Intercultural Psychotherapy

For Immigrants, Refugees, Asylum Seekers and Ethnic Minority Patients

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Marianne C. Kastrup
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Foreword

Psychotherapy in its various forms is indispensable in psychiatric practice worldwide, in scarce resource as well as in high-income countries. As professionals, we have an obligation to make our best efforts to ensure that psychotherapy is available to people who need it. Creating the conditions for this, which allow well-trained practitioners to provide good-quality care where and when it is required, either directly or through training and supervision of health and community workers, rests with professional associations, civil society and governments. They need to be united in recognising needs and solutions. It is well known, however, that the shortcomings in health-care resources and the organisation of services make this an aspiration rather than a reality in almost all countries.

The editors define intercultural therapy as the therapeutic work between psychotherapists and patients stemming from different cultural contexts with the consequent hampering of language- and culture-based understanding. They point out that in today's world, intercultural psychotherapy may well become the rule rather than the exception. The intercultural aspects are relevant to psychotherapy in general. In every psychotherapeutic encounter and in every training situation, the cultural backgrounds of the therapist, patient, trainer and trainee need attention. The challenges include how to ensure quality of psychotherapeutic work whatever the setting. Psychotherapists regardless of their specific methodological background are challenged to adapt to this reality.

Intercultural aspects of training and practice are particularly relevant and brought to prominence in work with those people in any country who are migrants or displaced or living as ethnic minorities. As Wenzel and colleagues point out in Chap. 5, the modern challenges of rapid culture change and unprecedented movements of people within and between countries, including forced migration, pose a challenge to mental health services globally, particularly psychotherapy. An increasing number of people with a migration background need good-quality psychotherapeutic treatment. The past experiences and the adverse, unsafe or isolated life that they often face daily leave many such people with high risk of distress and mental ill health as well as limited hope of finding help.

Overcoming these challenges requires a thoughtful adaptation of therapeutic practices, psychotherapeutic training and service settings. The editors have gathered a distinguished group of contributors to provide theoretical and practical insights and resources. A historical perspective and the significance of culture in education

and training sit together in the book with practical topics such as intercultural considerations in fostering the therapeutic alliance, working with interpreters and bilingual therapists, the development of cultural competency in psychotherapy and the use of the cultural formulation interview. There are illuminating insights into work with special target groups across continents, regions and settings. The cumulative effect of the work is to underscore the remarks of Dr. Alarcon in Chap. 17, to the effect that the intercultural approach can indeed be considered essential to all types of psychotherapy. It must be part of modern training curricula and shape the philosophical basis of multidisciplinary teamwork in mental health care.

I congratulate the editors and contributors on the publication of this significant volume. It responds admirably to the gaps in understanding and the skills required for the planning and practice of psychotherapy in today's world. I anticipate it will stimulate interest in psychotherapy including its intercultural aspects among clinicians, policymakers, scientists and students across the world.

Parkville, VIC, Australia Helen Herrman

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Intercultural Psychotherapy: An Historical Perspective

1

Ronald Wintrob and John M. de Figueiredo

The Origins and Basis of Psychotherapy

Among the most fundamental of human needs is the need to maintain a coherent sense of self, family, and community. It is the need to feel secure and valued as a person, family member, and member of an affinity group, whether tribe, ethnic, religious, or political group, or as a citizen of a nation state.

The security of those components of self-identification is fundamental to coping with life's vicissitudes, including interpersonal, intra-familial, intra-communal, and inter-communal stress and conflict. All of these stressors are intensified by unexpected losses, including illness and death in the family and community, natural disaster, inter-group conflict, war, forced migration, and traumatic re-settlement, whether to an unfamiliar region in one's region or country of origin, or to another country as refugee, asylum seeker, or legal immigrant.

Many people affected by such stressors and attempting to cope with their physical and psychological consequences will be compelled to question their core beliefs about causation, such as "why is this happening to me and my family (or community)"and "why now"?

The efforts to cope with these largely unanswerable human dilemmas have involved themes of fate, destiny, supernatural influence, religious faith, divine punishment, and a wide range of "healing rituals," including both "folk healing" and "faith healing." [1, 2]

Examples of these healing rituals in contemporary societies include fundamentalist Christian faith healing rituals in North and South America, as well as in Europe, syncretic healing rituals such as Candomble in Brazil, Santeria in

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predominantly Catholic and Spanish-speaking Central American and Caribbean countries, and Voodoo in several Caribbean countries. Spirit possession and exorcism rituals are practiced in a number of predominantly Muslim, Buddhist, and Hindu societies in Asia. Ritual healing of witchcraft, spirit possession, and soul loss beliefs is well known in the Americas, as well as in a number of North African and sub-Saharan African societies. Beliefs in "the evil eye" and other aspects of "magical thinking" and ritualized forms of magico-religious interventions for their relief are encountered in a number of countries in the Mediterranean region of southern Europe and North Africa [2].

There is a major differentiating feature of these various beliefs and ritualized coping methods in the face of seemingly inexplicable misfortune, illness, intra- and inter-communal conflict, natural disaster, and war. It is the division between personal responsibility, self-blame, and guilt on one hand, and on the other hand, fate, supernatural influence, divine will or divine punishment, destiny, or soul loss. Witchcraft or sorcery are believed to be inflicted by jealous and malevolent others, through malign magic, for which the victims or sufferers are believed to bear no personal or causal responsibility. This major distinguishing feature determines both individual and communal responses to misfortune by placing the locus and cause of distress symptoms as being primarily the responsibility of the sufferers, or, on the contrary, due to no intrinsic fault or responsibility of those afflicted.

In the case of ascription to personal responsibility, healing rituals are directed toward relieving self-blame, guilt, and the sense of personal, family, or communal failure—along the lines of individual, family, and group psychotherapy. By contrast, when causation of distress is attributed to fate, supernatural influence, or malign magic, and the individual, family, or group are not regarded as personally responsible for their experienced misfortune and symptoms of distress, healing rituals are directed at counteracting the wrath of divine spirits, counteracting behavioral taboos and malign magic, and restoring harmony with the spirit world.

In pre-colonial America, indigenous tribal communities had centuries of traditional beliefs and ritualized practices related to supernatural influence, spirit possession, and soul loss, as well as a wide range of healing traditions to relieve and counteract such afflictions affecting individuals, families, and their community settlements. Many of those traditions have survived and have experienced renewal and invigoration in recent decades.

The waves of immigration to the USA over the past two centuries have added a complex panorama of beliefs and practices related to misfortune, illness, personal, family, and communal loss, in the context of the religious and cultural traditions of the immigrants' countries of birth and upbringing.

Fundamentalist Christian beliefs in the possibility of divine intervention to relieve or reverse the misfortunes, illnesses, and losses of sufferers have had a strong influence on American life since the eighteenth century. *Faith healing* rituals have continued to be important in contemporary American culture among both Protestant and Catholic communities. In many fundamentalist Christian congregations, beliefs in divine intervention and redemption are encouraged and enhanced by services that emphasize "testimonials" by congregants of their personal and family members'

experiences of "healing" of both mind/spirit and body. The ministers of these congregations also give personal testimonials, during which they may "speak in tongues" (glossolalia) as evidence of their supernatural ability to receive divine inspiration and commune with the divine spirit. The service often includes intense religious singing and dancing, sometimes resulting in both glossolalia and trance induction among some congregants. Healing of the spirit may be followed by "the laying on of hands" to relieve sufferers of both physical and psychological symptoms. Further personal testimonials may follow before the service winds down. Strengthening of interpersonal relations, as well as a sense of inner peace, is often reported by congregants following such religious and healing services [2].

Another widely encountered set of beliefs and ritual practices is found particularly in southern states of the USA influenced by the history of slavery and by fundamentalist Christian traditions, along with cultural beliefs in malign magic and witchcraft emanating from West African societies. In the USA, these beliefs and the healing rituals associated with them are known as *rootwork* [3]. Congregants who have experienced ritual healing during services may be given amulets to wear under their clothing, as necklaces, in order to ward off malign magic in the future. Over time, these beliefs and healing rituals have incorporated both Christian and animistic elements. Migration of "southerners" over the past several generations has spread the beliefs and practices of rootwork to the northeast and midwest regions of the USA, increasing the similarities between rootwork ritual healing and that of fundamentalist Christian faith healing.

Fundamental and Shared Elements of Psychotherapy

Psychotherapy is the relief of demoralization in one or more persons by a trained professional using an approach based on a particular theory or paradigm. This definition, proposed by Jerome D. Frank, brings together a variety of interventions called "psychotherapy" in the Western world. According to Frank, all persons who seek psychotherapy are "deprived of spirit or courage, disheartened, bewildered, and thrown into disorder or confusion." He referred to their state of mind as "demoralization" and proposed that demoralization responds to certain elements shared by all psychotherapies, irrespective of the theoretical orientation of the psychotherapist or the diagnostic label of the demoralized person. He further suggested that demoralization involves a breakdown of the demoralized individual's assumptive world [4].

Wen-Shing Tseng offered a broader definition that may be more compatible with the theoretical framework of cultural psychiatry: "Psychotherapy is a special practice involving a designated healer (or therapist) and an identified client (or patient), with the particular purpose of solving a problem from which the client is suffering or promoting the health of the client's mind." Attempts to help people in times of trouble started as integral components of the culture and social fabric of the group. A belief system was created and translated into indigenous healing practices. Examples of such practices are trance-based practices, religious healing ceremonies, divination, fortune telling, and meditation exercises. Other practices, such as

Mesmerism, Naikkan therapy, and Morita therapy are influenced by a certain culture at a given time. A third group called "mainstream therapies" include most therapies practiced in the Western world or Western-influenced nations, such as psychoanalysis and other psychodynamic psychotherapies, client-centered psychotherapy, behavior therapy, cognitive and cognitive-behavioral therapies, interpersonal psychotherapy, wellness therapy, and marital, family, and group psychotherapies. This classification, proposed by Tseng, enables us to understand how psychotherapy, like the rest of medicine, progressed from a religious and philosophical foundation to a secular and scientific orientation.

In this section, we describe our evolving understanding of the mechanisms involved in the efficacy of psychotherapy across cultures [5].

In order to understand the complex relationships between cultural factors and the efficacy of psychotherapy, it is important to review the multiple roles played by culture in the pathogenesis of mental disorders. A mental disorder is characterized by certain unique features called "pathognomonic." These features are characteristic or distinctive of that disorder and not necessarily related to social or occupational functioning. In some cases, culture may be pathogenic, that is, create perceived stress, which, in turn, may precipitate, enable, or predispose to a mental disorder. In other cases, culture may dictate not only the type of psychiatric symptoms selected for expression or display but also the intensity, frequency, and content of those symptoms. The mental disorder happens to a person within a fabric of personality traits, and the resulting symptoms are influenced by ongoing interactions with the perceived environment ("Umwelt"), by the life story of the person [6]. These interactions, in turn, are assigned meanings by the patient, and those meanings are perpetuated by cultural transmission. Cultural factors, in turn, influence the compensatory or "pathoplastic" features of the clinical presentation [7, 8].

It should be noted that this conceptualization of mental disorders differs from the one proposed by the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association in which the threshold for what is called a "mental disorder" is established by social or occupational functioning. By establishing a pathoplastic threshold, the DSM created a major obstacle to the application of the DSM criteria across cultures. This problem was addressed in the current edition of the DSM (DSM-5), with the development of the "cultural formulation interview" as a practical, clinical application of the principles of "cultural formulation" which were included in DSM-4. The latest edition of the DSM (DSM-5) includes a 16-question instrument, the Cultural Formulation Interview (CFI), measuring cultural diagnostic components to be assessed during the initial assessment interview [9]. This interview is supported by 17 supplementary modules to broaden and deepen the information collected.

Several paradigm shifts took place in the growth of ideas about the mechanisms involved in the efficacy of psychotherapy. In pre-industrialized societies, illnesses were viewed as having a variety of causes, both natural and supernatural. Healing based on faith and magic viewed all illnesses, physical and mental, as resulting primarily from supernatural powers, and cure was seen as coming from manipulation of such power. In line with his or her cultural beliefs, the healer or "shaman" assumed the

role of an intermediary between the gods and the sufferer, using not only natural agents to achieve healing but also magic, prayer, atonement, and rituals. Some healing practices are based on the induction of a trance or altered state of consciousness (dissociation or possession) experienced by the healer (shamanism), or by the patient, or by both. The dissociation or possession is believed to be a link with supernatural powers that enable the reversal of malign magical spells, achievement of harmony with the spirit world, and thereby the relief of symptoms and suffering. Other healing systems take place within religious ceremonies through the ritual of prayer, confession, testimony, sacrifice, blessing, or spirit possession. Still other healing systems offer interpretation, direction, and guidance on choices about the future or the unknown. In these practices, the stated goal is not a radical change in the life of the demoralized person, but compliance with the wishes of the supernatural powers [1, pp. 517–527].

In fortune telling, physiognomy, and meditation, the healing system begins to shift from the supernatural to the natural and the goal becomes the achievement of harmony with the principles that rule the universe. Again, the goal is not a life change but restoring the harmony between the person and the universe and adherence to the laws of Nature [1, pp. 527–532].

Other healing practices portray a shift from metaphysics to a psychological or psychosocial orientation. Examples are reappraisal of interpersonal relationships in Naikkan therapy and self-acceptance and creation of a new life experience in Morita therapy. These practices attempt to foster a change in the philosophy of life [1, pp. 542–547].

In Europe, a major shift from the supernatural to the natural paradigm took place with the discovery of suggestibility in hypnosis, and, by implication, in other psychotherapeutic interventions. In the eighteenth century, a Viennese physician, Franz Mesmer, proposed that a natural transfer of energy occurred between all animated and inanimate objects. He called this energy "animal magnetism," and he believed that illness was caused by the depletion of animal magnetism and that the cure resulted from the healer transmitting some of his own magnetic force across the ether to the patient [10].

José Custódio de Faria, a Catholic priest born and raised in Goa, on the west coast of India, after traveling from Goa to Portugal and Rome, settled in Paris and became deeply involved in the study and practice of hypnosis, to which he referred as "lucid sleep" ("sommeil lucide"). Also known as Abbé Faria, he dismissed the theory of "animal magnetism" and demonstrated that "nothing comes from the magnetizer, everything comes from the subject and takes place in his imagination; that is, autosuggestion generated from within his mind." Thanks to Faria's revolutionary work, the brain of the patient became the focus of attention in the study of this phenomenon, called "hypnosis" by James Braid. More than a century later, it was demonstrated that the ether described by Mesmer does not exist [11, 12].

The study of hypnosis and suggestion inspired another Viennese, Sigmund Freud, a neurologist, to create psychoanalysis. He was puzzled by the symptoms and behaviors of patients with hysteria because they could not be explained by the neurology of his time. Central to his thinking was the role of unconscious life, transference, and abreaction of repressed emotions. He highlighted the unconscious

redirection of emotions from one person to another and called it "transference." Through hypnosis or suggestion, the experience that caused a repressed emotion was relived, and the emotion was expressed and released, a phenomenon he called "abreaction." Freud later abandoned both hypnosis and suggestion in favor of "free association," interpretation, and therapeutic neutrality.

Classical or Freudian psychoanalysis failed to acknowledge the significance of culture in the therapeutic process, and, as Aubrey Lewis noted, made the individual incorporate his environment, rather than interact with it [13]. This neglect of the critical role played by the interrelations of the individual with his or her society and culture was addressed by the so-called "neo-Freudians", who argued, like Erik Fromm, that a sick society can only produce sick individuals. Frieda Fromm-Reichman, in particular, noted that the patient's selection of subject matter for repression is determined by the cultural standards of his or her group [14, p. 83].

Nevertheless, Freud's psychological model of man shifted the locus of explanation of mental disorders from the supernatural to the natural. His concept of unconscious mind had a profound impact on anthropology, having influenced both "structuralists" like Claude Levi-Strauss and "functionalists" like Bronislaw Malinowski. The importance of the unconscious mind and its relationship to the conscious mind would become dominant themes in psychology, linguistics, psychiatry, sociology, and anthropology. In Western and Western-influenced nations, psychoanalysis became the forerunner of a range of psychodynamic psychotherapies based on the belief that psychopathology develops from intra-psychic and unconscious conflicts in the course of human development. Such therapies, however, presuppose certain cultural norms, such as individual freedom, personal autonomy, and independence from authority, more likely to be found in Western or Western-influenced nations than in more traditional agrarian and pre-industrial societies [1, pp. 552–553].

A perspective drastically opposite to psychoanalysis was represented by behaviorism. In its most radical form, as proposed by B. F. Skinner, psychology is the science of behavior, not the science of mind, and the sources of behavior are environmental, not internal. Although a reciprocal relationship between the individual and the environment is implicit in Skinner's use of the word "operant" to refer to what was later called "instrumental conditioning," the emphasis was always on environmental contingencies as determinants of behavior. In radical or Skinnerian behaviorism, the environment incorporated the individual. Such an extreme view was criticized and contested, first by Edward Tolman, who introduced the concept of "cognitive map," a concept that would be central to the understanding of demoralization, and later by new and important developments in cognitive psychology, psycholinguistics, and cognitive neuroscience.

Classical behaviorism highlighted the role of the immediate environment. The application of behaviorist concepts to the larger social and cultural contexts was slower to develop. The need for this application led to attempts to study the role of the environment in behavioral and cultural evolution by proposing a synthesis of cultural materialism and behavioral analysis. The application of behavioral analysis to cultural phenomena, in turn, led to the introduction of new concepts such as

contingencies at the cultural level (meta-contingencies), as distinct from contingencies at the behavioral level (contingencies of reinforcement), interlocking behavioral contingencies, cultural milieux, aggregate products, cultural consequences, and receiving systems [15]. The applications of these concepts to psychotherapy and to the clinical practice of cultural psychiatry are unclear at this time.

The study of semiotics and information processing offers a clear picture of the interrelations of culture and psychotherapy. As Frank elegantly stated, "just as nature is said to abhor a physical vacuum, so the human abhors a vacuum of meaning [4]." A philosopher, Ernst Cassirer, distinguished two types of vehicles of meaning: "signs" and "symbols." While signs denote and present, symbols connote and represent. In operant conditioning, the sound of a bell is a sign that announces to the animal that food is coming. A national flag is not just an object but a symbol of national pride. This distinction between signs and symbols is critical to the understanding of psychotherapy because, as Cassirer noted, words can be both signs and symbols. Signs and symbols can be studied objectively in terms of form, meaning, use, and function [16].

To bridge an individual experience, such as demoralization, to the group phenomenon called culture, Alexander H. Leighton introduced the concept of "sentiment." Sentiments, according to Leighton, are relatively stable components of personality made up of attitudes and values [17]. By means of symbols, the members of a society share ideas and sentiments. Ideas and sentiments are hierarchically organized, some being viewed as more fundamental to group survival and function than others. Among members of a society, symbols representing certain ideas and sentiments are meaningfully interconnected and shared with other members of that society. As Cassirer noted, animals other than humans cannot symbolize [16]. It is the ability to symbolize which allows humans to transmit symbols representing ideas and sentiments from one generation to the next by teaching and example, creating a repository of knowledge collectively called culture. At the level of the individual, personality consists of sentiments. The symbols representing the individual sentiments constitute the personal "Umwelt," the ambient world of the person. At the societal level, a more fundamental subset of individual sentiments—for example, who should marry who—is shared by the members of the society by means of symbols. These shared dominant symbols form the collective "Umwelt," the ambient world of the community or society [18].

In his comparative study of various modalities of psychotherapy, Frank concluded that they all share at least four structural components: "an emotionally charged, confiding relationship with a helping person (often with the participation of a group); a healing setting; a rationale, conceptual scheme, or myth that provides a plausible explanation for the patient's symptoms, and prescribes a ritual or procedure for resolving them; and a ritual or procedure that requires the active participation of both patient and therapist, and that is believed by both to be the means of restoring the patient's health." According to Frank, as far as these nonspecific features are concerned, the psychologically oriented therapies practiced in the Western world are no different than the indigenous healing practices found in pre-industrialized societies [4]. It should be noted, however, that while these four components

refer to *structure*, that is, to people and other resources, they may differ with regard to the other dimensions of quality of care identified by Avedis Donabedian, namely *process*; the activities of providing care which utilize resources and provide outcomes (what is being done and how it is being done), and *outcome*, the result of the clinical intervention as portrayed by the patient's health status and quality of life [19].

Frank distinguished between two effects of psychotherapy: symptom relief and improved functioning. Symptom relief is rapid, dependent mainly on the sense of hope and the prospect of help, and independent of the type of psychotherapy or the theoretical orientation of the therapist. Improved functioning appears to be related to the type of therapy received, the learning process promoted by the therapist, and social interactions outside the therapeutic setting [4]. This differential effect highlights the importance of distinguishing a mental disorder from personality, behavior, and the perceived environment, and the need to distinguish the pathognomonic features of a clinical presentation from its pathoplastic aspects [7].

The deconstruction of demoralization into distress and "subjective incompetence" enables us to gain a better understanding of the underlying mechanisms common to all psychotherapies, and the critical role played by the culture in the psychotherapeutic relationship. Subjective incompetence is a self-perceived incapacity to perform tasks and express feelings deemed appropriate in a stressful situation, resulting in pervasive uncertainty and doubts about the future. The stressful situation disconfirms assumptions about self and others, and about the continuity of the past and present with the future. Individuals with subjective incompetence are puzzled, indecisive, uncertain, facing a dilemma, unclear as to ways out of the situation, placed in a deadlock, impasse, quandary, or plight. Subjective incompetence is not the same as lack of self-efficacy. The two constructs may be inter-correlated, but subjective incompetence refers strictly to the loss of the directional component of motivation, that is, the loss of the cognitive map, and not to loss of the magnitude of motivation, whereas lack of self-efficacy refers to both.

While differing in the techniques employed, all psychotherapies share several goals: to reduce the allostatic load; reduce distress; enhance resilience; the polar opposite of subjective incompetence; improve emotional regulation; and promote functional improvement. These include individual psychotherapies (psychoanalysis, client-centered psychotherapy, and other psychodynamic psychotherapies, as well as behavioral, cognitive, and cognitive-behavioral psychotherapies); interpersonal psychotherapies, including marital, family, and group psychotherapies; and mind–body interventions, such as mindfulness and embodiment.

Psychodynamic psychotherapy attempts to optimize the common factors of psychotherapy by prioritizing listening, understanding, and validation of the patient's experience through clarification and interpretation. As a result, distress and subjective incompetence are both reduced [20]. Developing a secure attachment relationship within the psychotherapist can confer a sense of safety, a powerful force in emotion regulation [21]. Client-centered psychotherapy attempts to release the potential of the client to reorganize his or her inner awareness toward growth and

development. Its goals may be difficult to achieve in cultures that limit individual freedom and in which top-down authority is the norm [1].

