants living in Germany. One study compared mental health status and mental health utilization of Polish migrants, Vietnamese migrants, and a representative German sample living in Leipzig, Germany (Wittig et al., 2008). The results showed that Vietnamese migrants demonstrated the highest general score of physical complaints and higher anxiety and depression scores than Germans (Wittig et al., 2008). In a study on the utilization of Germany's first psychiatric outpatient clinic for Vietnamese migrants, Ta et al. (2015) showed that first-generation Vietnamese migrants with little German knowledge were particularly likely to present themselves. Moreover, for 2/3 of the patients, treatment in the specialized outpatient clinic was the first contact with a mental health service (Ta et al., 2015). In a study by Dreher et al. (2017), 110 Vietnamese patients of the specialized outpatient clinic were compared to 109 German patients from another outpatient clinic in Berlin. Vietnamese patients demonstrated higher levels of somatic symptoms than German patients, while the level of depression was similar between both groups (Dreher et al., 2017). The study results show that there are differences in utilization and perception of psychiatric illnesses among Vietnamese migrants. Consequently, there is a need to investigate migration-related and culturally shaped factors, such as migration-related stressors, acculturation, and the patients' perception of emotional distress to improve this population's mental health care services.

3.5 Objective

In study 1 of this dissertation project, the effect of migration-related stressors on the severity and symptom presentation of depression was examined (Wolf et al., 2017). Study 2 investigated the relationship between acculturation level and severity of depression (M. H. Nguyen et al., 2017). Study 3 applied a mixed-methods approach to explore emic themes of emotional distress among Vietnamese migrants (M. H. Nguyen et al., 2020). The following methods and results section of the present dissertation was already published in Wolf et al. (2017), M.H. Nguyen et al. (2017) and M.H. Nguyen et al. (2020). Adaptions for the present dissertation were made by the author M.H. Nguyen.

4. Methods

Data for this dissertation project was collected in a psychiatric-psychotherapeutic specialized outpatient clinic for Vietnamese migrants at the Department of Psychiatry and Psychotherapy, Charité-Universitätsmedizin Berlin (CBF) in Germany and a psychiatric outpatient clinic at the Department of Psychiatry and Psychotherapy at Evangelic Hospital Königin Elisabeth Herzberge in Berlin. All patient-related data was collected between 2013 and 2017. Ethical approval for these studies was obtained from the ethical committee at Charité-Universitätsmedizin, Berlin. All patients gave written consent that the collected data would be anonymized and used for research purposes. Before the first consultation, patients filled out a structured survey. This survey included questionnaires assessing socio-demographic information, migration-related stressors (MRS; Lujic, 2008), acculturation level (SMAS; Stephenson, 2000), and clinical evaluations with the Beck Depression Inventory-II (BDI-II, Beck et al., 1996) and the Patient Health Questionnaire (PHQ; Spitzer et al., 2000). Questionnaires were translated from German into Vietnamese using a 4-step back-translation approach (Beaton et al., 2000). Participants were asked to specify their ethnicity in the survey ("*Vietnamese*" or "*German*" or "*Other*"). Vietnamese participants in this study were born and socialized in Vietnam. The comparison group in study 3 consists of native Germans. The study designs of the three studies are cross-sectional. Statistical analyses were calculated with IBM SPSS Statistics for Mac OS X, Version 22. Qualitative data was analyzed using MAXQDA 11 for Mac OS X.

Study 1: Migration-related stressors and their effect on the severity level and symptom pattern of depression among Vietnamese in Germany

Wolf, S., Hahn, E., Dettling, M., Nguyen, M.H., Wingenfeld, K., Stingl, M., Hanewald, B. & Ta, T.M.T; 2017, *Depression Research and Treatment*, *2017*, 1-9. https://doi.org/10.1155/2017/8930432.

Participants for this study had to meet the inclusion criteria of having a current depressive episode, according to ICD-10 (Dilling et al., 2005) and having rated more than 75% of the MRS-items.

Measures. To assess experienced migration-related stressors (*MRS*), an adapted 25-item questionnaire by Lujic (2008) was used. Participants were asked to rate whether each stressor has occurred (1 = *yes*, 0 = *no)* during their migration process. The item scores were summed to an index of stressor-quantity (*SQ*), where higher scores indicated more perceived stressors. The severity of depression was assessed with the 21-item version of the BDI-II (Beck et al., 1996).

Participants rated each item on a 4-point scale ranging from 0 to 3, with a total score ranging from 0 to 63, with higher scores indicating higher symptom severity. In order to analyze the different facets of depressive symptoms, the BDI-II symptom-structure model by Buckley et al. (2001) was used. According to this model, the 21 items of the BDI-II can be clustered in a cognitive, affective, and somatic dimension. Thus, we constructed three equivalent subscales with the particular items: BDI-COG-B, BDI-AFF-B, and BDI-SOM-B.

Data Analysis. Demographic data was tested regarding differences concerning age (t-test), sex (Fisher's exact test), and education (chi-square test). Hypotheses were tested using hierarchical linear regressions. Also, post hoc analyses were performed for the single items of those subscales, which were significantly associated with the stressor-quantity (SQ) (Wolf et al., 2017).

Study 2: Acculturation and severity of depression among first-generation Vietnamese outpatients in Germany

Nguyen, M. H., Hahn, E., Wingenfeld, K., Graef-Calliess, I. T., von Poser, A., Stopsack, M., Burian, H., Dreher, A., Wolf, S., Dettling, M., Burian, R., Diefenbacher, A. & Ta, T.M.T; 2017, *International Journal of Social Psychiatry*, *63*(8): 708-716. https://doi.org/10.1177/0020764017735140

The patients had to meet the inclusion criteria of having a current depressive episode, according to ICD-10, and not meeting the ICD-10 criteria for other comorbid psychiatric disorders (Dilling et al., 2005).

Measures. To assess the level of acculturation, patients filled out the Stephenson Multigroup Acculturation Scale (SMAS; Stephenson, 2000). The SMAS consists of the 15-item *dominant society immersion* (DSI) subscale, which measures the patients' identification towards the mainstream society, whereas the 17-item *ethnic society immersion* (ESI) scale measures the patients' identification with the heritage society. Patients rated each item on a 4-point Likert scale (1 = *false*, 2 = *partly false*, 3 = *partly true*, and 4 = *true*). The first item of the DSI subscale and the fourth item of the ESI subscale were excluded to avoid misunderstandings. The scores for each subscale were summed, whereby higher values indicated a greater level of orientation towards the dominant, German, or the ethnic, Vietnamese society. The severity of depression was assessed with the 21-item version of the Beck Depression Inventory-II (BDI-II; Beck et al., 1996). Participants rated each item on a 4-point scale ranging from 0 to 3.

Data Analysis. Continuous variables in the demographic data were tested for group differences with analyses of variance (ANOVAs). Differences regarding ordinal variables were

tested with chi-square tests (χ^2). Hypotheses were tested using Pearson's product-moment correlation coefficients, hierarchical regressions, ANOVA, and a priori planned contrasts (M. H. Nguyen et al., 2017).

Study 3: Migration-related emotional distress among Vietnamese in Germany – An interdisciplinary, mixed-method study

Nguyen, M.H.*, Lanca, J.C.*, Hahn, E., von Poser, A., Heyken, E., Wingenfeld, K., Burian, R., Diefenbacher, A. & Ta, T.M.T; 2020, *Transcultural Psychiatry*, *0*(0), 1-17. **shared authorship.* https://doi.org/10.1177/1363461520920329.

The study is divided into two parts. In the first quantitative part, the sample consisted of German outpatients and Vietnamese outpatients. The German patients were recruited at the psychiatric outpatient clinic at Evangelic Hospital Königin Elisabeth Herzberge, and the Vietnamese patients were recruited at the outpatient clinic for Vietnamese migrants at Charité-Universitätsmedizin, CBF. In the second qualitative part, a new sample of Vietnamese patients was selected and individually interviewed. All patients had to meet the inclusion criteria either for depressive episodes, adjustment disorders, or anxiety disorders, according to ICD-10.

Measures. In the first part of the study, emotional distress themes were assessed, using the item "*What currently burdens you the most?*" of the Patient Health Questionnaire (PHQ; Spitzer et al., 2000). In the second part of the study, a semi-structured, ethnographic interview with 13 items in Vietnamese was developed (Emotional Distress Interview; M. H. Nguyen et al., 2020) based on the relative frequency of reported distress in the first part of the study. The interview aimed to elicit in-depth, contextualized narratives about emotional distress. The interviews with the Vietnamese patients were conducted at the outpatient clinic at Charité-Universitätsmedizin and lasted approximately two hours.

Data Analysis. In the first part, demographic group differences were analyzed with t-tests, chi-square tests, and Mann-Whitney U tests. Patients' answers on their emotional distress and the generated codes were quantified by rating the codes as present (1) vs. absent (0). Then, chi-square tests were conducted to explore differences in the frequency of reported themes of distress between Vietnamese and German patients. In the second part, interviews with the Vietnamese patients were analyzed by applying qualitative content analysis (Mayring, 2010).

5. Results

5.1 Study 1: Migration-related stressors and their effect on the severity level and symptom pattern of depression among Vietnamese in Germany

Wolf, S., Hahn, E., Dettling, M., Nguyen, M.H., Wingenfeld, K., Stingl, M., Hanewald, B. & Ta, T.M.T; 2017, *Depression Research and Treatment*, *2017*, 1-9. https://doi.org/10.1155/2017/8930432.

The final sample consisted of $N = 137$ first-generation Vietnamese migrants. The sample's mean age was 44.5 years (SD = 11.7), with 81% female and 19% male patients. On average Vietnamese patients reported nine stressful and migration-related experiences (M = 8.76; SD = 4.84). The following items were reported most frequently: communication problems in Germany (item 1; n = 85), longing for the family in Vietnam (item 19; n = 71), difficulties in adapting to the German society (item 20; n = 63), ambiguity about what to do in certain situations (item 16; n = 54), and feeling lonely or isolated in Germany (item 7; n = 51).

The first analysis explored how the stressor-quantity (SQ) is associated with the severity level of depressive symptoms. Hierarchical linear regression was performed and revealed a significant association between SQ and level of depression, $F(4,58) = 3.00$, $p = .03$. The results suggest that SQ is predictive of depressive symptoms and that more experienced migration-related stressors are associated with higher levels of depressive symptoms. The second analysis tested whether the stressor-quantity was associated with the cognitive, affective, or somatic dimension of depression. The analysis only revealed a significant association between SQ and the cognitive subscale $F(4,57) = 4.19$, $p = .01$. The results suggest that more experienced migration-related stressors are associated with higher severity of the cognitive domain of depression.

Lastly, post-hoc analyses tested which single items within the cognitive dimension were associated with the stressor-quantity. The symptoms pessimism, $F(4, 57) = 4.07$, $p = .01$, past failure, $F(4, 58) = 3.44$, $p = .04$, guilt feelings, $F(4, 57) = 3.94$; $p = .01$, punishment feelings $F(4,57) = 3.44$, $p = .01$ and suicidal thoughts, $F(4,51) = 2.64$, $p = .04$ yielded statistical significance. The results suggest that a higher stressor-quantity is associated with the manifestation of these symptoms. Stressor-quantity did not yield significance for the symptoms worthlessness ($p = .16$) and sadness ($p = .27$).

5.2 Study 2: Acculturation and severity of depression among first-generation Vietnamese outpatients in Germany

Nguyen, M. H., Hahn, E., Wingenfeld, K., Graef-Calliess, I. T., von Poser, A., Stopsack, M., Burian, H., Dreher, A., Wolf, S., Dettling, M., Burian, R., Diefenbacher, A. & Ta, T.M.T; 2017, *International Journal of Social Psychiatry*, *63*(8): 708-716. https://doi.org/10.1177/0020764017735140

The study comprised a total of N = 113 first-generation Vietnamese migrants. The sample's mean age was 44.74 years (SD = 11.83), with 73% female and 27% male patients.

