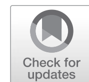

19 Working with Immigrants and Refugees

Youssef Hrar and J. Martin Maldonado-Duran

Mental Health Interventions with Immigrants and Refugees During the Perinatal Period and Early Childhood

"When I came to this country, everything seemed so different and odd. The way people looked, the way they talked, how they dressed, how they related to each other. I could not understand the language very well, despite having studied some English in my country. They spoke really fast and used a lot of words I did not understand, they call it slang. Everything seemed to be like in a movie. When people started talking to me, my mind went blank. I was not really listening, let alone understanding. I wanted to be polite and just tried to smile and nod as if I agreed with everyone. The information that they gave me I forgot very quickly. There were so many pieces of new information. They would ask me my "zip code" in agencies that help people and I did not know what that was. They spoke with acronyms I did not understand, and I was afraid to ask. It took me about a year for everything to seem less strange."

Y. Hrar
King Hassan II University, Casablanca, Morocco

International Service, Texas Childrens Hospital, Houston, TX, USA

J. M. Maldonado-Duran (✉)
Menninger Department of Psychiatry, Baylor College of Medicine, Houston, TX, USA
e-mail: Jxmaldo1@texaschildrens.org

"Cultural Sensitivity"

In many areas of medicine and disciplines of mental health (psychology, psychotherapy, counseling, psychoanalysis), there is an increasing awareness of the need to be culturally sensitive. But what does this mean? In many settings in North America it often means a brief presentation or a few hours of being exposed to "exotic cultures" and being careful not to offend anyone with stereotypes and assumptions about "other people." Such courses are taken at times as a way of fulfilling a requirement to "take into account the patient's culture" and beliefs. Then everything goes back to normal and the same practices and assumptions are more or less maintained, despite this "sensitivity training."

Perhaps a useful way to discuss the transcultural work is to consider from Marie-Rose Moro's statement (Baubet and Moro 2009): "every relationship is transcultural." This implies that not only in clinical work, but in schools, work places, marriages, friendships, etc. a person's history, sense of self, ideas, and assumptions are determined by culture in the broad sense.

In a clinical setting, and particularly in the area of mental health, the cultural background of the persons in front of us interacts with the clinicians' backgrounds. At all times, we gain impressions, assess statements, perceive motions, gestures and expression of emotion from our own

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cultural frame of mind, to which we are often blind.

This implies that clinicians, like the families and individuals they serve, will have prejudices, assumptions and ideas about "the other" of which they will not be aware. One tends to unconsciously assume things about those with whom we interact, and those presumptions will color our impressions, reactions, and what we say or do not say or do. It would be useful if the clinician interacting with a given individual or family wondered what prejudices or notions might be in play in his or her mind, particularly if unusual or strong reactions of dislike, fear, anger, disapproval, or devaluation are detected. This type of introspective work would certainly improve the clinician's level of cultural sensitivity among other benefits.

The Mind-Set of Clinicians in a "Transcultural Situation"

How can one work with a person from another culture? There may be interactions that are particularly difficult and questioning one's blindness to them might be helpful.

The clinician has the contradictory task of seeing what "is the same" and "what is different" about the person/family seeking our assistance. Only if one is able to perceive the "human condition" of any person no matter how different, unique, or odd their beliefs or practices are, one can relate to their situation: expecting a baby, having had a perinatal complication, having suffered the loss of a child, most people can relate to the possible reactions. There is something very basically human about people from any background to which we can relate. Similarly, even though the clinician may be from a very different ethnic or social group, the patient must feel that he or she understands, empathizes, and is able to comprehend what the patient/family is going through, and then offer a helpful view, understanding, or empathy.

On the other hand, a common problem is "not to talk about differences" as though they did not exist. The fear of prejudices, devaluation, or appearing judgmental may prevent the clinician from asking questions about a person who has very different beliefs or practices. One may tend to assume that the person is "like us," or wants to be like us, has the same aspirations, view of the world, of what being a father or a mother is, or what they may want for their child. The clinician has to feel a minimum of comfort to ask about different points of view, assumptions, and practices and to try to understand them within the world view of the person who seeks help.

A technical strategy may be called decentration (Wa Tshisekedi 2008) in the sense that the clinician is able to put himself or herself in the frame of mind of the other, suspend one's own intuitive or automatic appraisal, and try to see things from the other person's view. What would it be like if one thought that whatever adversity that happens is due to "karma," i.e., to a debt for a previous transgression that occurred in a former reincarnation? or that it is their fate to endure a difficult event and that everything is "already written" in the person's destiny book? The patient or family may think that a perinatal complication is written in their book of life decided by God and has to be endured as such. For example, the parents of an 8-year-old boy that passed away after battling cancer for many months, were extremely sad but had a smile on their face while discussing their child's death. They referred to it as "Allah's will" and said that their little boy was now an angel, resting in peace. This approach and ideology appeared to give them a lot of strength to accept the terrible loss they had endured. It also seemed to allow them to move through the grief processes and stages, as the acceptance phase had already started in some form. They had a newborn boy about a year later and named him after his late brother.

