Medically unexplained physical complaints among Turkish migrant women: exploring their illness experience and the underlying causes of their distress

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Objective: General practitioners in the Netherlands report a high prevalence of Turkish migrants with medical unexplained physical symptoms; diagnoses and treatment for these patients are not easily found. This qualitative study places the illness experience of Turkish women in a cultural context and explores why the women express themselves the way they do and which stressors underlie their distress.

Design: Semi-structured interviews were held with health care providers and women with a Turkish background (N=23 in total). During the interviews women were asked to tell their life stories and the way their experienced distress played part in it.

Result: The distressing factors Turkish women are experiencing are directly or indirectly related to their migrant status. In the interviews distress is expressed in both physical as well as emotional complaints. Though, in daily live the focus lies on physical complaints. This is caused by multiple factors that, through a sick role, influence the expression of distress to the outside world. The life stories of the women show how interwoven these physical and emotional concepts are and how they blend together into a complex life story with aspects of the individual body, social body and body politic; loss of identity, the lived economic situation, non-existing or shaken up family relationships, lack of social community and the life in the margins of Dutch society play hereby a major role.

Conclusion: The data shows that the women’s dis-ease should be placed in a broader spectrum of ways to communicated distress. The way women express themselves is functional. A sick role is prescribed by the outside world and a response from the community follows. Somatization (not somatoform disorders) should be taken out of the medical realm and loss of identity together with the crumbling social network should be taken as a starting point for non medical interventions. With the women’s stories as a leading guide it is then possible to develop interventions that will take the women’s experiences as migrants and their perception of health and illness as a point of departure. Whereby empowerment and gaining a strong identity within their own social and cultural setting should be key.

Keywords: somatization, health, immigrants, Turkish migrants, Netherlands, qualitative research, migration, identity, interventions, culture.

Introduction
In the beginning of the 1960s, a labor shortage led the Dutch government to look for workers across the border, among others in Turkey. Although both the Turkish labor migrants and the Dutch government thought their stay was going to be temporarily, a large group of immigrants ended up staying and filed for family reunion. Currently, almost 389 thousand Turkish immigrants and their
offspring reside in the Netherlands. This is the largest group of immigrants in the Netherlands. They make up for almost 2.5% of the total Dutch population. Of these almost 50% is of first generation.

The perceived health among the Turkish minority groups is worse compared to the native population (Uiters 2007, Dijkstra 2002, Can 2010). They suffer from more physical limitations in general and chronic illnesses when reaching old age (Wurff 2004). The experienced health is in comparison to men even worse among Turkish women (Can 2010). Rating their own health, 45% of the Turkish migrants rate their health moderate to bad compared to 15% of the indigenous population (Uiters 2007). In Wurff’s (2004) research 61.5% of the Turkish elderly report depressive symptoms on a self reported index scale compared to 14.5% of the native population. As a result Turkish migrants tend to contact the general practitioner more often then the indigenous population (Uiters 2007, Dijkstra 2002, De Jong 1996, Uniken Venema 1989).

Migrants in general present more somatic complains than the general population, this is also true for Turkish migrants during visits to family physicians. (Mirdal 1985, Devillé et al. 2006, Dijkstra 2002). There are indications in the Netherlands that the same might be true for people with low social economic status (SES). Women experience more unexplained physical complaints then men (Dijkstra 2002, Can 2010). The presentation of somatic complains from Turkish migrants is not only persist in the Netherlands. The same is noted by authors in other European countries; Belgium (Gailly 1997), Sweden (Bääärnhielm and Ekblad 2000) Switzerland (Yilmaz and Weis 2000), Denmark (Mirdal 1985) and is also seen among people in the Netherlands from low social and economic class. The term Medically Unexplained Physical Symptoms (MUPS) is used in reference to patients with physical symptom (like neck pain, tiredness, headache) for which the treating physician can not find a medical cause. Historically in literature MUPS and Medically unexplained symptoms (MUS) and somatization, are used interchangeably.

As a result of frequent doctor visits of Turkish women with somatic complaints physicians experience that at times treatment of Turkish patients is compromised. The physicians report a feeling of irritability, frustration and powerlessness. As a result patients feel distrust towards the proposed treatment (Dijkstra 2002). Patients feel they are not understood or taken seriously by health care providers (Uiters 2007, Dijkstra 2002). Without an explanation for the experienced physical complaints, the physical pain can become chronic. Ending in a vicious circle; bad prognoses, development of therapy resistance, high medical consumption, more medical complication and less functioning in social realm (Dijkstra 2002).

The central aim of the present study is therefore to explore the illness experience of Turkish women and give more insight in the complexity of their distress. The results might be used for a starting point for interventions. The study will answer the following two questions. First, why do women express themselves the way they do? Second, what are the underlying causes of their distress?

**Methods**

This paper stems from fieldwork as part of a masters degree research in medical anthropology, and a further elaboration and literature review after finishing the degree. During a seven-month period in 1999-2000, 23 people with a Turkish background were interviewed. Of these 23, 9 where health care workers, 11 Turkish migrants and 3 traditional healers.
Although the initial research called for only Turkish women to be interviewed, during the course of the research it became apparent that the opinion of Turkish health care professionals where an important addition. Their capability to talk about their personal experience as migrants and their professional opinion about health care problems Turkish women are facing was of great importance. It made it possible to place the stories of the women in the bigger context of migrant life.

All participants where interviewed at least once, depending on willingness to talk and available time, some people where interviewed multiple times. Three of the women where in outpatient treatment in the Mental Health institution in the South of the Netherlands. With these three women, in depth interviews where held. To reconstruct their life stories, the women where interviewed four to five times each in which they where asked to tell their life stories and the way their health problems were connected to this. Next to this, the field research took partly place in a community center. The interviews were when possible done in Turkish with the help of an interpreter. However, some of the women decided they wanted to speak Dutch during the interview. The meetings in community centers where all done without interpreter.