The first analysis tested the hypothesis that both higher orientation towards the mainstream, German society (DSI), and higher orientation towards the heritage, Vietnamese society (ESI) are associated with lower severity levels of depressive symptoms. Hierarchical multiple regressions were performed to investigate whether the addition of DSI and ESI improves the prediction of the level of depression beyond the control variables age, sex, education, and migration pathway (guest worker vs. boat people vs. third wave migrants). The model yielded an adjusted R^2 = .06, $F(6,104) = 2.12$, p = .059, after entering DSI and ESI, indicating that DSI and ESI predict about 6% of the variance in the level of depression. The results are consistent with the hypothesis and suggest that DSI and ESI are predictive of depressive symptoms and that more orientation towards the mainstream, German, and the heritage, Vietnamese society was associated with lower levels of depressive symptoms.

The second analysis tested whether the level of depression differs depending on the four acculturation strategies. In order to identify acculturation strategies for each patient, a median split (Field, 2013) was applied to the two acculturation scales, DSI (Mdn = 32) and ESI (Mdn = 57). Patients were classified to the integration strategy with DSI and ESI > Mdn, to the assimilation strategy with DSI > Mdn and ESI ≤ Mdn, to the separation strategy with $DSI \leq Mdn$ and $ESI > Mdn$, and to the marginalization strategy with $DSI \leq Mdn$ and $ESI \leq Mdn$. A one-way between-subjects ANOVA was conducted. A priori planned contrasts tested the hypothesis if integrated patients reported less severity of depression than marginalized patients. According to the hypothesis, integrated patient's severity of depression was significantly lower compared to marginalized patients, $t(109) = 3.89$, $p < .001$ (Figure 1).

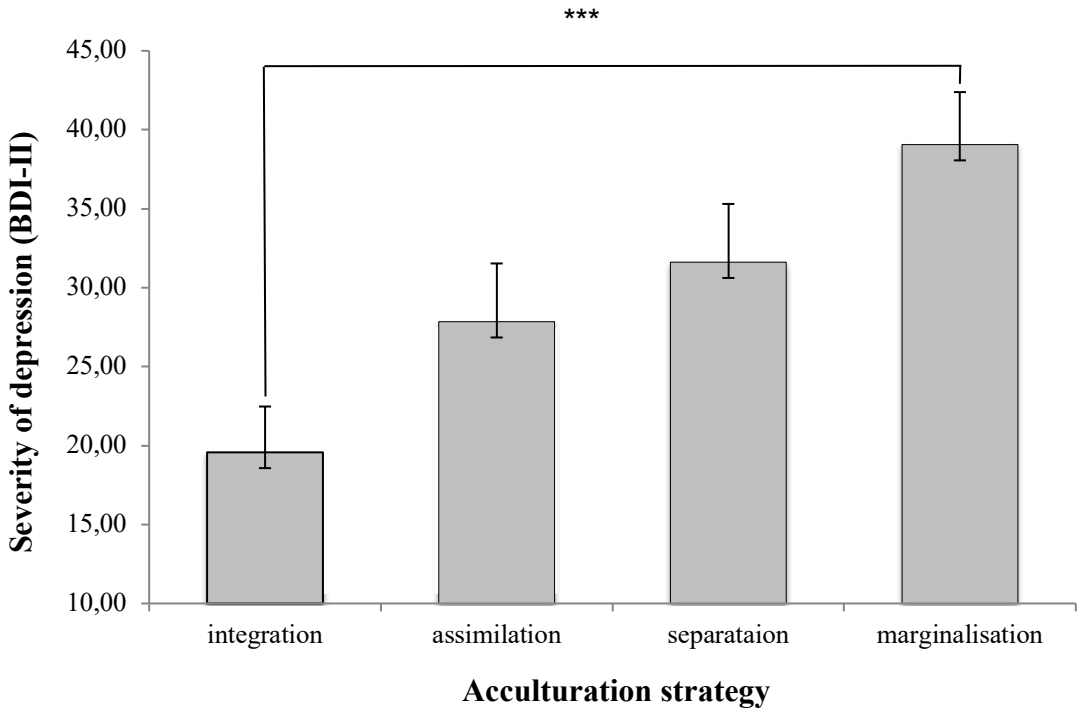

Figure 1. Differences in severity of depression (BDI-II) between the four acculturation strategies. Error bars represent the standard errors of the mean; *** $p < .001$, two-tailed. Figure 1 from M.H. Nguyen et al. (2017).

5.3 Study 3: Migration-related emotional distress among Vietnamese in Germany – An interdisciplinary, mixed-method study

Nguyen, M.H.*, Lanca, J.C.*, Hahn, E., von Poser, A., Heyken, E., Wingenfeld, K., Burian, R., Diefenbacher, A. & Ta, T.M.T; 2020, *Transcultural Psychiatry*, *0*(0), 1-17. **shared authorship.* https://doi.org/10.1177/1363461520920329.

The sample consisted of *n* = 104 German outpatients and *n* = 104 Vietnamese outpatients. The German sample's mean age was 42.36 years (*SD* = 12.23), and of the Vietnamese sample 44.27 years (*SD* = 11.24). In the first, quantitative part of the study, differences in frequency of reported distress between Vietnamese and German patients, indicative of cultural and migration-related issues among Vietnamese migrants, were explored. Vietnamese patients reported more health or illness concerns compared to German patients, $p < .01$. Vietnamese patients reported worries about their children more frequently compared to German patients, $p < .05$. However, German patients reported psychological issues such as stress, worries about the mind, and depression to be more burdensome than Vietnamese patients, $p < .01$. German patients reported more burdens involving their partners, $p < .01$ (Table 1).

Table 1

Chi-Square test and descriptive statistics of themes from the survey by ethnicity.

	Vietnamese *n* = 104	German *n* = 104		
Themes	Yes	Yes	*χ2*	*p*
Health/Illness	59 (57%)	13 (13%)	44.95	**.001**
Somatic	11 (11%)	15 (14%)	.70	.53
Psychological	7 (7%)	33 (32%)	20.92	**.001**
Children	23 (22%)	10 (10%)	6.09	**.022**
Partner	2 (2%)	14 (14%)	9.75	**.003**
Work	9 (9%)	14 (14%)	1.22	.377
Finances	8 (8%)	7 (7%)	0.72	1.00
Institutions	7 (7%)	0 (0%)	-	**.007**[a]

Note. [a]Cell size was < 5, Fisher's exact test was used instead of Chi-square test.

Table 1 from M.H. Nguyen et al. (2020).

In the second, qualitative part, additional contextualizing information was raised through ethnographic interviews with $N = 20$ Vietnamese patients. In total, 11 themes of emotional distress were identified. Six themes were previously mentioned in the quantitative survey responses (work ($n = 18$), children ($n = 18$), partnership ($n = 18$), psychological ($n = 17$) and somatic symptoms ($n = 18$), finances ($n = 16$) and institutions ($n = 14$)). In addition, five new themes of emotional distress emerged from the interviews (past ($n = 16$), future ($n = 15$), speechlessness ($n = 15$), isolation ($n = 11$), and language ($n = 11$)). One central emic theme of distress that emerged in the interviews was a state, which we labeled as "speechlessness." Speechlessness describes the difficulty of articulating certain experiences, norms of explicitly speaking about painful events, and the absence of people to confide in. These moments go beyond a lack of language proficiency and occur in different life domains in interactions with the mainstream society, the nuclear family, the local Vietnamese communities, and relatives in Vietnam.

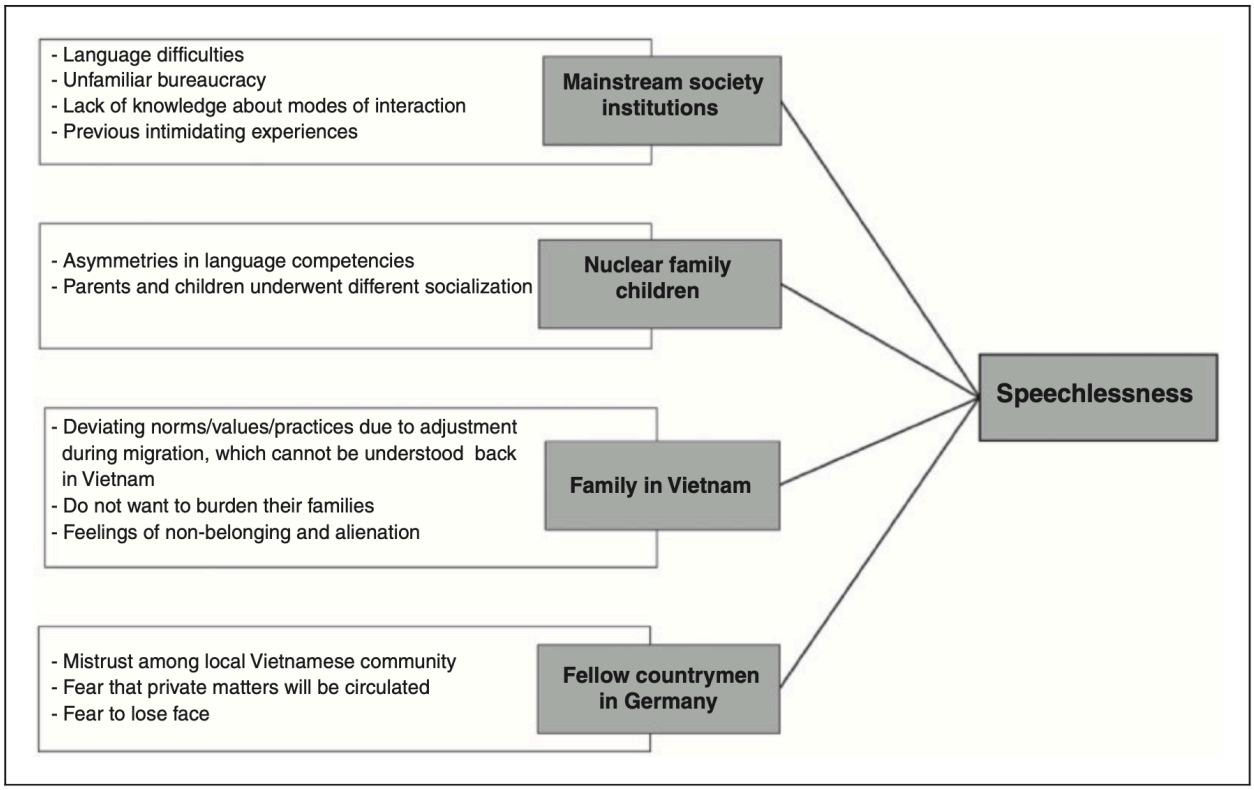

Figure 2. Reported moments of speechlessness in different life domains among the $N = 20$ interviewed Vietnamese outpatients living in Germany. Figure 2 from M.H. Nguyen et al. (2020).

6. Discussion

The three studies within this dissertation project contribute to a better understanding of migration-related stressors, acculturation, and emic themes of distress and how these factors influence the psychopathology of Vietnamese migrants living in Germany. The findings in study 1 suggest that a higher number of migration-related stressors were associated with a higher severity level of depression, specifically concerning depression's cognitive dimension (Wolf et al., 2017). The results in study 2 suggest that orientation towards the German society and the Vietnamese society was associated with lower depressive symptoms (M. H. Nguyen et al., 2017). Moreover, concerning acculturation strategies, the findings demonstrated that the level of depressive symptoms was significantly lower among patients with an integrated strategy, whereas marginalized patients reported the highest symptom severity (M. H. Nguyen et al., 2017). In study 3, an interdisciplinary, mixed-methods approach was applied by joining psychiatric-psychological and anthropological research methods. The findings in the first part of this study showed quantitative differences in perceived distress between Vietnamese and German patients (M. H. Nguyen et al., 2020). The results in the second part revealed additional themes of emotional distress among Vietnamese migrants. In the following, the three studies' results are discussed, and implications for future research and clinical work are addressed.