Examples of behavioral approaches are relaxation training, diaphragmatic breathing, progressive muscle relaxation, autogenic training, visualization and guided imagery, operant behavior therapy, graded activation, time-contingent medication schedules, and fear avoidance. These approaches are aimed at improving emotional regulation. With its emphasis on protocols, concrete changes, and targeted outcomes, behavior therapy appears to be better positioned for application across cultures than psychodynamic psychotherapies.

Having the patient as an active participant in the treatment plan, cognitive-behavioral psychotherapy promotes cognitive re-structuring and improvement in problem solving skills. Cognitive reappraisal is focused upon meaning, purpose and self-identity, rather than ruminations about suffering. Subjective incompetence is reduced because a cognitive map is being built. Behavioral approaches such as the ones mentioned above are also employed. Behavioral activation emphasizing absorption in pleasurable and gratifying experiences reduces distress and improves emotion regulation. The primary targets of cognitive therapy and cognitive-behavioral psychotherapy are cognitive distortions, or a combination of cognitive distortions and self-defeating behaviors, and not dysfunctional emotions. The emphasis of these therapies is the present and the future, and not the past. Cultural misunderstandings certainly can be an important source of cognitive distortions. These therapies can be modified when applied in different cultures, as demonstrated by the development of Taoist thought-oriented cognitive therapy.

After comparing various modalities of psychotherapy, Frank concluded that the specific theoretical orientation of the therapist is irrelevant for the success of psychotherapy. The active ingredients of successful psychotherapy, according to Frank, are the personal qualities of the therapist, the trust of the patient in the therapist, the expectations of the patient, and the nature of the therapist–patient relationship in a healing setting [4]. It should be noted however that while all psychotherapies may be equally effective at relieving distress, their effectiveness may differ in combating subjective incompetence, that is, in increasing resilience, reducing the allostatic load, and promoting emotional regulation and functional improvement.

In summary, whether by folk healing, religious healing, or forms of psychotherapy derived from the principles of social science, psychology, psychiatry, or psychoanalytic theory, discussing one's fears, anxieties, and interpersonal stressors with a culturally recognized healer or psychotherapist has offered hope of understanding, and of relief of symptoms of psychological distress to generations of sufferers. As Frank's pioneering research on the explanation of the phenomenon of symptomatic relief and improvement in self-esteem and interpersonal functioning resulting from psychotherapy has shown, hope of improvement and faith in the personal integrity of the psychotherapist and the effectiveness of the psychotherapeutic methods utilized by the psychotherapist are the main underlying factors in symptom reduction, increased self-esteem, sense of well-being, and improved social functioning.

Migration, Acculturative Stress, and the Challenges of Cultural Integration in the Twentieth Century

During major surges of immigration in the twentieth century to the most industrially developed countries of Europe, North and South America, and Oceania, the predominant national sentiment toward immigrants in most receiving host countries was that they should acculturate to the normative behaviors and values of the majority or mainstream culture of the national population. Most immigrants also wished to assimilate, to become part of the national society. This process of acculturative change can be seen as unidirectional, as individuals who identified themselves as part of immigrant and other minority groups both rejected and progressively lost distinctive aspects of their cultural heritage in favor of becoming part of the mainstream majority culture of the host country. In countries that encouraged this outcome of acculturation, people were expected to progress from un-acculturated, through the gradient of minimally, moderately, and fully acculturated [22]. However, this model of acculturation generally overlooked the issues of prejudice and discrimination within the majority host population that stood in opposition to immigrants and immigration, and strongly resisted the cultural assimilation of immigrant and other minority groups. In reaction to such negative pressures, groups that were discriminated against often formed, or were forced into communities of their own for mutual support and protection. Those ghettoized communities generated fear and resentment, both within the isolated communities and in the negatively stereotyped perceptions and behaviors of the external national majority community toward the readily identifiable immigrant and minority groups [23, 24].

The intensity of acculturative stress experienced by immigrant and other minority groups—including the individuals and families comprising those groups—has been directly proportional to the openness and acceptance of the host governments and their national majority populations.

The central issue is to what extent are immigrants' and other minority groups' customs, values, and differences from the majority population of the host receiving country accepted, encouraged, and welcomed as an enrichment of the host country's economic and cultural life, as opposed to being seen as alien, unwelcome, and a threat to the strength and even the continuity of the host country's majority culture. The "acceptance" position encourages the cultural integration of immigrants, whereas the "rejection" position encourages cultural exclusion.

During the last half of the twentieth century, the societal ideals of cultural diversity and multiculturalism have favored cultural integration rather than cultural assimilation. As positive ideas about cultural diversity and multiculturalism grew in acceptance and influence on public policy in most industrialized host countries for migrants, acculturation has been increasingly conceptualized as a non-linear, complex, and ongoing process. From this perspective, the acculturation process is conceptualized as progressive and dynamic, continuing over several generations. It involves acquisition and retention, as well as relinquishing, of values, thought patterns, and social behaviors of both majority and minority population groups as their interactions are modified by circumstances and over time [22].

Acculturation and the outcomes of acculturative stress for groups, as well as for the individuals who comprise those groups, are both social and psychological phenomena. The outcome of acculturative stress is not a finite end point, but rather a continuous process, with periods of greatly intensified intra-familial, intergenerational, and individual intra-psychic stress alternating with periods of comparative calm, insight, and successful adaptation to unanticipated change.

In order to assess the outcome of acculturative stress, for groups and their component individuals, two determining factors need to be considered. The first is the extent to which the group and its members value and wish to preserve their cultural uniqueness, including the language, beliefs, values, and social behaviors that define the group. The second factor is the mirror-image issue of the extent to which the group and its members value and wish to increase their contact and involvement with the majority culture.

This conceptual framework leads to four possible outcomes of acculturative stress that are not conceptualized along the unidirectional gradient from un-acculturated to completely acculturated. The four possible outcomes are separation, integration, assimilation, and marginalization [22, 25]. *Separation* is characterized by individuals' wishes, both conscious and intuitive, to maintain their cultural integrity, whether by actively resisting the incorporation of the values and social behavior patterns of the national majority cultural group, or by disengaging themselves from contact with and the influence of the dominant majority. *Integration*, as an outcome of acculturative stress, derives from the wish to both maintain a firm sense of one's cultural heritage and not abandon those values and behavioral characteristics that define the uniqueness of one's culture of origin. At the same time, such individuals incorporate enough of the value system and norms of behavior of the dominant majority cultural group, to feel and behave like members of that cultural group. Accordingly, the defining feature of integration is psychological: it is the gradual process of formulation of a bicultural identity, a sense of self that intertwines the unique characteristics of two cultures.

Psychological integration of two cultural traditions is neither easy to accomplish nor conflict-free. It involves continuous intra-psychic struggle to balance inherently conflicting components of a bicultural identity. That is, the outcome of acculturative stress for any individual is shaped by the particular intra-psychic conflicts and coping abilities of that individual. That is what accounts for the great intra-group variation among members of any cultural group during the process of acculturation over decades and generations.

Assimilation is the psychological process of the conscious and unconscious giving up of the unique characteristics of one's culture of origin in favor of the more or less complete incorporation of the values and behavioral characteristics of another cultural group, usually the majority culture. Examples include involuntary migration, when natural disaster, war, and social upheaval necessitate such changes for purposes of survival. However, there are many other life circumstances, including racial, ethnic, and religious discrimination, that motivate people to overlook, suppress, or deny aspects of their cultural heritage and wish to have a seamless fit within another group. The price of such an effort, in terms of intra-psychic conflict, can be high.

Marginalization is defined by the psychological characteristics of rejection or the progressive loss of valuation of one's cultural heritage, while at the same time rejecting, or being alienated from, the defining values and behavioral norms of another cultural group, usually that of the majority population. This is the psychological outcome of acculturative stress that is closest to the concept of identity diffusion. As such, it is most often exemplified by the angry, lost and anguished youth and young adults of many groups, whose intense intra-psychic conflicts are reflections of active intra-familial, intergenerational, intra-communal, and inter-communal conflict. Part of their search for psychological meaning and self-esteem is reflected in their turmoil about their ethnic identity and in their formation of a negative identity [22].

The literature on acculturation and acculturative stress emphasizes the need for long-term study of the process. The outcome of acculturative stress cannot be determined by cross-sectional, short-term analysis. The process is continuous throughout the life cycle and is strongly influenced by life events over which individuals, families, and cultural groups may have little control. At the same time, understanding the theoretical underpinning of acculturative stress and its possible outcomes can enable clinicians to take account of its complex influence on the clinical presentation of the very large numbers of people affected by it, and thereby improve the quality of their treatment of culturally diverse people [26, 27].

The rate of acculturative change and the circumstances that influence it vary greatly both between and within groups. For these reasons, studies of groups experiencing acculturative change often divide the groups between first, second, and third generation immigrants. Families within such groups have been categorized as traditional, transitional, or bicultural. Traditional families are defined largely on the basis of intra-familial use of pre-immigration language, residence in ethnic enclaves, resistance to or exclusion from interaction with majority cultural institutions, and maintenance of pre-immigration thought patterns, values, and social behaviors. Transitional families are characterized by greater fluency in the language of the host culture, by children becoming familiar with the values and social behaviors of the majority culture through their attendance at school and participation in school-related and general community activities. Bicultural families are those with a high degree of language fluency and economic stability, living in multiethnic communities and having a parental authority structure that is more egalitarian than patriarchal.

Finding ways to operationalize the concept of bicultural families and bicultural individuals has been the focus of much recent research. Scales have been developed to measure the nature and extent of individuals' identification with their culture of origin and with the majority or host culture. This has led to current efforts to describe and validate the concept of bicultural competence, including the cognitive, emotional, and behavioral characteristics of people who are capable of feeling comfortable and functioning effectively in two distinct cultural contexts. The more complex issue of understanding the process by which such individuals integrate the elements of both cultural traditions into a psychologically consistent sense of self remains to be elucidated.

Bicultural identity organization refers to the degree to which biculturally competent people perceive their mainstream and ethnic cultural identities as compatible and integrated, versus oppositional and difficult to integrate. Individuals high on bicultural identity integration tend to see themselves as part of an emerging third culture, and do not find it emotionally stressful to integrate both cultures in their everyday lives. On the other hand, people with low bicultural identity integration report difficulty in incorporating both cultures into a cohesive sense of self. Although low bicultural identity integration individuals also identify with both cultures, they are particularly sensitive to specific tensions between the two cultural orientations and see this incompatibility as a source of ongoing and unresolved psychic conflict [22].

During the last two decades of the twentieth century, the political ideal of multiculturalism or cultural diversity was increasingly adopted in a large number of host countries. This was seen particularly in host receiving countries that favored national policies of openness and acceptance toward immigrants and refugees, valuing cultural diversity and encouraging the initiative, resourcefulness, and resilience of their immigrant families in the economic, cultural, and political life of the nation [28].

Changing Attitudes Toward Immigrants and Refugees in the Early Twenty-First Century: An Era of Fear of Terrorism

Population migration has been a constant theme of human civilizations over many centuries, resulting from recurrent experiences of natural disaster, inter-communal competition for land and resources, ethnic and national conflict, war and exploitation—along with the search for new opportunities and freedoms in regions and countries foreign to the migrants' upbringing and pre-migration life experience [29].

At the start of the twenty-first century, the United Nations estimated that the number of international migrants worldwide in the year 2000 was 173 million. Migrant numbers have grown steadily since then to 222 million in 2010, and 244 million in 2015. Approximately 75 million international migrants now live in European countries, and an equal number live in Asian countries. North American countries (Canada, the USA, and Mexico) are currently home to 54 million international migrants. The USA is the country with the world's largest number of immigrants and refugees, about 47 million, nearly 20% of the total of the world's migrant population. Both Germany and Russia are home to about 12 million international migrants [30].

The number of refugees worldwide has reached the highest level since World War II. In 2014, the United Nations estimated that there were 19.5 million refugees in the world, comprising 8% of all international migrants. Erosion of civic services, regional intra-country and international conflicts, civil wars and internationally supported armed conflicts, as well as prolonged drought and other natural disasters have greatly fueled the numbers of refugees, particularly in Asian and African countries. Some 53% of the world's refugee population in 2014 came from just three countries: Syria, Afghanistan, and Somalia.

The proportion of the "foreign-born" in the receiving host countries has risen steadily over these past five decades, to 15% or more of the total population of many host receiving countries in Europe, including Germany, France, Britain, The Netherlands, and Sweden, as well as in the USA, Canada, Australia, and New Zealand. In the USA, the foreign-born proportion of the national population was 4.7% (9.6 million people) in 1970, rising to 11.1% (31.1 million) in 2000, and to 13.5% (43.3 million) in 2015.

Inevitably, there has been an accompanying increase in acculturative stress in many countries attempting to provide adequate housing, economic opportunities, health care, and educational resources for successive waves of immigrants and refugees [31].

In an increasing number of receiving countries, national policies of accepting and welcoming immigrants as "new citizens," bringing new energy, entrepreneurial activity, dynamism, and cultural diversity to the national population have devolved into more unwelcome reception of new migrants. There has been a rising resistance to policies of "open-door" immigration, reduction in quotas for new immigrants and refugees seeking asylum and permanent resident status, and a re-categorizing of migrants as "temporary residents," with no legal path to citizenship, or as refugees with ambiguous legal status or claim to secure residency, and barred from legal employment, state-provided health care services, access to publically funded education, public housing, and public funding in support of their basic living expenses during the first years of their re-settlement. Issues of prejudice and discrimination and, in an increasing number of cases, incidents of threat and harassment have occurred. In their wake, there has been an inevitable increase in psychological stress, loss of sense of security and of self-esteem, fear of discrimination and "ghettoization," risk of poverty, vulnerability to homelessness and possible extradition—all generating further levels of psychological, familial, and migrant community distress [32].

In many receiving countries, there has been the added complication to cultural acceptance and cultural integration that has been due to both the fear and the reality of incidents of threatening behavior and/or violence toward immigrants, as well as incidents of terrorism committed by some immigrants and refugees, which have further undermined the successful integration of immigrants in receiving countries. In addition, during the past several years, increasingly negative public sentiment toward accepting additional immigrants and refugees in many previously accepting countries—including the USA, Australia, Britain, Germany, France, and Sweden—has led to major changes in these nations' immigration policies, substantially reducing the legal limits on acceptance of both immigrants and refugees, and subjecting potential immigrants and refugees to intensive and protracted pre-migration screening procedures that had not been applied in past decades. Xenophobia has been strengthened and justified by fears of further acts of terrorism that might be committed by immigrants and refugees. As a consequence of these changes, both immigrant groups and members of the majority population have felt increasingly insecure, anxious, threatened in their security and stability, and subject to feeling victimized and traumatized. Resilience among both immigrant and host communities has been undermined [31, 32].

Meeting the Need for Intercultural Psychotherapy in Contemporary Receiving Societies

Throughout human history, natural disasters such as prolonged drought, intense flooding, hurricanes, earthquakes, and volcanic eruptions have devastated villages, towns, and entire regions, engendering intense trauma, illness, poverty, malnutrition, hopelessness, and despair, necessitating *involuntary migration* to safer regions and countries. And throughout the centuries, man-made disasters such as inter-tribal conflicts, regional and international wars have forced people to migrate for safety and survival. Waves of *voluntary migration* have been common since the nineteenth century, as people migrated in search of greater political liberty and religious freedom, as well as educational and economic opportunity. In the twentieth century, two world wars and a worldwide economic depression generated massive emigration from European and Asian countries to North and South American countries, as well as to southern African countries, Australia, and New Zealand.

Increased Immigration and Increased Racial and Ethnic Diversity of the US Population Since 1980

For generations, the USA has been described as "a country of immigrants," with borders open to both immigrants and refugees. But that has not always been the predominant sentiment of the majority "white" population, nor of government policy. There has always been a strong strain of public prejudice toward each new wave of immigrants, along with negative stereotyping of immigrants, including racial, ethnic, and religious discrimination toward the new settlers.

Fears of being overwhelmed by foreign-born migrants soared in the years following World War I, resulting in national policy changes that sharply restricted immigration in the 1920s. Economic depression in the 1930s led to further limits on immigration, including fears that immigrants would increase the national economic burden, would depress wages and replace Americans in the nation's already decimated work force. Restrictive immigration policies continued through the post-World War II, Korean War, and the "cold war" years, characterized by fear of nuclear war with the Soviet Union.

In 1920, the foreign-born component of the US population reached 14% of the nation's total. That proportion decreased steadily in the decades that followed, falling to just 4.7% (9.6 million) in 1970. Since 1970, as restrictive immigration policies were liberalized, the proportion of foreign-born American residents steadily increased to 7.9% (19.8 million) in 1990, 11.1% (31.1 million) in 2000, and 13.5% (43.3 million) in 2015. Since the 1970s, the number of immigrants from European countries has sharply decreased, while the numbers of Hispanic/Latino Americans and Asian Americans have soared.

Between 1980 and 2010, the total US population increased 30%, in large part due to increased numbers of immigrants. The demographic composition of the national population changed dramatically during those years. The Hispanic/Latino American

component of the national population increased 175%, to 50.5 million, comprising 16% of the total (315 million) US population in 2010. The Asian American population increased 223%, to 14.7 million, 5% of the total US population. By comparison, between 1980 and 2010, the White American component of the US population increased just 9%. The African American component increased 37% [33].

In 2015, 45% of all immigrants in the USA described themselves as "Hispanic" or "Latino." It is important to recognize that the majority of Hispanic Americans in the US population are US-born, not foreign-born, comprising 65% of the total number of 56.6 million Hispanic Americans living in the USA in 2015 [34].

As these demographic changes in the US population indicate, the national population has become more racially and ethnically diverse during the past four decades, most dramatically with respect to the surge in Hispanic Americans and Asian Americans.

Projecting ahead through 2050, the total US population is expected to increase from 315 to 420 million. The White American proportion of the US population is projected to decrease from 65% of the total national population in 2010 to 50% in 2050. The African American component of the national population is estimated to increase from 13% (40.5 million) in 2010 to 16% (61.5 million) in 2050. Hispanic Americans, comprising 16% (50.5 million) of the total US population in 2010, are projected to increase to 27% (102.5 million) in 2050. Asian Americans are projected to increase from 5% (14.7 million) in 2010 to 8% (33.4 million) of the total US population in 2050.

It is estimated that there are approximately 12 million illegal or "undocumented" residents in the USA. The majority of these undocumented residents are of Hispanic/Latino background, predominantly Mexican-born. They have been living, and working, in the USA for decades, and have established families in the USA. Their American-born children are entitled to US citizenship.

The number of undocumented residents who arrived in the USA as children, entering the country with their undocumented parents, is estimated to number more than two million. More than 800,000 have registered with US Immigration authorities in the past several years, in the hope of being accorded permanent resident status, and a legal path to citizenship. They have lived most of their life in the USA, and regard the USA as home. They are popularly known as "Dreamers," and there has been strong sentiment among Americans in support of their becoming eligible for citizenship.

Since 2000, approximately 75,000 migrants have entered the USA each year as refugees. The numbers authorized in 2015 and 2016 were increased to 110,000 per year, specifically to accommodate the surge of migrants from war-torn Iraq, Syria, and Afghanistan [34].

Increasing Racial and Ethnic Diversity of Health and Mental Health Professional Staff in the Twenty-First Century

In parallel with the steadily increasing numbers of racially and ethnically diverse immigrants to the USA since 1980, there has been increasing diversity in the

numbers of physicians and a wide range of health and mental health professional staff in clinical practice in the USA.

Seventy-five percent of US medical school graduates from 1978 to 2008 were White/Caucasian, according to data reported by the Association of American Medical Colleges [35]. African American medical graduates comprised 6.3% of US medical school graduates, Hispanic/Latino American graduates 5.5% and Asian Americans 12.8%. Comparative data for 2015 indicates that among all graduates of American medical colleges, 58.8% were White/Caucasian, 5.7% were African American, 4.6% Hispanic/Latino, and 19.8% Asian Americans.

Data reported by the American Medical Association [36] showed that of the total number of 1,046,000 physicians practicing medicine in the USA in 2012, 23% were International Medical Graduates (IMGs), with medical graduates of Indian, Pakistani, and Philippine medical colleges being the most numerous among IMGs. Among all US practicing physicians, 54.8% were White/Caucasian, 4.1% were African American, 5.4% Hispanic/Latino American, and 15.2% Asian American. US census data show that the proportion of the total population in 2013 categorized as White/Caucasian was 62.6%, African American 13.2%, Hispanic/Latino American 17.1%, and Asian American 5.3%.

These data reveal that African American and Hispanic/Latino American physicians are significantly under-represented compared to their proportion of the total US population, while Asian American physicians are significantly over-represented.

With respect to gender, 70% of all licensed physicians in the USA in 2010 were male, 30% female [37].

In 2017, the US Department of Health and Human Services published a report on racial, ethnic, and gender diversity of US health occupations for the period 2011–2015 [38]. The data on race and ethnicity of all US health care professional staff showed that 64.4% were White/Caucasian, 11.6% were African American, 16.1% Hispanic/Latino American, and 5.3% Asian American. Among physicians, 67% were White/Caucasian, 4.8% African American, 6.3% Hispanic/Latino American, and 19.6% Asian American, reflecting the under-representation of African American and Hispanic/Latino American physicians and the comparative over-representation of Asian American physicians.

For psychologists, 83.5% were White/Caucasian, 4.9% were African American, 6.3% Hispanic/Latino American, and 3.4% Asian American, indicating over-representation of White/Caucasian psychologists compared to the number of White/Caucasians in the total US population, and under-representation of African American, Hispanic/Latino American, and Asian American psychologists.

Social workers were 60.6% White/Caucasian, 21.5% African American, 12.0% Hispanic/Latino American, and 3.0% Asian American. Nurses were 73.5% White/Caucasian, 16.4% African American, 5.7% Hispanic/Latino American, and 8.4% Asian American.

With respect to gender, 52.8% of all US health care professional staff were male and 47.2% female. For physicians, the gender distribution was 65% male and 35% female. By comparison, among psychologists, 29% were male and 71% female.

The figures for social workers were 19% male and 81% female, and for nurses 10% male and 90% female.

A report published by the Association of American Medical Colleges in 2014 indicated that racial and ethnic minority physicians, to a significantly greater extent than their White/Caucasian colleagues, were practicing family medicine, general internal medicine, and pediatrics rather than other medical specialties, and were practicing in comparatively under-served and rural areas of the USA [39]. This finding also applies in the case of physicians practicing psychiatry; African American and Hispanic/Latino American continue to be under-represented among US psychiatrists. Furthermore, racial and ethnic minority psychiatrists, more than their White/Caucasian colleagues, practice in under-served and rural areas, and in publically funded clinical facilities.

