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What is considered to be emotional suffering by psychotherapy patients and their therapists in Eastern versus Western Germany? A mixed-methods study

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Abstract

Purpose: This study examined what aspects of life in Eastern and Western Germany are considered by patients, therapists and society to cause (or indicate) emotional suffering so that outpatient psychotherapy is sought and warranted.

Methods: In Germany, psychotherapy is covered by health insurance after patients submit an application accompanied by a written report from the therapist. We took a random sample of such applications and performed a qualitative text analysis of the reports, identifying all text units where some form of emotional suffering, distress or handicap was described. A coding system was developed based on the units, and all units were subsequently coded. The proportion of units per category was compared between reports from Western and Eastern Germany using chi-square tests.

Results: Out of 500 randomly selected reports, 25 were from Eastern Germany. An age- and sex-matched sample from Western Germany was added. From these 50 reports, a total of 716 text units describing some form of emotional suffering were extracted (359 units from reports from Eastern Germany and 357 from Western Germany). Thirteen categories of emotional suffering emerged. In Eastern Germany, emotional suffering was considerably more frequently described in terms of somatic symptoms and in feeling nervous and tense. Patients from Western Germany were more often described as feeling depressed and hopeless, helpless, anxious and without drive ($\phi = 0.19$, $p = .02$).

Conclusion: There is evidence that there are differences between Eastern and Western Germany in how emotional suffering is expressed and/or described.

KEYWORDS

culture, politics, political change, psychotherapy, depression, somatisation

1 | INTRODUCTION

Societal transformations may change the way people (including psychotherapists) think about psychological suffering, that is what conditions or life circumstances are considered to cause pain, what feelings or behaviours are considered to be 'symptoms', and what conditions are considered to be a disease that should (and can) be treated. For example, a 'querulant' was conceptualised as a person with a disease in the late 19th century (Kraepelin, 1883). This notion disappeared in the literature for a while and was 'reborn' in the second half of the 20th century; it can now be coded in ICD-10 again, as 'paranoia querulans' with the number F22.8. It can be assumed that this is related to how society looks upon people who express their opinion.

Another example of how societal transformations are reflected in how emotional suffering is seen is the increase in depressive disorders in recent years. We not only find this in epidemiological studies (Jacobi, Hofler, Meister, & Wittchen, 2002; Lieberz, Franz, & Schepank, 2011; Wittchen et al., 2011) but also in clinical practice: in a study where researchers analysed 100 applications for psychotherapy, they found that 80% of all diagnoses included depression in some way (Rudolf, 2001). Ehrenberg, a sociologist from France, argued that this increase in depression prevalence is due to a society that requires individuals to be autonomous and achievement-oriented, in contrast to previous times where it was more important to be disciplined and obedient (Ehrenberg, 1998). He thinks that melancholy used to be the disease of the 'extraordinary' and, nowadays, everybody needs to be extraordinary.

One of the major societal transformations that has happened in recent years is the political change in Eastern Europe, including Eastern Germany. Did this perhaps change the way people think about emotional suffering and, consequently, psychotherapeutic practice? Some authors assume that this has been the case (Barrett, 2017; Blass, 2016). The uncertainty provoked by this societal transformation could have influenced many therapeutic processes. It may have been a motivation for people to seek psychotherapeutic help or, on the contrary, may have stopped them from doing so. Moreover, it may have affected the way people think about themselves (and others) and what they consider to be a cause for suffering.

The German healthcare system offers a unique opportunity to investigate this issue empirically. In Germany, patients usually do not pay for psychotherapy themselves. Rather, it is paid by the health insurance (Strauss et al., 2015). The procedure is as follows: the patients complete a brief form, applying for payment of psychotherapy, and submit this to their health insurance company. This form is accompanied by a report, prepared by the psychotherapist, where he or she explains why therapy is indicated. The report has to follow a certain structure: first, the patient's complaints and symptoms need to be described. This is then followed by a diagnosis, the patient's biography, causal explanation of the symptoms (either psychodynamic or based on learning theory), the treatment plan and the assumed prognosis. Usually, the report's content is unknown to the patient. These reports are then submitted in closed envelops via the health insurance companies to experienced therapists for review and evaluation (Rudolf, Jakobsen, Hohage, & Schlosser, 2002). They decide based on predefined criteria that are defined in the psychotherapy law, which was established in 1999. In only about 1%–4% of cases do the reviewers not recommend financing (Gallas, Puschner, Kuhn, & Kordy, 2010); in 10%, they recommend a change, for example in terms of session frequency (Lieberz & Seiffge, 2011). In those cases, patients can apply for another review.

