‘I AM JUST SO IRRITABLE’:

PERCEPTIONS OF DISTRESS AMONG TURKISH MIGRANTS IN BERLIN

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Participating in the MSc Oxford medical anthropology class in 2006/2007, I wrote my thesis on concepts of the self in immunology and its use in the discourse on national identity in Germany. After returning to Germany, I continued my medical specialisation in neurology and psychiatry with a more open understanding of the social and cultural context of biomedical practice.

Working in a neuropsychiatric outpatient clinic in Berlin that serves predominantly Turkish migrants, I was surprised to observe how many patients complained about becoming very easily short-tempered, irritable, angry or aggressive. After inquiring further, it became clear to me that most of them also showed typical clinical signs of depression, such as low mood, lack of pleasure and interest, tiredness and sleep disturbance. However, the depressive symptoms were described only secondarily or after my asking explicitly about them. The spontaneous expressions patients used to describe their distress were either the German *nervös*, *gereizt* or *aggresiv*, which translate into English as irritable, angry, aggressive or nervous, or the Turkish *sinirli* and *sıkıntı*. *Sinirli* means irritable, nervous, angry, tense; *sıkıntı* translates as tightness, constriction, boredom, misery, distress or hardship (Wendt et al. 2001) .

In order to acquire an impression of the frequency of complaints of being *gereizt* or *sinirli* I conducted a ‘micro-survey’ in June 2011. I counted all 448 patients who had consulted with me in that one month. Around 50% could be diagnosed with depression according to a standard medical diagnostic system, the International Classification of Diseases (ICD-10). I found that about 20% of all depressed patients complained of irritability and anger as a main symptom. Almost 50% of the depressed Turkish patients complained about being *sinirli*, and being *sıkıntı* was reported by almost 60%. As far as I could see as many men as women were complaining of anger and irritability, while in total more women were diagnosed as depressed.

The questions that arose for me were how to incorporate complaints of feeling aggressive into a biomedical disease category as the basis for a so-called evidence-based therapy plan, and how to make sense otherwise of what I considered to be unusual reported feelings and/or behaviour, given that irritability and aggression are not core symptoms of depression according to the ICD-10 (World Health Organization 1994).[1] In addition, as patients told me, and as is reflected in, for example, several Turkish self-help books, the term 'depression' has a negative connotation in most parts of Turkey, as well as among many Turkish groups in Germany. Depression is perceived as a mental disease associated with a loss of mental function and sanity. Further, Turkish accounts of disease are known to be colourful and often physical or somatic (Zimmermann 2000). Mental disorders or distress will accordingly be more easily expressed in somatic terms.

Initially I wondered whether the complaints of being *gereizt* or *aggressiv,* i.e. angry or irritable, might have been wrongly translated by either the patients or the lay translators. But more fundamentally, from a psychiatric point of view, I questioned whether the complaints of nervousness, aggressiveness or *sıkıntı* represented a medical problem at all; they might ultimately be indicative rather of a social or family conflict instead. After realizing that depressive symptoms could occur together, I wondered whether I had misdiagnosed as depression what in fact was post-traumatic stress disorder (PTSD), a bipolar disorder, an anxiety disorder or a personality disorder. Each would obviously have different implications for the affected person and would lead to different therapeutic approaches.

From a therapeutic perspective, I wondered how I should react to complaints of aggressiveness (*sinirli*) and tension or boredom *(sıkıntı)*. Should I focus on the apparent symptoms and use sedating drugs or behavioural therapy? Would social counselling with

[1] Note, however, that another classification of psychiatric disorders, the DSM IV of the American Psychiatric Association (2003), lists irritability as a possible symptom of depression in children and adolescents. Daniel Hell, a well-known Swiss psychiatrist, discusses, among other things, the association between anxiety, aggression and depression, but also points to overlaps between these diagnostic categories (Hell 2009).

someone like a social worker be adequate, or should I understand these symptoms as secondary, try to treat the depression, and hope that the irritability might get better as well? Finally, from a medical anthropological perspective I wondered whether this finding was culturally specific. What living conditions might prompt aggressiveness instead of, for example, melancholy? Or was it maybe a 'reporting bias', i.e. were there fewer obstacles or less stigma associated with talking about such unwelcome emotions and behaviours as aggression and anger in the Turkish migrant population in contrast to other population groups? In order to explore these questions, I present a case study that describes being *sinirli* and *gereizt* in the context of depression.