These trends are corroborated by a finer-grained study of all psychiatrists practicing in Texas between 2000 and 2015 [40]. In 2015, the racial and ethnic composition of the Texas population was 42.2% White/Caucasian, 11.5% African American, 40.0% Hispanic/Latino, and 6.4% other (mainly Native American and Asian/Pacific). Since 2004, the number of psychiatrists had increased by 39%.

Among practicing psychiatrists in Texas, 62.1% were White/Caucasian, 6.0% African American, 7.8% Hispanic/Latino, and 24.1% other (mainly Indian and Pakistani-born immigrants). White/Caucasian psychiatrists were disproportionately male and older than other practicing psychiatrists, 55% were age 60 or older, and only 14% were age 40 or younger. By comparison, 56.1% of African American psychiatrists were age 50 or younger. Among Hispanic/Latino psychiatrists, 38% were age 50 or younger, as were 53% of Asian American psychiatrists [40].

In summary, the racial and ethnic data of psychiatrists practicing in the USA during the past two decades demonstrate increasing numbers of African American and Hispanic/Latino psychiatrists, although these groups are still under-represented by comparison with their proportion of the total US population. By contrast, Asian American psychiatrists are currently over-represented by comparison with their proportion of the total US population. However, in light of the rapid rate of increase of Asian Americans in the US population since 1980, the numbers of Asian American psychiatrists can be expected to be more consistent with the total Asian American component of the US population by 2050.

Until 2000, American psychiatrists were disproportionately male, but the number and proportion of female psychiatrists has been rising steadily since 2000.

As long as the phenomenon of waves of migration continues—and there is little persuasive evidence that it will not continue—receiving countries face the need to help integrate their immigrant, refugee, and asylum-seeking migrant populations into the fabric of their evolving, more diverse, and multicultural national societies.

There is a corresponding and continuing need for intercultural psychotherapists to expand their knowledge and expertise in “cultural assessment,” “cultural competence,” as well as “cultural formulation” of life stressors among immigrant and ‘culturally diverse’ members of the national population. There is a continuing need for intercultural psychotherapists to integrate that set of knowledge, skills—and

empathic sensitivity—in their psychotherapy with the diverse and multicultural population they will be encountering and treating in the decades ahead [41, 42].

Accordingly, there is a great need for mental health professional staff in general, and intercultural psychotherapists in particular, to become more familiar with and achieve greater competence in issues related to immigration, acculturative stress, and cultural integration, as well as issues of negative stereotyping, prejudice, and discrimination, and changes in national policies toward immigrants and immigration.

Changes in Popular Sentiment Toward Migrants and Changes in National Immigration Policies: A Current Humanitarian Crisis?

Over the past several years, there has been a dramatic surge of migrants coming to European Union countries from Iraq, Syria, and Afghanistan, as well as other countries in the Middle East, East Asia, North Africa, and sub-Saharan Africa, with large numbers experiencing great stress, physical risk in transit to Europe and other receiving countries, as well as limited subsistence support services and substantial discrimination in a number of transit and receiving countries. Since 2015, Germany has accepted more than one million such migrants, in keeping with a liberal and humanitarian national immigration policy of acceptance and integration of these culturally diverse new residents in Germany. The Netherlands, Sweden, Austria, and other EU countries also increased the numbers of migrants admitted as authorized residents [43].

This unexpected and massive surge of migrants to European countries has engendered considerable public backlash in a number of European countries, followed by public policy changes restricting open immigration, decreasing access by recent migrants to publically financed social support services, housing, health care, and permission to work. Nationalist, anti-immigrant, and xenophobic sentiments have become more strident in the past 2 years, and these sentiments have been mirrored in public policy changes in a number of EU countries. Previously open borders have been replaced with stricter border controls, sharply constricting legal access by migrants. Fear of terrorist acts committed by some recent migrants has become a major factor in both public sentiment and national policy changes concerning current and future legal admission of migrants.

In the USA, there have been equally dramatic changes in both public sentiment and national policy regarding immigrants and national security since the national election cycle in 2016. Rather than being welcomed and accepted as contributors to the vitality and resourcefulness of the nation, immigrants have become increasingly negatively stereotyped as unwelcome threats to the security, cultural integrity, and prosperity of the nation. Anti-Muslim and anti-Hispanic sentiment has intensified, along with fear of terrorist acts by immigrants and refugees. Current government policy has very dramatically restricted admission of refugees, to less than 30,000 in 2017, sharply limited visa entry authorization for foreign students, temporary

workers, and family members of foreign-born legal US residents. New pre-migration "extreme screening" procedures for both immigrants and refugees have been implemented, intended to greatly restrict the annual number of migrants accepted for permanent residency and eligibility for citizenship.

Perhaps most dramatically, current US government policy has reversed the policy of creating a path for legalizing the undocumented status of more than one million "Dreamers," who came to the USA as children, with their (undocumented) parents. When "Dreamers" registered with the US Immigration Service, they were required not only to provide detailed information about themselves and their immigration history but also about all their family members. Accordingly, both the Dreamers and all their undocumented family members are now subject to detention as illegal residents of the USA, and subject to detention and deportation.

What these recent changes in public sentiment and public policy have engendered, in the USA as well as in countries of the European Union, is negative stereotyping, prejudice, and discrimination of immigrants and refugees, fears of loss of "national identity" by receiving country citizens and intolerance of cultural diversity, along with fears of terrorist acts by migrants.

These changes may be temporary, as the long history of waves of immigration has demonstrated, with recurrent cycles of both acceptance and rejection of immigrants and open-border national immigration policies. However, the current cycle of rejection tendencies in public sentiment and in public policy is very troubling; undermining as it does, the altruistic and humanitarian sentiments and standards of communal behavior that for so long have represented the highest ideals of democratic societies.

In recent decades, waves of migration due to natural and man-made disasters have influenced local and regional cultures, created new social and economic challenges in host countries, and highlighted the need for a better understanding of cultural factors in the pathogenesis and presentation of mental disorders. The pathway of immigrants and refugees into the treatment system starts before the clinical encounter with the psychiatrist or psychotherapist. The less acculturated the families of the identified patient/client to the host country, the more likely it will be that the decision to seek help will be influenced by the cultural beliefs and practices of the migrants' countries of upbringing. Concepts about illness and healing that are characteristic of migrants culture of origin may be formalized as systems, such as, for example, Chinese traditional medicine or Indian Ayurvedic medicine, or as folk beliefs and healing rituals that have been handed down for generations. Such concepts and healing traditions derived from those systems or beliefs may influence the decision to enter—or avoid contact with—the medical care system in the host country. These social and cultural factors influence and shape what Hollingshead and Redlich called the "screen of lay appraisals" [44]. Many immigrants and refugees may feel uncomfortable sharing their innermost thoughts and feelings with someone from a different culture or racial and ethnic background. Some may see it as an admission of vulnerability, their own position in the social structure of the host country being poorly defined. If they came into the country illegally, they may never

seek help in the host country's treatment system for fear of detention and deportation.

Once the decision is made to seek help, the establishment of a doctor–patient relationship and a therapeutic alliance may be influenced not only by linguistic and communication barriers but also by differences in assumptions and expectations about health care delivery by clients/patients, or biased attitudes toward people of certain racial or ethnic backgrounds, and lack of familiarity with symptom patterns or expressions of suffering by the physicians and psychotherapists designated to treat them.

The role of the psychiatrist may vary in various societies. In some societies, psychiatrists treat the more severely impaired patients, while psychotherapy for the less severely ill is done by other mental health professional staff. An unfortunate consequence of the scarcity and maldistribution of psychiatrists is that the time available to treat a given patient/client often determines the pattern of clinical care. With few psychiatrists available to treat a large number of patients/clients, medication management may become the only type of service possible for psychiatrists working at publically funded clinical facilities. This, in turn, further discourages the establishment of the doctor–patient relationship and therapeutic alliance. Psychiatrists are expected to provide prescriptions for psychotropic medicines, with little time available to them for the provision of psychotherapy. Training of psychiatrists in psychopharmacology often supercedes their training in psychotherapy in general, let alone culturally sensitive psychotherapy. The use of "psychiatrist extenders" and, more recently, the use of tele-psychiatry are beginning to gain acceptability as approaches to overcoming the problem of limited access to more comprehensive clinical assessment and treatment.

Psychotherapy may not be well known or may even be discredited as a healing practice in some societies. Some patients and their families may not understand why a somatic complaint requires psychotherapy, or why medications may be ineffective or even contraindicated in certain cases. The rationale for certain methods used by Western-trained psychiatrists, such as free association or cognitive reframing, or the need to have regular follow-up appointments even after the initial symptom have been relieved, may not be obvious to patients/clients from non-Western cultures. Culture may affect the selection of words used during psychotherapy sessions, the topics chosen for discussion, as well as verbal and non-verbal communication patterns. In the initial session, the presenting problem may be described following an acceptable cultural style. Even in western societies, as medical terms become popular, patients/clients may self-diagnose or ask for laboratory tests resulting from material learned from mass media or their friends and become surprised or angry if the psychotherapist disagrees with the self-diagnosis or the appropriateness of the tests. Cultural prohibitions may interfere with disclosure of private matters based on age differential or gender differences between patient and care providers, and boundaries of confidentiality may be poorly understood. When interpreters are used, every effort should be made for the interpretation to be objective and unbiased—and interpreters should not be younger family members or friends of the

patient or family being treated. With training and experience, interpreters may be valuable assistants in the therapeutic process.

At a deeper level, culture, ethnicity, race, gender, and minority status may interfere with the therapist–patient/client relationship with potential barriers that may not be immediately obvious to the therapist or to the patient/client. Cultural empathy becomes critical in the development of trust and progress of therapy [45].

In summary, there is great need for mental health professionals in general, and intercultural psychotherapists in particular, to become more familiar with and achieve greater competence in issues related to immigration, acculturative stress and cultural integration, changes in national policies toward immigrants and immigration, prejudice, and discrimination.

Intercultural psychotherapists need to expand their knowledge and expertise in "cultural assessment," "cultural competence," "cultural formulation" of life stressors among immigrant and "culturally diverse" members of the national population, and to integrate that set of knowledge, skills—and empathic sensitivity—in their psychotherapy with the diverse and multicultural population they will be encountering and treating in the decades ahead. Culturally sensitive psychotherapies and psychosocial interventions need to be further developed, tested, and more widely applied in clinical practice.

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The Current Role of Intercultural Psychotherapy

2

Marion C. Aichberger

Introduction

It can be expected that the majority of European countries will consist of increasingly multicultural populations in the near future. The continuous movement of people particularly from regions where armed conflicts, political instability and severe economic difficulties are ever present has also created the need in the health care system to serve culturally diverse populations in the receiving countries. Over the past decade, the rise in political instability, violent conflict, civil war and deteriorating human rights abuses across the Middle East have forced thousands of refugees to seek refuge along the borders of Europe as well as within the European Union (UNHCR 2017). This last great influx of refugees to Europe has made evident the need for more elaborate concepts for (mental) health care provision, including psychotherapy, for this group. Shortcomings of the pre-existing systems have been unmasked due to the sheer number of new entries in many European countries [1, 2].

This has also started an ongoing debate about the need for more culturally competent mental health care provision and providers [3], as well as raising the question as to whether specific intercultural psychotherapy is needed, and which barriers exist to effectively treat patients with another cultural background than the therapist's [4]. While language competence may be one major concern for the provision of psychotherapy for a culturally diverse population, it is not the only factor of relevance here. Some barriers may be inherent in the origin of psychotherapy per se. Psychotherapy can be defined as the use of psychological methods to assist an individual (the patient) to attain a certain behavioural, emotional or cognitive change. However, since the first use of the term in late nineteenth century [5], there has been intensive discussion as to whether psychotherapy represents a form of healing and

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treatment in a medical sense, or shares more qualities with religious practices [6]. In their historic development, psychotherapeutic techniques reflected new insights and scientific concepts about the functioning of the mind. However, at the same rate societal processes have also shaped psychotherapy since its origin and may often have incorporated the cultural norms and moral attitudes within (Western) societies. Most of the concepts used in modern day psychotherapy are based on Western schools of thought, philosophy and scientific insights [7]. Western psychotherapy has its roots in the early nineteenth century, with the first ideas stemming from concepts reaching as far as Mesmerism to the Nancy school in France as one of the first institutions to use hypnotism as a medical practice [6]. While an in-depth discussion of the origins of all psychotherapeutic schools of thought would go far beyond the scope of this chapter, it appears of relevance to bear in mind that many aspects of modern day psychotherapy are deeply rooted in Western philosophical concepts [7]. This is important because mainstream psychotherapeutic approaches and their descendants, including psychoanalysis, psychodynamic therapy, cognitive-behavioural therapy or systemic therapy, all share this origin. While philosophical concepts and practices from other regions, such as meditation or the Buddhist practice of mindfulness, have nowadays been integrated into many psychotherapeutic practices [8], the underlying concepts about the perception of the self as a reflective entity which seeks self-awareness and aims to be in control of the person's emotional and mental development may to some extent be in conflict with cultural norms where the (individual) human being is not placed at the centre [9]. Furthermore, the majority of psychotherapeutic approaches require the patient to disclose intimate details about themselves and to be able to express internal perceptions and thoughts verbally, practices which may sometimes be in conflict with cultural practices about the disclosure of personal thoughts and experiences to someone not belonging to one's family or group.

Determinants of the Therapeutic Relationship in Intercultural Therapy

Qureshi and Collazos argue that the difficulties in the therapeutic process may originate from epistemological and relational sources [9]. While the first is expressed in differences in communication, general cultural values, norms and concepts, and understanding of health and treatment, the second may be less conscious and rather affect the transferential relationship. While the patient may be unfamiliar with the psychotherapeutic process, for the therapist the interaction with a patient from a different cultural background from their own may be unsettling to a similar extent. Earlier discourses about intercultural psychotherapy often referred to a form of 'cultural exchange' taking place between the therapist and the patient, one which opens up a form of 'space' resembling Winnicott's 'potential space', offering a room for development between reality and possibility [10]. This process may be exciting for both sides, accompanied by curiosity and interest in the 'unknown', but also by fear and distrust in the 'alien other' [11]. To some extent the therapeutic space will also

be infiltrated by the attitudes of the general public towards the newcomer and their group; both the current public and political discourse may be present in the mind of not only the therapist but also the patient [4]. Questions of eligibility to help, perceived and existing need, and prejudice might all affect the therapeutic relationship. The therapist will be confronted with culturally shaped norms, expectations and expressions he or she is not or only marginally familiar with. Language might pose one of the largest barriers [12]. Even where an interpreter is not necessary, difficulties in communication are likely to influence the relationship between therapist and patient. Especially when the language of the host country has been acquired later in life, affective states and deeper rooted emotions may be better expressed in the 'mother tongue', being more emotionally charged. Depending on the subject matter of the therapy and the psychotherapeutic approach, this difference in 'emotional charge' between the mother tongue and the second language may impact the therapeutic process to a greater extent. However, since all psychotherapeutic approaches include the reflection on and expression of emotions and underlying trails of thought, language will always affect the intercultural therapeutic process.

Intercultural Psychotherapy: Bridging a Gap

Intercultural psychotherapeutic approaches aim to engage the patient while being aware of the difficulties but also the opportunities that may arise in this 'transcultural space' [13]. Practitioners need to develop new skills to bridge the gap which may be created by their cultural differences, including the use of an interpreter in the therapeutic setting, acknowledging the role migration and resettlement play for the patient, and also accepting being frustrated in the therapeutic process due to misunderstands. Investigation of the experiences of therapists in an intercultural therapeutic setting found that therapists feel particularly helpless, overwhelmed and incompetent as compared with working with clients who share their own cultural background, but that the therapist's personal experiences with the respective culture also have a strong influence on the feeling of competence and security in their professional setting [14]. Working with specific migrant groups such as refugees and asylum seekers may pose a further challenge for many therapists because a highly polarised public debate regarding the group as well as the therapist's fear of being confronted with complex psychological and psychiatric problems, such as complex trauma, and their insecurity about legal and social conditions, may be overwhelming [4].

However, while cultural differences may certainly affect the therapeutic relationship, it may be argued that it is the human relationship—core to any psychotherapeutic approach—which will be the basis for effective psychotherapy. The acknowledgement of perceived as well as existing differences may therefore help to reduce any complications which may result from the diverging cultural backgrounds of the patient and therapist. Being open to the discourse with the 'unfamiliar' may be as essential for effective intercultural psychotherapy as seminars and courses offering training on the work with interpreters and intercultural competency.

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Standards in Intercultural Psychotherapy

3

Adam Montgomery, Antonio Ventriglio, and Dinesh Bhugra

Introduction

With an ever-increasing movement of people across nations due to a number of reasons and factors, it is apparent that delivery of psychiatric services needs to be more culturally appropriate and culturally sensitive. No clinician can ever be fully aware of all the cultural differences, but it is essential that they are cognisant of principles of intercultural therapy.

Intercultural psychotherapy refers to a type of psychotherapy where therapists recognise cultural differences between themselves and patient. This allows the therapist to build a culturally sensitive relationship with patients based on usual psychodynamic principles to enact a change in thinking or behavioural patterns, although this may lead to problems if the therapist carries some presuppositions about the culture of their patient. In today's increasingly globalised society, having an understanding of these cultural differences is imperative for the therapist to build good therapeutic relationships with patients. Such differences are varied and can include differences in race, values, religion, language and educational attainment. A therapist is at risk of making errors in diagnosis as well as therapeutic strategy if they fail to take into account these differences.

There are of course various models and types of psychotherapy, with different applications to clinical or psychological issues. However, most psychological treatments and principles have been developed in Western countries such as North

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America and Europe, which tend to be based on the self-orientated, ego-based models. The use of these psychological interventions in patients from socio-centric, familial-based cultures may be inappropriate. However, this may be changing with globalisation and urbanisation. Furthermore, there may be differing expectations for the therapist-patient relationship based on certain cultural norms. There is often much variation amongst cultures in attitudes towards authority figures and expectations from a therapy session. Patients whose culture recognises authority figures as autocratic, will expect a similar approach from the therapist, and may be happy to be challenged, directed and instructed in an authoritative way. Patients from a background where authority figures are more democratic and approachable will expect a similar level of democracy and equal participation in the therapeutic process from the therapist. Therefore, both the process and the attitude of the therapist are of great importance in intercultural relationships. In addition, post-migration, people's views and expectations may change and may vary from those of their cultural peers.

Quality, or standards, is paramount to any psychological or medical practice. WHO defines quality of care as "the extent to which health care services provided to individuals and patient populations improve desired health outcomes." This approach encompasses key domains such as safety, effectiveness, timeliness and efficiency. With regard to psychotherapy, some of these domains are difficult to measure objectively due to the subjective nature of the practice. In their approach to psychotherapy in response to specific needs of their patients, many clinicians may choose to offer a blend of different therapeutic techniques to meet the needs of their patient thereby making it difficult to measure the effectiveness of a single type of therapeutic intervention. There are challenges in applying rigid standards to intercultural practices. While recommendations have been made to improve cultural competence in intercultural psychotherapy, in practice most therapeutic interventions are to be adapted to the specific patient based on their own cultural patterns, expectations and ethnographic investigation. For a therapist wishing to seek guidance on a universally acknowledged approach to intercultural psychotherapy, the prospect may be daunting.

This chapter focuses on describing different types of psychotherapy and the respective issues with each, the notion of standards and quality in psychotherapy, how these can be applied to an intercultural setting, challenges in using standards in therapy, and further recommendations for future practice.

Intercultural Therapy: What Does It Mean?

The idea of cultural competence in psychiatry and psychotherapy dates back to the nineteenth century though its form and components have changed. During his visit to South East Asia, Emil Kraepelin observed: "If the characteristics of a people are manifested in its religion and its customs, in its intellectual and artistic achievements, in its political acts and its historical development, then they will also find expression in the frequency and clinical formation of its mental disorders, especially those that emerge from internal conditions [1]." Further developments by the

authors such as Wittkower and Kareem from the 1970s onwards established intercultural psychotherapy as a branch of psychiatry, and stated that to practise "cultural Psychiatry" is to acknowledge the cultural background of both themselves and the patient, and how these differences affect therapist-patient interactions [2, 3].

Psychotherapy is a process by which individuals work with a therapist on an interpersonal level to bring about sustained change in thinking or behavioural patterns to improve their mental lives. Due to language and cultural barriers, interpreters are often used to bridge the gap and help the treatment process. Various forms of psychotherapy have developed over time, and compared to placebo have been shown to be efficacious [4]. Its effectiveness depends, however, on a variety of separate processes. Some of these processes are innate and thought to be widespread throughout the global population, such as awareness of one's self in its purest form. Although cultural variations may variously define self as typically "egocentric" as often seen in Western cultures, or "socio-centric" as often seen in traditional cultures, e.g. in Indian cultures; the idea of self as "the individual's mental representation of his own person" is usually recognised as an inherently human trait [5]. However, other processes involved in psychotherapy are subject to more cultural variations, and failure to acknowledge these in assessment and in therapy can lead to difficulties in initiating and effectively engaging with patients from different cultural backgrounds.

Let us take for example the therapeutic models of psychotherapy. Often they are based on Western attitudes towards oneself, particularly those of Europe, North America and Australia. Although the "self" as an inner representation of the mind and body of the person is seemingly universal, how one applies oneself within one's culture is also subject to much variation. The trope of the "Western" self is described as individualised and egocentric, with its actions pertaining to the needs of the self as its first priority. This is compared to the "non-Western" self, which de-emphasises individual autonomy for the sake of collective goals and happiness [5]. The concept of self and importance of individualism in Western society is a concept that can be alien, and indeed threatening to non-Western societies [6]. Psychotherapy as a form of talking therapy differs from other methods of psychological intervention such as shamanist or folk healing practices by its focus on the thoughts, emotions and feelings of the patient, and their willingness to communicate these often highly personal and private matters [6]. Whether a person will be responsive to this type of therapy or not is highly dependent on their cultural background, and as mentioned above, even the very nature of therapeutic interactions with patients can be culturally inappropriate. A therapeutic approach based on democracy, active listening and suggestion is unlikely to be efficacious in a patient whose cultural expectation of authority figures is that they are direct, paternalistic and steadfast in their decisions [7]. Furthermore, despite the above, if the goals and structure of therapy are not entrenched in the culturally appropriate value system of the patient (that is, they are ego-dystonic), then no amount of engagement is likely to bring about therapeutic change. Therefore, a therapist has a huge number of considerations to bear in mind in order to be seen as "culturally competent" in their therapeutic approach [8].