Because some of the Turkish migrants where interviewed more than once, a total 31 semi-structured interviews where conducted. After concluding the research and finishing the master degree, further literature research led to viewing the collected women’s stories in a different light. Since the health problems of Turkish women from first generation has not changed it is seem to be acceptable to reanalyze the data with recent literature as a starting point. The interviews where analyzed again by labeling them by topic.

Both women and health care workers where given fictive names in this paper. A quote from a healthcare worker always will be accompanied by the a job description ea. psychologist of psychiatrist. In case there is no reference to a health care function it is quote from a Turkish woman.

## Results

In this first part of the results and answer will be given to the first question; Why do women express themselves the way they do. First, the concept of sick role will be explained. Next, the different factors that influence this sick role will be discussed.

### Sick role
According to the interviewed migrants the sick role Turkish women are presenting is influenced by multiple factors. The complexity of their stories showed that these factors are mutually interrelated and that the influence of these factors can differ from person to person. The community both the Dutch as well as the community of Turkish migrants, life experience, social circumstances, culture and migrant position all influence the sick role; the way individual experience sickness. But most of all it also determines what is presented to the outside world; the idiom of distress.

Selim (psychologist): ‘Physical complains are used for not feeling well but they are connected to their mental health or social problems. For example a man with a family does not have work en doesn’t see a future for himself here, he feels incapable of supporting his children, he lost his position as father. With his physical complaints someone like him can keep his position in the social community. He can than say: ‘Yes I have lots of headaches, if I hadn’t have those complains than everything would be fine, but now I can’t.’ Besides usually there is also loneliness that combines this. Sickness from a cultural point of view is that you have to visit the sick. The people who are lonely have a lot of broken social connections. Sometimes this can be caused by other (social) problems. Sickness can restore these contacts give them a fresh start.’

For Turkish women there are coexisting ‘idioms of distress’ culturally available (Kirmayer 1984b, Hoover 1998, Kleinman 1982, Nichter 1998). The social and moral stigma attached to mental problems play a role in the presentation of emotional distress as somatic pain; leading to emphasis of the physical problems (Canino et al. 1992). For Turkish women a physical illness is presenting the Turkish community with a ‘real’ disease. The medication prescription is seen as proof by the outside world that there is really something wrong with the woman; she is not crazy. In this way gossip can be avoided.

On the other hand, being sick can generate a response from the community.

Emine: ‘if someone is sick others will step in to help out. Someone will take care of you someone will cook.’

One should be careful generalizing on this. The Turkish community as a closed entity with an unanimous idea about what it means to be sick and how to express this does not exist. Women are individually different and should be treated this way. The different factors can therefore be seen as indicators that can influence a sick role and the accompanying idiom of distress. As one women pointed out during an question on if she believed if cins (spirits) where involved in the cause of her health problems: ‘I do not believe in them. Only people who are very religious believe in them. I do not.’(Ayla)

Besides cultural and migrant related factors, educational and language factors should also be taken into account. As noted by Turkish health care workers similarities are found between Turkish low educated migrants and low educated Dutch natives.

Havva (psychologist): ‘There is an educational factor involved. The moment people don’t know how to express themselves psychological they won’t say I have psychological problems, I am depressed. People will talk about it in a different form like ‘I have some sort of tightness, headache, pain in my chest.’ They wonder what they have in terms of physical problems like to I have heart problem, asthma.'
That’s their frame of reference, even more so than their cultural habit. If I look at Dutch who had low education I see them do the same thing.’

**Stigmatization**

First of all stigmatization with regards to psychiatric or psychological problems. Within the Turkish community psychological problems are stigmatized. As Turkish psychologist Selim points out:

‘The general notion is that if you don’t feel well, if you have physical complaints it is thought you are sick. Not feeling well is than related to physical wellbeing […] Psychological complaints can cause loss of face, loss of prestige it is easier to think in terms of physical sickness, since this is more accepted form.’

People will hide mental problems for the bigger social community. As one woman in the community center concludes about her son. ‘He is sick, but refuses to go and see a doctor, I will go and clean and tidy up his house and cook for him. He is not married because of his sickness. Only my family and neighbors know about it, no one else and I don’t want anyone to know.’

In most cases psychological problems will only be shared by the core group (direct family members) in some cases acquaintances. But is kept a secret for the outside world. Although the health care workers didn’t always agree on this and sometimes also suggested it was even not done to speak about this within families. As Havva noted: ‘Psychological disease is not being discussed in Turkish families. It is being spoken about in terms of physical complaints. There is enormous taboo around this subject.’ In part this has to do with the fact that physical problems usually are seen as temporarily and psychological problems lifelong.’ Therefore could also jeopardies someone’s future in terms of being able to find a marriage partner.

The social and moral stigma attached to mental problems plays a role in the presentation of emotional distress as somatic pain; leading to emphasis of the physical problems (Canino et al. 1992, Hoover 1998). In cultures that prohibit direct expression of certain emotions, individuals can not clarify, ventilate or express such feelings, instead people focus their attention on somatic complaints that accompany affects. This way they can speak about their bodily state divorced from other aspects (Kirmayer 1984b).¹ For Turkish women a physical illness is presenting the Turkish community with a ‘real’ disease. The medication prescription is seen as proof by the outside world that there is really something wrong with the woman and that she is not crazy. In this way gossip can be avoided. Hence, the community will accept an accommodating sick role.