The reports for these applications can be considered a *co-creation of patient, therapist and society*. The patients contribute their presentation of symptoms and their history, the therapists add their understanding and explanation of the patients' suffering, and the society (represented by the health insurance companies and the psychotherapy law) decides whether a therapy is 'worthwhile', which in turn influences how the therapists write up the reports and probably also which aspects of the patient's presentation they focus on while listening. Hence, by analysing these reports, we can probably get a better understanding of how societal changes are reflected in different expressions of emotional suffering, that is symptoms and complaints. It may also reflect a different understanding of what constitutes emotional suffering.

With our study, we aimed to answer the question as to whether there are differences in symptoms/complaints in reports between Eastern and Western Germany.

2 | METHODS

2.1 | Material and sampling

We had access to 40,000 applications for psychodynamic psychotherapy available from the years 2003 to 2017. The applications were available via a psychotherapist who had been asked by several health insurance companies to review applications since 1999, and she had stored electronic copies of them from 2003 until 2017.

Of these, we took a random sample of 500 copies for the qualitative text analysis. The applications contained neither the name nor address of the patients, but we additionally blacked out the patients' codes (because they contain the birth date of the patients and the first letter of the surname), as well as the name and address of the therapists, so that all potentially person-identifying information was removed. The original data were stored on a password-secured drive physically separated from the Internet. The anonymised data were stored on a password-secured drive that only the members of the study group had access to. A study protocol was prepared and received approval from the responsible ethics board of Rhineland-Palatinate.

For comparison between Eastern and Western Germany, we first selected the applications where the postcode of the practice was in Eastern Germany. This was done because Eastern Germany covers a smaller proportion of the German population than Western Germany, and there are consequently fewer psychotherapies performed in the East, resulting in fewer applications from Eastern Germany in the total sample.

We excluded applications where the patient was born after 1977, to ensure he or she had consciously experienced the split in Germany, and those where it became clear from the report that the patient grew up outside the German Democratic Republic (GDR). Another exclusion criterion was when the application was only for a continuation of psychotherapy and the report did not contain enough information for the qualitative text analysis.

We then selected the same number of applications from practices in Western Germany and applied similar exclusion criteria (born after 1977, grew up outside Western Germany according to the report, application for continuation of psychotherapy without sufficient information in the reports). The applications from Western Germany were selected in such a way that they matched the Eastern sample as much as possible regarding age and gender.

2.2 | Data extraction

This study employed qualitative text analyses of reports from applications for psychotherapy and subsequent quantitative analyses of the number of categories found (a mixed-methods approach). Based on previous experience (Lieberz, Krumm, Adamek, & Muhlig, 2010), we mainly focused on the texts of the reports, but also extracted some data from the forms that accompany each report, namely:

- Data on the patient: gender, age at the time of the report, ICD-10 codes.
- Data on the therapist: postcode of the practice, gender, profession, qualification.
- Data on the health insurance company: public versus private insurance.

The reports were anonymous, and the postcodes of the patients were thus unknown.

2.3 | Data analysis

First, we classified the region where the therapist worked, Eastern versus Western Germany, based on the practice's postcode. Based on this, the sample was selected. Characteristics of the sample were analysed using descriptive statistics (absolute and relative frequencies for categorical variables and means plus standard deviations for continuous variables).

Second, one of the researchers (VN) read the reports carefully and identified all text units describing symptoms or complaints. A text unit was defined as any part of the report where some form of suffering, distress or handicap was described. This could be either a description from the perspective of the therapist ('*She is depressed*') or quotes from the patient within the report ('The patient says *"I am depressed"*'). Text units could be whole sentences (e.g. *'I feel ugly and I am lacking any form of self respect.*'), parts of sentences or single words (e.g. *'depression*'). Repetitions within a report were handled as a new unit.