6.1 Migration-related Stressors

The findings in study 1 (Wolf et al., 2017) are consistent with several studies, showing a positive relationship between migration-related stressors and the severity level of depression (Alegría, Álvarez, & DiMarzio, 2017; Müller et al., 2018). The present findings are also in line with the results of study 2, which demonstrated that a separated acculturation style or a marginalized acculturation style were associated with a higher severity level of depression (M.H. Nguyen et al., 2017). Moreover, there are similarities in the response pattern between the migration-related stressors questionnaire (Lujic, 2008) and the behaviors and attitudes assessed in the SMAS (Stephenson, 2000). For example, the MRS assesses language proficiency ("*Do you have communication problems in Germany because of your limited knowledge of German?*") or feelings of loneliness and isolation ("*Do you often feel lonely or socially isolated in Germany?*"). The SMAS also assesses language skills ("*I feel comfortable speaking German*.") and social contacts with the mainstream and the heritage society, as well as feelings of belonging to the mainstream society ("*I feel at home in Germany*."). The similarities

display that acculturation, i.e., adapting to a new culture, can also be experienced as stressful by migrants (Berry et al., 1987).

Moreover, Vietnamese patients in study 3 reported similar themes of distress (e.g., language, isolation, finances) in the ethnographic interviews (M.H. Nguyen et al., 2020), like the migration-related stressors assessed in the questionnaire in study 1. In particular, the results showed that a higher number of experienced migration-related stressors is associated with a higher number of cognitive depressive symptoms, especially an increase in suicidal thoughts (Wolf et al., 2017). This is an important finding because the prevailing literature on Asian patients emphasizes somatic symptoms over psychological or emotional symptoms (Kirmayer & Young, 1998; Ryder et al., 2008). However, the present finding implicates that cognitive symptoms are also important during a depressive illness among a sample of Vietnamese patients. Therefore, in clinical encounters, practitioners should be very attentive when several migration-related stressors are reported and specifically ask for cognitive symptoms, especially suicidal ideation, as these are rarely reported spontaneously by Vietnamese patients (Ta et al., 2015; Wolf et al., 2017).

6.2 Acculturation

The results in study 2 (M.H. Nguyen et al., 2017) are similar to studies among Asian-Americans (Gupta et al., 2013; Hwang & Ting, 2008), indicating a beneficial relationship between an orientation towards the mainstream society and mental health outcomes. Concerning the acculturation strategies, the present findings are, in part, consistent with previous findings (Behrens et al., 2014). Unlike the results of study 2, Behrens et al. (2014) identified the assimilation strategy to be associated with the highest symptom severity and discuss that assimilation involves denying one's cultural roots. However, the results in study 2 demonstrated that a marginalized acculturation strategy was associated with the highest level of depressive symptoms. As discussed in the paper (M. H. Nguyen et al., 2017), the feeling of non-belonging, which most likely might be experienced by marginalized individuals, may be even more harmful than assimilation. Non-belonging is vividly captured in the poem *Diaspora Blues* by Ijeoma Umebinyuo (2015):

"So, here you are
too foreign for home
too foreign for here.
Never enough for both."

Belonging is a fundamental human need (Baumeister & Leary, 1995), which in case of deprivation is associated with a deteriorated health and mental health status (Hagerty et al., 1992; Keyes & Kane, 2004; Sargent et al., 2002). One can also conclude from the present results that an integrative strategy, meaning orientation towards both mainstream and heritage society, could act as a protective factor for mental health for Vietnamese migrants (M. H. Nguyen et al., 2017). As an implication for clinical work, cultural practices of the heritage society could be used to strengthen neglected resources of patients with a migration background, while at the same time encouraging participation in the mainstream society. At the specialized outpatient clinic for Vietnamese migrants, we have used these results and integrated them into therapy, for instance, using references to traditional Vietnamese dishes or familiar scents of herbs to foster and elicit positive emotions, which is a standard method of Euthymic Therapy (Lutz, 2009). In terms of health policy, measures to integrate migrants (e.g., language classes) should be actively promoted, and local migrant communities and organizations should be supported.

6.3 Culture and Perception of Distress

Similar to a study by Dreher et al. (2017), the results in study 3 demonstrated that German patients reported significantly more psychological symptoms than Vietnamese patients. Comparable to previous research on distress among migrants, economic stressors like financial burdens or low income were identified (Bhugra, 2004). Unlike previous studies which used existing questionnaires to assess these themes (Cavazos-Rehg et al., 2006; Jibeen & Khalid, 2010; Müller & Koch, 2011), this study took a further step and developed an ethnographic interview (Emotional Distress Interview; M. H. Nguyen et al., 2020) to assess the emic perspective of Vietnamese migrants. One central emerging theme was “speechlessness”, which describes the difficulty of speaking about certain burdensome experiences and the absence of trusted people to talk to on four life domains (M.H. Nguyen et al., 2020). This theme is an example that depicts the affective complexity of migration, specifically of navigating between cultural contexts (von Poser, 2018; von Poser et al., 2017). The present results are also consistent with the previous literature acknowledging the important influence of culture on the distress perception (Kirmayer & Bhugra, 2009; Kirmayer & Young, 1998).

Future research should continue to use interdisciplinary mixed-method research approaches to gain deeper insights into culturally shaped and migration-related factors influencing mental health. To improve mental health care for Vietnamese migrants, emic themes of coping should also be

investigated in the future. For example, Trovão, Ramalho, and David (2017) identified religiousness as an important coping strategy among Asian and African migrant working women in Portugal. Clinicians can use emic themes of distress (e.g., children, partnership, isolation) in their work with Vietnamese migrants and address previously unknown stressors such as speechlessness. In addition, treatment methods should be expanded in culture-sensitive psychotherapy to facilitate the articulation of emotional distress, e.g., through art therapy (Danner-Weinberger et al., 2019).

6.4 Limitations

Some study limitations have to be considered in the interpretation of the results. The three studies are cross-sectional studies, and therefore causal implications cannot be made. Longitudinal research designs should be conducted to explore the influence of cultural and migration-related factors on mental health over a long period. For instance, stressors can change during the process of migration. For example, in a study among female domestic workers from the Philippines, migration-related stress was assessed according to the different phases during migration (van der Ham et al., 2014). The authors found that the women were mostly distressed by finances or worries about leaving the family in the pre-migration phase, whereas during the post-migration phase, stressors surrounded loneliness or working conditions (van der Ham et al., 2014). Future studies among Vietnamese migrants should apply this longitudinal approach to investigate the influence of migration-related stressors during the whole course of migration. Furthermore, patients who suffer from a severe depressive episode may also perceive themselves as less part of society due to the negative cognitive bias of the depression (Beck, 2002). Also, acculturation questionnaires such as the SMAS (Stephenson, 2000) assess behavior that may decrease due to the depression. Therefore, it is difficult to separate whether specific acculturation strategies cause depression or whether depressive patients are prone to specific acculturation strategies.

Moreover, the studies were conducted in a sample of Vietnamese migrants who received psychiatric-psychotherapeutic treatment. Therefore, the results cannot be generalized to all Vietnamese migrants living in Germany. Furthermore, about 70% of the sample consists of female patients. However, this high percentage of women corresponds to the clinical reality of a gender difference of Vietnamese outpatients who utilize these services in Berlin (Ta et al., 2015). Ta et al. (2015) discussed gender roles, gender-dependent attitudes among the possible reasons for this unequal gender distribution. Also, a generalization of the results to other migrant groups can only be made to

a limited extent. However, our applied methodology could be used in future studies with other migrant groups.

6.5 Conclusion

This dissertation project provides a comprehensive investigation of cultural and migration-related factors and their influence on the depressive symptoms and the perception of emotional distress among Vietnamese psychiatric patients living in Germany. In the first two studies, existing questionnaires were used to investigate migration-related stressors and acculturation in Vietnamese migrants in Germany (M. H. Nguyen et al., 2017; Wolf et al., 2017). In order to capture the cultural influence further, an interdisciplinary, mixed-methods approach was chosen in the third study, which assessed the emic perspective of Vietnamese migrants (M. H. Nguyen et al., 2020). This methodological approach could also be applied to other migrant groups. Moreover, the results may be applicable within a health political and clinical context for improving mental health care for migrants. Structurally, policymakers could support specialized mental health services for migrants and take the identified migration-related stressors and risk factors much more into account. Since culture influences the perception and expression of psychopathological symptoms, general practitioners should also consider these and make referrals to psychiatrists or psychotherapists at an early stage. Furthermore, the results on specific migration-related stressors, adverse acculturation strategies, and emic distress themes could be applied in culture-sensitive training for multi-professional practitioners.

7. References

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8. Statutory Declaration

"I, Thi Main Huong Nguyen, by personally signing this document in lieu of an oath, hereby affirm that I prepared the submitted dissertation on the topic "*The relationship between cultural and migration-related factors, depressive symptoms and emotional distress among Vietnamese outpatients with depression in Germany"*, independently and without the support of third parties, and that I used no other sources and aids than those stated.

All parts which are based on the publications or presentations of other authors, either in letter or in spirit, are specified as such in accordance with the citing guidelines. The sections on methodology (in particular regarding practical work, laboratory regulations, statistical processing) and results (in particular regarding figures, charts and tables) are exclusively my responsibility.

Furthermore, I declare that I have correctly marked all of the data, the analyses, and the conclusions generated from data obtained in collaboration with other persons, and that I have correctly marked my own contribution and the contributions of other persons (cf. declaration of contribution). I have correctly marked all texts or parts of texts that were generated in collaboration with other persons.

My contributions to any publications to this dissertation correspond to those stated in the below joint declaration made together with the supervisor. All publications created within the scope of the dissertation comply with the guidelines of the ICMJE (International Committee of Medical Journal Editors; www.icmje.org) on authorship. In addition, I declare that I shall comply with the regulations of Charité – Universitätsmedizin Berlin on ensuring good scientific practice.

I declare that I have not yet submitted this dissertation in identical or similar form to another Faculty.

The significance of this statutory declaration and the consequences of a false statutory declaration under criminal law (Sections 156, 161 of the German Criminal Code) are known to me."

Date	Signature

9. Declaration of contribution to the publications

Thi Main Huong Nguyen contributed the following to the below listed publications:

Publikation 1: Wolf, S., Hahn, E., Dettling, M., **Nguyen, M. H.**, Wingenfeld, K., Stingl, M., Hanewald, B., & Ta, T. M. T., Migration-Related Stressors and Their Effect on the Severity Level and Symptom Pattern of Depression among Vietnamese in Germany, Depression Research and Treatment, 2017.

> **Contribution:** A part of the Vietnamese patients were cruited by the doctoral candidate. Moreover, a part of the database and data (data input) was maintained by her. Support of statistical analysis and manuscript revision.

Publikation 2: Nguyen, M. H., Hahn, E., Wingenfeld, K., Graef-Calliess, I. T., von Poser, A., Stopsack, M., Burian, H., Dreher, A., Wolf, S., Dettling, M., Burian, R., Diefenbacher, A., & Ta, T. M. T., Acculturation and severity of depression among first-generation Vietnamese outpatients in Germany. International Journal of Social Psychiatry, 2017.

> **Contribution:** Support to develop the hypotheses. Literature review. The doctoral candidate worked on the recruitment of a part of the test subjects. Preparing a database and maintenance of data, data screening and statistical analysis. Based on the statistical analyses, the doctoral candidate created tables 1, 2, 3 and Figure 1. Drafting and writing of the first manuscript draft. Coordination of the internal revision with the co-authors, submission, revision and communication concerning publication of the manuscript.

Publikation 3: Nguyen, M. H., Lanca, J.-C.*, Hahn, E., von Poser, A., Heyken, E., Wingenfeld, K., Burian, R., Diefenbacher, A., & Ta, T. M. T., Migration-related emotional distress among Vietnamese psychiatric patients in Germany: An interdisciplinary, mixed methods study. Transcultural Psychiatry, 2020. **shared authorship*

> **Contribution:** Literature review and recruitment of a part of the Vietnamese patients. Preparing a database and maintenance of data, data screening and statistical analysis. Coding of the patients' answers and discussion of the results with the co-authors. Tables 2, 3 and Figure 1 were created by the doctoral candidate. Development of the semi-structured interview (Table 1) with the shared first author under supervision. Drafting and writing of the first manuscript draft. Ethnographic and anthropological parts were written by the second first author. Coordination of the internal revision with the co-authors, submission, revision and communication concerning the publication of the manuscript.