In another scenario, a family may appear very stoic and inexpressive of emotion, even in the face of a severe illness in an infant, or after the death of a small child (Foss et al. 2004). One might assume that there was "no attachment" to the child, when in reality the person has a different way of experiencing grief: the open expression of sadness, particularly in front of strangers may be considered unseemly and a burden on the

other. The mother or father going through that experience may think that they must "endure inside" their feelings of pain and sadness, and that this is how these losses should be processed. This may be how they saw their parents and other relatives deal with losses.

A better understanding of those etiological theories, explanations, and reactions is facilitated by taking into account some cultural norms and strategies in the social background of the individual or family.

There are a number of challenging situations that could be described in great detail, pitfalls and "cultural clashes" that the clinician needs to consider in working with a person from any background.

We describe some common scenarios that may offer particular difficulty for clinicians regarding the "cultural factors" involved.

The Client and Therapist of the "Same Background"

This is a common pitfall in many clinical settings. If a therapist or clinician is from a determined ethnic background, that does not mean that all families from that particular ethnicity or origin should be treated by that person. Also, it does not mean that such clinician should have an entire caseload of the "same type of families." Often an Afro-American psychotherapist may be automatically assigned every African American family just because it is assumed they will "feel more comfortable." This at times means that other clinicians in that setting may find it difficult to relate and/or to understand families from that particular provenance. This maintains a stereotype of "like working with like." Clearly some families might have great reservations, but others might not and the interchange of different views and experiences may benefit both the family and the clinician.

It often happens that families may indeed feel more understood by a person from a particular ethnicity or background, or who speaks the same language, allowing for a more rich and complex communication with that therapist. However, it must not be assumed that just because someone is from a particular country or ethnic group, this makes him or her competent to work "only or predominantly" with clients of that group. This has been called a "particularist approach" to the matching between patient and therapist (Erdur et al. 2003). It assumes that people improve more, or stay longer in treatment, or find the therapy more credible if the patient and therapist are from the same ethnic background, sexual orientation, or both are handicapped for example. There is little empirical evidence for this, and some studies have found little difference between outcomes just based on similar ethnicity of clients and therapists (Erdur et al. 2003). When there is a language barrier, the therapist and the patient/family speaking the same language may indeed lead to a better experience and outcome. The same could apply when a group is considerably devalued and segregated, so the family may feel more comfortable with the therapist of a similar background.

In the United States, a common assumption is that a therapist from Spain, Chile, or Colombia is "Mexican" and therefore would prefer to work with those families, or that the families would favor such clinician. The same could be said of an "Asian" therapist who is thought to automatically anyone with a particular "Asian phenotype." There may be considerable differences in practices and beliefs between different countries and groups within them, even though they are lumped together as "Hispanic," and there is no a priori uniformity.

In a mental health service, a more complex approach to assigning therapists would be useful: the interest or expertise of the therapist with particular problems or issues, the variety of the clientele of the clinician, the interest in particular situations, the needs of training and exposure of other therapists, etc. Assuming that a clinician from a particular ethnicity or social background "understands everything" about a family is a false idea. Sometimes it is useful for a family to "have to explain" what they mean by terms such as "respect," "act like a man," "what a wife should do," etc. rather than just imagining that people from the same cultural group are thinking along the same lines.

Having the opportunity for supervision or consultation in psychotherapy with specific situations or families, as well as clinical discussions of particular cases, reflective discussion of the individual/family and the clinician's reactions would help to develop increasing capacity in the staff to deal with multiple situations (Banks 2001). The consultant or supervisor may help the clinician recognize biases, particularly common are those based on European perspectives on what constitutes normalcy, "boundaries between family members," and independence which a therapist might unwittingly attempt to impose to a family for which those are not important aspects of human development.

There are a number of instruments designed to detect prejudice in the therapist (Katz and Hoyt 2014), for instance the Multicultural Counseling Inventory (Sodowsky et al. 1994), or the Implicit Association Test (Greenwald et al. 2003) which helps to detect automatic prejudices against Afro-American people, among others. They may help detect how much bias there may be toward often devalued cultural groups, like Native Americans, Hispanics, African Americans, Muslims, etc.