Cultural competence is also relevant in the context of minority groups. With increasing global multiculturalism and population diversity, there may well be a greater need for minority groups to access mental health services. Furthermore, due to increasing population diversity, existing services often have required restructuring in order to meet the needs of minority groups, as in their pre-existing form they were often unsuitable for their needs [9]. Or take, for example, the approach of some minority groups to treatment. In some settings it has been demonstrated that minority groups are less likely to actively seek treatment for mental health disorders when compared to majority ethnic groups [10]. This can be understood within a cultural or historical context; for example, the mistrust of mental health professionals by minority groups who have been historically oppressed and displaced an invading population [11] may be one factor. On the other hand, sense of stigma or shame and also a lack of knowledge about how to seek help and from whom may also impact upon help-seeking. This can be due to variety in mental health literacy across different cultures, and a lack of awareness of whether a person's experiences can be considered symptoms of an illness. Without an awareness of these potential obstacles, minority groups may be thought of as being simply difficult or not engaging with the healing process. Or take the experience that minority groups have with mental health services in general. Regrettably there are still disparities in mental health outcomes when standardised for race. In the USA, African-Americans in general have poorer health outcomes when compared to their white counterparts [12]. They are also less likely to have access to mental health services when needed and less likely to receive good quality care [10]. This backdrop of racial and cultural differences can lead to a variety of psychodynamic processes that a "culturally competent" therapist should have at the forefront of their mind. For example, the process of transference (where the thoughts or feelings of one person towards another person are transferred onto a third person) in such a situation can involve a patient transferring their stereotypes of a certain ethnicity onto the therapist; perhaps stereotypes involving discrimination or previously negative experiences of mental health services [7]. Ethnic matching between patient and the therapist, while potentially improving initial engagement, has not led to more positive outcomes within psychotherapy [13]. The best approach therefore seems to be improving one's cultural competency.

Types of Psychotherapy and Specific Issues in Each Type

Many different branches of psychotherapy exist, and within each there are a number of issues to be addressed. Classically the main types of psychotherapy have been divided into: supportive, re-educative and constructive. In supportive psychotherapy, there is focus on providing encouragement, advice and reassurance in order to improve a patients' mental wellbeing [14]. Direct measures such as confronting stereotypes, past behavioural patterns or examination of interpersonal relationships may be used to explore behavioural patterns, with the aim to improve self-esteem and coping mechanisms. Supportive psychotherapy must be carefully distinguished

from a supportive relationship, which could be provided by contacts such as friends or family, by its focus on diagnostic clarification and symptom resolution. Ego defence mechanisms such as defence formation can be explored through supportive psychotherapy by forming a "therapeutic alliance" with the patient. This alliance allows a therapist to explore potentially sensitive issues in a friendly, conversational but therapeutic style, while still being able to challenge potentially debilitating ways of thinking in order to facilitate behavioural change [14]. Support can also be elicited from various occupational activities such as art or music therapy. This approach may be useful in crisis intervention or periods of acute stress for the patient by minimising the impact of threatening or transitional life events [8, 14]. Support is also provided to enable patients to reach a level of functioning where more long-term therapies can be successfully introduced [8]. However, its ability to enact long-standing change as a stand-alone therapy may be limited. There is insufficient evidence to suggest that patients with chronic mental health conditions such as schizophrenia receive a greater benefit from supportive psychotherapy than standard medical treatment [15]. From an intercultural perspective, the needs of the patient and the level of emotional support they require can be variable depending upon other types of support available to them and also accessibility. For example providing support and social skills to have confidence to initiate romantic relationships is unlikely to be useful for patients from cultures where arranged marriages are the norm [8].

Re-educative psychotherapy, such as cognitive behavioural therapy, is a more long-term intervention, with the aim of remodelling patient attitudes and behaviour. This may be achieved by a number of means, for example, assessing a patient's sources of anxiety with regard to interpersonal interactions, and identifying aspects of their behaviour that hinder their ability to adjust. Encouragement is then provided to adopt new interpersonal attitudes, rectify distorted worldviews, and reorganise behavioural patterns in order to become more adaptable [16]. As compared to, for example, psychodynamic psychotherapy, there is less emphasis on unconscious conflicts; rather, support is provided with the aim of promoting new behaviours. This can be seen as disadvantageous, as the emphasis on patients gaining "insight" into their problems can be minimal. Furthermore, there is little emphasis on patient needs and the individual experiences of their symptoms. No progress is likely to be made by forcibly altering behaviour if that person's symptoms serve as a defence mechanism that is resistant to change [16]. Further concerns have been expressed about the ethics of behavioural modification, particularly in incarcerated or institutionalised populations. Attempts at behavioural modification can be seen as an infringement of their human rights. For example, there may be little motivation to change in patients serving long sentences and who express little desire to change [16]. However, re-educative psychotherapy remains a well-used tool to enact change. Again one must be considerate of certain cultures, who may have an expectation of therapists to provide clearly stated goals, in which case re-educative psychotherapy may be particularly appropriate [8]. The role of family cannot be understated in these situations either, who can contribute in a more passive, supportive role, or take on a more active role, as in family therapy. This may be

particularly relevant in families from collectivist cultures, where individual decisions are secondary to group decisions, and the entire family unit may be active participants in remodelling patients' behaviour.

Constructive (or reconstructive) psychotherapy aims to explore the patient's experiences, whether positive or negative which may have shaped their development throughout their childhood, adolescence and adult life. Exploration of these experiences can reveal unhelpful thoughts as well as coping strategies, but also strengths and patients' capacity to enact meaningful change in their own lives [17]. Constructive psychotherapy is perhaps the most collaborative form of psychotherapy, with patients seen as agents of their own change. Mahoney in his textbook *Constructive Psychotherapy: A Practical Guide* highlights: "What they [the patients] choose to do is critical to their development. They are the ones who make the difference in their own lives. They are the ones who must live out the consequences of their choices [17]." Patients, and arguably their partners and relatives also, are enlisted to attempt to make these difficult changes. It can be a difficult process, and resistance to change is common. For many patients, this change represents an intense inner conflict where old patterns of coping are difficult to uproot, and often are never completely eliminated. However, constructive psychotherapy can offer some of the most meaningful and long-lasting changes, with common changes including greater self-esteem, increased self-awareness and openness to experience [17]. Constructive psychotherapies can be particularly accommodating to cultural sensitivities by the collaborative ability between the therapist and the patient to construct new beliefs around the patient and their worldview [18]. However, one must always bear in mind the issue of transference, which can be easily noted in an intense constructivist setting. Cultural variations and values can influence the degree of transference to potentially enhance or minimise engagement with the therapeutic process [8]. A discerning therapist should be aware of such a potential.

Standards: What Are Standards? How Are They Measured?

Looking at the notion of quality and standards in psychotherapy and their measurement, it becomes clearer that clinical quality of care encompasses a variety of domains. A structure to measure quality in healthcare proposed by Avedis Donabedian, which includes the structure of care, the application of evidence-based processes and clinical outcomes, has since become known as the Donabedian framework [19]. The World Health Organisation [20] makes further proposals about quality and suggests six points of focus in order to improve quality in health care in general. Below we will discuss how they relate to psychotherapy in general.

The six points are:

Effectiveness: (Evidence-based health care, based on need that results in improved outcomes)

Efficiency: (Delivering care in a timely manner that maximises use of resources while avoiding waste)

Accessibility: (Care that is timely and in an appropriate setting to the needs of the population)
Acceptability: (Patient-centred care that takes into account the preferences of individuals and their cultures)
Equitability: (Health care which is standardised in quality regardless of patient variables such as race, age, sex, ethnicity)
Safety: (Care that minimises risks and potential harm to service users).

These domains can be challenging to measure, especially in mental health, as the standards can vary greatly by geographical area and distribution of resources. It is the resources that dictate the availability of services, which depends upon healthcare systems and healthcare policies. As a consequence, this can adversely affect different ethnic and cultural groups depending on their geographical location. Although global mental health programmes suggest efforts and policies to standardise the quality of mental health interventions worldwide, in reality it is difficult to achieve because resources and healthcare systems will dictate what is done. Psychotherapy, too, is much more distinct, and application of standards that apply to healthcare in general may not be appropriate for psychotherapy. However, if we attempt to do so, the aforementioned domains of structure, process and outcome measures should be subject to accreditation, accountability and standardisation [21]. Practically this should involve:

- Improving infrastructure by the allocation of more resources (i.e. adequate staffing, training, knowledge, equipment).
- Assessing the efficacy of the processes in place and whether they are adherent to evidence-based guidelines.
- Assessment of outcome measures; i.e. whether the intervention improves functioning, symptoms, recovery. This can be measured by self-assessment or clinician-rated questionnaires for a variety of domains, for example PHQ-9 score for depression [21].

Application of the Donabedian framework to psychotherapy enables us to see more clearly key ways in which quality can be measured by domain. Later in the chapter we will discuss how these measures are applicable to intercultural psychotherapies. A brief summary of the quality measures, methods and sources is summarised in Table 3.1.

There are several advantages and disadvantages to measuring the quality of psychotherapy in the above described ways. Assessing structural quality measures (for example via audit) can be useful for clinical governance and advancing current practice, but is likely to be time consuming and with a high burden of workload. Furthermore, changing structural measures do not implicitly change the process or the outcome of therapy. Assessing process measures, such as contemporaneous documentation of evidence-based therapy in the process notes or assessing frequency of therapist contact, can be less time consuming and allow the data to be used in quality improvement projects or in therapist supervision. This however has the potential to become more of a "tick box" exercise and may not be able to inform

Table 3.1 Strategies to measure the quality of psychotherapy (After Brown et al. [22])

Type of measure	Measure concept	Data sources
Structural	Ability to deliver evidence-based psychotherapeutic interventions and measure outcomes (e.g. are there enough staff trained in evidence-based psychotherapy)	– Therapist notes – Audit (including of patient/therapist, standards of supervision sessions)
Process	Access/frequency of contact	Self-report
	Documentation of evidence-based intervention in therapy record	Medical/therapy records
	Patient and therapist-reported content of psychotherapeutic intervention	Surveys/questionnaires
Outcome	Outcomes reported by patients, family members etc.	Variation across providers; ideally standardised tools assessing improvement in functioning and reduction in symptom severity

positive correlation between the correct process and improved outcomes. More detailed methods of assessing the quality of process measures (such as the use of surveys to report on content, as noted in the Table 3.1) can build on existing therapies and assessments by patients reporting what parts of the intervention they find most helpful. However, this is difficult to control for bias or objectivity. Outcome measures, such as those reported by the patient and family members, allow a greater flexibility in approach and allow patients to discuss outcomes that are of the most importance to them. This, however, is difficult to standardise and compare across populations, as well as being highly work-intensive.

Other ways to measure standards in psychotherapy have been identified, such as "treatment fidelity" or "treatment integrity [23]." These interchangeable terms are used as a measure of how well the treatment was delivered as originally intended. This can be calibrated by a number of means:

Adherence: Whether or not the psychotherapeutic interventions were appropriate to treat the identifiable problem,

Competence: Whether or not the chosen interventions were delivered successfully and to a high standard,

Treatment differentiation: Whether or not the treatment delivered interventions were part of the intended treatment model,

Alliance: The bond: affective connection between patient and therapist, and task: agreement on the progress, activities and outcome of the sessions,

Patient involvement: Patient level of affective, behavioural and cognitive involvement in therapy sessions [23–26].

The quality of therapeutic interventions may also be ascertained by assessing therapist competence, however, care must be taken to effectively measure quality of psychotherapy and distinguish it from therapist competence. Therapist competence involves assessing the therapist's capacity to provide expected treatment to a high standard [23]. In practice, this can be assessed by measuring several domains:

Therapist knowledge:	This involves direct assessment of the therapist's understanding of a particular treatment and its uses. This can assess both knowledge of the process of treatment, but also the therapist's understanding of related domains such as adverse effects of treatment, pharmacology, and understanding of appropriate duration of treatment [23]. The value of evidence-based therapy (EBT) in mental health has been established [27].
Measure of skill at implementing a treatment:	i.e. the ability to apply their knowledge to clinical practice. This can be assessed by:

- Evaluation of patient outcome: Patient-led feedback.
- Evaluation of treatment sessions: A more standardised, widely used method of assessment, which involves an external assessor to observe therapy sessions (either in person or by audio/visual recording) and evaluate the therapy quality based on several key domains. In the field of CBT for example, this is widely practised using the Cognitive Therapy Scale (revised version—or CTS-R), which measures areas such as agenda setting, feedback, collaboration and application of change methods [28].
- Evaluation of standardised role-plays: For example, "OSCE" type scenarios [23].

There is a scarcity of data on the practical applications of quality measures to intercultural psychotherapy in particular, although many recommendations have been made. Using the Donabedian framework again, we can formulate methods of measuring standards in intercultural psychotherapy in general, and later apply the same framework to specific therapies, for example CBT and family therapy.

Application of Standards to Intercultural Therapy

Structure of Intercultural Psychotherapy

Here we focus on the ability of the therapist to deliver culturally sensitive and evidence-based psychotherapy. As mentioned above, this can be assessed by measuring a therapist's "cultural competence." In 1998, Sue suggested measurement of three domains to assess a therapist's cultural competence: Scientific mindedness, proficiency in dynamic sizing and culture-specific expertise [29]. Being "scientifically minded" means that the therapists act in accordance with the scientific method, i.e. forming hypotheses testing them, and basing practice on acquired data. With reference to intercultural practices, this is relevant because of errors which may

occur when assumptions are made based on one culture and erroneously applied to patients from another culture [29]. For example, a patient may report hearing the voice of God to their therapist. A therapist lacking in "scientific mindedness" may presume this to represent a psychotic or abnormal experience, but application of hypothesis testing may allow a therapist to uncover that this can be a culturally normal experience and carry great significance for those who experience it. Culture can also affect the experience of true hallucinations, with the content and frequency varying greatly between different cultures [30]. Cultural paranoia, where ethnic minorities (notably African-Americans) may experience mistrust and paranoia towards white therapists may also be non-pathological, and can be a maladaptive way of coping with experiences of racism and discrimination [30, 31]. Secondly, dynamic sizing is described as the ability of therapists to differentiate between individual traits and cultural traits. The culturally competent therapist should be able to use dynamic sizing in order to appreciate the influences of a culture without stereotyping [32]. Therapists may not be consciously aware of these stereotypes as part of their belief system, but nevertheless they may still be present [29]. Lastly, culture-specific expertise describes effectiveness at translating culturally specific knowledge into effective treatments. Practically this involves specific knowledge of the cultural groups with whom they are working, and possession of culture-specific skills in order to make effective interventions, allowing therapists to avoid confounding the cultural values of the patient with the values of the patient's ethnic group [29, 33]. These factors together have been used to form the "Cultural Competence Self-Evaluation Form," as seen in Table 3.2.

Process of Intercultural Psychotherapy

The progress of therapy sessions, and assessing whether individuals receive care or treatment that has evidence of improved outcomes is an important aspect of ascertaining therapeutic outcomes. In the first instance, the therapist and patient must be aligned with which issues to address and what the end goals should be. What the patient and therapist consider the goal of therapy may be different, and these differences may be based on cultural values or norms. Failure to meet some common ground regarding treatment plans and outcomes may prevent any chance of successful therapy from even being initiated [35]. If goals are successfully established and therapy is initiated, process measures can then be assessed by questionnaires and patient interview, as in other types of psychotherapy. With regard to intercultural practices, best practice dictates questionnaires and patient assessments should be conducted using two sets of cultural norms; those of the patient and the therapist. For example, conducting psychometric testing in a standardised, English-language version could be supplemented by separately testing in the patient's native language [9, 35], although one must be wary of category fallacy when translating psychometric tests from English to native languages. Furthermore, the process of using psychotherapy in order to elicit behavioural change may need to be adapted to the patient's cultural belief system. This should be achieved by assessment of each

Table 3.2 Cultural Competence Self-Evaluation Form (CCSE) [34]

Please Select Your Client's Ethnocultural Group:_____
(Then rate yourself on the following items of this scale to determine your "competence")

VERY TRUE OF ME 4	TRUE OF ME 3	SOMEWHAT TRUE OF ME 2	NOT TRUE OF ME 1	UNSURE ABOUT ME U

1. _____ Knowledge of group's history
2. _____ Knowledge of group's family structures, gender roles, dynamics
3. _____ Knowledge of group's response to illness (i.e., awareness, biases)
4. _____ Knowledge of help-seeking behavior patterns of group
5. _____ Ability to evaluate your view and group view of illness
6. _____ Ability to feel empathy and understanding toward group
7. _____ Ability to develop a culturally responsive treatment program
8. _____ Ability to understand group's compliance with treatment
9. _____ Ability to develop culturally responsive prevention program for group
10. _____ Knowledge of group's "culture-specific" disorders
11. _____ Knowledge of group's explanatory models of illness
12. _____ Knowledge of group's indigenous healing methods and traditions
13. _____ Knowledge of group's indigenous healers and their contact ease
14. _____ Knowledge of communication patterns and styles (e.g., non-verbal)
15. _____ Knowledge of group's language
16. _____ Knowledge of group's ethnic identification and acculturation situation
17. _____ Knowledge of how one's own health practices are rooted in culture
18. _____ Knowledge of impact of group's religious beliefs on health and illness
19. _____ Desire to learn group's culture
20. _____ Desire to travel to group's national location, neighborhood

TOTAL SCORE:_____ 80–65 = Competent; 65–40 = Near Competent; 40 Below = Incompetent

TOTAL # of U's: _____ (If this number is above 8, more self-reflection is need)

Your Age: _____ Your Gender: _____ Your Religion: _____ Your Ethnicity _____

patient and whether the model of chosen treatment is compatible with the patient's worldview and understanding of their own behaviour [8, 35]. Standards regarding the setting of therapy sessions and the intercultural effect are scarce, although some observations and recommendations have been made [36, 37].

Outcomes of Intercultural Psychotherapy

Outcome measures again can be assessed through the use of patient and therapist-rated questionnaires and feedback. However, when therapy sessions are culturally adapted, feedback may not be helpful in revealing which aspects, if any, of the intercultural adaptation were in fact useful. Strategies to study the evidence base of these interventions have been proposed through various means, including application of a standard intervention to a cultural group without cultural modifications to learn which elements are most useful, examining specific interventions from a cultural competence perspective and studying a group when these interventions are applied [38]. This may require altering of the entire framework of mental health services. An integrated approach, encompassing cultural competence, patient and therapist feedback and making adaptations to therapeutic practices has been described by the formative method for adapting psychotherapy (FMAP). Using a Chinese American population, this method involved gathering ideas about different aspects of cultural adaptation that could be implemented, integrating them into the standard CBT format, conducting bilingual focus groups, integrating the suggestions into the CBT manual and testing them at multiple time-points [39]. This integrated approach could be a useful tool for standard setting in intercultural practices.

Application of Standards to Specific Therapies

As we discussed earlier, the three main types of psychotherapy have been described as supportive, re-educative and constructive. Bearing in mind the standards we have discussed, we must now look at how these standards can be applied to specific therapy modalities.

Supportive Psychotherapy

A therapist offering supportive therapy in an intercultural setting must apply their cultural competence in order to adequately provide support in this type of therapy. Therapists must be aware of the cultural expectations for what they are expected to do by their patients can vary, and therapists may find themselves taking on other roles such as providing social support if this is required [8]. Specific methods of applying cultural competence to supportive psychotherapy have been described in the literature, such as developing mutually agreed upon goals, maintaining patients' vital defences, communication of a hopeful attitude towards treatment outcomes, recognising patient progress and engage in a mutual search for understanding of the patients' maladaptive relationships [40, 41]. However, additional types of therapies such as marital or couple therapy may be often needed [8], and it can be difficult to apply standards to this melting pot of therapeutic practices.

Re-educative Psychotherapy

Cognitive Behavioural Therapy

Amongst behavioural therapies, cognitive behavioural therapy (CBT) has considerable popularity and has often been adapted to different cultural groups [42–44]. There is some research evidence to indicate that culturally adapted CBT is more effective than standard therapy [45]. The general aim of CBT is to identify negative cognitions, which can be both a cause of and perpetuating factor of a psychiatric illness, and to develop strategies to deal with the negative emotions surrounding these cognitions. Culture can affect our cognitions and the manifestation of distress surrounding them, for example depression manifesting as shame rather than guilt in certain cultures [8]. The ecological validity model, a proposed model to guide intercultural treatments, has been adapted to different types of therapy, including CBT [46]. It consists of numerous dimensions, including language, concepts, goals and context. The model can be integrated in various ways. For example, the patients' explanatory model, which refers to the patients' understanding about their perception and explanation of what caused their illness, what are the expressions and also what they see as curing these symptoms of distress must be explored. This can widely differ across cultures but also in response to educational and socio-economic status. Interventions in culturally adapted CBT should ideally involve targeting and potentially modifying the patient's model of their illness. Other elements of their illness behaviour should be targeted in a culturally sensitive manner, such as exploration of CBT techniques, targeting of certain types and exploring different cultural stigmas. For example, in certain cultures psychopathology may be expressed mainly through somatic symptoms that may be of particular significance depending on the cultural context. Exploration of CBT techniques can be adapted using expressions and terms that are more culturally familiar to a patient, for example using proverbs to help express principles. Methods of relieving distress from negative cognitions can be adapted for different cultures, for example a Christian patient reading a passage from the Bible. For more detail see Hinton and Patel [47].

Psychodynamic Psychotherapy

The aim of psychodynamic psychotherapy is to build understanding and insight of one's thoughts, feelings and behaviours, and the influence of past experiences in current functioning. Standards in intercultural psychodynamic therapy are scarce, but some observations have been made on problems to be aware of, such as transference between ethnically similar patients and therapists [48].

Constructive Psychotherapy

Family Therapy/Couple Therapy

Application of the cultural competence model should be included in the curriculum and training programs of all therapists but perhaps more so in the case of family and

couple therapists, as the concept of family is varied across different cultures, for example nuclear family vs. extended or joint family. Knowledge of these cultural variations can be assessed using peer supervision and continued professional education [49]. Therapists should also be mindful of what behaviours may be considered culturally rooted, and what behaviours may be manifestations of problems within that relationship, while avoiding attributing all of the problems experienced based on the patients' race or cultural heritage [49, 50]. Family therapy should ideally follow some of the same principles, with specific sensitivities paid to the following elements:

- Level of acculturation, identity and lifestyle preferences.
- Family migration history.
- Levels of trauma and loss related to relocation.
- Family work/financial stressors.
- Language preferences.
- Specific family protective factors [51].

The use of the aforementioned ecological model has also been demonstrated to be effective in parent-child therapy, with high levels of parental satisfaction and reduced parental stress noted in one study [52].