Mr F´s case

> I met Mr F, a 42-year-old male patient, in a neurological and psychiatric outpatient clinic in Berlin, where I work as a neurologist and psychiatrist.[2] We had talked seven times in the course of seven months, in total for about four hours. His wife was present on three occasions. The conversation was held in German; while his wife was present, he translated her Turkish to me and my German to her. My first impression of him was of a tall and athletic man. His hair was cut short, and he wore casual sports clothes. He appeared tense, and his gaze was unstable. While sitting he changed his position, often with impatient movements. His account was brief, and he reacted with limited tolerance and understanding of my questions.
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> He had asked for a neurologic consultation because he felt distressed. He suffered from irritability and acted impulsively and aggressively; he perceived this as different from his normal behaviour, as not being quite himself, as something wrong and beyond his control. He specifically asked about the possibility of taking medication to calm down.
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> He told me that he had been a nervous and irritable person for a couple of years, but that so far he had more or less been able to cope with these feelings, which had been of lower intensity and had less impact on his daily life. The new and intense feelings generally arose at home and very often for trivial reasons, such as an untidy table or a noisy child. He usually responded by kicking furniture around or slamming doors whenever he felt angry, or he would leave the family apartment to avoid conflicts. However, for some months now he had started shouting at his two children or his wife. On rare occasions he had beaten his wife

[2] I asked him during one of our conversations if I could tell his story during the ten-year medical anthropology conference in Oxford and if he would agree to it being included in a publication. He agreed under the condition that his story would be presented anonymously.

or children, which he perceived as an overreaction and felt sorry for doing. For example, his ten-year-old daughter had let a cereal bowl fall on the floor. His wife, suffering from arthritis, had been lying on the sofa, and he asked her to clean up the mess, as he himself did not feel responsible for doing so. When she did not do so despite his repeated requests he started shouting, pulled her up and pushed her towards the table so that she fell down. He then left the apartment. The couple did not speak for several days. He felt sorry for being violent and later indicated a fear that he had behaved as his father had behaved towards him as a child.

At the first consultation, after I inquired, he also reported that he had severe problems in falling asleep, that he woke up several times during the night and that he felt very tired during the day. He complained of severe pain in his lower back that had already been treated for months by his orthopaedic consultant. When I asked further about signs of specific psychiatric disorders, he told me that hardly anything gave him a feeling of pleasure or distraction anymore, that he lacked energy, the ability to concentrate and memory, and that he easily became exhausted.

Mr F named certain circumstances and facts that he perceived as distressing. He told me that his feeling miserable physically and psychologically for several months now had consumed his patience and optimism; that was part of why he felt angry. He constantly had severe back pain and felt left alone with it. He told me about his two-room family apartment; he felt physically constrained in there and lacked a place to withdraw from family life and to be on his own undisturbed. Financial problems increased his stress. As he had tried unsuccessfully ten years ago to open a telephone shop, he still had debts to pay. Only recently had he managed to open the bankruptcy proceedings.

Mr F suffered from emotional distance in his marriage and family life, and he felt disregarded in almost all his social relations. Towards his wife he felt the need to hold up a mask of what he perceived to be masculinity, i.e. strength and authority, while in reality he felt weak and tired. He also felt obliged to maintain good family relations in order for his children to grow up within the larger family and be supported there, though in reality he hated his father. His wife did not understand his feelings towards his father; she would not believe his unhappy stories about his childhood, but only what she had learned about his parents from friends and other relatives.