Prejudice on the Part of the Patient/Family

A difficult situation for any mental health service is the request for a particular "type of therapist" (e.g., a Christian one), or the "veto" of a clinician from a certain background. The father of a young child who was requesting through a telephone call a consultation for his son's difficult behaviors, upon hearing the accent of the clinician asked if he was "one of those Muslims." The clinician was taken aback (he was not Muslim) and all he could manage to answer was "I wish." The father was rather surprised and made the appointment. He had been in the Iraq war and had very strong feelings about Muslim men, to whom he referred pejoratively as "sand niggers." In this case despite the physical appearance and the accent of the therapist, a therapeutic relationship became possible and the father's traumatic memories of his time in the Iraq war lead to understanding his feelings, and once these came to the fore the "prejudice" became more a question of the unique experiences he had had. A more suitable response by the clinician would have been "what is the reason for your question about Muslims" or something along those lines. The fact that the therapist was not afraid to embrace "the Muslims" seemed to prove to the father that he could talk openly to the clinician about his anger problems, which often were taken out on his little son.

In another instance, a young mother of a three-year old boy who was being seen for frequent temper tantrums and very difficult behavior asked the therapist "what he was" referring to his ethnic background. The therapist answered: "I am Mexican." The woman showed much empathy and said "don't talk like that about yourself" (implying "don't be so harsh on yourself") with considerable compassion. She had thought that "Mexican" was an insult as this is how she had heard it all her life, and only then realized that it also referred to a person born in that country. She was somewhat mortified and discussed her feelings about "Mexican people" against whom her mother had warned and who were seen as impoverished and potentially thieving people.

Sometimes the prejudice might stem from the cultural belief that the need to consult a therapist is not justified or needed. The patient or family might be very reticent to see the clinician in the initial phase. The clinician would have to explain his role and build a relationship of trust with the family. Using the strategy of de-centration discussed previously would be crucial in this scenario. It would allow the clinician to fully understand the source of the prejudice he is facing and turn it into a successful collaboration. Despite all his or her efforts, the clinician might fail to overcome those challenges. If the prejudice were very intense and entrenched, it might be counterproductive to attempt to engage with a person who is going to be frightened or has strong dislike or hatred for people of a certain background. The clinician or the organization has to decide, perhaps on a case by case basis, how to deal with such "vetoes" or "special requests" from families for a particular "kind" of therapist.

Hiding Behind One's Culture

At times a family or couple that experience difficulties may justify their behavior as based on "their culture," as a way not to deal with their individual or family issues related to their own life experiences and relationships. The clinician should consider carefully whether certain assumptions are "cultural" or are unique to the particular individual. Recently one of us worked with a young father from the Philippines who was particularly authoritarian with his wife, who "cried in silence" and just prayed when her husband would become enraged, scold her, accuse her of unjustified infidelities and exhibited very paranoid behavior in general. He said that is "the way men are in his country, particularly from Mindanao." While he was not challenged, when he started exploring his own childhood marked by an abusive father and a frightened mother, the source of his fears and the identification with authoritarianism became more "personal" than "cultural." When we worked on these memories and current circumstances, unique to his life, he gradually was able to become less controlling and more empathic. The clinician might have just taken his statements at face value, but still it would be very hard to believe that all or even "most" men from Mindanao were as controlling, insecure, and paranoid as the person affirmed.

The question of disciplinary practices and culture often comes to the fore in the clinical setting, particularly toward young children. At times parents say that "this is the way things are done in their culture." For example, the parents of a four-year-old boy with Down syndrome were very angry that he was disobedient and aggressive. The little boy had very limited language use and mostly growled to convey his emotions. As we explored the reasons for his frustration, the issue of physical discipline arose. The boy's mother was very controlling and frustrated, and she was originally from an Asian country. She wanted the boy to be normal, and "like every other child." She would hit him with a clothes hanger on the plantar area of the feet so that "she would not be reported" for child maltreatment by her child's preschool teacher if any bruises were left. She would hit him and threaten him often with doing precisely that. She said that: "everybody does it in my country." However, as we explored her desire that her son would become normal, and not accepting the reality of his language and intellectual limitations she started to mourn the loss of "an ideal child." She was able to think about how her son might feel being hit on the feet, his fear and his frustration. She started to accept the child that indeed was in front of her. She stopped hitting and accepted alternatives to teach the boy other ways of acting, less aggressively. She was able to acknowledge that she had been angry at her son for not being "normal."

In general, it is best to avoid any debates that involve religious dogmas, as the beliefs are based on faith and cannot be contested. Parents of various backgrounds fairly often say that children should be hit when disciplined as: "the Bible says so" in several places. A very angry grandfather was regularly spanking his four-year-old grandson for being difficult and strong-willed. He seemed frustrated that the boy had been conceived unexpectedly by his very young daughter, 18 years old, who had not married the father. He "allowed them to live at home" but was clearly resentful. David, the little boy, lived in a fairly toxic environment of tension, blame, constant reproaches, and threats (of being "kicked out") toward his quite depressed young mother. The grandfather said that in his culture (he was from the North of Mexico originally) people go to the psychiatrist only when they are crazy, and spanking is practiced regularly. He had joined the sessions only reluctantly, at the request of the therapist. As the issue of his constant threats and spanking David with the belt came forward, he kept saying that he was evangelical, and the Bible dictated this. The therapist did not challenge him until several sessions later. He asked the grandfather if he imagined Christ spanking children. The grandfather was taken aback, he remained silent and did not know what to say for a while. He finally said "no." This opened the door to a discussion about why the boy might be so angry and what could be done to set limits without physical aggression. He stopped the hitting and the boy seemed less angry and scared. However, it is

seldom very productive to engage in religious discussions of this sort.