Similar units were then grouped and categories generated. After about 50% of the material was coded, the categories were reviewed by two other researchers (JJ and LML). Each of them was trained in using the code tree and received 50 randomly selected text units. They then coded these 50 units independently from each other. After that, the three researchers met and compared what they had found in the text; they discussed the units until a consensus was reached. The code tree was then revised accordingly. This process was repeated until 80% of the ratings were identical.

In a next step, the entire research group (five members) reviewed the code tree and checked it for completeness and clarity. The aim was to create categories that are as distinct as possible. The code tree was then finalised, and one anchor example per category added.

The last step of the qualitative analysis was to code all text units. While doing this, whether the text unit stemmed from a patient quote describing his or her emotional suffering or from a therapist's description and interpretation of the patient's suffering was also coded. The person who had identified the text units (VN) was not blinded as to whether the report came from Eastern or Western Germany. All other coders were blinded in regard to this. As they only saw the text units and neither the entire text nor the application forms, they could not identify from where the reports came.

Finally, the frequencies of the categories were compared between Eastern and Western Germany using chi-square tests.

3 | RESULTS

3.1 | Sample characteristics

Of the 500 reports, 56 (11%) were from therapists in Eastern Germany. Of these, 31 were excluded because they did not fulfil the inclusion criteria ($n = 9$ because the patient was born after 1977, $n = 12$ because the application was only for a continuation of an ongoing therapy and not enough information from the reports could be abstracted, $n = 10$ because the report indicated the patient grew up outside the GDR).

Consequently, 25 applications from Eastern Germany could be used for in-depth text analysis. Another 25 applications were sampled from Western Germany, resulting in 50 reports together.

Thirty-six (72%) of the patients were female. The mean age was 46 years ($SD = 10$ years). In 29 cases, the therapists were females (58%) and the majority were psychologists ($n = 37$, 74%). More details are displayed in Figure 1 and in Tables 1 and 2.

3.2 | Emotional suffering (the categories)

From the 50 reports, a total of 716 text units describing some form of emotional suffering were extracted. There were 359 units from reports from Eastern Germany and 357 from Western Germany.

TABLE 1 Sample characteristics ($n = 50$)

	Location of practice:	
	Western Germany ($n = 25$)	**Eastern Germany ($n = 25$)**
Gender of patient		
Female	18	18
Male	7	6
Unknown	0	1
Age of patient		
Years, mean (standard deviation)	49 (11)	44 (9)
Gender of therapist		
Female	11	18
Male	14	6
Unknown	0	1
Profession of therapist		
Medical doctor	7	6
Psychologist	18	19
Type of therapy		
Low-frequent (psychodynamic)	17	22
High-frequent (psychoanalytic)	8	3

Note: Displayed are the absolute numbers unless otherwise specified.

TABLE 2 Psychiatric diagnoses according to ICD-10

Diagnosis	Western Germany ($n = 25$)	Eastern Germany ($n = 25$)
Mental and behavioural disorders due to psychoactive substance use		
ICD–10: F10–F19	1 (3%)	0 (0%)
Mood (affective) disorders		
ICD–10: F30–F39	12 (31%)	13 (36%)
Neurotic, stress-related and somatoform disorders		
ICD–10: F40–F48	14 (36%)	14 (39%)
Behavioural syndromes associated with physiological disturbances and physical factors		
ICD–10: F50–F59	6 (15%)	3 (8%)
Disorders of adult personality and behaviour		
ICD–10: F60–F69	5 (13%)	5 (14%)
Mental retardation		
ICD–10: F70–F79	1 (3%)	0 (0%)
Disorders of psychological development		
ICD–10: F80–F89	0 (0%)	1 (3%)
Total	39 (100%)	36 (100%)

Note:: Multiple diagnoses per patient were possible.

Of the 716 units, 13 categories of emotional suffering emerged: 1) Depression and Hopelessness; 2) Helplessness and Feeling Overwhelmed; 3) Guilt, Shame and Self-doubt; 4) Reduced Motivation and Interest; 5) Withdrawal; 6) Reduced Regulation of Emotions; 7) Alexithymia; 8) Anxiety; 9) Nervousness and Tension; 10) Cognitive Decline; 11) Somatic Complaints; 12) Experienced Deficit of/in Social Relations; 13) Factors in the Environment; and 14) Others. Only rarely, psychotic symptoms, dissociative states and slowed thinking were mentioned, which is why no categories were created for these. The anchor examples per category are displayed in Table 3. The inter-rater reliability of the coding was r = 0.82.