It became clear that Mr F constantly felt disregarded and humiliated, particularly by his family; his father and his brothers was accused him of being unable to maintain a job or care for his family appropriately. Further, he felt he had been put off by a rehabilitation institution, where he had gone for one month to treat his back pain. He did not feel that his complaints had been taken seriously there; he was suspicious that the institution only wanted to earn money, and he had to subordinate himself within a standard program that did not help him at all. In the end the doctors told him he could go back to work or report back to the state employment agency, even though his pain had not changed at all. He felt hurt and humiliated. The employment agency questioned his illness and his resulting inability to work and forced him to go to job interviews. He did not see himself working in a hierarchical employment situation after several negative

experiences, while options for self-employment were limited due to his debts from earlier business projects that had gone bankrupt.

As far as his recent social situation was concerned, Mr F reported having been married for a second time for fifteen years; from the second marriage he has two children, a daughter of ten and a son of five. He had been unemployed for four months. Previously, he had worked in a social project helping difficult young men aged eighteen to twenty-four to school education, for which he was paid for by the employment bureau. The work was very difficult, as the young men did not respect any authority and behaved as they pleased. He tried to help them but got very frustrated. He said that he would not accept work like that again, maybe only with younger boys. According to him, he lost his job because he had too much sick leave due to his back pain. As his back was still very bad and he generally felt poorly, he had no intention of looking for jobs in the near future, nor hope of finding anything appropriate for the moment. His wife used to work in geriatric care institutions; as she also developed chronic pain in her joints, however, she had also been on sick leave for several months. In the course of three months she also developed a major depression. However, she did not complain of being *sinirli*, but *sıcıntı*. His wife did most of the housework, but her abilities were limited in the past months due to her pain and depression. Despite the parents' problems the children were doing fine in school.

In the course of these conversations, Mr F disclosed more biographical information. He had been born in an eastern Anatolian province and spent his early years in a small Turkish village with his grandparents, as his parents had already left to work in Germany. He joined them with his siblings at age four. He felt that he had been the black sheep of the family all his life. His two older and two younger brothers were very well adapted and did not question their father's authority, but he had always had a curious and independent mind and had wanted to explore the streets and make his own experiences. This had led to constant conflicts with his father that resulted in the latter's attempt to educate and discipline him by severely beating him with a belt, putting him in cold water in the bath tub or locking him up. His mother suffered when he was punished but did not intervene. He left home for the first time aged fifteen and spent several days with relatives; in the end they told his father, and he had to return. He ran away a couple of times, and after being forced to return he felt betrayed and left alone by the relatives he had trusted.

At nineteen he married a non-related Turkish girl. Looking back he said it was a way to leave home. Together with his wife he opened a barber's shop and had a daughter. The marriage did not go well, and they divorced seven years later. In order to have a smooth separation he let his wife keep the barber shop, but Mr F ended up with debts of 40,000 Euros. His ex-wife did not want him to have contact with their daughter, and he did not object. His daughter first contacted him two years ago when she herself got married and needed financial support. They had not spoken for more than a year now.

Lacking a formal education, Mr F worked in various jobs. About ten years ago he opened a mobile telephone store with money he had borrowed with great difficulty from his brothers. The store went bankrupt. From then on, his father and his brothers refused to support him in any new business idea. The brothers

> were affluent and able to live off the rental income of houses they owned. According to Mr F they had been given the houses by their father, while he was left without any support.

To summarise, I understand this account as a life-long struggle for recognition, acceptance and security that led to frustration, disappointment and a perceived disregard by society, medical institutions, and Mr F's extended and close family. The constant efforts to achieve something and then to save face during failure, in combination with the experience of chronic pain, had led to depression, anxiety and his fear of being a bad father and husband. Mr F was also concerned about not being able to provide for his family and not getting better physically; this in turn might have led to symptoms of depression such as exhaustion, lack of pleasure, and pessimistic thoughts, as well as easily provoked anger and aggression – the most disturbing symptoms for the patient and his family. Mr F perceived his emotions and behaviour as inadequate and a medical problem, an evaluation supported by his wife. He perceived his distress as primarily a physical reaction, independent of possible social or psychological causes, which needed biochemical treatment in the form of psychopharmacological drugs.