**Honor and gossip**

Related to the stigmatization of psychological problems is the notion of gossip and honor. The fear of gossip is big among Turkish women. This creates a lot of tension around sensitive subjects like psychological problems or psychiatric illnesses. Gossip and honor are closely related. Most of the

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¹ This statement assumes a conscious way of playing with the cultural boundaries of what is and is not accepted in a culture. The expression of bodily complaints is mainly an unconscious act, a way of feeling the body, a way of life.
women grew up with the notion that the honor of the family is based upon the females within the family. The honor of the female is related to her social and sexual behavior, mainly her virginity. Isel, a woman working in a community center, latterly asked me not to come to the talking group for Turkish women anymore: ‘the women are too afraid that their men find out they have been talking to you.’ Marriage prospect, even from children, can be in jeopardy, especially for females, by the stigma of psychiatric disorders (El-Islam 2000); therefore, focus on the somatic complaints accompanying their discomfort is a safe way of getting medical attention.

Adem psychologist: ‘When people have psychological problems the chances to marry get slimmer. This is connected to family honor’.

Family structure plays an important part in this. Turkish children are, according to Gailly (1983), raised to develop loyalty to the in-group -- family and other people in the community. This loyalty is represented in the respect an individual shows to the members of this in-group. Individual motives, interests, ambitions and loyalty are subordinate to the interdependence of the community. In relation to this, gossip plays an important role. The interdependence of Turkish migrants is partly influenced by the fear for gossip and a ‘deep rooted feeling to be and stay one of them’ (De Vries 1987: 91-92). Both Rosnow (1979) and De Vries (1987) state gossip as a mechanism for creating uniformity of behavior to conserve culture. In case of ethnic minorities it marks out part of their identity. As the quote in blue points out, not only is it stressful to uphold family honor, it is also closely related to the history of migration and the status of being an immigrant.

In some cases family honor and the fear of gossip was part of the onset of the women’s problems. As Şarika pointed out when telling about the starting point of her problems and the way she felt a lot of pressure from her family to marry her husband Hasan, ‘No I don’t want to marry him, because if you marry relatives you will get handicapped children. Besides that, what if I don’t get along with my mother-in-law [paternal aunt]? I do not want to cause a split in the family’. The fear for causing a split in the family and therefore bringing her families name in discredit is vast. As a consequence Şarika decides to marry her cousin in spite of her personal negative feelings.

The fear for gossip is in relation to treatment of the health problems women are facing is expressed by Aysun:

‘My psychologist wants me to join a talking group for Turkish women. Talking doesn’t help solve my problems. It doesn’t help at all. And I don’t want everyone to know that I have a disease, I am not sure if I have to call what I have this [a disease]. There is already too much gossip. I always say everyone has a tongue that can twist in any direction. No one understands me, but I am not crazy you know.’
Since most Turkish women in this research did not have a lot of friendships their fear for gossip makes it hard or even impossible to talk to anyone about the way they feel. This is even more emphasized by stigmatization psychological problems have within the ‘Turkish community’. The fear of being labeled as being ‘crazy’, thereby putting shame on the family and making it impossible for, for example, a sibling to marry a good party is great. Physical expression is in that respect the safest way to go.

Body image

Most Turkish migrants came from rural area’s in which mental health care was underdeveloped. expression of physical problems where taken care of by a physician. Other problems, marital, mental or religious related where being taken care of by an imam or hodja. In the Netherlands the women use this same body model.

Adem (psychologist): ‘Usually the physical complains are psychological in nature. People who come from rural area’s will keep holding on to these organic explanations. When there is no physical cause found for their problems they turn toward religion and super national powers. […] Usually people won’t tell someone they are using a traditional healer; people are afraid to be laughed upon, own might think it sounds unbelievable. They don’t want to aggravated the angry spirit even more. If you would tell others it might create more accidents.’

Linking psychological problems to physical experienced complaints is hard for these women (see blue quote).

Unlike the woman in the quote, the body image of most interviewed women was related to religion. The Western distinction of mind and body is therefor not seen in the same way. Havva a Turkish psychologist explains it this way.

‘The content of the notion of mind is more comprehensive. The meaning connected to mind is not the same as the psyche in the west. The general way of thinking is more connected towards mental structures like not being able to think, not being able to understand, wanting rest in your mind, too much thinking etc. […] The balance between body and mind has a different character in Turkey. The balance is also being sought but mind is connected to the Holy and the body to the earthly.’

Or when asked if he recognizes the difference between physical and mental problems Adil (islamic healer) responds:
‘Of course, that difference exists. The body can respond to the spirit and the spirit to the body. The soul is very important. People visit me with physical problems. When people come here I first check to see what they have. I first have to determine if they have something physical or spiritual world. If they have something I can’t heal and for which they should go and see a doctor I will send them back to the doctor. Usually I present them in these cases with a diagnoses. If people have physical complaints I will give them herbs. But most people who come here present spiritual problems, about 80%. These can have different causes. For example they are sleeping wrong or are possessed by the evil eye. If depression is caused by a spirit I have to remove the spirit so the body can heal. When women come here, it can also have to do with her relationship with her husband. It can for example be that she doesn’t feel love for him.’

This connection to religion and spiritual is in turn is reflected in the way people experience their distress. When asked if there is connection between her health problems and religion Kiral says:

‘Problems are send to you by God. Not as a punishment for the things you do wrong, but as a test to see if you will solve them right. If you solve them right they will be written down on your right side (she points to her right shoulder) if you solve them wrong they will be written down on your left side (points to her left shoulder). When you die you will wait in a waiting room until Judgment Day. All death will come to a waiting room and your right and left, good and bad will be weighed. If your scale goes down on the right you are good and you will go to paradise. If your scale tips over to the left you will go to hell. To pray with Allah is mental, but the physical part attached has to do with being sick and not able to pray (physically not able to do so) or when you need to fast you don’t have to when there are physical restrictions like being pregnant or having your period.