Pretending There Are No Cultural Differences

Sometimes a sort of "collusion of silence" develops between the mental health clinician and an individual or family when they are from different cultural or ethnic background. They both hope that the process will go well if they do not have to talk about the uncomfortable subject of marked differences when they exist. If there are some language challenges, or very different world views, it would be helpful for the clinician to put on the table such differences so that they can be discussed as openly as possible. If the clinician is "foreign" and the family feels uncomfortable, but they do not want to be perceived as "racist" or prejudiced it may be preferable to discuss what is happening and assess whether the therapeutic work can proceed (Cardemil and Battle 2003). If the family holds back discussing practices and beliefs that they suspect will be judged as primitive or ignorant, the clinician could encourage them to say what they "really think" and not to fear judgment, as the clinician is interested in learning how things are done in their family.

For example, a family from the Middle East might strongly believe that a Western mental health clinician would not understand their perspective and approach to difficult life events because of cultural and religious differences. Moreover, if the clinician ignores and does not address these differences, it would strongly reinforce their feeling. It is important for the clinician to initiate a dialogue about differences and perspectives for better therapeutic outcomes.

The Question of Interpreters

Translating figures of speech and words denoting complex emotions from one language to another is difficult and not everyone can do it just because they technically speak a certain language (Rousseau et al. 2011). The clinician can usually read the "language of the heart" to try to read the messages from the family instead of just focusing on the "digital" message, i.e., words. The behavior and the emotions are often more important than what people are saying.

The term interpreter is preferred to "translator" as the former is expected to have an ability to be a "bridge between cultures" and assist clinicians with some references or figures of speech that if translated literally might be misunderstood. A person with such training is essential particularly with less commonly seen immigrants or languages. The discretion and confidentiality of the interpreter is crucial so that people can actually discuss their painful experiences or family secrets. In one experience we had with a young pregnant woman in the hospital, this did not occur. The pregnant woman spoke Togolese and had become almost mute and developed a psychogenic amnesia. An interpreter from Togo had been present in a previous appointment with the obstetrician, and the patient had been told that she was positive for the HIV virus. The patient had been very scared, but the bigger problem for her was that the interpreter knew the patient as there was the very small community from Togo in that city. The translator told her acquaintances about the HIV infection and through telephone texts the patient started to receive, she realized that "everybody would know" about the HIV in her community. She felt she had lost face and it was then that she developed the psychogenic amnesia. When this was eventually processed with the patient, and with hypnotherapy, she "recuperated" her memories. She had forgotten her name, the names of her previous children, her maternal language, and only had been able to speak with a few English words.

The gender of the interpreter can be of extreme importance in some cases. A Muslim woman, for example, would generally feel extremely uncomfortable to speak about certain topics such as sexuality if the interpreter is a man. She might even request a female interpreter as well as a female clinician.

It is very difficult even for large hospitals or institutions to have interpreters for many languages, and even more so for smaller organiza-

tions. In some institutions, it is thought that a member of the staff, just because of their last name, or ethnic background can be an interpreter. This can lead to problems as the translation may be inaccurate. That staff member may feel pressured to "know the language very well" and not to appear incompetent. Also, sometimes the child of a patient is the translator, which may be unavoidable in urgent situations but puts a heavy burden on a child, particularly if the situation at hand is painful. The telephone services and the video conferencing that are available in many countries are not ideal but often are the only possibility available, particularly with languages that are less widespread. Mental health clinicians need to do their best to schedule "in-person" interpreters when possible and to be sensitive to the family's preference for the interpreter's gender when it applies. This would lead to an optimal level of communication.