Somatic complaints were most frequently mentioned ($n = 125$ units). These were, for example, sleep problems, pain or appetite change. The second most frequent category was Anxiety ($n = 97$ units). This encompasses feelings of insecurity, fear, worry, anxiety and obsessions. Another frequently mentioned domain was Depression and Hopelessness ($n = 68$ units). Table 4 contains all counts per category.

3.3 | Comparison Eastern versus Western Germany

In Eastern Germany, emotional suffering was considerably more frequently described in terms of somatic symptoms, for example: *'She lost a lot of weight because of appetite loss'* (C064)[1] or *'problems falling and staying asleep'* (B015), and in feeling nervous and tense, for example: *'I am nervous and unstable.* (B026) or *'a man that seems to be immensely under pressure during the first contact'* (D011) (Table 4).

In contrast, patients from Western Germany were more often described as feeling depressed and hopeless *('she suffers increasingly from depressed mood, she looks dispiritedly towards the future'*, C020), helpless and overstrained (*'says he feels constantly unable to cope and without orientation'*, C075), anxious (*'he is very afraid of the future'*, C010) and without drive (*'The patient reports she is weary and dull'*, C010). These differences were statistically significant with a moderate effect size ($\phi = 0.19$, $p = .02$).

When analysing only the parts of the report where **patients'** self-characterisation was mentioned, often as a quote from the patient, we find that patients from Eastern Germany describe their emotional suffering in the form of somatic complaints more frequently than patients from Western Germany (26% versus 15%), whereas patients from Western Germany complain about anxiety (17% versus 11%) as well as depression and hopelessness (11% versus 5%) more often (see Figure 2 for details). These differences were statistically significant ($p = .01$).

When analysing only the parts of the report where the **therapist** explicitly describes his or her impression of the patient, and leaving out the parts where the patient's words are quoted, 'Guilt, Shame and Self-doubt' was the category where the largest difference between Eastern and Western reports occurred (delta of 7%). It constituted 11% of all text units in reports from Eastern Germany compared to 4% in Western Germany. A delta of 6% was observed in 'Nervousness and Tension', which was also mentioned more often from therapists in Eastern (10%) than in Western Germany (4%). 'Reduced Motivation' was more frequently seen in their patients by therapists in Western (8%) than in Eastern Germany (3%). However, these differences could also be due to chance ($p = .13$).

Of note, while patients mentioned 'Factors in the environment' equally frequently in East and West as burdensome and causing

TABLE 3 Categories of emotional suffering with anchor examples

Category	Example
Depression and Hopelessness	She suffers increasingly from depressed mood; she looks dispiritedly towards the future.
Helplessness and Feeling Overwhelmed	Feels constantly swamped and without orientation.
Guilt, Shame and Self-doubt	I like to blame myself for everything.
Reduced Motivation and Interest	He says he is weary during the day; he sits dismally at home.
Withdrawal	She avoids large groups of people, has few relations with others.
Reduced Regulation of Emotions	She says she has mood swings… and easily gets a bad temper.
Alexithymia	Without my help… she could talk about her feelings only with the same repetitive words: 'normal' or 'strange'.
Anxiety	He says he has intense fears of the future.
Nervousness and Tension	The patient says she is hounded and feels stressed.
Cognitive Decline	She can't concentrate anymore and realises she forgets many things.
Somatic Complaints	He complained about stomach problems.
Experienced Deficit of/in Social Relations	She says she would like to have a friend and social contacts.
Factors in the Environment	There are many ongoing lawsuits that are distressing to him.
Other	Has reduced ability for empathy.

TABLE 4 Number of units per category of emotional suffering and percentage of all units