Signature of doctoral candidate (Thi Main Huong Nguyen)	Signature, date and stamp of first supervising university professor (PD. Dr. Thi Minh Tam Ta)

10. Print copies of the selected publications

This dissertation includes the following original articles:

Study 1:

Wolf, S., Hahn, E., Dettling, M., Nguyen, M. H., Wingenfeld, K., Stingl, M., Hanewald, B., & Ta, T. M. T. (2017). Migration-Related Stressors and Their Effect on the Severity Level and Symptom Pattern of Depression among Vietnamese in Germany. *Depression Research and Treatment*, *2017*, 1–9. https://doi.org/10.1155/2017/8930432

Study 2:

Nguyen, M. H., Hahn, E., Wingenfeld, K., Graef-Calliess, I. T., von Poser, A., Stopsack, M., Burian, H., Dreher, A., Wolf, S., Dettling, M., Burian, R., Diefenbacher, A., & Ta, T. M. T. (2017). Acculturation and severity of depression among first-generation Vietnamese outpatients in Germany. *International Journal of Social Psychiatry*, *63*(8), 708–716. https://doi.org/10.1177/0020764017735140

Study 3:

Nguyen, M. H. *, Lanca, J.-C. *, Hahn, E., von Poser, A., Heyken, E., Wingenfeld, K., Burian, R., Diefenbacher, A., & Ta, T. M. T. (2020). Migration-related emotional distress among Vietnamese psychiatric patients in Germany: An interdisciplinary, mixed methods study. *Transcultural Psychiatry*, *0*(0), 1–17. **shared authorship.* https://doi.org/10.1177/1363461520920329

10.1 Study 1

Wolf, S., Hahn, E., Dettling, M., Nguyen, M. H., Wingenfeld, K., Stingl, M., Hanewald, B., & Ta, T. M. T. (2017). Migration-Related Stressors and Their Effect on the Severity Level and Symptom Pattern of Depression among Vietnamese in Germany. *Depression Research and Treatment*, *2017*, 1–9. https://doi.org/10.1155/2017/8930432

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10.2 Study 2

Nguyen, M. H., Hahn, E., Wingenfeld, K., Graef-Calliess, I. T., von Poser, A., Stopsack, M., Burian, H., Dreher, A., Wolf, S., Dettling, M., Burian, R., Diefenbacher, A., & Ta, T. M. T. (2017). Acculturation and severity of depression among first-generation Vietnamese outpatients in Germany. *International Journal of Social Psychiatry*, *63*(8), 708–716. https://doi.org/10.1177/0020764017735140

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10.3 Study 3

Nguyen, M. H.*, Lanca, J.-C.*, Hahn, E., von Poser, A., Heyken, E., Wingenfeld, K., Burian, R., Diefenbacher, A., & Ta, T. M. T. (2020). Migration-related emotional distress among Vietnamese psychiatric patients in Germany: An interdisciplinary, mixed methods study. *Transcultural Psychiatry*, *0*(0), 1–17. * *shared authorship.* https://doi.org/10.1177/1363461520920329

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Migration-related emotional distress among Vietnamese psychiatric patients in Germany: An interdisciplinary, mixed methods study

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Abstract

Culture and socialization influence how individuals perceive and express emotional distress. Research therefore, must consider the context to capture individual experiences. However, the majority of studies on factors associated with emotional distress among migrants use quantitative approaches, limiting an in-depth understanding. This study investigates emic themes of emotional distress among Vietnamese migrants by integrating anthropological and psychiatric approaches. The mixed methods study first quantified differences in reported themes of distress between Vietnamese ($n = 104$) and German ($n = 104$) patients, who utilized two psychiatric outpatient clinics in Berlin, Germany. Based on these differences, ethnographic interviews were conducted with 20 Vietnamese patients. In the quantitative part, differences in frequency of reported distress between Vietnamese and German patients indicate cultural and migration-related issues among Vietnamese migrants, such as the upbringing of children in a transcultural context. In the qualitative part, interviews with Vietnamese patients elicited contextualizing information and additional themes of distress. Besides commonly expressed socioeconomic themes, such as work and finances, we identified affectively charged themes concerning roles toward partnership and children. A central emic theme is expressed as "moments of speechlessness," which go beyond a lack of language proficiency and challenge patients in different spheres of life. Migration entails complex affective dynamics, determined by a specific migratory and post-migratory context. Within this context, norms and values determine which themes of distress patients articulate openly. Therefore, an interdisciplinary, mixed-methods approach can yield a contextualized understanding of emotional distress and the complex nature of migration.

Keywords

emotional distress, migration, interdisciplinarity, mixed methods, emic perspective, Vietnamese patients

Introduction

Ongoing processes of global migration require that local mental health institutions provide adequately tailored treatment for changing populations of migrants. In 2015 alone, about 2.1 million people migrated to Germany (Federal Office of Statistics of Germany, 2018a). A significant body of research shows that only a fraction of migrants in need use existing mental health services (Abebe et al., 2017; Kirmayer et al., 2011; Ta et al., 2015). Numerous factors influence access to mental health institutions, including

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language barriers, gender, level of acculturation, perceived stigmatization, insufficient knowledge about services, and different concepts of illness and treatment (Augsberger et al., 2015; Lauber & Rössler, 2007). Thus, a deeper understanding of migrants' needs and difficulties and their heterogeneous experiences is necessary. In this article, we pursue this by investigating a population of Vietnamese psychiatric outpatients living in Germany, using an interdisciplinary, mixed-methods approach.

Cultural impact and emotional distress

We consider culture as intrinsically dynamic and malleable (von Poser, Lanca, Heyken et al., 2017). Rather than being defined by clear-cut boundaries, ethnicity, or nationality, we view culture as a process of meaning-making and as a basis for collective and societal cohesion and belonging (Pfaff-Czarnecka, 2013). Culture thus relates to shared knowledge, practices, frameworks, and conventions and allows for identification and legibility within a group. Culture is acquired and (re)shaped in lifelong processes of learning and impacts perceptions and embodiments along with discourses and emotions.

Culture influences how individuals perceive and express their emotional distress (Kirmayer, 1989; Kirmayer & Young, 1998). For example, East and Southeast Asian patients with mental health problems tend to present clinically with somatic symptoms that are more socially accepted, such as pain or dizziness, rather than with emotional symptoms, such as sadness or hopelessness (Kleinman, 1988; Ryder et al., 2008). However, if asked directly, they acknowledge emotional symptoms at a similar rate as patients from Western societies (Dreher et al., 2017; Keyes & Ryff, 2003). Moreover, reactions to distress vary across cultures. For example, Vietnamese patients may present a culturally specific response to traumatic events described as *orthostatic panic*, with sensations of dizziness and palpitations when they stand up (Hinton et al., 2007). Understanding cultural notions of illness and distress can help to promote effective mental health care services, especially among minority populations with different cultural backgrounds.

Migration-related stressors and distress

Previous research has identified a number of migration-related stressors or factors associated with emotional distress, such as migration regimes, trauma during migration, legal status, and language proficiency (Jurado et al., 2017; Salvo & Williams, 2017; Wolf et al., 2017). However, symptoms of mental illness can pose an additional obstacle to acquiring language skills or to obtaining legal status (Eamer et al., 2017). Although most migrants hope to improve their lives, some experience losses at various levels, such as their socioeconomic status, social (support) network, or close family ties, and they are often confronted with some forms of discrimination (Chou, 2012; Pantelidou & Craig, 2006). Furthermore, migrants have to continually navigate between different cultural contexts and emotional orientations (Boccagni & Baldassar, 2015; Röttger-Rössler, 2016). Such navigations may entail stressful experiences, especially when cultural norms conflict with each other (Ta et al., 2017).

Etic vs. emic perspectives

Current psychiatric and psychological knowledge about factors associated with migrants' emotional distress stems mainly from quantitative research, which aims to formulate generalizable statistical descriptions about larger populations. However, such approaches rarely target patients' individual experiences and their heterogeneous affective lives (von Poser, 2018). Furthermore, the majority of studies on migrants' mental health are based on current diagnostic classification systems (e.g., DSM-5, ICD-10) and a nosology primarily developed from studies in Western, educated, industrialized, rich, democratic (WEIRD) contexts (Henrich et al., 2010).

Social sciences label approaches that are embedded in the researchers' viewpoint as *etic* perspectives. While etic constructs are potentially transferrable, reliable, and generalizable, they are not designed to capture *emic* knowledge, that is, knowledge situated in the cultural and subjective life contexts of the affected research participants. Emic knowledge encompasses culturally shaped notions, individual views, or interpretations that form perceived realities. Therefore, an inductive, qualitative research design that targets the patients' emic perspectives can reveal distress related to individual experiences of migration.

Interdisciplinarity

Recognition of the relevance of culture and context for mental health has led to collaborations between anthropologists and psychiatrists with a joint interest in theoretical and methodological questions (Heyken et al., 2019; Kleinman, 2001). In general, anthropologists draw on qualitative ethnographic approaches to understand local contexts and peoples' different responses to crises. One example for the strengths of combining psychiatric and anthropological methods is a study by Mendenhall et al. (2016), who used the Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977), a commonly used

standardized assessment in mental health care, to complement and interpret ethnographic interviews. The study aimed to investigate the meaning of psychological distress by analyzing the symptomatology. The authors concluded that incorporating standardized mental health assessments into clinical anthropology facilitates the process of researchers drawing conclusions from smaller data sets, such as ethnographies, and also increases the robustness of the interpretation of results.

Mixed-methods designs can add to the benefits of qualitative and quantitative research by integrating different kinds of data. Several studies have demonstrated the validity of such approaches in research on culture, society, and mental health (Doucerain et al., 2016; Groleau et al., 2007). Terpe (2015) suggests combining data and methods in the process of methodological triangulation, in which qualitative data is quantified, allowing researchers to relate and to complement qualitative outcomes with quantitative data—and vice versa. Such interdisciplinary mixed methods approaches can balance the need for generalizability and sensitivity for specific emic perspectives when investigating migrants' emotional distress, even in smaller samples.

Vietnamese cultural contexts

According to the Federal Office of Statistics of Germany, (2018b),roughly 185,000 people of Vietnamese heritage lived in Germany, making them the largest Southeast Asian migrant population. Nevertheless, little research has been conducted in this population to date. Various philosophical and religious influences shape Vietnam's cultural and social life (Nguyen, 2016; Vuong et al., 2018). Confucian principles emphasize social order, respect for authority, and filial piety (*hiếu thảo*), e.g., respecting one's parents and the elderly. Taoism and its striving for thrift, humility, compassion, and harmony have also strongly influenced Vietnam. Additionally, over 70% of Vietnamese identify as Buddhists, and a minority is either exclusively or syncretistically Christian. Most Vietnamese persons practice some form of ancestor worship (*thờ cúng tổ tiên*), which reflects the importance of the family unit. In this frame of reference, sociocentrism is usually valued more highly than individualism, with corresponding moral norms and role expectations (Kim, 2014).

This background is palpable in the everyday experiences of cultural difference for overseas Vietnamese persons (*Việt Kiều*); worldwide, their population amounts to roughly three million. Migration motives have been shaped by Vietnam's more recent history of decolonization—35 years of consecutive wars, and socioeconomic hardships. While Vietnamese populations in the United States and Western Europe consist mainly of refugees from after 1975, others migrated to Europe as students in the context of French colonial rule from 1883 to 1954. In Eastern Europe, a large number of Vietnamese arrived before 1989 through international socialist cooperation, e.g., as students or labor migrants. Apart from that, migration continues for various reasons, causing a unique diversity of migration biographies (GIZ, 2016).