The individual way the religious part is experienced is evident in the women’s stories. While some women describe their distress as a test from Allah, others experience it as a punishment or in some cases connect it to the evil eye or cin possession. Spirit possession can be a way to get the attention focused on being to blame for something (not being married) to being a victim of the evil spirit (who is than to blame of not being married) (Nichter 1981)

A cin is a bad spirit that can take any form it wants. Most of the time, it will take the form of an animal. They can be anywhere at anytime and are especially attracted to water and in situations when the body is impure. You have to be careful not to angry them2. The life of cins is a reflection of the human social world -- they can marry, have children, have social relationship, hierarchy, etc. A cin who takes possession of a person, takes over the human body; it can make this person do whatever it wants. The possessed person is in most cases not held accountable for her actions.

‘I got it [psychological problems] after my third child was born. It had to be delivered with a Cesarean section and seven days later, I was allowed to go home. The stitches where still in there and I could not do anything. In the beginning, I felt fine, but four months later, it started. […] I dreamed that my husband died. He was lying on the bed completely naked, because he had to be washed -- that is the way it goes in our culture -- there were many people gathered there. At one point, I turned around and saw my husband standing behind me, completely naked. I started screaming. My husband told me he was going to kill me. I started running away from him and everyone around me asked: ‘what is the

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2As one woman warned me not to pour hot water in the sink if you boil vegetables, the cin might live in the drain and the hot water might angry him
matter with you, where are you going?’ I ran faster and saw he had a big eye on his belly. I kept on running and yelled to them that he was going to kill me. At that point, I saw my brother standing in front of me. He is a kind of *hoca* [religious healer]. He had soldiers with him and my husband did not come closer any more. Since that dream, I had a lot of problems. I felt depressed, could not do anything; I did not want to do anything. I just sat on the couch and could not do anything. I even could not move. I did not know what to do. My family doctor said to me: ‘you should take it easy’. But I did not do anything! I just sat on the couch and did nothing. I could not take it easier. My brother is a *hoca* so I asked him if he could read me from the Koran. When he came, I felt completely weak, I could not stand up, I could not do anything. My brother started with the reading, and I felt cold moving from my feet all the way up through my body. It left me on the top of my head. And suddenly I sat like this.’ [She changes her body language from a slack body without energy, lying on the couch to a strong lady who is sitting strait up, full of energy] ³ (Müge)

To make certain subjects more debatable, the processes of possession can be seen as a way of unconsciously bringing the overwhelming situation a person is experiencing to the attention of the social surrounding. The ‘sick role’ of the possessed person that accompanies the spirit incorporation of the body, leads to a raise in attention from family and friends, so that the ‘bad’ situation may change. Müge’s experience with possession is from this perspective a good example. Müge’s possession, developing while her body was in an impure state, can be seen as a way of coping with an overwhelming situation. The time she was possessed, family and friends join in to help her cope by taking care of her children, husband and house. This possessed role made it possible to withdraw for a while and recover from the birth of her third child and the tensions between her and her husband.

Some women expressed the possibility of their experienced distress being caused from within (see quote in blue). But where struggling with this notion. Their social surroundings didn’t understand this notion, nor where they themselves fully able to comprehend the idea; the felt physical complaints are very real and the fear of gossip is big.

*Migrant status*

The lack of being able to speak Dutch prevented the Turkish women from experiencing the same development as the general Dutch population; changes in development of status of women, sexual liberty and health, body and psychology.

³ Although, the word *cin* is not present in Müge’s story, she is talking about it. It’s reflected in the dream, not having control over what she wanted to do, the *hoca* who came to heal, and the feeling of cold leaving her body as the spirit left. Women regard it as dangerous to talk about possession by a *cin*. It makes a person vulnerable and open for possession by one of them. In most cases, indirect stories where told about possession by these evil spirits. Müge was the only one who actually told her own experience.
The Dutch policy in which the return of the Turkish migrants was seen as the final outcome of the guest workers program contributed to this lack of development. By seeing the guest workers as temporarily citizens they were placed outside the Dutch society and had to live under harsh conditions. Not only did these conditions cause stress as we will see later it also didn’t create opportunities for the Turkish women to learn the Dutch language and integrate in the Dutch society. The expressive form of distress women took with them from Turkey where therefore expressed in the Netherlands. Both the expressive forms used within the cultural group as well as the health care structure and the expressive forms acceptable there. The gap between the Dutch health care system and their knowledge about health care and the lack of an strong social community, as we will see later on in this article, might cause that the idioms of distress for these women available fail to communicate adequately.

In conclusion stigmatization, honor and gossip, body image and migrant status all influence the sick role and accompanying idiom of distress (and figure 1). These factors are interrelated and personally influenced. Women’s individual experiences, level of education, the grasp of the Dutch language cultural background and tradition play a role in the degree of which these factors play a role.
The underlying causes of Turkish women’s distress.

The sick role is now more clarified. The reason why women express themselves the way they do is put into context. The question that remains to be answered is what Turkish women see as the main stressful factors in their lives; the causes of their dis-ease. Some of these stressful factors are mentioned above; tension around family honor and the fear for gossip, Allah being able to punish or test you whenever He feels the need for this, etc.

The most named stressful factors in the women’s lives where first the historical migratory related factors. Second the loss of social network and thirdly the loss of identity. What is abundant is that these factors are very much interwoven into the stories of the women. Causes for their distress where not placed on one of the factors explained below, but was always described as a combination between different factors imbedded in and interconnected to stigmatization, honor and gossip, body image and migrant status.