Category	Total	West	East
Depression and Hopelessness	68 (9%)	40 (11%)	28 (8%)
Helplessness and Feeling Overwhelmed	49 (7%)	29 (8%)	20 (6%)
Guilt, Shame and Self-doubt	54 (8%)	24 (7%)	30 (8%)
Reduced Motivation and Interest	45 (6%)	27 (8%)	18 (5%)
Withdrawal	21 (3%)	9 (3%)	12 (3%)
Reduced Regulation of Emotions	42 (6%)	21 (6%)	21 (6%)
Alexithymia	25 (3%)	9 (3%)	16 (4%)
Anxiety	97 (14%)	59 (17%)	38 (11%)
Nervousness and Tension	49 (7%)	19 (5%)	30 (8%)
Cognitive Decline	41 (6%)	24 (7%)	17 (5%)
Somatic Complaints	125 (17%)	49 (14%)	76 (21%)
Experienced Deficit of/in Social Relations	55 (8%)	28 (8%)	27 (8%)
Factors in the Environment	31 (4%)	15 (4%)	16 (4%)
Other	14 (2%)	4 (1%)	10 (3%)
Total	716	357	359

emotional suffering (both with 6%), this category was never found in therapists' descriptions of the patients (Figure 2). 'Factors in the environment' were coded if a patient had described emotional suffering from issues outside of his mental or physical life, for example *'the atmosphere at home is tense'* (C006), *'it is especially the noise that stresses her'* (C009) or *'quarrelling within the family'* (C027).

4 | DISCUSSION

This study examined what aspects of life are considered by patients, therapists and the society to cause (or indicate) emotional suffering so that outpatient psychotherapy is sought and deemed warranted, in Eastern and Western Germany.

A first interesting result is that the most frequently mentioned issues were somatic symptoms, not psychological ones, despite the fact that these were texts prepared to apply for financial compensation for psychotherapy. Similarly to a previous study (Rudolf, 2001), we also found that depression was a common complaint described in the reports. In contrast to Rudolf et al. (2002), however, who based their findings on the number of ICD codes, we found that somatic symptoms and anxiety were described even more commonly than depressive feelings.

Our main purpose, however, was to compare reports from Eastern and Western Germany. A major finding of our study is that in Eastern Germany, somatic complaints were mentioned far more frequently than in Western Germany. Other expressions of emotional suffering that were more often mentioned in reports from Eastern Germany were nervousness and tension, and therapists interpreted the problems more often as a results of not being able to feel and express emotions (alexithymia). These differences cannot be explained by different age or sex distributions in the two samples because they were matched in regard to this. Our results are in line with findings from Waza et al. who found that Japanese patients with depression present with more physical symptoms (such as headaches, abdominal symptoms and neck pain) than depressed patients from Cleveland in the United States (Waza, Graham, Zyzanski, & Inoue, 1999). Their study used a methodology similar to ours; they audited the medical charts of patients with clinically confirmed depression. The results are also in line with epidemiological data showing that depressive symptoms are more common in Western Germany, whereas in Eastern Germany young people in particular suffer commonly from psychosomatic complaints (Wittchen, Lachner, Perkonigg, & Hoeltz, 1994). Similarly, Haroz et al. report that somatic symptoms are more commonly presented by depressed patients in collectivistic countries (Haroz et al., 2017). In contrast, Frommer et al. found in a qualitative analysis of first consultations for psychotherapy from two German cities (Magdeburg in