Overcoming Cultural/Ideological Barriers

One could argue that part of the therapeutic experience for some young families would be to learn to trust a person that "is very different" from their background. This could be an African American therapist working with an Euro-American family, or a Caucasian French therapist working with someone from Vietnam, formerly a colony of France. At times these combinations are unworkable, but often it can be part of the exploration of assumptions and fears on the part of a family seeking help. A young "White" family from an inner city in the United States sought help for their baby who was crying excessively. The young mother was depressed and the father, also young, was frustrated and did not understand why their baby cried so much. As they sought help, the pediatrician referred them to a Hispanic male therapist. The young father was a "skinhead" and a "Neonazi." He had a swastika tattooed on his arm and spoke openly about this from the start, saying he was a white supremacist. The therapist interpreted this as a provocation and started to focus on the mother's and father's perception of their baby. The mother was eager to see her baby more comfortable and a number of sensory integration issues and high muscular tone were noted in the baby. The clinician gave the parents some suggestions on how to help the baby feel less overwhelmed by his sensory world and to help him calm (flexion positions, increased holding, massage, etc.). The parents came for a follow-up session and the baby had been crying much less. The father brought some "art work" involving Nazi imagery and one in which the words "to hell with minorities" were included. The therapist read these as an invitation to discuss his beliefs, and tried to engage the father by focusing more on the "personal experience" of the parents, instead of their political ideas. The young father had been in a "White gang" before and had grown up without a father. He was very resentful and felt unwanted and rejected. This was perhaps the source of his hatred for "the other." The therapist was much older than the young father. Gradually, as the latter expressed his resentment and then his sadness, the relationship with the therapist changed. He started speaking of "Mexican friends" and that "not all minorities are bad" and became more open. His rigid ideology of "hating" was in part concealing the unresolved pain and anger at feeling unwanted and neglected by his father. The experience with the "Mexican" therapist who did not counterattack immediately and tried to contain him seemed to be a therapeutic experience for him.

A father from the Middle East that came to the United states for his child's treatment was complaining that they were treated differently than American patients. He thought the staff was making them wait longer than other patients and would treat them in a condescending way. He referred to the staff as "*Kuffars*" which means "non-believers" in Arabic. He was certain that there was a discrepancy in the way they were treating his son compared to an American or to be more precise a Christian child. If we fast forward many months later, the father realized that his ideas were preconceived and erroneous. He confessed at the end of their stay that they had been treated "better than in their own country" and

could not thank the medical team enough for what they had done for his child.

Self-Expression

The "other" (the minority, the foreigner, the immigrant, etc.) may have difficulty speaking in the local language, English, French, German, etc. It is understandable that if a person uses very simple phrases and has a limited vocabulary, the clinician might conclude that as the patient or family does not think in a complex, nuanced or multi-layered way, or is not educated, but this could be a wrong assumption. In his or her original language, a person might express complex ideas, nuanced thoughts and feelings that might be difficult to put in the language of the host country. The therapist can supplement the digital communication with reading the behavior and emotion of the person (Fassin 2011). Some immigrants or refugees fleeing war zones may have to take work in unskilled labor despite their professional training (Chen et al. 2010; Erdogan et al. 2011). Also, in many cultures it is a matter of politeness to not speak about one's accomplishments and knowledge, but rather to minimize them for modesty and not to appear boastful or to be bragging. This is a different cultural stance than it is common to see in countries like the United States, where people speak more spontaneously and openly about their accomplishments. They do not expect to be the object of envy, but that other people would be happy about their good fortune or accomplishments. A Muslim new father from Iraq revealed the following:

"I was afraid of the neighbors. The Jewish center for assistance to refugees provided a house for the first few months after we arrived here. We could not speak English and it was very hard to move around. I hardly let the children go outside because I was afraid something would happen to them. At night I could not sleep, the sound of the bombs in Iraq and the memories of the people we knew and who were killed kept haunting me. I sometimes felt overwhelmed with feeding the baby. When she would cry, I would go into a panic, imagining something terrible was happening to her. In my country I was a mathematics professor and here I got a job delivering pizzas, but every little bit helps."

The Unspeakable

When working with an expecting woman or couple, there may be particular concerns about self-disclosure or talking about the pregnancy itself or the baby in utero due to regional beliefs. One concerns the gender of the therapist: for a very traditional Muslim woman it may be thought inappropriate to meet alone with a male clinician. A woman clinician might be more suitable, but if this is not possible, her husband or her mother or sister might be acceptable. Eye contact should be kept to a minimum and shaking hands with her on getting acquainted generally is inappropriate. Talking about some topics, even in front of her husband, may be difficult, particularly if there is marital conflict or disagreement. In many other cultural groups it is easier for the expecting woman to talk to a woman therapist, although if the male therapist explains the reason for the questions and the purpose of understanding, it may overcome an initial reticence. The questions should be tactful and allowing the woman to "save face" and not answer them.