Challenges in Using Standards in Therapy: A Critique

Measuring quality of care in mental health has its own challenges and often falls short of expected standards. When compared to a general medical population, quality of care in mental health unfortunately falls short, and improvements over time are slower [53]. With regard to psychotherapy, measuring quality of care must be a consideration of how well different types of psychotherapy achieve their respective aims; aims that were discussed above, such as reorganisation of behavioural patterns, improved self-esteem and higher quality of interpersonal relationships. These domains can be difficult to measure empirically, considering the highly subjective nature of these measurable domains. A report by the faculty of medical psychotherapy of the Royal College of Psychiatrists in 2016 identified several standards for outcome measures in the context of medical psychotherapy, such as ease of use, relevance to patients, reliability of data and immediate feedback of data to influence ongoing treatment [54]. Recommendations were made to receive data based on four outcome measures: Clinical Outcomes in Routine Evaluation (CORE-OM), Inventory of Interpersonal Problems (IIP), Work and Social Adjustment Scale (WSAS) and the Patient-experience questionnaire, and for these to be administered in the pre and post-treatment phase in order to measure change [54]. These questionnaires measure a variety of personal characteristics, not limited to: distress arising from interpersonal difficulties, leisure activities, patient wellbeing and level of functioning. Evidence for the reliability of these questionnaires for measuring outcomes is generally good [55–58], however it must be noted that these questionnaires are all either

self or clinician rated. The "Self-assessment bias," where workers in a number of professions overestimate their ability compared with peers, has been known for decades [59, 60], and this effect has been noted in therapists, with reports showing over-estimation of therapists own abilities when compared to peers [60, 61]. This has a number of implications on the practice of good quality psychotherapy; for example, a less competent therapist may continue with the same methods without being aware of a need to improve their standards [61]. It also questions the entire means of measuring quality outcomes in psychotherapy. Patient's views of their own health have been shown to be dynamic, changeable and subject to a variety of health and social factors [62], further questioning the validity of questionnaires as a reliable measure of assessing outcomes. Another problem with objectively measuring the quality of psychotherapeutic interventions is that often the outcome measures do not look at the content of the interventions, only if improvements were seen. For example, a therapeutic intervention might be measured as having a favourable outcome if adherence to treatment was high, without taking into consideration the possibility that the intervention delivered was of low quality by a less competent therapist. This makes it difficult to objectively standardise quality of psychotherapeutic interventions [23, 27]. Clinical variables around therapist competence are sensitive to change. For example, it has been suggested that regular supervision, or additional post-graduate qualifications, may improve clinicians' self-awareness of their abilities, and therefore be in a better position to make effective interventions [60].

Conclusions and Way Forward

To conclude, intercultural psychotherapy is increasingly practised and has been demonstrated to bridge a better understanding between therapists and patients (and, when relevant, interpreters) to help with the recovery process. There are a myriad of studies and recommendations for various intercultural practices, but little in the way of objective, standardised guidelines. Often different intercultural practices and principles are adapted for use in therapies like CBT, and some studies have shown effectiveness from this method. In practice however, this is difficult to standardise and assess quality based on the domains of structure, process and outcomes. Some recommendations could include standardisation of training of intercultural practices, including adaptation of intercultural teaching into curricula. Focused peer supervision has also been suggested to improve intercultural competency and therapists' awareness of their own limitations. Self-assessment of therapists' culture-specific knowledge (as illustrated by the cultural competence self-assessment form) can further question underlying assumptions and improve approach to treatments. Widespread distribution of questionnaires/assessment forms in the native language of patients may make the process of therapy more standardised. Further research into the location of therapy sessions and how this affects patients' engagement with treatment would be a very useful development, as studies that have already been conducted offer interesting insight into how these variables can affect client opinions. More widespread research into the cultural sensitivity of different targets and

outcomes of therapy may prevent disengagement and establish longer lasting, more meaningful therapeutic relationships. Finally, design of more detailed patient and therapist feedback questionnaires (with particular reference to the specific interventions performed) may reduce subjectivity and increase validity of the results.

Talking therapies can be generally efficacious across cultures, and therapists should be aware of the myriad of cultural and interpersonal influences on their practices and patient interactions. Awareness and exploration of these key issues in a sensitive manner can only expedite the recovery process.

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Using the Cultural Formulation Interview in Intercultural Psychotherapy

4

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This chapter discusses potential uses of the DSM-5 Cultural Formulation Interview (CFI) within intercultural psychotherapy. We present this chapter in three sections: (1) challenges that may emerge within the cross-cultural therapeutic encounter, (2) recommendations that have been offered to overcome such challenges, and (3) the extent to which the clinician's application of the CFI responds to such recommendations. Our goal is not to provide an overview of the CFI or its general pertinence to psychotherapy, which we have provided elsewhere [1, 2]. Instead, we situate this work within the scholarship on intercultural psychotherapy for practitioners trained in this orientation. We restrict ourselves to a critical review of English-language articles, while acknowledging that intercultural psychotherapy has elicited scholarship in multiple languages.

The Challenges of Intercultural Psychotherapy

We begin with an overview of intercultural psychotherapy. In a seminal article from over four decades ago, Jing Hsu and Wen-Shing Tseng define intercultural psychotherapy as "psychotherapy in which the therapist and the patient have different cultural backgrounds so that interaction of the cultural components is involved in

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addition to the ordinary process of psychotherapy" ([3], p. 700). Although they do not define culture, they view it as an individualised process of meaning-making rather than a set of "dos and don'ts" for social groups convened around demographic characteristics such as race, religion, ethnicity, language, or country of origin: "Every person has his own unique cultural background, associated with his own personal experience, family situation, and social environment, which constantly affects the process of ordinary psychotherapy" ([3], p. 700). Hsu and Tseng list critical factors that reflect the influence of culture during psychotherapy, which are presented in Table 4.1.

Apart from transference and countertransference, the factors in Table 4.1 refer to the effect of culture on the ideational aspects of psychotherapy, i.e. the process of cognition-based information exchange between patients and clinicians. This exchange includes delineating the boundaries between normal and abnormal behaviours for diagnostic purposes, clarifying the patient's communication styles, negotiating treatment goals, and integrating cultural information throughout all aspects of care. Over time, other therapists have identified culture's influence on the emotional aspects of psychotherapy. For example, cultural differences can catalyse countertransferential reactions by preventing the clinician from understanding the patient's internal frame of reference, exhibiting non-judgmental respect, and participating within the relationship in a fully engaged manner [4]. Patients may also stop the therapeutic relationship from deepening or by resisting the clinician's interpretations if they perceive that the clinician does not understand them [5]. Indeed, transferential and counter-transferential reactions can span a whole range of emotions—even when patients and clinicians share similar cultural

Table 4.1 The influence of culture within intercultural psychotherapy

Factor	Quotation from Hsu and Tseng [3]
Diagnosis	"Sociocultural deviance is situationally determined and is relative to the norms of a given community. Therefore, it should be considered and judged within the context in which the behavior occurs" (p. 701)
Social supports and stressors	"The therapist should make an effort to obtain knowledge not only about the norms and value system of the patient's cultural environment, but also the usual stresses members of his culture must meet" (p. 702)
Transference and countertransference	"The issue of therapist-patient relationships should be carefully watched and handled in the situation of intercultural psychotherapy" (p. 702)
Communication	"The best language and concepts to be used are those familiar to the patient so he can receive the explanation with ease and will find it meaningful" (p. 702)
Goals of treatment	"The therapist should be free to talk with his patient and to ask his cooperation in searching together for the most suitable way for the patient to cope with his problems" (p. 703)
Formulation	"It is appropriate and useful to make a cultural evaluation of the patient as part of the total evaluation for diagnosis and treatment planning" (p. 704)

backgrounds—such as overfriendliness, irrelevant interest in cultural differences, denial of such differences, ambivalence about the relationship, and sometimes outright hostility [6].

In fact, cultural psychiatrists have pointed out how culture constructs fundamental forms of knowledge and practice that are too often taken for granted in psychotherapy. Culture shapes the sociolinguistic codes through which patients decide which circumstances are acceptable—when, where, how, for what purposes, and to whom—for narrating their experiences of wellness and distress [7]. For instance, secular Euro-American models of talk therapy assume that all individuals act to advance self-interest and feel comfortable with articulating their psychological conflicts, which people from collectivistic backgrounds or unaccustomed to speaking with strangers may not share [8]. Through models of health and illness that are exchanged with families and friends, culture moulds patient perceptions of acceptable treatments such as which modalities are judged to be helpful, which costs or side effects are worth risking, and how long treatment should last [9]. Finally, culture constrains the knowledge and practice through which clinicians interpret patient narratives, such as a clinical formulation based on psychodynamic or cognitive-behavioural models of the mind [10]. This perspective affirms Hsu and Tseng's assertion that all clinicians must customise psychotherapies based on the unique cultural characteristics of individual patients.

Recommendations to Overcome Clinical Barriers in Intercultural Psychiatry

In the 1970s and 1980s, clinicians created guidelines for specific racial and ethnic groups and encouraged patients and clinicians to be matched accordingly, in response to the US civil rights movement and immigration reforms; by the 1990s, a new generation of clinicians began to offer practice recommendations for intercultural psychotherapists irrespective of whether the patients or clinicians belonged to a particular race or ethnicity [11]. Table 4.2 lists recommended practices which have achieved widespread acceptance.

In addition, intercultural psychotherapists have recommended an ethnographic approach to conducting interviews. For example, Karen Seeley has identified anthropological variables such as "selfhood, human development, cognition, emotion, language, and relationship as culturally shaped and as cross-culturally variable" which can be helpful to explore ([13], p. 123). She calls on psychotherapists to act as clinical ethnographers in their therapeutic work: "Clinically adapted ethnographic inquiry provides psychotherapists with tools for exploring the indigenous categories and conceptions of mind, self, relationship, and disorder that structure their clients' experiences. By doing so it offers clear alternatives not only to treatment approaches based on cultural knowledge, but also the presumptive Western notions of disorder that are embedded in standard therapeutic procedures and diagnostic categories" ([13], p. 124). To clinical ethnography, Adil Qureshi adds clinical hermeneutics which assumes that patients and clinicians jointly construct clinical

Table 4.2 Recommendations for successful intercultural psychotherapy

Area to address	Recommendation (adapted from references [11, 12])
The setting of the patient	Therapists must pay attention to people's common behaviour patterns, beliefs, customs, and daily practices
Patient expectations	Therapists should explain the purpose of specific therapeutic techniques (i.e., free association, interpretation, paradoxical suggestions) for patients to observe during treatment
The relationship model	Therapists should understand a patient's cultural views of authority and how this informs expectations of an exploratory or directive relationship
Communication	Therapists should pay attention to the content, grammatical sophistication, and focus of patient communication
Theories of psychopathology	Therapists should learn from the patient about his or her cultural views on the nature of the distress or illness since it would be impossible for clinicians to possess full knowledge about all cultural systems
Countertransference and interviewing approaches	Clinicians should develop skills in learning how to discuss their own and their patient's cultural backgrounds, ideally concentrating on cultural similarities first before discussing differences

meanings: "Rather than simply consisting of an exchange of information, the relationship and interaction between the participants is key in the interpretive process. The disposition of the participants towards each other impacts not only the manner in which information will be received but also affects the way it is sent" ([14], p. 121). He rejects the idea that clinical meanings are singly produced either by patients or clinicians: "The client's 'reality' is not independent and transcendent; rather, it is affected by the preoccupations of the client and the interaction with the counselor, precisely because selfhood is understood to be constituted dialogically" ([14], p. 124). From this perspective, clinicians who follow broad recommendations for patients based on group-level demographic traits such as race, ethnicity, or religion violate a critical principle of co-constructing meaning: "Prescriptions for multicultural therapeutic work are problematic. Privileging a particular method as *the* means for effective therapy implies that one can know a client in advance; it ignores our socio-historical situatedness and dialogical interaction" ([14], pp. 125–126). Recommendations for clinical ethnography and hermeneutics also have an independent lineage within cultural psychiatry and psychiatric anthropology, as this quote from Byron Good and colleagues exemplifies: "A hermeneutic analysis of clinical phenomena focuses attention on the role of deeply embedded personal texts in the interpretive process. Interpretation is not limited to the cognitive manipulation of clinical models, because the symbols, models and images of an individual's therapeutic discourse have deeply rooted and unexamined personal meanings and are associated with powerful affects" ([15], p. 283). One pivotal insight unites these disparate authors: clinicians must work with culture to uncover how patients interpret themselves, their experiences, and the world around them. As noted earlier, this jointly developed interpretation should evoke both cognitions and affects to enable the desired behaviour change.

The DSM-5 Cultural Formulation Interview and Intercultural Psychotherapy

We believe that the CFI responds to many recommendations from intercultural psychotherapists. The CFI refers to a collection of three types of semi-structured interviews that facilitate a pragmatic cultural assessment, either by interviewing patients or their close associates such as family or friends. These three types of interviews are: a 16-item questionnaire that is increasingly becoming known as the "core" standard within the CFI practice community; a CFI-Informant Version for obtaining collateral information from caregivers; and 12 supplementary modules to inquire about topics introduced in the core CFI and to assess specific populations (e.g., immigrants and refugees).

The DSM-5 Cross-Cultural Issues Subgroup followed a rigorous methodology in developing the CFI from the DSM-IV Outline for Cultural Formulation by: (1) conducting a comprehensive literature review of 140 publications in seven languages, (2) field testing a preliminary version of the core CFI with 321 patients, 75 clinicians, and 86 family members in six countries, and (3) revising this preliminary version to form the final version included in DSM-5 based on patient, clinician, and family member feedback [16]. This design responds to calls within the literature on developing psychosocial (i.e., talk-based) interventions that need clinical trials to test mechanisms of action [17] but must also enroll patients from diverse diagnostic [18] and demographic backgrounds [19] for broad applicability. For several months in 2011 and again in 2012, a draft of the CFI was also posted on the DSM-5 website of the American Psychiatric Association (APA) to elicit comments from the public in recognition that cultural assessments have sparked interest among multiple stakeholders such as patients, clinicians, and clinic administrators [20].

The field trial utilised a variety of qualitative and quantitative measures with patients, clinicians, and family members to understand the CFI's effects on the therapeutic relationship at the process level. Qualitative research can help to develop culturally competent, evidence-based practices by recognising that study participants are experts on their lives and experiences, allowing researchers to isolate variables of interest [21]. For example, we learned through qualitative debriefing interviews after CFI sessions that patients regarded the CFI as improving clinical rapport through open-ended, person-centred, and non-judgmental questions whereas clinicians valued the CFI's elicitation of patient perspectives on illness and treatment [22].

The CFI has been designed for use with any patient in any mental health setting. It may improve the therapeutic alliance and the case formulation if it is used as intended during the initial session with new patients before proceeding to a diagnostic interview [23], regardless of the psychotherapist's training in a theoretical orientation. On average, the CFI takes about 20 min to complete [16]. Hence, a clinician could set the therapeutic frame using a culturally informed approach. However, DSM-5 specifies that the CFI may be helpful at any point in the treatment, not just during the initial session. Use of the CFI may be most needed when there is difficulty in assessment owing to differences in the cultural, religious, or socioeconomic backgrounds of the clinician and patient; when there is uncertainty about the fit between culturally distinctive symptoms and official diagnostic criteria; when it is

difficult to judge illness severity or impairment; when patients and clinicians disagree on treatment planning; or in instances when patients do not adhere to treatments or attend appointments [23].

The Core and Informant versions of the CFI include instructions to clinicians on the left side and question on the right so that clinicians know what kind of information is sought and how it can be clinically used. The CFI-Informant Version can be used when collateral information is needed or when the patient cannot participate in care, as with young children or individuals with cognitive impairments due to dementia, substance intoxication, or florid psychosis. In addition, there are two types of supplementary modules: (1) those that expand on sections of the core CFI and (2) those that address the cultural needs of particular populations. The CFI supplementary modules that expand on sections of the core CFI are those on the explanatory model; level of functioning; social network; psychosocial stressors; spirituality, religion, and moral traditions; cultural identity; coping and help-seeking; and the patient–clinician relationship. CFI supplementary modules for specific populations address school-age children and adolescents; older adults; immigrants and refugees; and caregivers. Psychotherapists have recognised the need to adapt evidence-based tools and interventions to the unique cultural needs and preferences of patients [24]. The semi-structured nature of these interviews and the diversity of topics furnish clinicians with interviews that can be customised according to clinical exigencies.

Given the growing interest in the CFI, the APA has posted the CFI for free on its website. All of the interviews can be found at the following weblink which can be copied and pasted into any Internet browser: https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0ahUKEwi2_tnmxf3OAhWGKx4KHfIkB0YQFggcMAA&url=https%3A%2F%2Fwww.psychiatry.org%2FFile%2520Library%2FPsychiatrists%2FPractice%2FDSM%2FAPA_DSM5_Cultural-Formulation-Interview.pdf&usg=AFQjCNELEKr7I88QBl0En0mVxKIE5OLGbg&sig2=R-WOpqHH400rELTxCyWmJw&bvm=bv.131783435,d.dmo.

Video illustrations of the CFI are available free of charge through the APA via the website: https://www.appi.org/Lewis-Fernandez. The illustrations show clinicians using the core CFI in various clinical settings and the supplementary modules on level of functioning; spirituality, religion, and moral traditions; and older adults. An online training module on the core CFI is also available via www.nyculturalcompetence.org or by emailing cpihelp@nyspi.columbia.edu.

The rest of the chapter discusses how the core CFI responds to the recommendations of intercultural psychotherapists. We anchor this chapter to the core CFI since all of the interviews are based on its structure. The core CFI is comprised of four domains. The first is known as the Cultural Definition of the Problem and has three questions. Question #1 is “What brings you here today?” If patients provide little detail or only mention biomedical information, the follow-up probe question is: “People often understand their problems in their own way, which may be similar to or different from how doctors describe the problem. How would you describe your problem?” Question #2 is “Sometimes people have different ways of describing their problem to their family, friends, or others in their community. How would you describe your problem to them?” This question operationalises the recommendation

in Table 4.1 that clinicians should endeavour to understand how cultural systems of knowledge and concepts are learned and transmitted in social groups. Tables 4.1 and 4.2 note that clinicians should communicate with language that is familiar to patients, and this question asks patients directly about how patients frame their problem linguistically. Question #3 is "What troubles you most about your problem?" Table 4.1 encourages clinicians to judge sociocultural deviance relative to the norms of a given community, and this question helps clinicians appreciate the problem's impact on quality of life and level of functioning. Table 4.2 notes that therapists should pay attention to the behaviour patterns, beliefs, customs, and daily practices of patients, and the questions in this first domain start to uncover the patient's perspective without presuming any prior fluency in biomedical concepts or vocabularies.

Questions #4–10 belong to the second domain known as Cultural Perceptions of Cause, Context, and Support. Questions #4–7 elicit the patient's illness explanatory model on causes, social stressors, and social supports, a topic of abiding interest to cultural psychiatrists for privileging the patient's understanding of health and illness [25]. Table 4.1 also notes that psychotherapists benefit from understanding patient theories of psychopathology. To that end, the rest of the CFI encourages clinicians to use the patient's linguistic description of the illness wherever the placeholder "[PROBLEM]" appears. Question #4 is "Why do you think this is happening to you? What do you think are the causes of your [PROBLEM]?" To encourage a fuller expression of patient narratives, a follow-up to this question for clinicians is: "Some people may explain their problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes." Question #5 expands this question to include close associates as a way of recognising that culture is transacted within social groups: "What do others in your family, your friends, or others in your community think is causing your [PROBLEM]?" Table 4.1 notes that clinicians should inquire about each patient's culturally unique forms of social stressors and supports; questions #6 and #7 pursue these tasks. Question #6 is "Are there any kinds of support that make your [PROBLEM] better, such as support from family, friends, or others?" Question #7 is "Are there any kinds of stresses that make your [PROBLEM] worse, such as difficulties with money, or family problems?"

After the patient's illness explanatory model has been elicited, the discussion turns to cultural identity. An introduction to this section affirms the well-established tenet that all psychotherapy is inherently an intercultural exercise because every individual has a unique background. The introduction is: "Sometimes, aspects of people's background or identity can make their [PROBLEM] better or worse. By background or identity, I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, or your faith or religion." Question #8 asks the patient about background or identity: "For you, what are the most important aspects of your background or identity?" The goal of this question is to create a space for patients to self-select a cultural identity rather than for clinicians to assume an identity based on a group affiliation such as race or ethnicity without inquiring about its personal importance [26]. Question #9 asks the patient to reflect on how this identity relates to the current problem: "Are there any aspects of your background or identity that make a difference to your [PROBLEM]?" This question

helps clinicians with integrating cultural information through diagnostic and treatment planning. Finally, Question #10 asks patients to consider cultural factors that may not immediately seem pertinent, but that could nevertheless impact care, such as problems with migration, gender roles, or intergenerational conflict: "Are there any aspects of your background or identity that are causing other concerns or difficulties for you?"

The next three questions belong to the third domain, which is known as Cultural Factors Affecting Self-Coping and Past Help Seeking. The third and fourth domains address culturally based goals of treatment, as recommended in Table 4.1. Question #11 is "Sometimes people have various ways of dealing with problems like [PROBLEM]. What have you done on your own to cope with your [PROBLEM]?" Question #12 normalises the possibility that patients may have sought help outside of the biomedical system: "Often, people look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing have you sought for your [PROBLEM]?" To help patients identify successful modalities for the current illness episode, a probe question for #11 asks: "What types of help or treatment were most useful? Not useful?" Answers to this question may assist clinicians with creating treatment plans that incorporate previous forms of care that were helpful while avoiding those that were not. Question #13 asks about past barriers to treatment so that clinicians understand which resources could be mobilised in the present, ideally with the goal of tailoring treatment plans in a patient-centred way: "Has anything prevented you from getting the help you need?" A follow-up question lists examples of barriers: "For example, money, work or family commitments, stigma or discrimination, or lack of services that understand your language or background?"

The last three questions belong to the fourth domain, Cultural Factors Affecting Current Help Seeking. Question #14 asks the patient about current treatment preferences: "Now let's talk some more about the help you need. What kinds of help do you think would be most useful to you at this time for your [PROBLEM]?" Question #15 explores treatment preferences that may be expressed by close associates: "Are there other kinds of help that your family, friends, or other people have suggested would be helpful for you now?" As with Questions #2 and #5, this question explores the transmission of culturally related health information in social groups. Tables 4.1 and 4.2 caution clinicians to recognise cultural forms of transference and countertransference and to learn interviewing approaches to assess and discuss similarities and differences between patients' and clinicians' cultural backgrounds. Hence, Question #16 starts with an introduction: "Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations. Have you been concerned about this and is there anything that we can do to provide you with the care you need?" The introduction serves to normalise patient concerns around intercultural differences. Whether it is answered in the moment or deferred, the question signals to patients that the therapeutic encounter is a safe space to air differences. The question itself provides a template to clinicians for evoking reflection on intercultural differences and similarities.