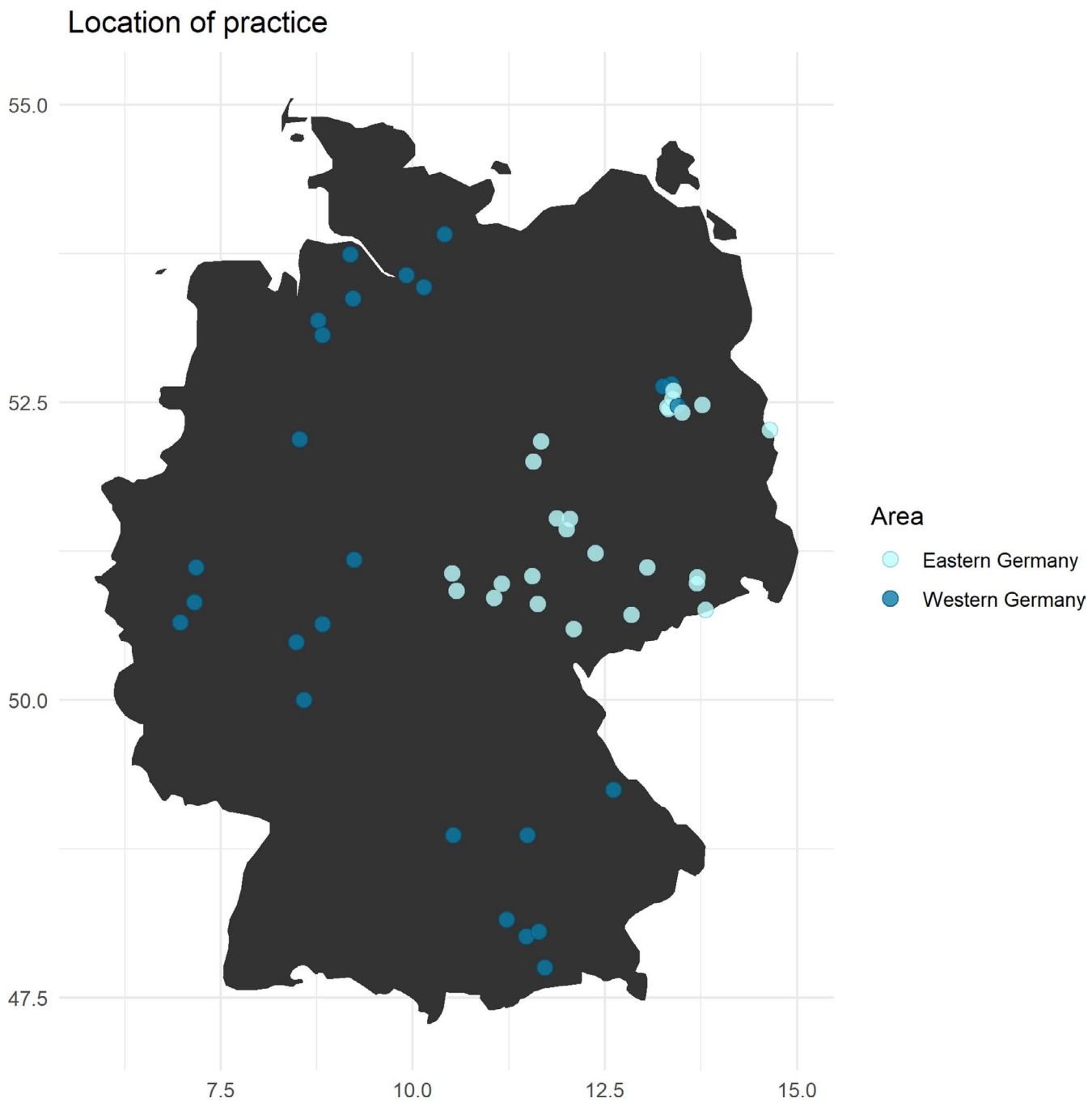

FIGURE 1 Location of the practices where the reports came from

Eastern Germany and Düsseldorf in Western Germany) that especially patients with anxiety disorders described their emotional problems more frequently in terms of physical malfunctioning; there were only a few differences in the interviews from Eastern and Western patients (Frommer, Knüfermann, Krause, & Wittig, 1999). Patients with depression, in contrast, described their problems more with psychological concepts. Interestingly, they also found in another study using questionnaires that anxiety symptoms were more frequently reported in Eastern Germany, whereas depression was more frequently found in the West (Frommer, Hoffmann, Hartkamp, Tress, & Franke, 2004).

Another, rather speculative, explanation for the difference found in our study would be that people in the East experience themselves more with their body than patients in the West. Culturally, the relation to the body in the GDR differed from the FRG (Federal Republic of Germany, i.e. Western Germany before the reunification) in a sense that it was much more common to be nude in public spaces (e.g. beaches) in the GDR. Nudity was regarded to be natural, so it was less related to erotic feelings but more to feeling free and relaxed. According to the Frommer study, it could be possible that the somatic complaints are indications of somatoform anxieties. Of note,