Speaking about negative feelings from the start may be unacceptable. The patient may consider it is terrible to say anything negative about her mother, her father, siblings, her children, or her husband, even if she has such negative feelings. The person might think she should always say that of course she loves her mother, because it is her mother, for instance. Even if the mother has difficulties such as alcoholism, or has been abusive, this cannot be addressed at the beginning as it is considered a shameful revelation. The clinician may need to spend considerable time at first helping the woman or family feel welcome, not pressured and taking time to say what is happening in her own terms and to develop trust. The communicational style may not be direct and "to the point," but meandering and oblique. The same goes for other family members. The very business-like style of direct

questioning that is common in many modern countries may be perceived as disrespectful and too direct for the woman/family. Writing on a computer while talking (Van Dellen et al. 2008), or looking at the screen instead of at the family may be perceived as distant and cold if not disrespectful. Families of many backgrounds may not be used to answer difficult questions directly, but in a "meandering way," referring to other things, or giving many details that for our ears may seem irrelevant. This style of conversing, or telling a story is very prevalent in many traditional cultures and the clinician should be patient to try to grasp what the family or woman is trying to tell.

Many people from traditional societies are not used to verbal communication of feeling and internal states (Fazel and Stein 2002). This might include emotions like sadness, doubt, anxiety, and instead may manifest their emotions in a behavioral way. The expressions may be bodily manifestations, such as pains (headaches, back pains, muscular pains), digestive problems (cramps, diarrhea principally), urinary frequency, "heart" problems (pain in the chest, palpitations, tachycardia) among others.

Expressing ambivalence toward a pregnancy or a baby in utero is difficult in any culture. In some it might be almost blasphemous because a pregnancy may be thought to be the will of God or a blessing that one should not fail to appreciate. The woman may express her feelings through gestures and the tone of voice but not necessarily in words. In this case the use of an interpreter may make things difficult, as the nuances and the tones are hard to grasp at first, but with time it may be possible.

Speaking at all about one's pregnancy, about the baby in the womb might be considered "bad luck" or an ominous conduct that would bring negative consequences, particularly earlier on in the pregnancy. This may apply to many traditional women from African cultures, who may consider it taboo. In some of them, it may be thought improper to discuss the pregnancy details with strangers, as this might be a bad omen. Admitting that one is depressed, or very sad, may be thought unacceptable. Women may endorse feeling tired, having a lot of pains, having little energy, feeling exhausted and crying, headaches, back aches, muscle cramps, all of these may be present, but she might never talk about feeling sad or pessimistic.

Once the baby has been born, it may also be impossible to speak of negative feelings toward the child. It may require some work to suggest that the Westernized notion of "ambivalence" permits that one would love a person and still be angry, even at a baby, while still loving him or her intensely.

Group interventions might be more appropriate in some cultural settings than in others. Many women from traditional cultures may not be as concerned with "privacy" of their information and might be more able to discuss thoughts and feelings if other women also speak about them, such as marital problems, a difficult relationship with parents in law, or with one's children and doing so in a group format.

In a setting in Paris, Moro (Baubet and Moro 2009) has described a *dispositif* of transcultural psychiatry, which involves a mental health intervention with families, but through a group meeting, with several therapists and students from different backgrounds. The various members talk about the issues brought up by a family, usually an immigrant one. Instead of a "prescriptive approach" which is common in countries like the United States or the United Kingdom, they use an evocative one. Each member of the team discusses how the problem at hand might be handled in their own culture, if a shaman might be consulted, an infusion given, a marabout might be consulted or a priest, or some cleansing ritual may be preferred, or seeking advice from elders. The notion is that this allows people to feel accepted and free to say what "they really feel" and to introduce a relativism in terms of etiological theories and therapeutic strategies. Many of such interventions might be equally effective as, for instance, prescribing a psychotropic medication. The group emphasizes that this mode follows a customary practice in many cultures, in which a group discusses a problem and offers possible solutions rather than "individual encounters" which may be seen with suspicion.

In many cultures, it is customary to first engage in what in the West we consider as "small

talk" and to discuss various unrelated issues, to soften the social interaction and "smell the air," before going to the issue at hand. Issues and problems may be introduced gradually and only if the interpersonal climate permits it. People from very traditional societies will find it very hard to speak directly about a number of topics. Issues of maltreatment during childhood, physical abuse, neglect, and particularly of sexual abuse are considered taboo and not to be discussed, particularly not with a stranger. A person that discloses this might bring shame to her or himself, and to their entire family. Often this information is strenuously suppressed until it can be alluded to in an oblique way, implied, when there is trust in the therapist.

Something similar could be said about the status of marital relationships, particularly intimate relationships. It might be considered a betrayal to discuss issues of marital conflict or sexuality.

There are cultures that place a heavy emphasis on verbalization of feelings, emotions, and states of mind. Other cultures less so, and people then use other vehicles of communication, be it somatic symptoms (an ill feeling in the stomach, something stuck in the throat, headaches, backaches) as the language of their distress. Another way of expression is the posture, attitudes of the body, crying, being dissociated or distracted, and not remembering things. The modern tendency to address problems quickly with psychotropic medications often will be turned down for fear of addictions or "becoming dependent" or generally fear of taking medicines. This may be possible and indicated once the clinician has gained the confidence of the patient, but not too quickly. Latinos in the United States, for example, are a group with considerable misgivings about psychotropic medicines in general (Lanouette et al. 2009; Kaltman et al. 2014). This is all particularly marked during the pregnancy and postnatal stage (Lupattelli et al. 2015).