Tables 4.1 and 4.2 note that psychotherapists should also attend to issues of countertransference. The core CFI does not address countertransference, but a

supplementary module on the patient–clinician relationship includes the following questions for clinicians to ask themselves after the interview.

1. How did you feel about your relationship with the patient? Did cultural similarities and differences influence your relationship? In what way?
2. What was the quality of communication with the patient? Did cultural similarities and differences influence your communication? In what way?
3. If you used an interpreter, how did the presence of an interpreter or his/her way of interpreting influence your relationship or your communication with the patient and the information you received?
4. How do the patient's cultural background or identity, life situation, and/or social context influence your understanding of his/her problem and your diagnostic assessment?
5. How do the patient's cultural background or identity, life situation, and/or social context influence your treatment plan or recommendations?
6. Did the clinical encounter confirm or call into question any of your prior ideas about the cultural background or identity of the patient? If so, in what way?
7. Are there aspects of your own identity that may influence your attitudes toward this patient?

These questions operationalise Qureshi's [14] attempt to foreground the dialogical nature of the therapeutic relationship. Question #1 of this supplementary module addresses the emotional connection between patients and clinicians, Questions #2 and #3 emphasise communication, and Questions #4–7 consider how the patient–clinician relationship affected the content of the session. These questions may help clinicians reflect on the cultural dynamics of transference and countertransference, whether they work in solo practice, multidisciplinary teams, or in academic settings where supervision of cases is possible.

We close this chapter with a discussion on the definitions of culture in DSM-5. DSM-5 offers a definition for culture in several locations. The introduction states: "Culture provides interpretive frameworks that shape the experience and expression of the symptoms, signs, and behaviors that are criteria for diagnosis. Culture is transmitted, revised, and recreated within the family and other social systems and institutions. Diagnostic assessment must therefore consider whether an individual's experiences, symptoms, and behaviors differ from sociocultural norms and lead to difficulties in adaptation in the cultures of origin and in specific social or familial contexts" ([23], p. 14). The DSM-5's introduction to the CFI states that culture refers to:

- The values, orientations, knowledge, and practices that individuals derive from membership in diverse social groups (e.g., ethnic groups, faith communities, occupational groups, veterans groups).
- Aspects of an individual's background, developmental experiences, and current social contexts that may affect his or her perspective, such as geographical origin, migration, language, religion, sexual orientation, or race/ethnicity.
- The influence of family, friends, and other community members (the individual's social network) on the individual's illness experience ([23], p. 751).

The DSM-5 Cross-Cultural Issues Subgroup based these definitions upon a review of the medical and psychological literature on cultural assessments from 1994 to 2011 that was conducted to inform revisions for DSM-5. Our goal has not been to dictate a definition, but to provide a common conceptual framework for clinicians from discrepant backgrounds and orientations. The DSM-5 definition is consistent with the description of culture in Hsu and Tseng [3] and other seminal intercultural psychotherapy writings that represent culture as an individualised and context-dependent process of meaning-making rather than a static characteristic of social groups. A person-centred, process-based definition such as the one that informs the CFI is more conducive to self-understanding and the negotiation of behaviour change in psychotherapy than a more static, group-based approach that is less sensitive to context and to individual variation. We hope that intercultural psychotherapists will engage with these concepts as the CFI disseminates, presenting clinicians with more opportunities to devise and revise cultural tools for improving clinical care.

Conclusion

Intercultural psychotherapists have described a series of challenges and recommendations for clinicians who emphasise the cross-cultural aspects of psychotherapy. The DSM-5 Cultural Formulation Interview is a systematic tool for case formulation that can help clinicians operationalise these recommendations into specific questions during clinical assessment and treatment implementation. The person-centred cultural information thus obtained may be used to guide treatment choice, negotiate psychotherapy goals, understand transference and countertransference reactions, and develop the therapeutic alliance. The CFI can serve as a useful standardised framework to fulfil the tasks of intercultural psychotherapy.

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5 The Significance of Intercultural Psychotherapy in Further Education and Professional Training

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Psychotherapy: Universal?

Ethnocentrism, especially in a time of globalisation, should be viewed not as an obvious, but rather as an implicit factor leading to problems in different health care services [1]. This is of particular importance for mental health, as demonstrated by the increasing criticism of overly-generalised conclusions made by psychopharmacology, for example, when recommendations are based on data from unclearly defined or overly specific ethnic and regionalised populations [2]. When teaching psychotherapy, even more care should be taken to avoid such generalisations when the patient has a different upbringing, family system, conflicts and expectations. This might appear obvious, but is still sorely lacking in daily healthcare training and practice in most countries.

In the finely crafted book "Mr. Muo's Travelling Couch", Dai Sijie describes a young Chinese man who comes into contact with psychoanalysis during a stay in Europe, but despairs in the effort to offer a mobile dream interpretation service in rural China [3]. Instead of attempting to apply unmodified psychotherapy models and training to all cultures, this author wishes to state the case for the development

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of new models of training, support and treatment which rise to the challenge of addressing the above-mentioned issues.

The growing importance of transcultural aspects can be seen in the newest version of the American Psychiatric Association's Diagnostic and Statistical Manual [4], which had previously been criticised as being too "medical" and not sensitive enough to cultural and psychological approaches. This reflects both an increasing awareness of this major aspect in public and mental health and the influence of a more interdisciplinary approach. Concepts like "cultural formulations" and "idioms of distress" must therefore become part of any mental health professional's training. The use of tools such as the "Cultural Formulation Interview" has already been demonstrated to at least generally increase the intercultural sensitivity of healthcare professionals [5]. The wealth of research on culture-based early bonding, child rearing and development, values, conflicts, illness experience and efficient strategies to support those afflicted by psychological symptoms in sociology and cultural anthropology can be expected to have a decisive impact on the development of not only transcultural psychotherapy and psychiatry, but also of a more globalised understanding of mental health. This requires that mental health care professions both attend to and apply this knowledge to re-evaluate and reshape therapy concepts and practice.

An additional challenge is represented by the fact that trained psychotherapists either do not exist or exist only in small numbers in majority of the countries. The limited resources available in most countries [6] and the frequent stigma attached to most aspects of mental health lead to the question of which direction the field and consequently the education of future psychotherapists should take. A careful reconsideration of the existing models taught in psychotherapy training and an adaptation to reflect the rapidly developing knowledge on diverse cultures should be expected from all organisations and institutions involved in this process. This specific situation creates challenges, but also new opportunities for the future of different psychotherapeutic models and "schools" in a globalised and interdisciplinary social and health care environment. As a consequence, some of the professional umbrella organisations, including the European Association for Psychotherapy, have published guidelines to draw attention to the professional and ethical aspects of this situation.[1]

In the following chapter we will give a short overview that will outline some of the most relevant issues that should consequently be considered for psychotherapy training curricula in regard to the treatment of migrants, refugees and ethnic minorities.

The History of Different Approaches in Psychotherapy: Open vs. "Closed" Models as a Background to Teaching

It should be kept in mind that most psychotherapeutic schools have developed in a very specific culture and can be expected to be implicit in the values, health belief models, social conflicts, politics and dynamic development of that culture. This will

[1] http://www.europsyche.org/contents/14809/eap-guidelines-psychotherapy-with-refugees, accessed 27.3.2018.

also be reflected when teaching the concepts developed in this context [7]. In this way, classical psychoanalysis was influenced by Sigmund Freud's turn of the century Vienna [8], while Aron Becks' model of "Cognitive Therapy" developed against the background of the 1960s in the USA [9], with transcultural influences that were more or less prominent depending on the context. The discussion of culture was highly eclectic and at times selected based on personal expectations in some schools as in the case of C.G. Jung's psychodynamic approach [10]. A psychotherapist or psychiatrist, most frequently a medical doctor, might, for example, have offered a diagnosis based on common theories, local health belief models and "idioms of distress" prevalent in Freud's time. This would have included symptoms of "hysteria"—caused in ancient medical teaching by a "moving" uterus—or "fainting" spells, that are rather rarely observed in present Europe or the USA today [8].

A varying degree of openness and self-reflection is found among psychotherapists in terms of their interaction with the rapid development of interdisciplinary research, especially in regard to transcultural issues and treatment settings [11].

The complex discourse of specific modalities on this issue, such as that of Freudian psychoanalysis, is beyond the scope of this chapter, but has been critically explored, for example, by Reichmayer in his book on the history of Ethnopsychoanalysis [12], and in a number of recent publications ([13], pp. 179–211). A number of authors such as Hinton have demonstrated that a specific psychotherapeutic approach, developed originally in one cultute, in this case cognitive behaviour therapy, can be newly adapted to address the specific needs of clients in widely differing cultures [14] if care is taken in preparation of such interventions [15]. The use of the aforementioned data from other professions, unbiased fieldwork, participant observation and qualitative methods, along with the reconsideration, translation, adaptation and revalidation of existing concepts and diagnostic instruments [16] is required to provide the basis for that task and should also be considered in the evaluation of the possible evidence base of treatment models and training [15]. An open, self-reflective, and interdisciplinary approach that deals critically with the culture-based assumptions and historical development of a specific psychotherapy model should consequently be part of all training programs [17].

Psychotherapy: A Universal "Profession"?

Given today's globalised situation, the following discussion should not focus on the context of high-economy countries alone. The availability and quality of psychotherapy varies greatly on a worldwide scale. While the practice of medicine follows accepted and usually strictly regulated frameworks in most countries, both psychotherapy practice and training present another picture entirely. Whilst in some contexts, psychotherapy training includes several years of personal therapy alongside in-depth learning and supervised practice, there are many contexts in which a person may hold the title of psychotherapist without having received training, or after having attended only a short programme without supervision or personal therapy.

Adequately trained psychotherapists are therefore unavailable in many countries, hampering the development of both training and practice [6], or are too stigmatised to be effectively integrated into effective public health services due to a general bias against mental health problems. Furthermore, due to limited or non-existent coverage by health insurance, the barrier to psychotherapy is very high in many countries. Consequently, if available at all, training is often expensive, must be funded privately and is unlikely to be repaid by later income, or else might be short and rudimentary as compared to many EU countries or the USA.

The development of psychotherapy training, therefore, requires not only the culture-sensitive adaptation of existing concepts, but also efficient strategies in providing affordable, culture-sensitive and relevant training in developing countries and treatment models that can be applied in crisis regions or even refugee camps, offering a responsible balance between the quality of treatment and the resources available. Such models have been developed by a number of groups, but require further evaluation [18]. The alternative, discussed later in this chapter, would be the use of more general psychosocial models such as the UN/WHO model (see below). Similarly, strategies are needed to increase the number of trained therapists from the cultures of migrants in host countries, including refugees with language fluency and the experience with culture of these groups, but who can rarely afford expensive training programs [19]. These groups may also play an important role in bringing adequate training and resources to their countries of origin and counterbalancing the 'brain drain' that is a common problem in many countries [20]. Finally, they can further provide critical input on the culturally sensitive adaptation of training and practice in the host countries.

Intercultural Aspects of the Training Setting

The risk of an uncritical acceptance of an assumption, such as that the teacher or trainer is "infallible", can be a collusion or reflect a "sacrosanct" psychotherapeutic school dogma, as described from personal experience by Samuel Shem (pseudonym) [21], and should therefore be avoided. The critical re-evaluation of concepts based on a deeper understanding of a large range of cultures with different values, problems and concepts in a globalised setting is therefore particularly important and challenges such untested but influential concepts. This can require a lifelong learning approach that also extends to trainers, especially in psychotherapeutic schools or training programmes where neither an evidence-based nor a culture-sensitive concept is firmly implemented in the general training and practice setting.

Further, the therapist-in-training, or even the trainer, could be a first- or second-generation migrant, and might be faced with a process of reconciling his or her cultural identity, health beliefs, biases, professional values and priorities with his or her own background. The conflicts, including transference or countertransference issues, between trainers and trainees might therefore differ from the established common patterns usually addressed in training programs. This issue has rarely been addressed in research and publications on psychotherapy training. Re-evaluation of

values and priorities including gender roles on the background of culture is another challenge. It should in our opinion be explored in a dynamic process that cannot be replaced by formal teaching or stereotypes. Internalised and transmitted traumas such as identification with social roles created in colonialism, for example in Africa or Latin America, can also be issues to be addressed [22].

Key Issues in Intercultural Therapy to Be Addressed in Training Programs for Work with Migrants and Refugees

When working with clients from a culture which is different from their own, psychotherapists might experience difficulties already when traditional psychotherapeutic approaches and mental health services fail due to differences in language or background culture; potentially, this can lead to a situation of mutual "culture shock" between client and therapist [23]. Such a situation can be both detrimental to the health of the client and distressing to the psychotherapist, due to their insufficient capacity to address, for example, the often traumatic experiences in refugees. Training should therefore prepare the psychotherapist adequately for these specific challenges.

Migrants and refugees, as individuals, as families or as groups, face continuous challenges to their identity, the need to cope with adverse events and changes, separation and discrimination, including difficulties with access to healthcare. Learning about the specific needs of these groups is an indispensable part of any training in transcultural mental health. Further, psychotherapists could, as noted previously, themselves be migrants or refugees operating in a diverse local or "host" culture.

The terms defining migrants, in the broadest possible sense, include legal, sociological, psychological and medical aspects that can create a wider range of highly diverse living environments, problems and solutions. In general, migration and forced migration in refugees frequently lead to different challenges (Table 5.1).

Specific Aspects of Psychotherapy with Migrants and Refugees

According to these different backgrounds, a number of factors that might be less prominent or common in other groups have to be considered. For the following short overview, we will group these key issues into different areas, many of which will also be covered in more detail in other chapters of this book.

Persecution, Traumatic Stress, Displacement and Insecurity

Traumatic stress is a common problem among refugees. For a trainee, it can be challenging to adequately understand and consider the impact of extreme life experiences such as torture, intense war exposure and severe persecution on the individual, family and transgenerational systems interacting with present stressors [24, 25], especially if the trainee comes from a relatively safe and stable environment. Trainees with a similar background, in contrast, need to recognise and seek special

Table 5.1 Differences: "free" migration, forced migration

	Migration	Forced migration
Preparation possible: learn language, prepare documents, get familiar with culture, build network	Yes	No
Contact with family easy and reliable	Yes	Often no
Visit to or by family members in case of emergency (such as illness, death) possible	In principle yes	Usually no
Return possible	In principle yes	Usually no
Loss of property	Rare	Frequent
Severely traumatic background	Less frequent	Common
Possible danger in host country	Usually not	Possible
Family reunion	Possible in principle	Frequently difficult or impossible
Break in life plan	Less frequent	Common
Open (unfulfilled) obligations	Common	Less frequent

support for their own primary or second generation trauma that must be dealt with in depth before client contact, and supported by professional supervision. Training, supervision, support and treatment models must be adapted to these increasingly important challenges. Student exchange programmes and internships in developing countries, (safe) post conflict zones, or refugee camps could be important components of training curricula.

Culture Specific Stressors and Help Seeking

Many migrants seek help because of conflicts which are common within a specific culture. For example, if a young woman marries and moves in with the husband's family, tensions frequently arise between the mother-in-law [26] and the young wife, and might lead to one of the parties seeking psychological help. Understanding the cultural aspects of relevant examples of such situations and discussing possible strategies for resolution should be explored during training.

Immediate Stressors

A multitude of current stressors usually exist in the lives of migrants and refugees, both common and specific, and these must be identified and seen as priorities, even compared to post-traumatic symptoms. Adaptation of the common treatment setting might be required in order to address these stressors, and this should be covered in special training modules. Common issues include separation and the insecure fate of family members, family conflicts, racism and hate crimes, alongside practical needs such as protection against forced return to a country where torture or death can be expected. In the last case, the client may require the psychotherapist to write a report to be used in asylum hearings, for example to confirm alleged persecution as an argument for protection, treatment needs or impaired psychological capacity. This would be based on standards such as the UN "Istanbul Protocol" [27], which should be provided and covered in psychotherapy training and continued professional development.

Countertransference, Burn-Out and Vicarious Trauma

These issues need special consideration due to the sometimes complex interaction between transcultural and trauma-related factors common in work with refugee populations. A psychotherapist must be prepared for the feeling of helplessness and countertransference problems [28, 29], such as feelings of omnipotence or being subjected to overwhelming obligation in this setting, while vicarious (or secondary) trauma is also a common problem. The importance of the issue should be made clear in any training programme, teaching reliable "care-for-caregivers" strategies to be integrated into professional practice, including the need for supervision and/or intervision [30].

Culture, Language and Cultural Differences in Everyday Life and Health Care

Translation vs. Mother Tongue

It is commonly assumed that a mental health intervention such as psychotherapy must be provided in a shared language, preferably the native tongue of the client, due to the complexity of the expression of emotional issues and non-verbal behaviour that runs parallel and interactive with verbal communication. However, the lack of trained experts and rapidly changing populations might require compromises. While it is obvious that family members and untrained helpers cannot be usefully called upon in a confidential setting, alternatives such as video-interpreters [31], the integration of specially trained health care interpreters or treatment in multilingual settings require practice that should be acquired under supervision and not solely through a "learn-by-doing" approach [32, 33]. The need for low-barrier training for therapists from minority ethnic and linguistic groups has already been covered earlier in this chapter.

Alternatives, Complementary and Holistic Treatment

Consideration should also be paid to the fact that for many migrants, as well as cultures with dual or changing healthcare systems, parallel or complementary treatment by traditional experts is common. Such treatment reflects specific cultural beliefs on health and illness, but is usually not covered in training curricula. Methods used in traditional healing systems might include the use of plants, animal parts, minerals, physical interventions like cupping or a wide range of psychological interventions. They might also include counselling and family-based interventions, the use of amulets, rituals or exorcism, and need to be understood in their usually complex cultural contexts and health belief models, especially when metaphysical health beliefs—common in many cultures—are present. While some of the treatment models might fulfil similar functions to psychotherapy and might effectively address especially culture-based expressions (idioms) of distress and frequently encountered sociocultural problems, others are inadequate when dealing with more severe psychological or psychiatric symptoms. Treatment might be beneficial but can carry the risk of side effects, and it can be useful to have an understanding of them as part of the overall treatment setting. Plant medicines can have

psychological side effects or interact with prescribed medication through the cytochrome system [34]. Opioids, Khat, Betel or other substances [35] to be considered are used not only as recreational drugs or stimulants, but also potentially in traditional medicine. Patients might not report parallel treatment either because they do not perceive it as relevant, or because they expect criticism or a lack of acceptance by the "Western" professional. Resulting complications or side effects can then become a challenge, and might lead to misdiagnosis. The World Health Organisation is aware of the important role that traditional healing models and healers may play, and that effective treatment might require collaboration between methods, and has therefore promoted the issue in their specific strategic program.[2] Generalisations including extreme positions, such as a principal bias against healers or uncritical assumptions that, regardless of the culture, "shamans" (a term that requires precise definition and is often used uncritically) are "always" the "better healers" need to be avoided. The embedding of traditional healing practices into the often highly complex cultural setting requires a comprehensive understanding of the concrete cultural background, and might require collaboration with cultural anthropologists or culture brokers, while general principles should again be part of any mental health training.

Universalistic Approaches: Community-Oriented, Salutogenic or Psychosocial Interventions, Curative Justice and Reconciliation

A significant international development in the mental health field is an increased awareness of the need to avoid medicalisation, especially among migrants and refugees; this is based on a set of arguments, including the more efficient use of often limited resources, increased cultural fit, reduced stigmatisation and the need for salutogenic approaches. For example, refugees and helpers can be taught positive coping skills and resilience, as demonstrated by Chemali et al. [36]. The International Federation of Red Cross and Red Crescent Societies[3] and other organisations[4] offer special online resources in this area. Activities such as sports have also been demonstrated to be highly efficient in reducing present and post-traumatic stress and building self-confidence and resilient group structures (see Ley et al. [37], for example).

Especially in the case of socially or politically motivated violence, healing is also seen as a group or community issue that cannot be addressed through individual treatment of the victim only. There is a need for due legal and community processes to confirm the suffering and dignity of the victim, prevent impunity of the perpetrator and safeguard against future violence. In many societies, especially the traditional ones, rituals such as Mato Oput (Acholi, Uganda) or traditional court systems exist, and efforts have been taken to adopt or adapt such structures; outcome data are however scarce and sometimes controversial (see Hamber for a comprehensive

[2] See the WHO Handbook: WHO traditional medicine strategy: 2014–2023, online at www.who.int.

[3] http://pscentre.org/topics/life-skills/ accessed 27.3.2018.

[4] www.resilience-project.eu.

discussion [38]). These new and important tools should also be covered or at least mentioned in the training of psychotherapists. Even if this support is not provided by the psychotherapist, training should create awareness of the necessity for creation of an interdisciplinary setting that integrates a holistic treatment plan and interaction with other services.

Mental Health and Psychosocial Needs and Resources in Major Humanitarian Crises

International organisations including the WHO and UNHCR promote the "Mental Health and Psychosocial Needs and Resources in Major Humanitarian Crises" (MHPSS) model which is based on a distinction between psychosocial needs that are common and can and should be covered by the community or other psychosocial resources, versus severe mental health problems that should be covered by highly trained health care experts.[5] Psychotherapists must learn how to integrate their role and skills against the background of this increasingly important model so that maximally efficient use of these resource networks can be made.

Migration as a Process of Negotiating Identity and Daily Practice: A Short Synopsis as an Example of Issues to Be Considered in Training Curricula

While many of the key questions surrounding inter- and transcultural psychotherapy are discussed in other chapters of this book, we want to use the central issue of migrants in mental health care as an example to demonstrate the issues we consider to be essential in a training curriculum in more detail, and which have been addressed in the aforementioned task force of the European Association for Psychotherapy.[6]

Migration as a Process of Negotiating Identity: From Longing to Belonging

Migration from one country to another is a complex psychosocial process which impacts on the identity of a migrant in numerous ways with lasting effects. In their classic work on this topic, psychoanalysts Grinberg and Grinberg [39] and Akhtar [40] described migration as a process of negotiating identity which may lead to a major crisis in an individual and/or potentially the "rebirth" of a successful new identity. The outcome of this process depends on a migrant's predisposition to migration, his/her age and personality traits, whether or not migration is voluntary, and with or without the protective rite of farewells, whether it is permanent with no possibility to return or temporary, and on the circumstances and attitudes a migrant encounters in the host country.

Grinberg and Grinberg [39] perceived migration as a traumatic event similar to the trauma of birth, causing a feeling of helplessness and loss of the migrant's

[5] See http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf, accessed 27.3.2018.

[6] https://www.europsyche.org/contents/14809/eap-guidelines-psychotherapy-with-refugees accessed 4.9.2018.