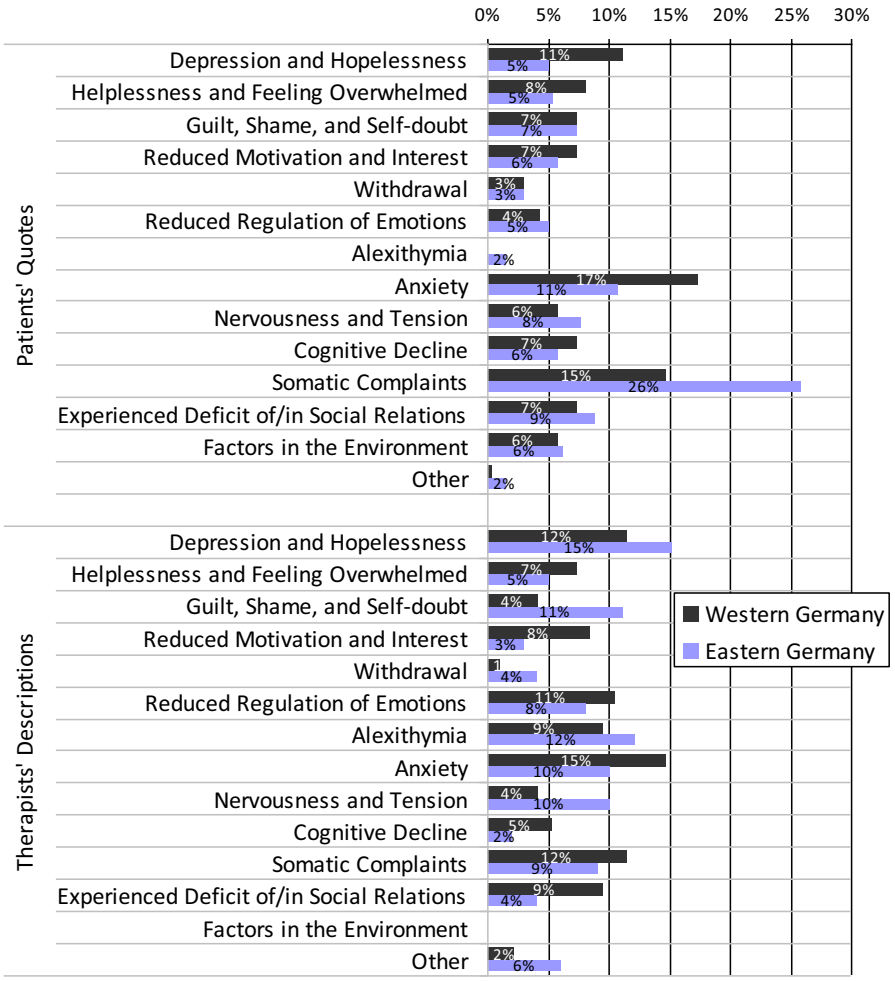

FIGURE 2 Percentage of text units describing emotional suffering in Eastern versus Western Germany

the therapists in Eastern Germany interpreted the symptoms of their patients more often in terms of alexithymia.

It could also be possible that 'inherent' cultural differences (i.e. a *state*) are not responsible for this, but rather the political *change* that had happened in Eastern Germany. The uncertainty provoked by this societal transformation could have reduced the ability to symbolise and weakened the egofunctions (Holter, 2005).

In reports from Western Germany, in contrast, emotional suffering was more often described in terms of depressed mood, feeling helpless, reduced motivation, anxiety and cognitive problems due to rumination and reduced concentration. Hence, the 'symptom cluster' in these reports closely resembles clinical depression. This finding was a bit surprising because the public opinion/stereotype about people from Eastern Germany is that they are insecure and feel easily overwhelmed and helpless, whereas the stereotype for West Germans is that they are strong individuals with clear goals, maybe arrogant, but independent, competent and tough (Doll, Mielke, & Mentz, 1994; Rippl, 1997; Schmitt & Maes, 2002; Schneider, 1997). It is possible that indeed this is also the ideal self-image of Western people, and they suffer if they think they do not match it. Recent analyses of regional variances of personality styles have shown that people in Western Germany described themselves more often as extrovert and open than East Germans (Obschonka et al., 2019).

We would like to discuss potential limitations of our study. First, the classification of Western versus Eastern Germany was not as straightforward as one would wish for such a comparison. As the reports and the application forms did not contain the address of the patient, nor their birthplace, we could classify only the region of the practices based on their postcode. It is of course possible that patients migrated before or after the reunification. If this was explicitly mentioned in the reports, we excluded this report, but the fact that it was not mentioned of course does not imply that the patient did not migrate. Hence, it is possible that a patient who was born and raised in Western Germany, for example, had moved to Eastern Germany and went to a therapist there. This person would then have been misclassified if this move was not mentioned in the reports.