In cultures in which not much verbalization is common, drawing, art representations such as ceramics and collages may be more useful, to "put on the medium" emotions and experiences that may have been traumatic or the feelings one is experiencing presently.

Working with families may be a preferred modality if there is much stigma to the "individual patient" as being the weak, crazy, or the nervous one. Trying to normalize the reactions of the patient and to see them on the context of the family may be more acceptable. This can also mobilize strengths in the family to assist the person who is experiencing the most emotional pain. Also, other family members may experience similar feelings and this may help the patient not to feel so different, strange and as an additional burden. The relatives can provide support and reinforce some of the interventions that the therapist may have suggested during sessions.

Gifts

Many families from traditional societies are used to express their gratitude through gifts. They may offer a gift to the physician, for instance after a boy is born, this is customary in many Muslim families. In Latino families, the mother of a child may bring the pediatrician a small gift, or food that is considered special or a delicacy, the same is often seen in Philippino families. Rejecting the gift may be considered a major slight and a rejection, as though one were disgusted by their food or is rejecting a token of appreciation (Hahn 1998). This practice often runs counter to policies in many hospitals and clinics that prohibit personnel to accept gifts. If one must reject one, it is important to explain that it has nothing to do with the source or personal preferences. In general, the gift if it is not excessive could be accepted and explain to the family the policy regarding gifts for future reference.

Facing a Foreign Family

There is perhaps a "built in" reaction to people who are very different or who look very different. This might particularly true in highly homogeneous societies, as Japan or Sweden were generations ago. With exposure to "the other" and interacting with "foreigners," usually people come to appreciate the strengths and values of

other cultures and may embrace many of them. Increasingly large cities in the world are multicultural and people get used to different languages, foods, dress, customs, etc. With the rise of racist ideology in many countries in the last decade, fascist groups with this ideology foster this mistrust of the "other" and an "us versus them" mentality, emphasizing differences and the fear to be absorbed by the invading threat (Stanley 2018).

These issues are often not talked about, and many people would be worried about being thought to be "racist" or prejudiced. There is generally very scarce literature on the reactions of clinicians to their clients, except in psychoanalysis, which take into account the subjectivity of the patient and the psychoanalyst. There is also little information about the reactions of the clinician facing a dyad, a mother baby dyad, or a triad (mother, father, infant) who are from a very different cultural background.

There are many variables to consider in one's reaction to "foreign" patients: depending on the age, experience, gender, personal history, expertise, and cultural background of the clinician. These reactions are strongly influenced by the "work culture" or the place where the foreign family is being treated. Each work place has a "culture" which may or may not promote discussing or even acknowledging issues of differences between clinician and family. On one side a place or a center can be "open to all" or, on the other extreme, the presence of a foreign family represents "a problem" because of the need to find an interpreter and the general discomfort of not knowing what to do.

The experience of the family may be very different depending on the setting. A prestigious children's hospital in Montreal, Canada, has in its main entrance a very large wall where the word "welcome" is written in over 50 languages. There is a different stance if the hospital has all its signs only in one language, English, French, German, or any other "dominant language" in the country in question.

The policies of the work place may or may not facilitate providing that assistance to families who "come from elsewhere" or to whom the staff may not be used to deal with. This attitude is facilitated or thwarted by the people in the leadership of that clinical setting.

In many Western countries, increasingly clinicians who are originally from a foreign country, or who "look ethnic," may be asked to see patients that are "similar." In some hospitals, having a "Latino surname" may be sufficient to be asked to see most "Latino patients" indicating on the one hand the wish to help families feel comfortable, but also to avoid discomfort to other clinicians who may be unfamiliar with "those families." Also, in some settings co-workers may feel uneasy working with clinicians who are "ethnic" or colored. They may encourage everyone to "dress the same," i.e., as the dominant group, and not to show any individuality. A clinician in a very large medical center was asked to remove ornaments from his office because they "looked too ethnic," even though they did not reveal any religious or ideological biases. The clinician was encouraged to use a more "mainstream" decoration. A large pediatric hospital in an urban center had a policy of hiring mostly Caucasian physicians and prided itself in having "very few international medical graduates." This was not an openly stated policy, but one embraced in many centers in an unspoken trend.

In some centers or hospitals there is no interest whatsoever, in developing multicultural resources, materials in other languages or to make "foreign" people feel welcome. It is expected that all families "should be like us," or only a cosmetic minuscule investment is made in some resources, such as one interpreter, one or two "minority staff," and a minimal effort is made to communicate with those families. A true multicultural perspective may require greater efforts and to think of the experience of the families "in their own eyes." These differences between one center and the other convey important messages to the clients, as well as the staff.