The Department of Psychiatry and Psychotherapy at Charité – Universitätsmedizin Berlin, Campus Benjamin Franklin (CBF), has acknowledged cultural variations in symptom presentation and the demand for cross-cultural openness in mental health care services, and opened Germany's first specialized outpatient clinic for Vietnamese migrants in 2010. This outpatient clinic offers culturally sensitive psychiatric and psychotherapeutic treatment in the Vietnamese language, especially for patients who refrain from seeking out mental health care elsewhere due to their language barrier. In cooperation with this initiative, a second outpatient clinic dedicated to Vietnamese migrant patients opened in 2012 in the psychiatric department of a large general hospital, Evangelical Hospital Queen Elisabeth Herzberge (KEH), in Berlin. These clinics provide the setting for this study.

Objectives

This study aimed to investigate *emic* themes of distress among Vietnamese psychiatric outpatients. In the first part of this mixed-methods study, we explored quantitative differences in reported distress between Vietnamese and German outpatients. We contrasted both groups in order to gain an initial point of reference to identify possible experiences of cultural and migration-related distress in the community of Vietnamese migrant patients living in Berlin. In the second, qualitative part of our study, we used semi-structured ethnographic interviews with Vietnamese patients to contextualize, broaden, and increase the external validity of the quantitative analyses. The study also sought to demonstrate the synergetic benefits of interdisciplinary work among psychiatrists, psychologists, and anthropologists and to show how ethnographic interviews can contextualize patients' reports and reveal new emic themes of emotional distress that are relevant for clinicians.

Methods

Recruitment

Patients were recruited from a psychiatric-psychotherapeutic outpatient clinic specialized in the

care of Vietnamese migrants at the Department of Psychiatry and Psychotherapy, Charité – Universitätsmedizin Berlin, CBF, in Germany, and from the outpatient clinic of the Department of Psychiatry and Psychotherapy at KEH in Berlin.

All patient-related quantitative data was collected between 2013 and 2016. All participants were born and socialized in Vietnam and sought culturally sensitive counseling and psychiatric or psychotherapeutic treatment in the Vietnamese language. All patients in the present study initially met the ICD-10 criteria either for depressive episodes, anxiety disorders, or adjustment disorders diagnosed by a board-certified psychiatrist in Vietnamese. Patients with acute psychosis, acute suicidality, a neurodegenerative disorder, severe PTSD, or a comorbid substance-related disorder did not participate in the study. Ethical approval of this study was obtained from the ethical committee at the Charité – Universitätsmedizin, Berlin. All patients gave informed, written consent that collected data would be anonymized and used for research and scientific publication purposes only. This study uses a cross-sectional design. Before the first consultation and treatment, all patients were asked to complete a structured survey. This survey included questionnaires assessing socio-demographic information, clinical psychiatric evaluation, and psychometric scales such as the Patient Health Questionnaire (PHQ; Spitzer et al., 2000). Vietnamese patients were asked to fill out surveys in the Vietnamese language (Dreher et al., 2017; Ta et al., 2015).

In the first part of the study, the sample consisted of 104 Vietnamese and 104 German outpatients. The German sample was selected to match the Vietnamese patients' demographic characteristics, considering age, sex, education, and diagnosis. In the second part of the study, a new sample of 20 Vietnamese patients was selected and individually interviewed. Patients were included in the qualitative study if they were first-generation Vietnamese migrants (i.e., born and socialized in Vietnam) and met all the criteria for the quantitative study as described above. Moreover, the sample was chosen to capture the range of demographic variation on age, sex, and length of stay in the larger sample.

Measures

Patient Health Questionnaire (PHQ). The PHQ (Spitzer et al., 2000) is a self-report questionnaire, which is widely used in primary care to screen for mental disorders based on diagnostic criteria from the DSM-IV. The central question for our study was one item asking: "What currently burdens you the most?" (German: Was belastet Sie zur Zeit am Meisten?; Vietnamese: Điều gì làm anh/chị bận tâm nhất hiện nay?). The survey was translated from German into Vietnamese using a four-step back-translation approach (e.g., Beaton et al., 2000).At first, a native Vietnamese psychiatrist translated it into Vietnamese. Then, a state-certified Vietnamese translator back-translated the Vietnamese draft version to German. Afterward, the original survey was compared with the back-translated German versions and was edited to address resulting issues. Based on the corrected back-translation, a final Vietnamese translation was agreed upon by both translators.

Emotional Distress Interview. Based on the quantitative results on the relative frequency of reported distress in Vietnamese and German patients, relevant themes for the Emotional Distress Interview (Table 1) were chosen. We considered themes to be relevant if there were (1) statistically significant differences in frequencies between the two groups, indicating possible themes related to special experiences and/or to the migration experience of Vietnamese patients; or (2) overall high frequencies within the group's responses. This selection and the subsequent phrasing of the semi-structured interview were discussed by an interdisciplinary team[1] that had extensive research experience with Vietnamese migrants in Germany. We applied the method of person-centered ethnography, addressing interviewees as both informants and respondents (Hollan, 2001), to generate a detailed narrative of patients' phenomenological experiences and understandings of their reported emotional distress. The interviews were conducted by the first authors of this article in 2017 at the outpatient clinic at Charité –Universitätsmedizin in Vietnamese language and lasted approximately two hours.

Data analyses

Quantitative analysis. Statistical analyses were conducted with IBM SPSS Statistics for Mac OS X, Version 22. Demographic group differences regarding continuous variables (age) were analyzed with *t*-tests. Differences regarding ordinal variables (sex, education) were tested with chi-square tests and Mann-Whitney *U* tests. If cell size was < 5, Fisher's exact test was used instead of the Chi-square test because of its sensitivity to sample size. Patients' answers on their emotional distress and the generated codes were quantified by rating the codes as present (1) vs. absent (0). Chi-square tests were conducted to explore differences in the frequency of reported themes of distress between Vietnamese and German patients.

Qualitative analysis. Qualitative data was analyzed using MAXQDA 11 for Mac OS X. Patients' answers on

Table 1. Emotional distress interview in Vietnamese and English.

1. *Anh/Chị có vấn đề sức khỏe gì lúc anh/chị đến phòng khám?* Which "health problem" did you have when you first came to the outpatient clinic?
2. *Hồi đó sức khỏe anh/chị như thế nào? Anh/Chị đã gặp những khó khăn gì?* How was your health during that time? What difficulties did you have?
3. *Anh/Chị tâm sự về những khó khăn đó với ai? Điều gì hoặc ai đã giúp đỡ anh/chị trong giai đoạn đó?* To whom do you talk concerning your difficulties? Who or what helped you during this period?
4. *Anh/Chị có thể liệt kê cho tôi những người quan trọng trong cuộc đời của anh/chị?* Could you please name us important people in your life?
5. *Lúc anh/chị bị bệnh/gặp những khó khăn những mối quan hệ đó có thay đổi gì không?* Did the relationship to these people change during your illness?
6. *Anh/Chị có gặp khó khăn với con cái mình không? Cụ thể là gì?* Do you have difficulties with your children? What are these difficulties?
7. *Theo anh/chị, người Việt tại Đức hay gặp những khó khăn gì với con cái của mình?* What difficulties do Vietnamese living in Germany have with their children?
8. *Họ tâm sự với ai về những vấn đề của con cái?* Who do they talk to if they have problems with their children?
9. *Bản thân anh/chị có thể tâm sự với ai nếu anh/chị có những khó khăn với vợ/chồng/người yêu mình?* Who can you talk to if you have problems with your partner?
10. *Khi có vấn đề trong mối quan hệ vợ chồng theo anh/chị người Việt hay kể với ai?* When Vietnamese have difficulties with their partners, who would they talk to?
11. *Anh/ chị có gặp khó khăn trong công việc không? Cụ thể là gì?* Do you have difficulties at work? What are these difficulties?
12. *Theo anh/chị, người Việt tại Đức hay gặp những khó khăn gì trong công việc?* What difficulties do Vietnamese living in Germany have at work?
13. *Theo anh/chị công việc quan trọng không?* Do you think work is important?

their emotional distress as well as interviews with the Vietnamese patients were analyzed by applying qualitative content analysis (e.g. Hsieh & Shannon, 2005). Next, a coding scheme for patients' answers to the open question in the survey was developed. Answers were then separately coded; any differences were resolved in interdisciplinary discussions. Afterward, codes were quantified and statistically analyzed. Based on these results, a semi-structured interview was developed, and $n = 20$ Vietnamese patients were interviewed. Further themes of distress beyond these categories were identified and clustered, generating new categories.

Results

Participants characteristics

The final sample consisted of $n = 104$ German patients and $n = 104$ Vietnamese outpatients. Descriptive statistics of both samples and statistics testing group differences are presented in Table 2.

Quantitative results

In the survey, Vietnamese patients reported more concerns regarding their health or illness compared to German patients, $p < .01$. Vietnamese patients also reported worries about their children more frequently compared to German patients, $p < .05$. However, German patients reported psychological issues to be more burdensome compared to Vietnamese patients, $p < .01$. Psychological issues comprised worries about stress, the mind, and depression. German patients also reported more burdens involving their partners, $p < .01$ (see Table 3).

Qualitative results

In total, 11 themes emerged from Vietnamese patients' interview narratives. Six themes that were previously found in the quantitative survey responses were also found in the subsequent interviews (work (n = 18), children (18), partnership (18), psychological (17) and somatic symptoms (18), finances (16), institutions

Table 2. Comparison of sociodemographic and diagnostic characteristics of Vietnamese and German groups.

	Vietnamese ($n = 104$)		German ($n = 104$)			
Variable	*n*	%	*n*	%	*Test statistic*	*p*-value
Sex (female)	76	73.0	81	78.0	$\chi^2 = 0.65$	0.52
Diagnosis						
Depression	88	84.6	88	84.6	$\chi^2 = 0$	1.00
Anxiety disorders	13	12.5	13	12.5	$\chi^2 = 0$	1.00
Adjustment disorders	3	2.9	3	2.9	$\chi^2 = 0$	1.00
	M	*SD*	*M*	*SD*		
Age	44.27	11.24	42.36	12.23	$t = 1.18$	0.24
Education (years)	10.17	2.92	10.83	1.21	$U = 5259.00$	0.70
Years in Germany	15.99	10.13	–	–		
	n	%				
Language skills						
Very good	2	1.9	–	–		
Good	13	12.5	–	–		
Moderate	27	26.0	–	–		
Insufficient	44	42.3	–	–		
None	18	17.3	–	–		

Table 3. Comparison of themes from the survey by ethnicity.

	Vietnamese $n = 104$	German $n = 104$		
Themes	Yes	Yes	$\chi 2$	*p*
Health/illness	59 (57%)	13 (13%)	44.95	**.001**
Somatic	11 (11%)	15 (14%)	0.70	.53
Psychological	7 (7%)	33 (32%)	20.92	**.001**
Children	23 (22%)	10 (10%)	6.09	**.022**
Partner	2 (2%)	14 (14%)	9.75	**.003**
Work	9 (9%)	14 (14%)	1.22	.377
Finances	8 (8%)	7 (7%)	0.72	1.00
Institutions	7 (7%)	0 (0%)	–	**.007**[a]

Notes: [a]Cell size was < 5. Fisher's exact test was used instead of Chi-square test. Bold face value indicate $p = .000$

(14)). In addition, five new themes of distress emerged from the in-depth interviews (past (n = 16), future (15), speechlessness (15), isolation (11), language (11)). In the following, these themes will be described and illustrated with quotes from a patient. First, we present themes that were identified in the survey responses and elaborated in the semi-structured interviews (Themes 1.1–1.6). Second, we present new themes that were unmentioned in the survey, but which emerged as relevant during the interviews (Themes 2.1–2.5).