Secondly, we do not know from what region the therapists originally came. Being from the same or a different region or culture is known to influence the way people think about each other (Schmitt & Maes, 2002), and it can affect the therapeutic relationship (Farsimadan, Draghi-Lorenz, & Ellis, 2007). Similarly, the age or socialisation of the therapists might play an important role. This, however, could not be taken into account in our analyses because the application forms do not contain such information about the therapist.

Thirdly, text units were treated as if they were independent elements. However, they were in fact clustered because some text

units came from the same report. Because of the relatively small sample size and the primarily qualitative nature of this study, we did not employ multi-level analyses. The sample size was limited because the majority of therapies (86%) were performed in Western Germany. This underlines that our sample reflects the general population, as 84% of the German population lives in Western Germany according to the German Statistical Office (www.destatis.de). Use of outpatient psychotherapy in the general population is very similar in East and West, namely 4.1% and 4.4%, according to a representative survey with 8,152 participants (Rattay et al., 2013). However, the disadvantage of this low proportion of reports from Eastern Germany is that the total sample size is relatively low, as we wanted to create two samples similar in age and gender and of equal size. Even with this relatively small sample, however, we can assume that it represents the clinical population relatively well as the distribution of age and gender was similar to two large representative studies in Germany. In our study, 72% of the applications came from females. The same proportion, namely 72%, of participants in a representative interview study with (previous) psychotherapy patients were women (Albani, Blaser, Geyer, Schmutzer, & Brähler, 2010). In another study by the same author, the proportion of women among those using outpatient psychotherapy was 66% (Albani et al., 2009). The mean age in our study was 49 and 44 years, respectively; it was 47 years in the Albani study (Albani et al., 2010).

Another limitation is that we have no data from before the German reunification in 1989 or shortly thereafter. The reason for this is simply that the German psychotherapy law was established in 1999. In the Federal Republic of Germany, psychologists could not directly offer psychotherapy before that time (Vangermain & Brauchle, 2010). In the German Democratic Republic, it has been possible since 1981, but only in counselling centres and in clinics and not in private practices (Frohburg, 2004). Only since the law came into place in 1999 were the reports that we used for our analyses produced. It is possible that differences between East and West decreased in these 10 years due to cultural exchange. Contrasting evidence comes from a study by Angermeyer and Matschinger who conducted a large representative survey immediately after the reunification (in November and December 1990), where they found nearly no differences between Eastern and Western parts of Germany in the way people think about mental health illnesses (Angermeyer & Matschinger, 1999).

Finally, the reports cover only psychotherapy in the outpatient setting. Konzag et al. compared psychotherapy inpatients from two university hospitals in different German cities, one in Eastern and one in Western Germany (Konzag et al., 1999). They found no large differences in self-reported symptoms between patients from East and West, measured with a symptom checklist (SCL-90-R). Patients from Eastern Germany even scored slightly lower in somatisation, which is in contrast with our findings. Our study did not use questionnaires or symptom checklists but analysed what is described in psychotherapy reports as creating emotional suffering. In this way, we assume the perspective of the society is better reflected.

In summary, by looking at these reports, we can see a clinical reality, depicting concepts that were not created in the artificial world of an academic study but in real life. We found that emotional suffering is expressed in terms of somatic complaints more often in Eastern Germany, whereas anxiety and hopelessness is more often expressed in Western Germany. Hence, we think that the way emotional suffering is experienced and seen is influenced in some way by societal differences and changes.

4.1 | Implications

Clinicians should be aware that the way emotional suffering is experienced and expressed by their clients and patients might be coloured by their cultural and historical background. People from countries with former socialist governments might present more often with somatic complaints, whereas people from Western cultures describe themselves more often as hopeless and helpless. This is in contrast to certain stereotypes of East and West. It is also possible (and likely) that the therapists and counsellors themselves consider other issues to be emotionally disturbing depending on the society they grew up in.

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CONFLICT OF INTEREST

There are no financial conflicts of interest.

ETHICAL APPROVAL

The study protocol was approved by the responsible ethics committee of Rhineland-Palatinate and has been performed in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki and its later amendments.

DATA AVAILABILITY STATEMENT

The quantitative data that support the findings of this study are available from the corresponding author upon reasonable request. The qualitative data are not publicly available to protect the privacy of the patients and therapists.

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ENDNOTE

[1] The code within brackets denotes the pseudonym (ID) of the report.

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