Historical migratory related factors

There are different historical migratory related factors. First, are the disappointment related to the promised work in the Netherlands. Secondly the influence the migration had on their family structure.

Disappointment

In the beginning of the 1960s, a labor shortage led the Dutch government to look for workers across the border, among others in Turkey. A lot was promised to these workers by the Dutch government -- mainly originating from rural Turkey -- most importantly a good job and a place to live. Most of the men went to the Netherlands to make money, with in the back of their minds the return, as a rich man, to Turkey. For most men the arrival in the Netherlands brought disappointments.

Şarika’s husband: ‘From people at bank where I was working in Turkey I heard a lot of positive stories about migration to the Netherlands. I also wanted to go to Europe so I enrolled in a Turkish labor exchange office. After three months there was an invitation to go to the Netherlands. We would be able to work in a mattress factory and we would get housing; a room for ourselves. When I came to the Netherlands I found out I had to share a room with three others. A small room with two bunk beds. I didn’t want to stay and wanted to go back to Turkey. So I went to Human Resources. They told me I had signed a year contract and if I wanted to go back I had to pay them 2200 gilders, since that’s what they paid to get me to the Netherlands. I was only paid 150 a week, so I couldn’t return. This was a hard time.’

The labor was hard, jobs on the bottom of the labor market, low wages, and the promised apartment failed to materialize. Some men had to share a tiny room with four other men, instead of the promised apartment for themselves. Also, the late sixties and seventies was the time of ‘revolution’ against the established order and social rules. So called hippies ‘fought’ for the right to live their own lives, make their own decisions, especially in relation to women rights. For men coming from a segregated society
(Gailly 1983, Pierce 1964 and Place 1989), this sometimes was a big shock. The Turkish migrants felt they were exploited:

Usman (psychologist): ‘Mentally people thought they would be coming here on short term grounds that’s also what was thought by factories and companies that hired them. That’s why people where exploited, we where just temporary workers. For a lot of Turkish time in the Netherlands have been bad, that’s why they don’t dare to go back to Turkey.’

The treatment of their husband of fathers still causes grieve for the Turkish women. The problems their husbands are facing like physical problems and gambling problems are contributed to this and are connected to the deconstruction of family life. The men’s response to the start of their lives as migrants has had a great impact on the women’s lives and contributes to their daily experienced stress. The original point in which the Turkish migrants where suppose to be temporarily in the Netherlands plays a stressful role in the lives of women and their men.

Adem (psychologist): ‘Within the first generation, the original migrant workers, their notion of ambivalence between temporary and permanent stay in the Netherlands plays a role. They thought they would come to the Netherlands for a couple of years and then would go back. Now one is still living in the Netherlands, and still people would like to go back.

They ambivalence between what the Netherlands brought them and should have brought plays a role. The status they thought live in Europe would bring failed to materialize. Losing face and go back is hard, also Turkish society changed and developed when women talk about Turkey they comment on how they are not seen as Turkish anymore but European Turks. Wanting to return to Turkey is a big issue in the lives of the first generation women.

Usman (psychologist): ‘The people of the first generation are physically in the Netherlands, but mentally there in Turkey. They need to make a choice. When they chose to stay here they will be both physically and mentally in the Netherlands.’

This choice creates tension within a marriage in which the man usually wants to return to Turkey and the woman wants to stay in the Netherlands.

Adil (psychologist): ‘The fist generation is actually lost. They came here to work, to earn money and to go back. It is a big disaster that this didn’t happen. They often say we lost everything: our children and our health. They have no option to return to their own country. A new generation took their place, developments took place. This also creates a big disaster between men and women. Men usually want to go back, women want to stay here because of her children. Often people get divorced over this. But usually people just have to swallow this reality. They swallow it all and this makes the stress grown, the disease grow.’
**Family structure**

The immigration to the Netherlands has shaken up family relations dramatically. According to Can (1997) and De Jong (1996), migration can be viewed as a ‘rite de passage’. This ‘rite de passage’ knows three phases; separation, liminality and reintegration (Van Gennep 1996). First, a physical and later on a psychological, social and cultural separation occurs in relation to the motherland. In the new country, the liminal phase starts; a new life has to be created. Last, the liminal phase is closed and only then, we can speak of integration (De Jong 1996). This migration process can occur in a variety of ways for Turkish migrants; family members can all pass through these phases differently; ‘This can lead to role confusion and disorientation’ (Pannekeet 1991). Roles of family members change in this situation. Children for example might have more knowledge of the Dutch language and suddenly need to help their mother and father to get information for them about social security benefits or to pay a visit to the doctor. This dependency on kids can be humiliating in their patriarchal culture (Al-Issa 2000). Not only for the adults, but as women described who have been translating for their parents when they were younger also for the children themselves.

Rapid modernization and urbanization due to migration and normal processes in life creates conflict between old en new. The rural, traditional background of most of the first generation Turkish Dutch women can come in conflict with the rapid modern urbanized life in the Netherlands. Women describe the lack of social relations and the crumbling down of family structure as they now it. The so-called second generation becomes increasingly more influenced by the Dutch culture. By regarding the family as part of their identity, the Dutchifying of their children might make women afraid of losing their Turkish identity – especially to the outside world. Women feel they are becoming more estranged from their children:

Anonymous woman from the Turkish woman talk group in an outpatient treatment facility: ‘one of the reasons I am still thinking about the past is because haven’t been able to share both the positive and the negative from the past with anyone. I wasn’t able to do this, I had to be quiet, be obedient. Newly wed women are not suppose to laugh, girls are not suppose to laugh. Everything we do we just had to take in, without asking questions, without saying no. Now our children say no to us.’