In this context, were the complaints of being aggressive or angry mistranslations of the Turkish words *sıkıntı* and *sinirli*? In general I reject this idea; Mr F had a profound knowledge of both Turkish and German, and he used *aggressiv* and *gereizt* as well as *sıkıntı* and *sinirli* to describe his illness in terms of his aggressive behaviour. Mr F perceived his altered emotional condition and his behaviour as primarily a disorder, something that needed medical treatment and was tightly linked to a physical dysfunction, i.e. his back pain and the ensuing related complaints. Still, he also linked his complaints to several social stressors, including his interpersonal problems with his wife and his father and brothers, his financial problems and his difficulties with the employment agency. Certainly, the post hoc interpretation of the

meaning of depression as *sıkıntı* and *sinirli* can be framed within psychological theories of repression and the individual's reaction to it. However, for the doctor–patient relationship in this specific case, a distinction between the biomedical and socio-cultural domains is of limited relevance.

Discussion

The link between depression and syndromes involving altered nerve perception or function has been elaborated widely in medical anthropology (Kleinmann 1982, Sobo 1996). Correspondingly, in most of the cases I observed, I concluded that most of the complaints of being *aggressiv, gereizt, sıkıntı* or *sinirli* were associated with clinical depression according to the International Classification of Diseases (ICD-10). In some cases other psychiatric diagnoses might have been identified as well.

The most challenging question for me was the fact that these specific complaints were expressed almost exclusively by Turkish migrant patients. German or Swiss patients who suffered from depression rarely reported being aggressive. It was not perceived as something that bothered them, although it might have been something that would be mentioned when explicitly asked. Sobo (1996) described two nerve experiences in Jamaica and presented different 'feeling states' associated with an altered experience of what is called *nerves, nervios, nerva*, etc. Low (1994) reported many similarities between nerve experiences in Costa Rica and Guatemala, and compared them to examples in the literature from Greek immigrants in Canada, from Newfoundland and from Kentucky. All these examples had in common the fact that altered bodily sensations and associated emotions were referred to as a dysfunction of *nerves* (with different concepts of what *nerves* are). Symptoms included an aching body, fainting, shaking, insomnia, weakness, hot/cold sensations, pain and itching, as well as being temperamental, not feeling or acting oneself and being restless. Both authors stress the widespread and bodily grounded, physical nature of nerves, despite their cross-

cultural variations. Kleinmann (1982), in his account of neurasthenia in China, stresses the co-occurrence of this nerve syndrome with chronic pain. Hence, could the complaint of being *sinirli* be another 'culturally influenced mode of perception' (Sobo 1996: 316)? And if so, what might the 'actors of culture' be? Low noted differences in *nervios*, for example, between urban and rural areas of Costa Rica. In the case of Turkish migrants, could certain living conditions be identified as prompting aggression? Or could socioeconomic or educational conditions, gender, age or social norms or values be held responsible for the apparently particularly unpleasant perception of aggressive feelings?

Mr F (like most other patients) perceived the condition primarily as a physical problem that might be corrected through psychopharmacologic treatment. In fact, he tried different antidepressants and felt better. Though not expressed explicitly, his underlying concept was one of a state of disequilibrium in his nervous system; that is, the chronic pain and the additional worries and concerns had overburdened his body, leading to a feeling of not being quite himself, acting differently, not being able to control his emotions. An explicit distinction between body and mind or physical or mental/psychological aetiology was never expressed. However, patients did make a distinction between physical reactions, symptoms or complaints, and the social context in which such reactions could arise. They reported most of all their concern with physical dysfunctions such as pain, insomnia, weakness, memory impairment, or dizziness that need medical treatment, even if they linked the condition loosely with difficult living conditions such as worries with children, problems with parents, spouses or in-laws, financial constraints etc.

The complaints were uttered by men and women, by first-, second- and third-generation migrants, by different age groups and by people with diverse educational, professional and financial characteristics. However, I argue that *sinirli*, together with the perception of *sıkıntı* – with all its physical connotations of both emptiness and deficit, as well as pressure, tightness, crowdedness and stiffness, and their behavioural expressions in acting

in offensive, angry, aggressive and uncontrolled fashions – can be understood as a culturally shaped bodily experience that serves the communication of distress and the quest for a cure.