1.1 Work. The majority of patients considered their work to be burdensome due to physical exhaustion, long working hours, and the pressure to perform well. Almost all patients reported that they had maintained an intense work-related level of stress for several years without taking a break, while taking care of their local family and kin overseas. Struggles with an unresolved residence status were also addressed as distress and related to their illness, eventually leading some of them to quit their work. The following quotes summarize common responses:

> I worked so much back in Vietnam and here. I sold flowers, owned a restaurant. And then it [the illness] happened. It was too much pressure; I had to hire people, file the paperwork, I had to organize everything until I was overworked. (Mr. U., 53)

> They [the Vietnamese] are carried away by their work. They work so much in order to make money and are totally immersed. They work from dawn till dusk. Once I talked to a doctor; she said that Vietnamese only go to treatment when it's almost too late. Vietnamese don't have a vacation. (Mr. A., 54)

Despite perceiving work as burdensome, patients also highlighted its importance for their quality of life, as a way of participating in society and as a means of financial and personal independence. Patients repeatedly underscored that they wanted to work if their health would allow them to do so: "It's very important to participate and not to receive welfare. No one wants that. No one. If one is ill, one suffers. I really want to work; I just can't do it" (Mrs. V., 57); "Working is a source of joy because one is able to have contact, one learns a lot. Back then when I was working, I was happy and time passed away" (Ms. Q., 44); "The mind is happy and one is satisfied with life. I think it doesn't matter what kind of job it is; the important thing is that you're working" (Ms. I., 31).

1.2. Children. The second most often mentioned theme of distress referred to children. Patients worried about the "right parenting" of their children. They experienced a clash between parenting beliefs and practices prevalent in Germany and their own upbringing in Vietnam. Vietnamese parents wanted their children to be autonomous and integrated into German society, or even considered their children to be German-Vietnamese (Việt-Đức). Meanwhile, their own parenting style was strongly influenced by Vietnamese cultural values:

> I find it difficult. The two cultures. We want the Vietnamese upbringing as a benchmark, but we have to adopt the German culture. For example, they want to have a partner too soon. I wanted to forbid it. (. . .) But when you forbid it, it's also not working. (Mrs. B., 51)

> The Vietnamese [first generation] press Vietnamese upbringing methods on their children. But the children, who live here, they live like Germans. It's difficult to change their thinking. They don't understand a lot of Vietnamese, but a lot of German. (. . .) Back then I had to play at home, but nowadays the children here go out in cafes, put make-up on, or have boyfriends at 14or 15. I'm afraid my children will turn out like that. (Mrs. I., 32)

In addition to the difficulties related to raising children in the context of contradictory norms of parenting, there were language problems. Patients, whose ability to speak German was very basic, reported that they suffer because their children do not speak Vietnamese well enough. Therefore, profound communication was difficult: "It's difficult because they do not speak Vietnamese. They always say some weird sentences. But once it gets deeper, they can't say it" (Mr. A., 54).

Moreover, the elder generation of Vietnamese patients complained that their children did not support them sufficiently in chores, such as filing paperwork or translating at doctors' appointments. Patients were often disappointed, because their expectations were not fulfilled by their children: "I'm sad when I can't ask them a favor. For example, translating. It's just a small favor, but they won't do it. Every time I'm sick I ask them, but they never come along" (Mrs. P., 60).

1.3. Partnership. In contrast to the quantitative results, which showed that Vietnamese patients did not report partnership problems, the interviews revealed numerous difficulties with partners. Among the listed burdens, the majority of female patients reported longtime domestic violence in relationships with Vietnamese or German men. Moreover, female patients reported distress because they did not get enough support from their partners in household tasks, especially during pregnancy and the postpartum period. Patients also said that it was especially burdensome to suppress all difficulties in social encounters instead of addressing them with others, in order to adhere to the norm of social harmony to "save face" (*thể diện*): "My husband took all my money. He beat me. Back in Vietnam my husband also beat me. I was very scared" (Ms. X., 48); "I just wanted to be healthy and wanted to work. (. . .) Here [in Germany] I had a beating husband and I had to call the police. (. . .) Now I'm just scared that he'll find me" (Mrs. V., 57); "They're afraid the man will lose face. They [Vietnamese women] are afraid that their happiness will break; that's why they swallow everything" (Mrs. V., 57);

> He always said "bye" and went away with his friends. I was alone, pregnant. I told him to stay at home and to help, but he always went away with his friends. (. . .) He was gone every day and I was alone with the baby, had to run errands all by myself with the baby. Or when the baby was sick . . . I had to go alone to the doctor. I was very sad because of my husband. (Mrs. H., 44)

1.4. Psychological and somatic symptoms. A theme that emerged repeatedly in the interviews was the impact of psychological or somatic symptoms, which occupied and burdened patients' daily lives. Psychologically, patients named the core symptoms of depression; for instance, feelings of sadness, hopelessness, and experiencing little interest or pleasure. Moreover,

patients reported fear, stress, and worries and used the Vietnamese term for depression (*trầm cảm*): "I don't feel any joy. That is why I have this trầm cảm" (Mr. U., 53); "I just want to disappear, I am so hopeless. When I go out, I don't feel joy. Outside, I'm just scared" (Mrs. V., 57).

Furthermore, patients listed numerous somatic complaints, such as weak nerves, pain all over the body, and trouble sleeping: "I feel a lot of tension. It's like something with my nerves. I often fight with others and I'm aggressive. My nerves are too weak and I just wanted to break everything" (Mr. U., 53); "I couldn't sleep and had pain all over the body. The right side of my body was in pain. It feels like little crabs bite my body. And my head hurts brutally" (Mrs. L., 54).

1.5. Finances. Patients named financial burdens, such as the discrepancy between their longing for wealth and their inability to achieve this goal due to health problems. Moreover, for those depending on welfare, limited income was also experienced as burdensome. In addition to this limitation, some patients still have to support their family in Vietnam financially: "My husband and I worked a lot. I worked in kindergarten and he was a cook. But then he sent all the money to Vietnam to support the family. And I didn't have any control" (Mrs. B., 51);

> In the past, I also wanted to be wealthy. But I couldn't do it. I think everyone wants to be wealthy. When one has enough money, one can buy things, food – whatever you want. I receive €300 per month, and I have to buy a ticket for public transportation and food for the family. It's not a lot. (Mrs. R., 49)

1.6. Institutions. Patients repeatedly reported the pressure of government authorities and the formalized bureaucracy in these institutions as a major source of distress. They often felt pressured and humiliated by pending decisions regarding residency titles and employment permits, by child protective services, or by obligations to the federal employment agency "Jobcenter," which administers unemployment benefits. The following quotes outline the dense network of institutions about which the patients are concerned:

> I do not want to depend on the Jobcenter. One has to be independent, to receive a permit of residency from the department of foreigners, in order to have work. One has to be diligent, to have less stress, and not to think too much. (Ms. I., 32)

> You have to file all the paperwork. They always ask you, every two weeks you have an appointment, only because you receive a couple of Euros. Good Lord, they make me crazy! They make my head explode. It's like you're homeless. If I had the strength, I would work. Life like this . . . it isn't quiet.(Mrs. T., 47)

> Child protective services didn't allow me to see my children. I didn't know where they were, and I didn't see them for six months. I felt like I lost my children and I was so scared and thought that I'm going crazy. At home, it was so cold because my children were not there. (Mrs. X., 48)

2.1 Past. One of the new emerging themes was the impact of the past and the strategy of not thinking too much about the past. Patients report having had burdensome and traumatic experiences in the past, such as war or violence. They urgently avoid thinking about the past to avoid physical pain or additional psychological stress: "One tries not to talk about the past. It's not useful" (Mr. U., 53); "Of course I sometimes think about the past. But I think it's not useful. It just hurts you, and it's a waste of time. I always tell myself: I don't think about it" (Mr. E., 58).

However, memories of the past cannot always be suppressed, which our patients experience as very burdensome: "From time to time I think about the past. I cannot forget it. Especially, when I'm alone, the past comes back and I cannot throw it away" (Ms. B., 51).

2.2. Future. Concerning the future, reports of patients were ambivalent. Some stated that they felt pressured into thinking about the future and tried to avoid thinking about it, which is comparable to the avoidance of the past:

> I think it's better not to think about the future. It's not too late to paint a picture of the future. I used to sit around and paint my future. But the reality is different. That's why one shouldn't think about it. (Mrs. L., 54).

However, other patients perceive the future as an important motivation and want to improve their situation:

> You cannot avoid thinking about the future. You have to make an effort for the future. And if you know that, you just have to find a way for yourself. When I think about the future, I always tell myself that my health is the most important thing.(Mr. A., 54)

2.3. Speechlessness. Another burdensome theme that was reported in interviews was a state that we labeled as "speechlessness." Speechlessness was mentioned in

different domains, mostly expressed in terms such as "difficult to say" (*khó nói*) or "not being able to speak" (*không nói được*). It encompassed the difficulty in articulating certain experiences, norms against explicit mention of painful events, and the absence of a trusted person to confide in. Patients mentioned mistrust and fear that people would circulate their personal stories around the Vietnamese community: "I don't have anyone to talk to. My husband is dead and my daughter works from the morning until the evening. I have to solve my difficulties by myself. I don't want to burden her" (Mrs. L., 54);

> The Vietnamese ... I used to tell something about myself, about my family, but very often they told it to other people. Once I made her promise not to tell it to anyone ... but afterwards, she talked about everything to others. (Mrs. H., 44)

Speechlessness was also reported between parents and children due to language difficulties:

> The children don't speak Vietnamese. It's difficult to convey one's affection. That's why I have to show my affection through actions; for instance, I stroke their backs. And then they ask me whether I can stroke their back again. (Ms. X., 48)

Moreover, Vietnamese patients seem to face a double burden: neither are they able to confide in their fellow Vietnamese peers living in Germany, nor are they able to share their difficulties with their family in Vietnam, because they fear that their families cannot understand their difficulties abroad or might worry too much. They feel caught between two worlds:

> I mostly talk to my friends here. Only here are they able to understand reality. I am scared to talk about my situation, that I have a boyfriend here. In Vietnam, I would have to marry. Abroad they don't understand this. (Ms. X., 48)

2.4 Isolation. Vietnamese patients also reported feelings of marginalization and isolation, and limited contact with other people. Their social withdrawal was a symptom of the depression, but mental illness also reinforced social withdrawal tendencies: "Because of the illness, I don't have any contact with people anymore" (Mrs. L., 54); "No one understands how ill I am. No one understands us [depressive patients]. I act as if I'm fresh from the outside, but inside I'm dead. I can't meet people" (Mrs. T., 47); "I live alone and I am sad. But if I had to go back to Vietnam, I would be sad as well. I cannot find friends; that's why I have this depression" (Mr. U., 53).

2.5. Language. Finally, patients also addressed language difficulties as a heavy burden. Patients often felt guilty and ashamed of their limited ability to speak the German language: "The difficulty the Vietnamese have is that they cannot speak the language. And if you don't understand it, you have to ask others" (Mr. A., 54);

> I think it's hard for them because they don't speak the language very well. For instance, when I worked at the kindergarten back then, I had difficulty understanding everything. And there were a lot of misunderstandings. I understand most of it, but sometimes I can't respond. (Mrs. B., 50)

Discussion

The first quantitative part of the study suggests that the differences, and perceptions of emotional distress, between Vietnamese and German patients partly reflect cultural and migration-related experiences of Vietnamese migrants. In the second, qualitative part, we gathered additional contextualizing information through in-depth interviews with Vietnamese patients, and found new themes of distress that were not mentioned in the survey. Therefore, this study suggests that an interdisciplinary, mixed-methods approach can reveal migrants' emic themes of emotional distress and contribute to a broader understanding of migrants' mental health. In the following, we discuss our findings in light of migrants' diverse sociocultural backgrounds, and their implications for research and clinical work.

Work and finances

In the survey, both German and Vietnamese patients mentioned work as a source of distress. Almost all of the interviewed Vietnamese patients mentioned work as a major burden, but most of them also acknowledged that being able to work was a resource as well. This finding is in line with other studies, which have associated work or unemployment with stress among various migrant groups (Chen et al., 2012; Jurado et al., 2017; Warfa et al., 2012). In the context of Vietnamese cultural values, work is an obligatory contribution to the family's welfare and to social harmony. In Confucian ethics, work is viewed not as an individual contribution, but instead as a relational contribution to stability and harmony in one's family and society, and by extension in the universal order (Kim, 2014).

Different migratory pathways structured the meaning-making about work in this population. After the war and reunification of Vietnam in 1975, thousands of South Vietnamese sought refuge under hazardous conditions. The Federal Republic of Germany accepted about 40,000 Vietnamese refugees. They were uprooted and had to start anew. Hard work allowed them to build a future for themselves and their family.