**Migrant status**

Another source for psychological conflict that is migratory related, is the social and economical situation of Turkish families. The unemployment of Turkish migrants is high in relation to other migrant, health related problems are especially for first generation Turkish migrants the cause. As a consequence, high number of families depend on welfare (Zorlu et. al. 2010). This combination of welfare dependence, not speaking Dutch, hardly knowing bureaucratic Holland and experiences of discrimination results in a lot of frustration for some Turkish women. For instance Ayla, a divorced woman with three children, gets social security assistance every month. Month after month, she spends her money carefully. She does not understand how, in her eyes, the arbitrary system works. Her twin sons want to do karate but the Social Service does not want to help her to meet the costs.

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‘I do not understand, it is good for my boys to sport. They miss all the fun their friends have. There are Turkish people, who get financial assistance just like me, and they drive a big BMW and go to Turkey for vacation every year. I went to the Social Service and they told me I first have to have debts before they can help me with financial aid. I do not understand, I live a good life and make sure we meet ends every month’.

This is causing Ayla a lot of grief and makes that she feels she does not have a free life; she is left in the mercies of the whims of the Social Service.

Besides, most families experience pressure from their family living in Turkey, asking for financial support. Their expectations are high since they have ‘rich’ family living in Europe. It is hard to explain them they are not rich. Besides, by explaining this it not only shatters the dreams of their family members, they themselves have to face reality and accept their position in the Dutch society.

The awareness of being a migrant and feeling a migrant towards the outside world creates tension:

Selim (psychologist): ‘The feeling of the migrant; people are following me with their eyes. I can’t do anything it is always seen by someone. The feeling, I live like a minority, in a bad social position. That is very tens, their life is very tens. That’s why they can not be vulnerable that’s why they hold on to their old traditions. They can change and develop when they have a better social position. If they have a better social position they are able to be vulnerable and open to new idea’s and the Dutch norms an values. […] Migrants have a very harsh life. Being their own choice or not, they don’t live in their own country.

Loss of social Network

Secondly, the women considered not being part of a social network as stressful and a cause of their problem. In part the roots for this feeling lays in the migration history. Most of the men, like their wife’s, were illiterate and uneducated workers, coming from rural gender segregated villages. In the uncertain situation of migration, they started to hold on to the only certainty they knew; the Turkish culture and Islam. Although in a migrant situation religion can work as ‘suffocating and controlling it is at the same time one of the few binding factors and a hold on in a Christian society’ (Pannekeet 1991). By the time, the Turkish women came to the Netherlands, in most cases more than a decade had past. The past had left an imprint on their men, and most of the women started an isolated life, protected by their men. Next to this, all family members had to get used to each other again. This protectionist behavior implied that the women only had (and in most cases still have) contact with other Turks, who are lots of the time relatives (Vermeulen 1884, Can 1997, Willems 1989, Van der Wal 1999). According to Gijsberts (2007) 70% percent of the Turkish population only have contact within their own group. Paradoxically, this does not mean that the women feel being part of a solid Turkish community. Most women expressed feeling lonely.

Kiral: ‘People have problems because they have problems in the Netherlands with making contacts. In Turkey others are important, more important than you are. Women always go and eat and drink with other women. Then they talk and don’t keep things inside. But this is very hard in the Netherlands. You can’t go eat and drink with others very often, as a result you keep everything inside and then you
become sick. It is very important that people get social contacts. We care more about others than about yourself. Money is not important, others are important connection to others. Part of this also has to do with discrimination. Like, when I bring my children to school, parents will ask: “Why don’t you come to the coffee meeting for parents in the morning.” But if I do all the Dutch are sitting on this side and the Turkish people on the other side. When they see a woman with a headscarf they think she is stupid and can’t speak Dutch and they won’t speak to us. A psychiatrist cannot help Turkish women. The only thing that really helps is social relationships.’

Consequently, social control is strong, and the interdependence of Turkish migrants is even strengthened by the fear of gossip. The fear of gossip plays a big role in the interviewed women’s lives. Decisions that need to be made are always placed against the possibility of the outcome creating gossip and thereby placing the family in a bad light. Especially for women who’s family is back in Turkey this can be stressful, since she has no one to rely on (of her own family) in, for example, time of conflict. One of the situations where women experience conflict is there marriage.

Selim (psychologist): ‘Families became smaller here, therefore there is more need from help from outside. The Turkish community is from the outside seen as a strong group. But for me looking from the middle I don’t see a community with strong ties. Therefor the community can’t support each other anymore. A lot of people left the person they trusted most behind. In the years they lived here they haven’t made real friends. The social isolation of the first generation is big, the social economic disadvantaged always have in this respect from their weaker position in society and desolate life a higher risk in developing psychological problems.’

Not only the response of the Turkish community to migration has a cause in this. The response from the receiving country played a role.

The status as migrant means for the women a limited amount of possibilities to express emotional distress as women note when comparing the Netherlands with Turkey. As an anonymous woman in a community center mentions, ‘The problems of Turkish women are related to social contacts. In Turkey, others are important, more important than you are. In the Netherlands, it is very hard to get in contact with people. It is not possible to get something to drink or have dinner with someone, because of this you keep everything inside and than you become sick. A psychiatrist cannot help Turkish women. The only thing that really helps is social relationships.’