Migratory Grief and the Ulysses Syndrome

The clinician should consider and investigate multiple contributing factors to a potential migratory grief. How long has the family been in their new home country? Are they somewhat adapting to their new environment or not at all? How much are they missing their country of origin? as well as take in consideration their age, sex, and country of origin.

Migrants are often exposed to very high levels of stress due to various factors. Symptoms like insomnia, migraines, anxiety, and irritability can all be aggravated by those factors contributing to what is described as Ulysses Syndrome. "The Ulysses Syndrome" (Diaz-Cuellar et al. 2013) refers to the psychosocial symptoms experienced by migrants who live in extreme situations. These symptoms are the response to the efforts of the migrant to adapt to contextual stressors.

Perceptions of the Clinicians

Families from very traditional cultures may have a very different view of what a therapist or psychiatrist is. In the Western world, as in the United States, most therapists or psychiatrists are considered "providers" which means that they offer a service, which is paid for by the family in general terms. The clinician is an "employee" of the family and mostly is at their service. They expect to contract with the provider for a service which the therapist provides. The family may decide to suspend this engagement at any time if they are dissatisfied with the work of the therapist and they take his or her views as suggestions. The family reserves the right not to follow any of the recommendations of the therapist. Families from traditional cultures may expect a more direct "prescription" or even "orders" from the doctors as it used to be decades ago in the Western world. The physician or therapist was seen as a person with high status and who had "authoritative knowledge" and was to be respected or honored. A very "consumer oriented" approach where all the decisions are left to the family may seem somewhat disconcerting for some families. In other cultures, there is a difference perception of the therapist. The health care worker may be seen more as an authority figure, a person with advanced education, an expert, and someone that "knows" how to deal with problems. The family is likely to try to follow the advice, which may be given in the form of a verbal prescription to do something. The family may feel disappointed if the therapist only invites the family to reflect, rather than offering practical suggestions about how to deal with a problem. The therapist in many countries, like a doctor may "order" or give a recommendation to a family to carry out certain actions and for the most part the family will follow it, if they trust the clinician.

In a recent encounter with a family of immigrants from Vietnam, the clinician pointed out to the mother of a child who had been born very premature and with multiple malformations, that she seemed sad. She had spoken of being irritable and fighting with her husband and of marital discord besides. When he pointed out that she seemed also very sad, the mother asked the psychiatrist if he was a "fortune-teller" that would know her thoughts from merely looking at her face, and whether he was going to give further advice. In Vietnam and China, as in many other countries people may go to a fortune-teller who through various devices can read what is happening with a family and give recommendations of a behavioral and psychological nature to help the family. This may include calendrical calculations, astrological ones, or looking at the shape of the ear of the adults to divine what is going to happen to them. A family might feel somewhat disappointed if the therapist does not answer certain questions as "not wanting to help them." Others may perceive the therapist as withdrawing useful suggestions, expecting he or she already knows things that have not been discussed yet. It would be useful to remember not to assume that the family has the same expectations as the clinician.

Many primary care physicians find that families of patients from traditional societies, be it pregnant women or with young children, expect something fairly concrete in terms of help from

the clinician. They may expect an injection, tablets, a physical treatment and not only an expectant observation or a conservative management. This may be felt by the family as begrudging things like vitamins, antibiotics, etc. which are expected even as preventive efforts.

Another "clash of cultures" occurs between treating physicians in highly urbanized hospitals and families from low income countries, who often come from rural settings. The doctor is seen often as rushed, spending very little time with the patient, and not involved enough to spend more time with the family.

Time and Schedules

Families who face multiple stressors or recently arrived in the host country might find it difficult to settle in an industrialized country and "enjoy the pregnancy" due to the worry about the baby. In these circumstances, with everything being so new, they may not realize that the adherence to the appointed time is not related to how nice the therapist is, or how flexible he is, but to "realities" and constrains regarding time. This reality exists in the mind of the therapist, who may have to adhere to a schedule and his or her institutional demands. A family may imagine that if the appointment is at 3:00 p.m., this does not literally mean that time on the clock but an approximate time. If they arrive around 3:15 and the therapist mentions they are late, they might feel rejected and never come back, or interpret that really the therapist "did not want" to see them. The fact that a session takes place or not is not perceived as a fact governed by time and the clock, but by interpersonal relationships, as it is common in most traditional societies.

This concept is even more true with immigrant families coming from countries where their expectation from the medical institution is very high or unrealistic. In some countries, people that are "well connected" have the ability to be seen by a doctor or clinician even on a very short notice and at a time that is convenient for them. When faced with this type of situation, a new expectation needs to be set but in a subtle and "gentle" way to avoid any tension between the family and the clinician.

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