During the 1980s, the German Democratic Republic recruited more than 60,000 temporary labor migrants from Vietnam through a bilateral agreement (GIZ, 2016). Becoming a 'contract worker' was initially prestigious and allowed one to financially support one's family during Vietnam's economic crisis. The German reunification, however, rendered these migrants largely unemployed and disenfranchised. According to ethnographic research in the community, gainful employment was a pathway of paramount importance to structural security, social entitlements, and successive migration of their families (von Poser, Lanca, & Heyken, 2017).

Today's ongoing Vietnamese migration to Germany consists mainly of people from rural regions of Vietnam with limited access to education, seeking to improve their economic situation and to support their families. Due to irregular migration pathways, many of them are indebted to traffickers and lack a working permit, as well as legal residency. Another large group of Vietnamese migrated to Germany for educational or training purposes (e.g., nurses) (GIZ, 2016). However, the pressure to earn money is omnipresent and burdensome. Therefore, work (or the lack thereof) has a different meaning depending on individual migration pathways. Additionally, work and the wish to contribute to society are highly valued among Vietnamese, and receiving social welfare is associated with shame and loss of face. Our ethnographic data indicate that work is perceived as both a burdensome obligation and a central strategy of self-validation.

Children

Compared to German patients, Vietnamese patients mentioned children more often as a source of distress. Worries often revolved around parenting, especially the need to find a balance between local parenting styles and those acquired in Vietnam. Our results are in line with the existing literature on parenting of Vietnamese migrants living in the United States, Australia, and Norway (Nguyen, 2015; Tingvold et al., 2012). For instance, Confucianism values filial piety, which comprises children's obligations to honor their parents through displays of obedience and respect. This more authoritarian parenting style does not allow children to disagree with their parents. In contrast, current educational notions in Germany value children's autonomy and more democratic parenting styles. Thus, children socialized in Germany may find their Vietnamese parents' beliefs to be anachronistic and unjust compared to the values that structure their German peers' experiences (Beth & Tuckermann, 2008).

Moreover, support systems and strategies connected with the paramount societal value of collectivism in Vietnam often fail to work in a more individualistic society and instead engender further difficulties. For instance, in Vietnam, children stay in full-time (pre) school and teachers, grandparents, and neighbors are much more involved in their upbringing. Family members' intervention often mediates conflicts. With life in a nuclear family in Germany, however, such sociocentric solutions are often no longer available (Röttger-Rössler & Lam, 2019).

Partnership

German patients mentioned difficulties with partners significantly more often than Vietnamese patients in the quantitative part. However, when we asked directly for partnerships as a possible source of distress, this theme appeared more frequently in the Vietnamese population. A recent study investigating explanatory models of primary health care providers in Vietnam also identified social and familial expectations to be linked as a cause of depression (Murphy et al., 2018). Keeping the familial harmony and saving face (Hwang, 2012; Pham, 2014)may be one reason why Vietnamese patients withheld such issues in a written account. The Vietnamese proverb "Xấu chàng hổ ai" reflects this notion and means: If the husband's negative traits are shared with others, it will bring shame upon the wife. However, directly addressed in confidential interviews, patients shared both their views on Vietnamese partnerships in general and their personal experiences. While they mostly described ideal partnerships as a relation of solidarity in which partners co-shoulder struggles, a lack of open communication was mentioned as a common problem in Vietnamese marriages. Reported difficulties encompassed unreliability, unfaithfulness, and lack of commitment. For several patients and regardless of gender, their partners' disdain was a major source of distress, and several women even reported experiences of domestic violence.

Ethnographic data from different contexts underscore that, for migrants, altered norms, discrimination, and structural marginalization can elicit feelings of disempowerment and inferiority, especially in men (Farahani, 2012; Khosravi, 2009). In response to being excluded from hegemonic masculinity (Connell, 1987), some men perform aggressive hypermasculinity

as a means of self-assurance. With notions of Germans' partnerships as egalitarian, hierarchical partnerships can also serve some men to construct and consolidate a gendered sense of cultural identity by exaggerating traditional patriarchal Vietnamese values, such as the Confucian ideal of male dominance over women (Do et al., 2013). This might account in part for reported male domestic violence and calls for further qualitative investigations.

According to our clinical observation, some of our female patients reported that their partners displayed longstanding sleeping disorders, impulsive behaviors, or social withdrawal. Rather than seeking professional help, they often used alcohol for self-treatment. Statistics on the utilization of mental health services among Vietnamese migrants in Germany showed an underrepresentation of male patients (Ta et al., 2015). The lack of appropriate coping strategies paired with alcoholism elevates the risk for conflicts. Other studies have also reported an elevated prevalence for domestic violence among Vietnamese (Do et al., 2013; Garcia-Moreno et al., 2006; Nguyen, 2006).

Psychological/somatic symptoms and isolation

German patients reported significantly more psychological symptoms explicitly than did Vietnamese patients. The frequency of somatic symptoms was not significantly different between the two groups. When we interviewed our patients, both psychological and somatic symptoms were equally articulated as sources of distress. Our findings are in line with the existing literature, indicating that the mind-body dualism—rooted in European enlightenment philosophy—is less influential for Asian patients, whose spontaneous symptom presentation instead typically emphasizes somatic symptoms (Choi et al., 2016; Dreher et al., 2017; Ryder & Chentsova-Dutton, 2012). A new theme of distress that emerged from the interviews was social isolation, either as a symptom or a consequence of patients' psychiatric illness. Previous acculturation research on Vietnamese migrants has shown that marginalization—meaning being oriented toward neither the mainstream nor the heritage society—is associated with higher levels of depression (Nguyen et al., 2017). Losing one's social network and difficulties with establishing and maintaining new social ties after the act of migration are frequently reported experiences among migrants (e.g., Hurtado-de-Mendoza et al., 2014).

Past and future

During the interviews with the Vietnamese patients, the past was often articulated as being associated with distress. Patients repeatedly said that they tried not to think about the past. Our results echo the existing literature. Kaiser and colleagues (2015) have identified "thinking too much" (*suy nghĩ nhiều*) to be a worldwide idiom of distress, which overlaps with "Western" symptoms such as rumination. Studies among Southeast Asian societies have explained the negative experience of "thinking too much" by referring to valued and shared Buddhist principles, which emphasize equanimity or non-attachment toward emotions or thoughts (Cassaniti, 2011; Nhat Hanh, 1999). Thus, inability to control one's mind is associated with weakness and with the failure to practice the Noble Eightfold Path to liberate oneself (Kaiser et al., 2015; Merkel, 1996). Patients try to distract themselves by suppressing their thoughts; however, when the illness is too severe, these coping mechanisms fail (Wenzlaff & Luxton, 2003). Hinton et al. (2016) relate "thinking too much" among patients with a Southeast Asian background to negative moods as well as to mental and somatic symptoms, and point out their potential to engender catastrophic cognitions.

Concerning the future, patients were ambivalent. Some patients avoided thinking about the future to prevent "thinking too much," while others hope for a better future to motivate themselves. In our therapeutic context, we used these findings and practice to return to the present by applying mindfulness-based interventions, which are rooted in Buddhism and therefore very accessible to our patients (Fung, 2015). Acceptance and mindfulness techniques have also been successfully applied in culturally adapted CBT (CA-CBT) among Latino and Southeast Asian refugee populations with PTSD (Hinton et al., 2013). Moreover, in psychoeducation, we reframe rumination as a depressive symptom rather than a flaw in character, which helps patients to accept themselves more.

Speechlessness and language

Another theme that emerged in the interviews we labelled as "speechlessness." Importantly, this theme was related to, but went beyond, communication barriers, which involved difficulties with German language. Moments of speechlessness occurred in different spheres of life, concerning interactions with the mainstream society in Germany, the nuclear family, and relatives in Vietnam or the local Vietnamese communities. Research on acculturation has shown that language proficiency is often a gateway to a society (Berry, 2005; Schachner et al., 2014). These results also matched the described difficulties of our patients when dealing with German institutions and bureaucracy. Such challenges were often perceived as overwhelmingly burdensome, mainly because the

patients lacked language skills, but also because of the uncertainty regarding culturally accepted modes of interaction or previous intimidating experiences in their migration histories. Similar results were obtained in previous studies, which also concluded that administrative obstacles were an additional barrier to receiving mental health care for migrants (Kung, 2004; Straßmayr et al., 2012).

On another level, within the nuclear family, communication difficulties between parents and children were aggravated due to language barriers. Children born in Germany did not speak enough Vietnamese to engage in profound communication with their parents. Meanwhile, parents did not speak German sufficiently for deep conversational exchange. Ethnographic research with children of former Vietnamese contract workers living in Berlin (Röttger-Rössler & Lam, 2019) has shown that asymmetries in German language competencies between parents and children may subvert the hierarchical family structure and notions of filial piety. These new asymmetries may engender affective dissonances and emotional distress within the family. Additionally, deeply ingrained norms may appear natural to parents, making it hard to recognize and explicate them verbally to their children, who underwent different socialization in Germany.

Beyond the nuclear family, disruption and speechlessness were also reported when communicating with family members in Vietnam. Migrants have had to adjust to the new social and cultural norms and practices in Germany. Their everyday life differs from that of their distant relatives. Thus, relatives in Vietnam often cannot imagine life in Europe. In addition to the problem of conveying their local experiences, migrants do not want to burden their relatives in Vietnam with concerns about their transnational lives. Interview data suggest that these hardships can result in a disruption of belonging and feelings of alienation (Röttger-Rössler, 2016).

Lastly, patients reported a distinct mistrust of and grave concern about gossip within the Vietnamese communities (von Poser, Lanca, & Heyken, 2017). They feared that their private matters, once entrusted to friends or acquaintances, might be passed on to others, circulate more widely, and lead to adverse judgment and loss of face among their countrypeople (*đồng hương*). The migrant communities were reportedly prone to gossip, given the small size and tightly interconnected nature. Ethnographic accounts and our own cultural knowledge suggest that difficulties in transposing previously acquired social strategies and practices to the German context might explain this phenomenon. In Vietnamese society, losing face (*mất mặt* or *mất thể diện*) is associated with social disapproval of one's image or of the family's image; therefore, face-threatening contents are kept within the extended family (Nguyen, 2015; Nhung, 2014). This is also reflected in the common Vietnamese proverb "Vạch áo cho người xem lưng" (Don't take off your shirt to show your back), which conveys the notion that one should not talk about private family problems in public. However, during the process of migration, extended family structures shrink to the nuclear family (Tingvold et al., 2012). Attempts to share private matters with members of the local, extended community instead often disappoint; without clear

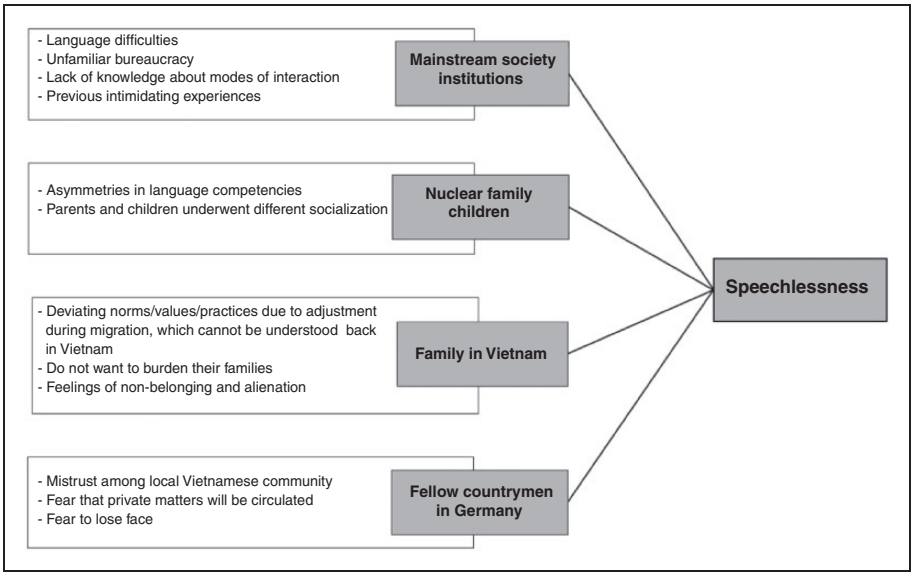

Figure 1. Reported experiences of speechlessness in different spheres of life among the $n = 20$ interviewed Vietnamese outpatients living in Germany.

affiliation, the rule of keeping private matters within the family to "save face" fails.