Identity loss
Loss of social network is connected to the third stress factor in the women’s lives. By migrating women lost their social networks. As a result women are depreciated because ‘the role which they have been socialized to fulfill competently are no longer needed under new conditions’ (Mirdal 1985). Mirdal (1985) states that the Turkish women in Denmark who accompanied their husbands were more dependent and isolated than they would have been in their home country. The immigrant status makes it hard for women to fulfill their role as wives, mothers, sisters, cousins, etc. The social network in which the role of women gets it meaning has changed due to migration and the migrant status in the

5 Gally also describes this about the Turks living in Belgium (Gally 1997: 150)
Netherlands. As in the women of Qatari, described by El-Islam (2000), the Turkish women develop a mixture of somatic complaints covering the entire body; in this way elicit sympathetic attention from family members and medical professionals. But it can also be seen in a reverse interpretation in which women instead of being seen as social failures are seen as somatic victims (El-Islam 2000).

The to migration related dependency makes women feel they have hardly any control of what is happening in their lives. This starts in most case already with the onset of marriage. Which for most women comes unexpected and fast. Yıldırım nikahı (fast marriage) is in many cases responsible for the unprepardness of the women. As in Şarika’s case; she had to marry within fifteen days and within three months she found herself in the Netherlands. Her husband was a very protective and jealous and her life as a modern self-consciousness woman was over; ‘my husband destroyed all my mini-skirts and in Izmir I was used to look someone in the eye while talking, but my husband forbids this.’ If this situation had occurred while she was living in Turkey, Şarika could have had back up support from her family. Dominated by her mother-in-law, and with her nuclear family far away, Şarika did not have a place to run to and seek shelter. So, she continued to live an isolated life. Her husband later states:

‘My wife’s problems are not caused by one thing; there are multiple causes. Her mother died and we first had a healthy child that later became mentally and physically handicapped. But the most important thing is that my wife lived in Turkey in a big city. She had a free and social life there. She went to movies, theater, and cabaret. Here in the Netherlands, it’s not so free, here you don’t have it [this freedom] Here, in the Netherlands we don’t speak the language very well and we are not in the position in society where we are suppose to be’.

Şarika’s former happy social life, the freedom to do the things she liked, was left back in Turkey. Hence, she lost part of her identity. After her marriage, she became the wife of a man she didn’t love, she became a gelin and had to fulfill a role her mother-in-law wanted her to fulfill, she became an ethnic minority, a migrant, she became unwillingly a mother (Şarika hadn’t wanted any children out of fear of them being handicapped since she was married to her cousin), and lost with the death of her mother part of her identity as daughter. If Şarika had been more of an easygoing woman, a woman without a strong will, she might just have settled in peace with the situation. But Şarika had plans for herself. She wanted to study at the university, live in the city in Turkey, and have a rich social live. By being ‘forced’ into marriage, at least that is the way she felt, Şarika lost part of herself.

The concept of fast marriage and the relation to identity is also noted by Gürhan (psychiatrist):

‘Women usually where not prepared to come to the Netherlands and their move usually came unsuspected. Within a couple of weeks everything was arranged en the women find themselves in a complicated situation in the Netherlands. They find it hard to be in the Netherlands, it is like going through a mourning period. They feel like they don’t have anybody, they are watched by their family (in-law) all the time, are obligated to attend family meetings and are in some cases not allowed to call to Turkey to make them get used faster. A women feels humiliated and placed in a situation of dependence. She feels insecure and doesn’t speak the language, she came unprepared to the Netherlands and her dreams where shattered. They usually married young and the development of their personality came to and immediate hold. A lot of women tell me the moment I married I died.'
Another source of psychological and identity conflict lies in the marginalized position of Turkish migrants in the Netherlands. Just like Şarika all migrants had plans for themselves of what their future would hold. For most these plans didn’t materialize. Living in the Netherlands a substantial large percent of the Turkish first generation migrants are dependent on state welfare due to unemployment or long term disabilities. Respectively, almost 15% of Turkish first generation migrants live on disability support compared to 9 % of the native Dutch population. For unemployment social security benefits, 5% of the Turkish migrants first generation depend on it, while only 2 % of the native Dutch population (Zorlu 2010). Besides, most families experience pressure from their family living in Turkey asking for financial support. Family members back in Turkey have in some cases high expectations since family members living in Europe are considered rich. Explaining their family members they’re not rich would not only entail shattering the dreams of their family members, but also facing reality about their marginalize position in the Dutch society. In their research among immigrants in Rome Aragona (2011) linked somatizing to Post Migration Living Difficulties (PMLD) according to him four PMLD’s were highly correlated with somatizing. Two of these are indirectly related to social exclusion and identity; not being able to work and poverty, loneliness and boredom. Aragona states that although working is not only of practical importance it is also giving people a clearer sense of identity and a social recognition. Aragona (2011) further comes to the conclusion that ‘poverty, discrimination, and social exclusion may play a remarkable role in increasing the life stress and that the associated feelings of loneliness, boredom and low self-esteem may contribute to passive stances and social withdrawal which in turn amplify their marginalization, their distress and somatization as on of the few possible permissible ways to express it.’

More than once I heard of the onset of health problems (both physical and mental complaints) after the death of a parent, especially the mother. For older women the death of a relative in Turkey brings questions about their own death. Of the interviews a fair amount state they don’t want to die in the Netherlands and would like to return home. The fear of losing their children who’d like to stay in the Netherlands, the acceptation that their dreams of becoming rich are chattered, and their dependency on financial assistance which they might loose if the move back, all make it hard to go back.