On the question of stigma, it is important to note that Mr F felt guilty about behaving aggressively towards his wife and children, and that he himself perceived aggressiveness as an unwanted emotion in this setting. My colleague Dr M. Dilmac called the syndrome of being *sinirli* and having *sıcıntı* one of *Harmoniestörungen*, i.e. disorders of harmony, resulting from a deeply embedded culture that stresses smooth and conflict-free social interactions. One patient lost his jobs as a cook and waiter several times because he was easily provoked by his colleagues for small and trivial reasons, and he wanted treatment in order to hold down a job for a longer period of time. He perceived his behaviour as a pathological overreaction and stressed the importance of having good relations with his co-workers. Even more often, patients complained that irritability arose in everyday situations with the close family, directed in particular towards the children or spouse. One man, a taxi-driver, told me that, although he was quickly put off by his customers (emotionally), this did not bother him too much, while being impatient and angry against his children made him feel bad. So, aggression seems generally to be an unwelcome emotion, and it seems difficult to talk about. Further, I was told that aggression was perceived as a disorder and was subject to medical, that is, biological treatment. Compared to German patients, I did not find evidence of more frequent, easier or less stigmatized reporting of aggressive behaviour.

In interpreting being *sinirli, sıkıntı* and *gereizt*, one needs to be careful neither to generalize perceptions that are labelled with the same words but that arise in very different individual situations, nor to over-emphasise small differences out of context. Since the Turkish migrant community in Berlin is a very heterogenous group, although the concept of *sinirli* and *sıkıntı* might be helpful in expressing certain forms of distress, this may reflect very different and individual experiences. Good (1994) refers to complains of *sıkıntı* in the context of epilepsy narratives in Turkey. It remains unclear if the presentation of depression

and being *sıkıntı* is a local phenomenon of Turkish migrants in Berlin, or if it is found in Turkey as well.

The total *sinirli/sıkıntı* and *aggressiv/gereizt* complex – that is, the physical and emotional perception and its labelling – seems to be helpful for the affected individual on several levels: it helps patients make sense of their perceived unwellness and frames this in a communicable way, it makes unwelcome behaviour more socially acceptable and might provide excuses for misbehaviour or deficits in daily functioning, and it might lead to a medical diagnosis with social benefits in the form of sick certificates. Still, its potential metaphorical meaning remains unclear to me; its implications for understanding the concepts of the body and disease need further exploration. The heterogeneity of the affected patients and the local context needs to be stressed to avoid false generalizations.

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REFERENCES

American Psychiatric Association (dt. Bearbeitung: Saß, et al.) 2003 [2000]. *Diagnostische Kriterien DSM- IV-TR*. Göttingen: Hogrefe Verlag.

Good, Byron J. 1994. *Medicine, rationality and experience*. Cambridge: Cambridge University Press.

Hell, D. 2009 [1992]. *Welchen Sinn macht Depression? Ein integrativer Ansatz*. Hamburg: Rowohlt Taschenbuch Verlag.

Kleinman, Arthur 1982. Neurasthenia and depression: a study of somatization and culture in China. *Culture, Medicine and Psychiatry* 6, 117-190.

Low, Setha M. 1994. Embodied metaphors: nerves as lived experience, in T.J. Csordas (ed.), *Embodiment and experience*, Cambridge: Cambridge University Press.

Sobo, E.J. 1996. The Jamaican body´s role in emotional experience and sense perception: feelings, hearts, minds, and nerves, *Culture, Medicine and Psychiatry* 20, 313-42.

Wendt, H.F. et al. 2001. *Taschenwörterbuch Türkisch.* Berlin: München Langenscheidt KG.

World Health Organization 1994. *International classification of diseases*. Geneva: WHO.

Zimmermann, E. 2000. *Kulturelle Mißverständnisse in der Medizin: ausländische Patienten besser versorgen.* Bern: Verlag Hans Huber.