"containing object". This occurs both in individuals brought up in individualistic, Western societies with an I-self organised around the individual and embodied by the primary nurturer, as well as in those stemming from collectivist societies, whose sociocentric self is organised around multiple attachments within their original social group [41]. In order to survive a rupture of many previously present and important ties with loved ones, social networks, culture and livelihood, and to ensure a sense of continuity of one's own existence through time, migrants need to construct a "transitional space and time" between their previous lives and their new ones. This potential space should grant them the possibility to experience migration as a "game", an experiment, and gradually rebuild the continuity between their selves and the new surroundings. In this "space and time", a migrant shifts between the longing for familiar people and places and the enjoyment of being in unfamiliar places and forming new relationships. He/she also shifts between longing for the old and belonging to the new existence. Those individuals with a stable ego, a firmly established sense of identity and secure bonds with positive internalised objects possess the ability to endure the internal and external changes due to migration and are personally enriched by this process. Otherwise, they may experience migration as a catastrophe leading to deep feelings of insecurity, isolation, loneliness and a weakened sense of belonging to a social group.

Anxieties that all migrants experience at the beginning of the process may vary in intensity and duration, and can be of the persecutory, depressive or confusional types. Persecutory anxieties emerge when a migrant perceives the demands of migration as overwhelming, and cannot tolerate loneliness and the inability to communicate in a foreign language or to rebuild daily life routines and a social position. Depressive anxieties result from experiencing the great loss of everything they have left behind, alongside the fear of never being able to recover these losses. These anxieties can further develop into confusional psychotic states with paranoid delusions or disorientation in time and space, past and present, and loss of a sense of identity. However, migrants may also react with over-adjustment to the new surroundings in an attempt to defend themselves from anxieties. Regardless in which way, a migrant has to endure the feelings of loss whilst making an effort to respond adequately to the current demands of the new surroundings. They must give up part of their individuality, at least temporarily, in order to integrate into the new environment.

Upon simultaneously feeling pain and sorrow for the losses endured, along with fear of the unknown and excitement about a new beginning, a migrant may recover the ability to make plans for the future and live a full and enjoyable life in the present without their past interfering with it. They may integrate with the new surroundings and consolidate the sense of identity as a combination of the old and the new ones. If this is not the case, the migrant will either reject the new environment, its people, language and culture, fully assimilate and build a new identity at cost of the former one, or marginalise and devalue both their own and the dominant culture of the host society [42].

Akhtar [40] discussed migration as the "third individuation process" in a migrant's life, after birth and adolescence. The dynamic shifts, beginning with a

mixture of "culture shock" and mourning over the losses at the start of the process, gradually give way to psychostructural change and identity transformation. Over time, a migrant constructs a new, hybrid identity. Four interlinked strands are involved in the fabric of identity change among migrants. These involve the dimensions of drive and affects, interpersonal and psychic space, temporality and social affiliation.

Regarding the dimension of drive and affects, a migrant shifts from loving or hating, idealising or devaluing the old and new environments (splitting), to developing an ambivalent stance towards both. For the dimension of space, they shift from finding themselves too near or far from the country of origin to experiencing being at an optimal distance. Failure to negotiate the distance strand results in one of two opposite and problematic outcomes: ethnocentric withdrawal and idealisation of one's culture of origin, or counter-phobic assimilation characterised by total renouncement of the original culture. The dimension of temporality undergoes a shift from yesterday or tomorrow to today. A migrant may idealise lost objects from the past and develop fantasies of return to the country of origin upon retirement or death. Both idealised fantasies rob them of emotional investment in the present. Only through a gradual process of de-idealisation of lost objects, life in the present becomes possible. Finally, Akhtar describes the dimension of social affiliation, shifting from "yours" or "mine" to "ours". While at the beginning of the migration process, both migrants and their hosts hold their distinctive cultural characters, cultural mutuality gradually develops over time and they start to feel affiliated with each other in social ways.

Moreover, it is important to bear in mind that complex arrays of tensions are at stake between different social systems of which a migrant is part. Migrant families from many non-Western societies often have a hierarchical familial power structure with clear role definitions, and a gender-based authority with instrumental roles belonging to males and nurturant ones belonging to females [43]. Members of a migrant family are likely to become acculturated at different levels, depending on age, gender and circumstance. This may lead to intergenerational conflicts within a family. While parents may tend to retain the traditional norms and values of their original culture and traditional values regarding appropriate role behaviour and standards of conduct for their children, their offspring may adopt the norms and values of the host society more rapidly due to their involvement in school activities, new friendships with children from the host country and a greater facility for the new language [44].

The children of migrants are therefore often caught between conflicting bicultural expectations and may challenge their parents' authority. This may lead to conflicts and trigger parental behaviours that may not have been present before migration and may be unacceptable in the context of the host environment [45]. Also, a shift of power may take place in marital relationships among migrants due to exposure to a host culture and a set of opportunities different from those in the culture of origin. For example, men may not be perceived anymore by their wives as an authority and women may have more rights and opportunities in the host society. As the difference in power resources between the spouses decreases, difficulties in

the relationship may arise [46]. Therefore, while assessing problems among migrant families, it seems essential to evaluate their resources for social, cultural and economic integration, which are closely tied to foreign language ability, literacy, socioeconomic status in the country of origin and the extent of exposure to the social and cultural patterns of the host society. Further, it is important to discriminate between migrants' realistic and unrealistic expectations regarding opportunities and their entitlements in the host environment, as well as to evaluate their problem-solving capacities, learning capabilities and motivation for adaptation, and to explore family functioning within the context of origin and identify transferable work skills [47].

The Therapist's Attitude Towards Migrant and Refugee Clients

Beyond the reduction of symptoms and associated suffering, the key aims of all psychotherapeutic interventions for migrants and refugees should be to help them regain control over their lives, restore self-efficacy and a sense of agency, re-attach with humanity, make meaning out of their life experiences and suffering and regain hope for the future. Therefore, the role of the therapeutic relationship cannot be under-estimated [48]. Applying a certain treatment technique cannot be expected to lead to success in healing unless clients experience certain key ingredients in the therapeutic encounter, including a sense of trust, support, affirmation, respect, confidentiality and the confidence that they are being believed and understood.

Deep professional compassion on behalf of the therapist has long been identified as the core healing factor in all therapeutic processes [49]. However, particularly in encounters with refugees, this compassion goes beyond the conventional notion of empathy in Western psychotherapy. In this context it extends to the necessity of taking action by assisting and advocating for the client as an integral part of interventions aimed at reducing the impact of current stressors in refugees' lives and taking the human rights perspective into account. As Mazzetti [50] suggested, an excellent psychotherapist for refugee clients is one not restricted only to encounters in the office, but a person who decides to be a social actor in public. The therapist should have a role in the creation and promotion of the already mentioned integrated multidisciplinary networks (including social workers, lawyers, city council, etc.) that provide services assisting refugees and asylum seekers, as well as strengthening their capacity to draw on their inner strengths and social networks to strengthen resilience.

Cultural competence has long been highlighted as one of the important skills practitioners should have in working with migrant populations. This term refers to the characteristics of service providers, agencies and organisations which enable practitioners to provide adequate and effective health interventions to culturally diverse client populations. Cultural competence can be seen as consisting of four components: cultural awareness, knowledge acquisition, skill development and inductive learning [51]. Cultural awareness is the awareness of the practitioner's own cultural roots, with its biases and experiences in contact with other cultures, as discussed earlier in this chapter. Knowledge acquisition involves learning about other cultures and undertaking a critical evaluation of this knowledge. Skill development refers to the development of interventions which are culturally consonant and rooted in an understanding of the cultural issues experienced by migrant clients.

This knowledge should be transferred to other practitioners through a process of inductive learning. Finally, organisational and systemic cultural competency have been added over time to the list of requirements [52].

Alternatives to the concept of cultural competence have also been formulated. One of them refers to "cultural safety", which goes beyond an individual practitioner's skills to analysing power imbalances, institutional discrimination, colonisation and colonial relationships which may impact on the delivery of health care [53]. Another is the concept of "cultural humility", which refers to a practitioner's willingness and ability to listen and learn from culturally diverse clients and let them be a guide where it comes to culturally rooted issues impacting on the provision of services [54]. Selkirk et al. [55] proposed that adopting a curious stance towards migrant clients' experiences is more helpful in assisting them then imposing culturally incongruent therapeutic models.

However, a systematic review of studies of the issue of cultural competence [56] revealed the limited value of cultural competency in improving migrant clients' health outcomes, and only moderate evidence of improvement in provider outcomes, healthcare access and utilisation outcomes. The authors also warned about a lack of methodological rigor in the conducted studies. Another study [57] showed that there is limited evidence on the effectiveness of cultural competency training and service delivery.

The notion of cultural competence has been submitted to conceptual critique [58] as it incurs the risks of generalism and essentialism. Cultural competence has been conceptualised around the personal attributes and qualities of the practitioner, the "kind of person he/she needs to be", at the cost of developing general clinical competence. The authors of this chapter, therefore, suggest that the focus, when developing adequate care provision for ethnically diverse populations, should not be on the practitioners as culturally sensitised persons, but on a "bottom-up" creation of new psychotherapeutic interventions, in collaboration with the potential recipients of such treatments, namely the clients themselves.

The other important issue to be discussed is the practitioner's technical attitude in healing encounters with clients from different cultural contexts. Since a culture of privacy and silence seems pervasive among most migrants, and they look for a knowledgeable authority to coach them with their problems when seeking help, a directive approach in assisting them was recommended [47]. For some ethnic groups of clients, practitioners have been advised to reframe psychological problems as medical problems to reduce resistance to therapy [59], and to de-emphasise the necessity for self-disclosure [60], or to take an action-oriented approach with a focus on solving external psychosocial problems [61]. Thereby, the practitioner's self-disclosure as a technique in contact with migrant clients should be used prudently. Although this may help in building an empathic relationship, it may also cause suspicion in clients and a concern that a practitioner is struggling personally with the same problems and may not be the right person to offer guidance [62].

Sue and Zane [63] highlighted the importance of the processes of credibility and giving in psychotherapy with migrant clients, criticising the above-mentioned

suggestions regarding technique-oriented recommendations, as these were found to be necessary but distal to the goal of an effective intervention. These authors defined credibility as "the client's perception of the therapist as an effective and trustworthy helper" (p. 7), and pointed out that credibility is enhanced by the practitioner's ascribed and achieved status. While the ascribed status is the one that is assigned by others, the achieved one can be fostered by the practitioner's ability to conceptualise the client's problems in a culture-congruent way, offering means for problem resolution and setting treatment goals together with the client, taking into account their own explanatory model of the problems and hierarchy of needs. Compromise and consensus are required to nurture a fruitful treatment and working alliance [41]. All of this should be achieved within the first three treatment sessions in order to establish an adequate therapeutic relationship.

Giving is defined as "the client's perception that something was received from the therapeutic encounter" (p. 7). Migrant clients should feel a benefit from treatment almost immediately. This can be achieved by the normalisation of their psychological suffering through an increased understanding that their emotions and thoughts are shared by many others in similar circumstances, by developing cognitive clarity and understanding the chaotic experiences they are going through, through the alleviation or reduction of symptoms using pharmacological interventions, or otherwise through reassurance, the acquisition of skills, coping perspectives, hope, faith and goal setting.

Migrant clients may prefer to seek out assistance from practitioners with the same cultural background, expecting that being able to communicate in the same language and sharing some cultural, religious and spiritual values might lead to a better quality service. However, the notion of ethnic/racial matching in psychotherapy has recently been challenged. A meta-analysis [64] suggested that migrant clients indeed show a moderate preference for a therapist of the same race/ethnicity, but that ethnic/racial matching of clients with therapists has almost no benefits to treatment outcomes. On the other hand, migrant clients may also prefer to seek therapists outside of their cultural group because of issues of confidentiality. Other reasons could be that they perceive encounters with fellow nationals as traumatic because of earlier life experiences, or that they belong to a different ethnic or religious minority within the same country of origin.

Since migrant clients, as outlined earlier, often suffer from a complex set of problems which may be presented all at once when seeking assistance, practitioners should be able to determine whether the difficulties emanate from clients' individual and intrapsychic problems or from ongoing stress related to societal and organisational issues. These sets of problems require different sets of interventions. The "one size fits all" approach should, therefore, be submitted to caution and critique [65].

Finally, therapists need to pay attention both to what their clients share in sessions and also what is left unsaid. They should develop tolerance for "not knowing", for not always being in control over the treatment process, and be ready to deal with ambiguities, uncertainties and cultural inhibitions to sharing emotionally burdened material [66].

Psychotherapy with Migrants and Refugees: An Overview of State-of-the-Art Knowledge

Although we are emphasising the mental health impacts associated with the migrant and refugee experience, it is vital to acknowledge that the majority of migrants and refugees do not develop major mental health problems. Even for those who may exhibit severe distress, time seems to be a powerful healer. These populations exhibit a natural resilience and capacity for spontaneous recovery, especially if post-migration environments are favourable. Nevertheless, even though only a minority develops overt mental health problems, the absolute numbers of the affected are substantial.

Reviews of the existing literature [67–69] estimate that between 12% and 34% of refugees experience post-traumatic stress disorder (PTSD) and/or depression (often together with anxiety and somatic symptoms). Comorbidity is common and generally signifies greater morbidity and a poorer outcome [70]. In general, these mental disorders are twice as common among refugees than among comparable groups of economic migrants (approximately 40% vs. 21%) [71]. Moreover, refugees are ten times more likely to suffer from PTSD than age-matched native populations of host countries [68], and significant differences have been observed in the prevalence of psychosis [72].

Although levels of distress in migrants and refugees appear high when compared to the host population, research indicates that service utilisation rates in these groups are low [55]. This study also pointed out that the reasons for underutilisation of services by voluntary migrants are logistical barriers in terms of clinic locations and opening times, cultural mismatches between service providers and migrants, and preferences for alternative sources of assistance. On the other hand, those migrants with a stronger identification with the host than with the original culture, better fluency in foreign language, higher socioeconomic status, female gender or older age have more favourable attitudes towards seeking help for psychological problems.

The field of migrant and refugee mental health has been expanding for several decades, but unfortunately still shows only limited evidence for the effectiveness of many forms of intervention for various ethnic groups [41]. Some research [73] has suggested a moderately strong benefit of culturally adapted interventions in general, but also that cultural adaptations for specific groups may be more beneficial than general multicultural adaptations, and that treatment effects are larger when the therapists deliver treatment in their clients' native language.

With regard to psychotherapy approaches in the treatment of depression, a systematic review of treatments for first-generation migrants [74] revealed that culturally adapted cognitive-behavioural therapy (CBT) and behavioural activation (BA) tend to improve depressive symptoms, while problem solving therapy (PST) improved depressive symptoms even without adaptations. The same research showed that collaborative care and exercise did not significantly improve depressive symptoms among migrant clients. Another review [75] of culturally sensitive treatments for depression reported that the accommodation of culture-specific values

related to interpersonal relationships, family and spirituality result in better treatment outcomes. Several studies have focused on the treatment of depression among refugees. Recent meta-regression analyses [76, 77] support the effectiveness of different psychotherapeutic interventions when applied across cultures and racial/ethnic groups. Effective interventions include CBT, interpersonal therapy (IPT), problem-solving therapy and behavioural activation therapy.

Regarding other mental health problems, specifically among ethnic minority youths, another review [78] suggested that there are "possibly efficacious" treatments for anxiety-related disorders, attention-deficit/hyperactivity disorder, conduct and substance abuse problems and trauma-related psychopathology and depression. Several psychological treatments for PTSD have been developed and/or adapted specifically for refugee populations. Systematic reviews and meta-analyses of these treatments [79–82] concluded that the effectiveness of these approaches is not yet firmly supported by scientific evidence. The most consistent evidence has been provided for narrative exposure therapy (NET) [83–85] and trauma-focused cognitive-behavioural therapy (TFCBT) [86, 87]. In contrast, evidence for the efficacy of eye movement desensitisation and reprocessing (EMDR) amongst refugees is still limited [88]. Moreover, multimodal and multidisciplinary phased trauma treatment approaches are often used in clinical practice with refugees, and have been recommended for this population [89], but their effectiveness is also not yet sufficiently supported by scientific research [81]. However, recent research revealed that a multidisciplinary and multimodal treatment for traumatised refugees has a positive effect on both trauma-related symptoms and quality of life, with younger clients benefiting more from the treatment than older ones [90].

A number of studies have investigated the effectiveness of group psychotherapy approaches with asylum-seeking and refugee clients. A randomised controlled study (RCT) found a school-based group psychotherapy program for war-exposed adolescents in Bosnia-Herzegovina [91] to be effective. A recently conducted controlled cohort study [92] examined the short-term effectiveness of a 1-year phase-based, trauma-focused, multimodal and multicomponent (group psychotherapy in combination with nonverbal therapies) group therapy with Iranian and Afghan asylum seekers and refugees within a day-treatment setting. The results showed that this approach leads to a significant decrease in psychopathology compared with the waitlisted control group, and that nonverbal therapies have a distinct positive impact on treatment outcomes. Moreover, a unique 7-year follow-up study of this group treatment approach [93] showed a sustained improvement in psychopathology up to the 5-year mark. Over an even longer period of time, at an average of 7.4 years, treatment gains were maintained, but the effect showed some attenuation starting 5 years after termination of the treatment. The first ever study comparing group cognitive processing therapy (CPT) [94] with individual treatment was recently conducted with Congolese female survivors of sexual violence in a low-income, conflict-affected setting. The study suggested that group CPT, provided by community-based paraprofessionals, was more effective than individual supportive therapy in reducing PTSD, depression and anxiety symptoms. It also improved the overall functioning of the participants. The effects of CPT were found to be substantial, and improvements were maintained 6 months following treatment.

Delivery of treatment for PTSD and depression over the internet is expanding. A recent meta-analysis of RCTs [95] with different populations showed that internet-based CBT and expressive writing (EW) present promising results. Web-based CBT in written form, consisting of ten writing assignments over a 5-week period, was proven feasible and effective in a recent RCT study [96] looking at Arab patients in Iraq who have been subject to ongoing war violence and abuse. On the other hand, a RCT study of internet-based culturally sensitive problem-solving therapy for Turkish migrants with depression in the Netherlands did not show a significant reduction of symptoms [97]. However, internet-based approaches may open new avenues for assisting clients in contexts where conventional mental health care provision is limited, and when clients highly value the flexibility and privacy of the internet as a medium.

There is compelling clinical evidence that migrant and refugee experiences have a profound impact on the cohesiveness and inter-connectedness of families. Therefore, family interventions are considered to be highly relevant to comprehensive interventions. Unfortunately, there remains a lack of evidence in support of the effectiveness of systemic family therapy, as concluded by a recent systematic review [98]. Psychotherapeutic interventions enhancing resilience among migrants and refugees have yet to be rigorously studied, methodological obstacles being formidable.

Conclusions

Migration among the global population—including health care professionals—increases considerably due to either practical or work related considerations or flight because of overwhelming needs and dangers. Therefore, models of mental health care, especially those in psychotherapy, must be adapted in order to respond effectively to this new situation. Such adaptation should also be reflected in training curricula, not only by lowering the barriers to access, but also in the general conceptualisation of trainings. Further, it is of utmost importance to continue permeating the consciousness of policy makers and funding bodies with the notion that migrants and refugees should not be perceived mainly as "categories with special needs", and that pointing out this label of "otherness" can have a detrimental effect on their mental health [99]. Migrants and refugees are an integral part of the population of many countries worldwide, their mental health needs must be met, and they should be actively involved in the process of creation of new models for delivery of adequate mental health in the multicultural world.

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The Role of Language in Intercultural Psychotherapy

6

Meryam Schouler-Ocak

Introduction

A growing number of immigrants, refugees and asylum seekers worldwide have limited or no proficiency in the language(s) spoken in the host countries, thus affecting their ability to participate in regular psychotherapy services. Besides cultural barriers, these language barriers represent major challenges in the medical treatment of immigrants, refugees and asylum seekers whose access to health care is often already limited by other factors such as lacking knowledge of the local health care systems or unclear insurance status [1]. Fiscella et al. [2] have demonstrated a clear disadvantage in terms of correctness of diagnosis, quality of care, and risk for chronification of symptoms or disorders among immigrants, refugees and asylum seekers. Bauer and Alegria [3] underlined that while this is true for all medical fields, it is especially true for those disciplines relying most heavily on communication with the patient, such as psychiatry and psychotherapy, where language is the main working tool. A diagnostic interview (such as the Cultural Formulation Interview) [4] is necessary to detect patients' symptoms [5]. False diagnoses can lead to inappropriate treatment of the disorders and suffering of the patients and their relatives as well as increased costs for the health care system [5]. Particularly among immigrant, refugee and asylum seeker patients who have only recently arrived in the hosting countries, the risk of wrong diagnoses in psychiatric care is extremely high [6].

Additionally, in practice, psychometric instruments are not generally suitable for the diagnosis of people from other cultures. The few available translations are rarely validated in their respective cultures, having been developed specifically for Western cultures with regard to issues such as disease, symptoms, the concept of disease or mentality; this makes them only partially transferable to other cultures [7]. In this

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line, Birck et al. [8] highlighted the dilemma of diagnostic testing in the field of intercultural psychiatry and psychotherapy. Thus, such methods cannot be used in cases where insufficient language skills are possessed. Özkan [9] has pointed out the problematic areas in trauma-centred work with ethnic minorities. Schouler-Ocak et al. [10] have insisted on the importance of cultural factors in intercultural treatment processes. Moreover, without such an understanding, taking a medical history, diagnosis and treatment are very difficult to manage; in a psychiatric–psychotherapeutic treatment context, these become virtually impossible.

Koch et al. [11] found in a pilot study in 12 large facilities in Germany that when asked about comprehension difficulties with patients with a migration background, multiprofessional teams of health professionals cited language-related problems in 27% of cases, culture-related difficulties in 38% of cases, and both culture- and language-related communication problems in 44% of cases. Pette et al. [12] reported that one example of the effects of such difficulties was shown by the results of a study of patients with a Turkish migration background and native German patients in a women's clinic in Berlin. The result was that low competence in spoken German among the women with a Turkish migration background correlated with having a poor level of information about the diagnosis and treatment, as well as a lack of information during an inpatient stay and the associated process of therapeutic education [13]. Yeo [13] added that communication problems in the therapeutic context also lead to fewer consultations with therapists, a poorer understanding of medical explanations, more frequent laboratory tests and increased utilisation of emergency departments.