**Discussion**

This study focuses on expression of distress and the different stressors that are experienced by Turkish women in the Netherlands. It shows the complexity of experiences of dis-ease and places it into a broader context. Turkish women and Turkish migrants working in the health care make apparent that expression and experience of health is related to a complex of interrelated factors. It places the women’s health problems into context and shows the complexity of it’s relationship to migration, honor, gossip, stigmatization, body image, language and education. Which of these factors play a role, is individually related. Women unconsciously ‘choose’ their own way of expressing themselves within the borders of their own cultural system. This makes ultimately clear why generalizations are not easy to make. Individual opinions, family traditions, regional cultural idea’s, Islam, and national organization of healthcare – in other words individual, social, political, and economical circumstances – all merge in to each other and create an unique way of expressing the ‘mindful body’.
Literature about MUPS show similar explanations for persistent somatic complaints, but do miss the complexity of it. Four explanations for MUPS can be found in literature. First, the expression of psychological problems as somatic complains (Kirmayer 1984, Moffaert & Vereecke 1989, Mirdal 2006, Huss and Cwikel 2008). The underlying assumption being the inability to express feelings verbally.

Secondly, the guest workers body as a capital investment (Moffaert and Vereecken 1989). The somatic complaints are related to the status as guest worker or guest workers family in which social survival and bodily integrity are strongly intertwined. It is, according to Moffaert and Vereecken (1989), therefore understandable that physical health is central to their concepts of health.

A third definition, has been proposed by other authors (Hulme 1996, Koss 1990, Kleinman 1982, Hoover 1998, Gailly 1997, Moffaert and Vereecken 1989), according to this paradigm, somatic complains are characterized as a culturally accepted idiom of psychosocial distress to indirectly implicate family, school, work, financial and other social problems’ (Hulme 1996: 33). Closely related to this notion is expression of somatic complains as a form of resistance (Gupta and Ferguson 1997, Mirdal 1985), a means of adjusting social situations to meet the migrants need (Huss and Cwikel 2008) and a ‘metaphorical expression of individual and social complains’ (Scheper-Hughes and Lock 1987). In this respect Huss and Cwikel (2008) describe how Bedouin mothers in Israel work hard at balancing the values of working on integration in the host country and maintaining original values. As a result they experience role overload, marital stress, discipline problems and lack of support systems. They may cope by overcoming depressed and present themselves to the health care system with somatic complains. Using the body as a symbolic but embodied site of expressing pain, the physical expression of emotion was effective way to monitor social oppression an change each others behavior (Huss and Cwikel 2008, Meleis and Pollara 1995).

Closely related is the fourth explanation which sees MUPS as a functional form of distress (Hoover 1998, Gailly 1997, Moffaert and Vereecken 1989). This notion is closely connected to the above mentioned sick role and idiom of distress. In any given culture a variety of ways exist to express and experiencing distress (Hoover 1998). These expressive modes, idioms of distress, are culturally constituted; they initiate particular types of interaction and are associated with culturally pervasive values, norms, generative themes, and health concerns (Nichter 1981). Generalizations are not easy to make (Burton 2003). Individual opinions, family traditions, regional cultural idea’s, Islam, and national organization of healthcare – in other words individual, social, political, and economical circumstances – all merge in to each other and create an unique way of expressing the ‘mindful body’ -- ‘Culture, then represents the symbolic and linguistic system within which individual experiences are labeled and acted on (Nancy Scheper Hughes 1987). Hence, the community will accept an accommodating sick role and a socially approved way of obtaining relief from the stressful conditions (Mirdal 1985, Kleinman 1982). A sick role releases a person temporarily from routine social responsibilities and obligations; it allows to control interpersonal relations; receive attention, sympathy and emotional support from others; affords them care and practical support; gives an opportunity to reintegrate the sick person into the social support group and; reaffirms the norms of solidarity and social control in the community (Kleinman 1982, Kleinman 1977, Kirmayer 1984b, Al-Issa 2000, Hoover 1998, Yilmaz and Weiss 2000). What is crucial in understanding symptoms as communication is not the potential meaning it supplied to the outside observers but the effective meaning is has to
significant people in the immediate social network (Kirmayer 1984b). For example in a study by Yilmaz and Weiss (2000) a Turkish man in Switzerland with pain complaints got more understanding from his family; his father became more tolerant and sympathetic, even though a cause for the pain could not be found. Somatization as a functional form of expressing distress is then seen as an acquired “coping mechanism”, an adaptive behavioral pattern that triggers the social support system. Besides, according to Gailly (1983), somatization also pinpoints the cause of the illness in nature away from other people so that potential interpersonal conflicts are avoided.

Concluding, explanations like the above have a one explanation focus. As shown in the article the women’s stories encompass all of the above except for the explanation of the body as a capital of investment. The women’s expression of the somatic complaints can therefore be seen as a cultural excepted form of distress, an inability to express themselves in psychological terms due to language problems and a low educational background. But also as a functional form of distress in which the loss of social network and identity play key.

A limitation of this research is the relatively small set of informants therefore it is not possible to truly generalize. Furthermore, the data is not recently collected. However, the experiences of this group of women and the way they express their distress does not seem to have changed over the last 10 years. The complexity of the problem of MUPS in primary care seems still present.

**Conclusion**

In this paper it is shown that experienced dis-ease by Turkish women and the way they express this is a culturally accepted idiom of distress in which the individual body communicates about the social body and body politic. These three bodies are not isolated concepts; they overlap and have mutual relations with each other. The body therefor should not be seen as an isolated object but should be placed within the broader social, economic and cultural context around it. Communication of patients should therefore also be placed in a broad spectrum. Time is essential to gain trust, knowledge about cultural, social, economic and historical background is key. Unexplained physical complaints should always be taken seriously. Loss of social network and identity should be a starting point for interventions for these group of women in which empowerment should be a key element. As long as the stressful events in the women’s lives; loss of social network, loss of identity and migratory related stress factors are not fully addressed it can not be expected that the somatic complaints the women are experiencing will disappear.

In future research it would be interesting to focus more specifically on the feeling of loss of social network and identity and to assess whether an intervention which would women help restore these aspects would positively change their feelings of distress and physical complaints.

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