In summary, moments of speechlessness are experienced in various spheres of our patients' life (see Figure 1) and demand consideration in therapy. Encounters in a neutral therapeutic space may serve as a safe *third space* in which patients can productively address feelings of mistrust toward fellow Vietnamese migrants, and that enables new experiences (Bhabha, 2004). Responding to this need, the specialized psychiatric-psychotherapeutic outpatient clinic in Berlin has offered culturally sensitive group therapies in the Vietnamese language, focusing on concepts such as belonging and acknowledging the hardships of migration (e.g., Pfaff-Czarnecka, 2013; Ta et al., 2017).

Limitations

The findings of the present study should be interpreted in light of several limitations, which should be addressed in future studies. First, our study is a cross-sectional study and cannot determine causal relationships. Second, our sample consists of a population utilizing mental health care services, and their experience with psychiatry and with particular forms of distress might influence their perception of social stressors. Therefore, our results cannot be generalized to the overall local Vietnamese population or communities. Third, we focused on investigating migration-related emotional distress and did not interview a German group to compare social structural stresses that might be common across the groups.

Conclusion

The interdisciplinary, mixed-methods approach employed in this study provided valuable information of areas of distress for Vietnamese immigrants. While generalizations are usually misleading in the heterogeneous Vietnamese population of Berlin, there were clear parallels in the biographies of our interlocutors based on shared experiences, accounting for commonalities in their intersectional positionality and group-specific characteristics in our sample. In addition to commonly expressed themes of distress related to socioeconomic conditions including work, finances, or language, we identified affectively charged themes, such as partnership and children, and particular moments of speechlessness, which were burdensome and influenced multiple spheres of life. Our results also highlight that, besides socioeconomic burdens, migration processes entail potentially stressful affective dynamics. Future studies should investigate perceived distress among other populations of migrants who underutilize mental health services, and evaluate whether there are differences in perceptions of distress. The identified themes can be utilized to develop clinical questionnaires to promote culturally sensitive assessments. In terms of intervention, psychotherapy may address the themes of distress that we have uncovered and offer specific coping strategies. In conclusion, we believe that this research approach can provide better understanding of the complex and entangled phenomena of mental health and migration, as well as helping to advance culturally sensitive, person-centered medicine.

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Jörg-Christian Lanca, MA, studied South East Asian Studies and Gender Studies at the Humboldt Universität zu Berlin and in Hanoi, Vietnam. He is a doctoral researcher in an interdisciplinary project at the Berlin-based CRC *Affective Societies*. He spent several mid- and long-term stays in Vietnam for study and research purposes. His special research interests lie in the gendered aspects of aging in migration, embodied belonging, and the nexus of bodies, labor, and affects.

Eric Hahn, Dr. MD, works as a consultant psychiatrist and psychotherapist at the Department of Psychiatry of the Charité – Universitätsmedizin Berlin, Campus Benjamin Franklin, Germany. He is head of the working group Global Mental Health and the Schizophrenia research group in the Department. Additionally, he is co-heading an anthropological-psychiatric project within the CRC *Affective Societies* and a collaborative project concerning psychological distress of refugees within the BMBF Project "Affective and Cultural Dimensions of Integration as a Result of Flight and Forced Migration." His research interests concern cross-cultural attitudes and illness models of mental

illness, development of IT-based therapy tools, as well as the adaption of mindfulness-based psychotherapies for patients with schizophrenia.

Anita von Poser, Dr. Phil., holds a teaching and research position at the Institute of Social and Cultural Anthropology at the Free University of Berlin, Germany. She co-heads an anthropological-psychiatric project within the Collaborative Research Center 1171 *Affective Societies – Dynamics of Coexistence in Mobile Worlds*. Dr. von Poser's regional interests are the Southwest Pacific (Papua New Guinea) as well as Vietnamese diasporic worlds in Berlin. Her theoretical interests pertain to the field of psychological anthropology. Her published works focus on relatedness, personhood, empathy, aging and the life course, affect and emotion, care, and im-/mobility.

Edda Heyken, MA, is a social and cultural anthropologist working as a research associate in the applied anthropological-psychiatric project "Affective Efforts of Migration" at the CRC 1171 *Affective Societies* located at the Free University of Berlin, Germany. Currently, she is working on her dissertation on silence, vulnerabilities, embodied memories, and place-making strategies in the lives of elderly South Vietnamese refugees in Berlin. Her published works focus on the affective efforts of migration, (post-)war, displacement, and belonging, as well as conceptual and methodological issues of ethnographical research in mental health services.

Katja Wingenfeld, Dr. Phil., is head of clinical psychology and professor of psychology at the Department of Psychiatry at Charité – Universitätsmedizin Berlin, Campus Benjamin Franklin, Germany. One focus of her research is the investigation of the connections between mental illnesses and stress. She is particularly interested in changes in biological stress regulation systems, such as the hypothalamic pituitary adrenal axis and the autonomic nervous system. In several projects she investigates the connections between cognition (e.g., memory function) and various stress hormones. In addition, she tries to better understand the relationship between stress and physical symptoms in mental illness.

Ronald Burian, Dr. Med., MD, is the head of the Psychiatric-Psychosomatic Day Treatment Center and the consultation liaison service at the Queen Elisabeth Hospital in Berlin, Germany. Dr. Burian is a peer-reviewed ACT trainer of the ACBS, and gives workshops and trainings about Acceptance and Commitment Therapy (ACT) around Europe. His research interests focus on consultation-liaison services for psychiatric and psychosomatic disorders, chronic pain, mental health services for Vietnamese patients, and ACT.

Albert Diefenbacher, MD, PhD, MBA, FAPM, is the head of the Psychiatric Department at the Queen Elisabeth Hospital in Berlin, Germany. Dr. Diefenbacher researches mental health services for Vietnamese patients, as well as service delivery in general hospital settings, especially postoperative delirium. His published works focus on mental health services research, patients with somato-psychic comorbidity, learning disabilities, and psychotherapy, especially Acceptance and Commitment Therapy.

Thi Minh Tam Ta, Dr. Med., MD, is a consultant psychiatrist and psychotherapist and head of the psychiatric outpatient clinic at the Department of Psychiatry of the Charité – Universitätsmedizin Berlin, Campus Benjamin Franklin, Germany. She is also a Clinician Scientist at the Berlin Institute of Health (BIH), Germany. Since 2010, she has worked as the founder and head of a large university outpatient clinic for Vietnamese migrants in Berlin, Germany. She is co-heading an anthropological-psychiatric project within the Collaborative Research Center *Affective Societies*. Her primary research interests concern influences of culture and migration on attitudes and illness models of psychiatric disorders, dynamics of explanatory models, and illness-related help-seeking behaviors. She actively develops adaptations of emotion-focused psychotherapies for Vietnamese patients using mixed methods.

11. Curriculum Vitae

Mein Lebenslauf wird aus datenschutzrechtlichen Gründen in der elektronischen Version meiner Arbeit nicht veröffentlicht.

12. Publications

Peer reviewed articles (IF 2019 (Database))

Dreher, A.; Hahn, E.; Diefenbacher, A**.; Nguyen, M.H.;** Böge, K.; Burian, H.; Dettling, M.; Burian, R.; Ta, T.M.T. (2017): Cultural differences in symptom representation for depression and somatization measured by the PHQ between Vietnamese and German psychiatric outpatients. In: *Journal of Psychosomatic Research* 102: 71-77. https://doi.org/10.1016/j.jpsychores.2017.09.010. **Impact Factor: 2.860 (JCR)**

Martensen, L.K.; Hahn, E.; Cao, T.D.; Schomerus, G.; **Nguyen, M.H.**; Böge, K.; Nguyen, T.D.; Mungee, A.; Dettling, M.; Angermeyer, M.C.; Ta, T.M.T. (2018): Impact of perceived course of illness on the desire for social distance towards people with symptoms of schizophrenia in Hanoi, Vietnam. In: *Psychiatry Research*, 2018 Oct: 206-210. https://doi.org/10.1016/j.psychres.2018.05.046. **Impact Factor: 2.118 (JCR)**

Nguyen, M.H.; Hahn, E.; Von Poser, A.; Ta, T.M.T.; Wingenfeld, K.; Graef-Calliess, I.T.; Stopsack, M.; Burian, H.; Dreher, A.; Wolf, S.; Dettling, M.; Brian, R.; Diefenbacher, A. (2017): Acculturation and severity of depression among first-generation Vietnamese outpatients in Germany. In: *International Journal of Social Psychiatry* 63(8): 708-716. https://doi.org/10.1177/0020764017735140. **Impact Factor: 1.439 (JCR)**

Nguyen, M.H. [*]; Lanca[*], J.C.; Hahn, E., Von Poser, A.; Heyken, E.; Wingenfeld, K.; Burian, R.; Diefenbacher, A.; Ta, T.M.T (2020): Migration-related emotional distress among Vietnamese psychiatric patients in Germany – An interdisciplinary, mixed-method study. In: *Transcultural Psychiatry* 00(0):1-17. https://doi.org/10.1177/1363461520920329. **Impact Factor: 1.936 (JCR)**

Wolf, S.; Hahn, E.; Dettling, M.; **Nguyen, M.H.**; Wingenfeld, K.; Stingl, M.; Hanewald, B.; Ta, T.M.T. (2017): Migration-Related Stressors and Their Effect on the Severity Level and Symptom Pattern of Depression among Vietnamese in Germany. In: *Depression Research and Treatment* (1), 2017 Aug: 1-9. https://doi.org/10.1155/2017/8930432. **Impact Factor: 0.932 (SJR).**

Book chapters, working papers, and case reports

Hahn, E.; Ta, T.M.T.; **Nguyen, M.H.**; Graef-Callies, I.T. (2017): Möglichkeiten und Bedingungen von Akkulturation in der Zivilgesellschaft. In: Graef-Callies, I.T.; Schouler-Ocak, M. (Hg.): *Migration und Transkulturalität*. Schattauer Verlag.

Heyken, E.; Von Poser, A.; Hahn, E.; **Nguyen, M.H.**; Lanca, J.C.; Ta, T.M.T. (im Erscheinen, 2019): Researching Affects in the Clinic and Beyond. Multi-perspectivity, Ethnography, and Mental Health-Care Intervention. In: Antje Kahl (Hg.): *Analyzing Affective Societies. Methods and Methodologies.* Routledge.

Ta, T.M.T.; **Nguyen, M.H.**; Hahn, E.; Spennemann, N. (2017): Psychische Beanspruchung durch Migration am Beispiel vietnamesischer Migrant_innen. In: Kocatürk-Schuster, B. et al. (Hg.): *UnSichtbar. Vietnamesisch-Deutsche Wirklichkeiten.* DOMiD, 240-255.

Ta TMT, **Nguyen, M.H.**, Hahn E. (2016). Panik und Depression bei vietnamesischer Migrantin. *NeuroTransmitter*. 27(9), 28-32. https://doi.org/10.1007/s15016-016-5641-1

Von Poser, A.; Lanca, J.C.; Heyken, E.; **Nguyen, M.H.**; Hahn, E.; Ta, T.M.T. (2017): Annäherungen an das Unsagbare - Artikulationen des Affektiven und die Formierung transkultureller Emotionsrepertoires im Vietnamesischen Berlin. *Working Paper Nr. 8 SFB 1171 Affective Societies 03/2017.*

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“Công cha như núi Thái Sơn
Nghĩa mẹ như nước trong nguồn chảy ra.”

Die Mühen eines Vaters sind so groß wie der Thái Sơn Berg -
Die Liebe einer Mutter ist wie Wasser, das aus der Quelle fließt.
- Vietnamesisches Sprichwort -