Several authors have highlighted that in order to avoid misdiagnosis, inappropriate treatment and frustration, not only good verbal communication is necessary, but also the consideration of different explanatory models regarding the cause, course and cure of certain health problems [14–18]. Description of the respective diseases can have a thoroughly different meaning in a specific cultural context. Additionally, explanatory models and expectations regarding the treatment are also subject to permanent variation connected to cultural changes, traditional elements, personal experiences and information from the social environment or the media [19]. Another issue which should be taken into consideration is that explanations can differ on the one hand between different cultural contexts, and on the other hand due to class-, age- or gender-specific factors [20]. This is a dynamic process in which these factors may also influence each other, meaning that experiences can therefore change too [15, 16, 19]. Therefore, working with the CFI can be very useful.

Intercultural Psychotherapy

In intercultural psychotherapy, the patient and the therapist come from different cultural backgrounds including different languages, traditional elements, personal experiences, etc. According to Gün [21], not only linguistic, but also cultural, religious and ethnic differences can lead to misunderstandings, which may play an important role in intercultural psychotherapy. The process of 'joining'—the willingness of the therapist to empathise and enter into the lives of the patients and their families with a migration

background—is an important condition of the psychotherapy [22–24]. In cases where the psychotherapist and immigrant, refugee or asylum seeker patient originate from different cultural contexts, two types of bias may occur. One is that the differences between the cultural contexts can be overemphasised, so that in extreme cases, a native psychotherapist might even consider psychotherapy to be impossible with an immigrant, refugee and asylum seeker patient. A second aspect is that differences can be denied, so that the influence of culturally defined social circumstances on the immigrant, refugee and asylum seeker patient could be ignored. As Fisek and Schepker [25] underlined, both attitudes could be problematic.

Morina et al. [26] further underlined that language is the most essential tool in psychotherapies, making treatment impossible if there is no common language between therapist and patient. Thus, to enable communication between therapists and patients not speaking a common language, the use of professional, trained interpreters is inevitable. In this setting, a third person—the interpreter—is present so that a triad is established, a situation which bears inherent difficulties, but also chances. Morina et al. [26] discussed the difficulties and opportunities of this setting and offered recommendations to optimise the work of interpreters in a psychotherapeutic setting. One of the recommendations is that interpreters should familiarise themselves with the principles of the psychotherapeutic methods being used, while another one is that clear role concepts for both therapists and interpreters should be defined.

According to Rosenblum [27], language contributes greatly to the formation of a person's identity, their memories and their experiences. Enveloped in language is a person's history(ies), culture(s), racial, ethnic, socioeconomic, spiritual and sexual identity(ies) as well as experiences. Additionally, these identities are felt, understood and conveyed differently depending on the language(s) chosen to communicate. In line with this, diverse affective and verbal communication is present when the intersubjective space in therapy flows between languages, because language is central to therapeutic work—indeed, it is its main tool. The therapists rely on language to build alliances, establish rapport and understand the inner worlds of their patients and themselves. Consequently, in a psychotherapeutic process, it is vital to develop an understanding of how languages describe concrete as well as symbolic meanings and experiences [27], and how linguistic- and cuture-specific aspects can be translated to and from the language and culture of the patients with an immigrant, refugee and asylum seeker background. Therefore, psychotherapy in an intercultural context needs special training in intercultural competence for both psychotherapist and interpreter. Intercultural psychotherapy is without doubt one of the ways to reduce the psychotherapeutic treatment gap among immigrants, refugees and asylum seekers.

Mother Tongue

Freud, who emigrated to the UK during World War II, described "the loss of the language in which one had lived and thought and which one will never be able to replace with another for all one's efforts at empathy" ([28], p.156). Language is a

major part of a person's identity formation, memories and experiences. Thus, when switching to a different language, multilingual people often change parts of their identity, even adapting their tone of voice and gestures. According to Nikitin, "in psychotherapy, language contributes greatly to the formation of therapeutic alliance, trust and understanding. It is often linguistic nuances, subtle gestures, cultural symbolism and language-specific idioms that enable a therapist to fully relate to and empathise with the client. So would therapy be more effective if it was in the client's native language?" [29].

Amati-Mehler et al. [30] described that it is necessary to discuss the role of the mother tongue, or, in other words, "the language in which the child first learns to speak and to think". "Native language", is the language to which a person was exposed from birth or during a "critical period", in which linguistics is connected to language acquisition in early childhood [29]. In bilingual or multilingual people who have been exposed to more than one language, this is different. People who are exposed to different languages at different stages of life or in different relationships might have more than one "native language". According to Nikitin and Morawa and Erim [29, 31], the older we grow, the more our language skills and vocabulary change and adapt to our needs, environment and experiences. During the process of migration, therapists are often exposed to bilingual or multilingual patients, as well as that they are likely to be one of them too. Therefore, it is important to note the role of the language in the therapeutic process [29, 32]. It should be mentioned that there are many words that lose some of their meaning when translated, or others that are so culturally specific that their meaning is completely lost in translation [26]. Krapf [33] defined the mother tongue as the language of the identity of the person, in which an "intrapsychic registry" is served for words and sounds that encoded and could trigger memories and fantasies from early infancy. Additionally, Tantam 34 highlighted that ethnic matching also plays an important role in psychotherapy. Several authors have underlined that the process and experience of learning to speak the mother tongue is deeply influenced by the relationship between the mother (or primary caregiver) and the infant [33–36, 37]. Additionally, Pérez Foster [36] emphasised that the emotional lives of individuals are narrated by their first language and how the meanings of words are inextricably linked to the texture of the relationship between the child and their mother [36]. As reported by Canestri and Reppen [38], there is a powerful connection between the relationship between mother, child and language preference. In case of bi- or multilingualism, they pointed out that "when the mother's relationship with the child is disturbed, the mother tongue is disturbed and this makes it particularly difficult for the child in a bilingual or multilingual home to become fluent in the mother's language" (pp. 153–154). The authors stated that the process of learning a new language can aid in repairing inner relationships by offering new tools with which to process painful memories and experiences [38]. Greenson [39] discussed the idea of different representations of the self and discussed the dual sense of self among bilingual patients. This idea was revisited by Bamford [40]. A lot of literature about the role of language was published. One of the authors was Pérez Foster [36, 41–43], who has contributed immensely to the body of literature on language use within the

therapeutic framework. In one of her publications (1998), she valued the significance of understanding what role language plays in a person's psychic processes and development. Furthermore, she highlighted the need to provide recommendations for clinical practice to enable clinicians to think about and work with different languages in the room. This was the basis for thinking about how to use an interpreter in a therapeutic session with patients without language competency. Additionally, Pérez Foster highlighted the idea that a bilingual individual experiences a dual sense of self and has different language codes that help them think about themselves, express emotions and ideas, and interact with others. Pérez Foster [42] and Aragno and Schlachet [44] pointed out that memories which are recalled in the actual language of an experience, whether or not in the dominant language, are explored and discussed more deeply than when they are relayed in another language.

Language Switching

In a study with Mexican-American individuals, Ramos-Sánchez [45] focussed on two groups of therapists, namely Mexican Americans and European Americans, who were all bilingual Spanish and English speakers. Ramos-Sánchez [45] reported that upon hearing the European American clinicians speak in Spanish, there was greater emotional expression on the part of the Spanish speaking clients. Ramos-Sánchez [45] discussed multiple possible reasons for this. One of them was that there might have been a lack of language matching, meaning that the switch from one language to another was not initiated by the client and thus the client was less forgiving with the Mexican American clinician for this misattunement than they were with the European American therapists. Another reason was that the clients had lower expectations of the European American clinicians specifically with regards to their language capability, so upon hearing their Spanish the clients were pleased and honoured that the clinician would make such an effort and thus opened up to their therapist. Furthermore, it could also be possible that it was assumed that the Mexican American therapists would speak Spanish and thus the clients were not impressed by their movement between languages. Sprowls [46] interviewed nine bilingual Spanish- and English-speaking therapists, and found that they often switched languages when they could not remember a word or a phrase. Additionally, the therapists would switch to their first language when they were angry or when they wanted to convey something with a deep meaning. Difficulties were inherent in switching language. For people who are multilingual, the way in which experiences and emotional reactions are encoded becomes more complex when more than one language is spoken. One of the ways in which multilinguals cope is by splitting and creating new selves for each of the languages spoken [47]. Pavlenko [48] investigated the question as to whether multilinguals feel that they become different people when they change languages. The author wanted to know how multilinguals make sense of these perceptions and what prompts some to see their language selves as different. Pavlenko [48] carried out an open questionnaire (?) about "feeling

different in a foreign language", and found that two thirds of the participants reported feeling different when using another language. Their perceptions of different selves were attributed to four causes: "(1) linguistic and cultural differences; (2) distinct learning contexts; (3) different levels of language emotionality; (4) different levels of language proficiency" (p. 10). Dewaele and Nakano [49] measured multilinguals' perceived shifts on five feeling scales (i.e. feeling more logical, serious, emotional, fake and different), using pair-wise comparisons between their different languages. The authors reported that a systematic shift was found across the four languages of the study, with participants feeling gradually less logical, less serious, less emotional and increasingly fake when using languages acquired later in life. Therefore, it can be argued that being able to access a range of languages also gives one the possibility of the expression of different emotions [49]. According to Harris [50], intense emotions from the formative years will have been encoded in the native language. However, there are many situations where emotional expression is facilitated by speaking another language. Furthermore, the additional language can circumvent the superego (as embedded in the native language), and so taboo words or emotions can be allowed to be expressed in a way that would not be allowed in the native language [50]. For example, Dewaele [51] described how several Arab and Asian participants stated that they switch to English to escape the social taboo in their native languages and cultures. Thus, Djakonova-Curtis [52] suggested using bilingualism as a tool in therapy, paying attention to the patterns of switching languages in therapy because therapists also often feel more comfortable speaking about taboos and touchy personal subjects in the second language.

Interestingly, Tehrani and Vaughan [53] underlined how bilingual differences and language switching in therapy can increase emotional mastery and how exploring past problems in a new light can be aided by a new language. Costa and Dewaele [47] reported that individuals who are multilingual may have access to a greater emotional range and have a more developed facility for managing plural cultural identities than their monolingual peers.

Bilingual Therapists

According to Alessi [54] and Burck [55], the research indicates that the process of an individual's bilingual identity development may reflect the development of bilingual psychotherapists' professional identity as they learn to practise in their second language. The internal process of the integration of their dual linguistic selves, and the successful development of the bilingual therapist's competence, is beneficial in their provision of successful cross-lingual psychotherapy, especially when practising in their clients' first language [55]. For many bilingual therapists, issues related to translation are an obstacle, not only between languages, but also between dialects and variations of words. Sprowls [46] and Verdinelli [56] reported that in a therapeutic session involving an interpreter, the translation affects the timing of interventions in the session, energy levels and the overall pace of sessions, and contributes to the development of negative self-cognitions in the therapist that can be

detrimental to the therapeutic relationship and maintenance of empathic attunement. Bilingual therapists' ability to apply their clinical skills across languages and cultures should be underlined. This ability points out a successfully integrated bilingual identity. According to Sella [57], the passage of time usually brings an improvement in therapists' ability to manage their own language-related issues as well as showing improvements in overall linguistic competence which is further reflected in their clinical work. Verdinelli [56] has emphasised that therapists' proactive relationship with the new culture and language is fundamental to their becoming skilled in the provision of bilingual therapy.

Verdinelli's [56] and Sprowls' [46] central findings were that therapists found bilingual work difficult, predominantly due to language barriers. The energy-consuming aspect of translation, the non-translative meaning of certain words and the increased effort sometimes needed to convey simple ideas in another language were identified as underlying sources of cross-linguistic difficulties. As Sprowls [46] emphasised, the work in the second language required the shifting of cadence between languages and having to work between languages brought up therapists' lack of confidence in their ability to provide adequate therapy for their patients. Thus, the bilingual therapists' ability to adapt to each culture through knowing the culture and their role boundaries, as well as successfully managing their cultural identities, proved to be an advantage in their cross-cultural work [46].

According to Skulic [58], the research indicates that the therapist's level of proficiency in the patient's native language can significantly influence the process of psychotherapy. Marcos and Urcuyo [59] and de Zulueta [60] underlined that these findings partly support the research stating that the therapist and the immigrant, refugee and asylum seeker patient should ideally be linguistically matched. The authors stated that the immigrant, refugee and asylum seeker patient's sense that they are understood by their therapist positively influences the process of therapy. Along these lines, the therapists' lack of bilingual proficiency can diminish their understanding of their patient's communication and adversely affect the establishment of a therapeutic alliance. Even when a solid alliance is established, a lack of proficiency can create additional resistances in the patient that can impede their working on presenting issues. According to the authors, research suggests that therapy can be successful despite a lack of linguistic proficiency between the therapist and the immigrant, refugee and asylum seeker patient, if the therapist is able to manage his or her own feelings about not understanding the patient and find a channel to communicate effectively with the immigrant, refugee and asylum seeker patient [58].

Using an Interpreter

Skulic [58] underlined that translation and its management within the bilingual therapeutic session can be approached and understood in several ways. As Verdinelli [56] reported, the translation of words and terms on the lexical level, as well as between the word forms in respective languages, is the process that bilingual

therapists find difficult when they are not proficient in the language of their immigrant, refugee and asylum seeker patient. According to Mahoney [61], the second type of translation resonates with Freud's idea of transposition, which is more specific to psychoanalytically based psychotherapies where according to Jimenez [62], the state of linguistic non-understanding can be combined with analysts' own counter-transferential material and as such used for the interpretation of the immigrant, refugee and asylum seeker patients' unconscious communication.

According to Oquendo [63], cultural nuances may be encoded in language in ways that are not readily conveyed in translation, even when the immigrant, refugee and asylum seeker patient use equivalent words in the second language. The monolingual psychotherapist may clarify these nuances through consultation with an interpreter who shares the immigrant, refugee and asylum seeker patient's first language and culture. It should be pointed out that in psychotherapy, immigrant, refugee and asylum seeker patients may use a second language as a form of resistance, to avoid intense affect. In these cases, the therapists may use language switching to overcome this resistance and to decrease emotional intensity. Additionally, psychotherapy can also be affected by the attitudes toward speaking that are part of the immigrant, refugee and asylum seeker patient's culture of origin. Therefore, discussions with bilingual and bicultural consultants can elucidate these effects for the therapist who is unfamiliar with the immigrant, refugee and asylum seeker patient's culture [63]. Well-functioning stabilisation mechanisms, psychohygiene, supervision and intervision are all crucial when working with patients, whichever background they are from.

Final Considerations

Griner and Smith [64] pointed out that across 76 studies, the resulting random effects weighted average effect size was $d = 0.45$, indicating a moderately strong benefit of culturally adapted interventions. This means that interventions targeted to a specific cultural group were four times more effective than interventions provided to groups consisting of patients from a variety of cultural backgrounds. Additionally, interventions conducted in patients' native language were twice as effective as interventions conducted in English, the language of the hosting country. However, the authors noted that more research is needed on how to evaluate whether therapists are culturally competent and how to determine which specific practices help immigrant, refugee and asylum seeker patients succeed in therapeutic goal. Therefore, they also call for increased foreign language training for psychology graduate students [64].

Psychotherapy in the native language of immigrant, refugee and asylum seeker patients generally fails due to the low number of qualified therapists, making intercultural therapy the usual option. Since not a single therapist can be expected to know all cultural-related issues, nor master the languages of all his/her immigrant, refugee and asylum seeker patients, the involvement of professionally trained interpreter seems inevitable [7]. Intercultural psychotherapy is hindered not only by

language barriers, but also by more complex communication problems, based on different explanations of the causes, characteristics and treatment options for various illnesses. However, immigrant, refugee and asylum seeker patients deserve access to the same professional psychotherapy as those being treated in their own cultural context.

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The Role of the Interpreters in Intercultural Psychotherapy

7

Ulrike Kluge

Introduction

Interpreters and translators support and enable the creation of relationships between people and languages in culturally and linguistically heterogeneous societies in a context of migration, in a wide variety of different settings, institutions and dimensions.

Due to migration and globalisation, users of psychosocial and psychotherapeutic services are becoming increasingly international and heterogeneous. As the diversity of cultural, ethnic and national backgrounds has increased both in European societies and worldwide, the diversity of first languages of patients and users in mental health services has also widened. Besides others, the review carried out by Schleifer et al. [1] discusses the consequences in medical encounters when language barriers occur: these include delays of treatment, poor therapy outcomes, mistreatment, etc. Different approaches as to how to overcome the resulting language barriers have been discussed over the last decades, ranging from mother-tongue professionals to telephone interpreting services and translation apps with relevant terms and interview guides for consultations. For several years, informal interpreters have been engaged in both psychotherapeutic and medical settings. However, informal, ad hoc interpreting by lay interpreters—often the children or relatives of patients—can not only decrease the quality of the interpreting itself, but is also sometimes overwhelming for the interpreter and can result in role confusion, divided loyalties, etc. [2, 3]. Fortunately, in practice, most psychotherapists have come to these insights themselves, and are aware of the need for professionally trained interpreters.

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For the variety of health and mental health care settings, diverse approaches and tools will be needed in the future. However, it is especially in psychotherapeutic settings, where trust and relationship building are major starting points for the treatment, that we need interpreters and mother-tongue professionals to be either physically available or present via video in order to be able to grasp the verbal and non-verbal dimensions of the communication processes.

For mother-tongue or bilingual professionals, the language barrier is not an issue when working with patients from the same cultural and language background, but in most settings and (transcultural) services, the variety of languages needed cannot be served by the health professionals who are available, especially in heterogeneous catchment areas.

Furthermore, high expectations of loyalty and understanding in these settings can also lead to monocultural dead ends. When asked, mother-tongue practitioners (especially in transcultural teams) report that they would not want to provide care exclusively for patients from the same cultural background, as this would increase segregation in care delivery on both sides. With this in mind, transcultural therapeutic approaches pay special attention to the negotiation process between the familiarity of the context of origin and the new context of the immigrant's host country. Nonetheless, regardless of conceptual considerations, the lack of appropriate care in the required languages for non-mother-tongue patients makes mother-tongue speaking practitioners as well as treatments with language and cultural interpreters necessary. Hence, we do indeed need language and cultural interpreters for psychotherapy with immigrants and refugees who do not speak the language of the host country sufficiently.

Language in Psychotherapy

Language is the main working tool in psychotherapy. As early as the nineteenth century, Freud had already named it the "talking cure".

Bauer and Alegriá emphasise the relevance of language in regard to psychiatric treatment compared to other medical disciplines as follows: "There are numerous reasons to postulate that language proficiency may impact the quality of psychiatric care more than medical care. Psychiatric evaluation hinges on obtaining a thorough history since many key symptoms are not associated with directly observable behaviours and can only be elicited via self- report […]" ([4], p. 2). They continue: "(…) Finally, language barriers may hinder the identification of important contributors to the process of care, including stigma, shame, patients' explanatory models of illness, acceptance of diagnosis and treatment, and development of a therapeutic patient- provider alliance" (ebd., p. 2). The authors conclude that it is not a question of whether to work with interpreters or not, but rather *how* to work with them (ebd.)

Language incorporates symbols, representations and metaphors of the specific cultural background. To understand intentions, fantasies, feelings and meanings of the words and language of our patients, we need to get an understanding of this symbolic level as well, and need interpreters who can transfer this level in their

interpretation. The term *interpretation* clearly indicates that there is no neutral interpretation of words from one language to the other, and that shifts of meanings are inherent [5]. Interpreters can support us in creating a therapeutic productive dialogue, not only between languages but between different belongings, values and narrations (ebd.).

The general basis for our therapeutic work is a shared level of language and symbolisation, on which narratives and meanings can become understandable. If this is not given per se, as in most transcultural settings, the first step of our work is to develop a shared therapeutic language. Bien Filet [6] developed the idea of a "symbiotic core" that needs to be developed in transcultural encounters and contexts [5, 6]. He argues that "(…) in the psychoanalyst, different languages, sublanguages and their representations of the respective groups are simultaneously activated in his or her mental apparatus as well as in the patient's utterances. (…)" From his point of view, working with patients in foreign languages results in "(…) an (unconscious) process of "polyglott" interpreting. In this process, both listeners undermine the fluid boundaries between and within their languages in order to reach a level that can be temporarily perceived as a *symbiotic core*. (…) This so-called symbiotic core of understanding will probably only last for a short time and ultimately prove to be fragile. From an interactional point of view, it can better be understood as a transitional space in which both parties negotiate the meanings they offer each other." (translation by the author, [6], p. 173).

Often, impatience arises in transcultural psychotherapeutic settings. The need for a therapeutically progressive process, a development, is more often frustrated in such a triadic setting, since the process of developing a "common language" can already be complicated and time-consuming. However, if we face this challenge with openness and curiosity, this process can open up a wealth of knowledge about our "own" and "the foreign Other" regarding language and cultural contexts. On the other hand, behind this impatience are also resistances "against an understanding of the foreign object, the incomprehensible culture" which Filet describes as "resistance to the narcissistic illusion of self-sufficiency and the omnipresent validity of one's own symbolisation" ([6], translation by the author). The fact that one's own symbolisation, culture and language are not universally valid, are not the only existing ones, has therefore to be reflected, especially in transcultural settings. In addition, alleged disturbances can lead to an increase in reflexive knowledge in the therapeutic process and interpreters are an important support in order to gain access to those disturbances and underlying differences [5].

The Triadic Setting and Its Particularities

The idea of conceptualising these settings as a triad includes the acknowledgement of the relations between the three people in the room [7–9]. Expecting interpreters to be neutral language transmitters is an illusion [5, 10], as all three (patient, therapist and interpreter) are in the room, with their role, their personality, their narratives, their specific individual use of language, etc. According to this, interpreters as

well as patients and professionals act, communicate and intervene in the (therapeutic) relationship, whether consciously or unconsciously [5, 11, 12]. The fitting between the patient and the interpreter is as important as between patient and psychotherapist. We should be aware of this and consider gender, age and specific community belonging when choosing a certain interpreter [5].

Based on our qualitative research and clinical experience, the following key findings shed light on issues which can be anticipated when working with language and cultural interpreters in psychotherapeutic settings [5, 7, 13]:

First of all—as stated above—we have to acknowledge that settings with interpreters are a triadic therapeutic relationship that should be treated similarly to working in a small group. As therapists in those settings it is our duty to be aware of the resulting dynamics in this triadic therapeutic process. One main and striking challenge for professionals as well as for interpreters is the clarification of the respective roles in the setting (ebd., 8). According to our research and clinical practice [5, 7, 13], the main aspects on how to work with interpreters in a psychotherapeutic setting are as follows (see Fig. 7.1):

1. Before we start working with an interpreter in a concrete session, we should have preparation time with them, including informing the interpreter about his or her role, the institution, the setting, confidentiality and ethical requests. Interpreters should be introduced to our specific therapeutic principles, goals and the respective language, because they might be coming from another institution/working environment where the expectations, goals and language were different. Even one of our colleagues might have different expectations about and images of the role of the interpreter or might use language differently due to another

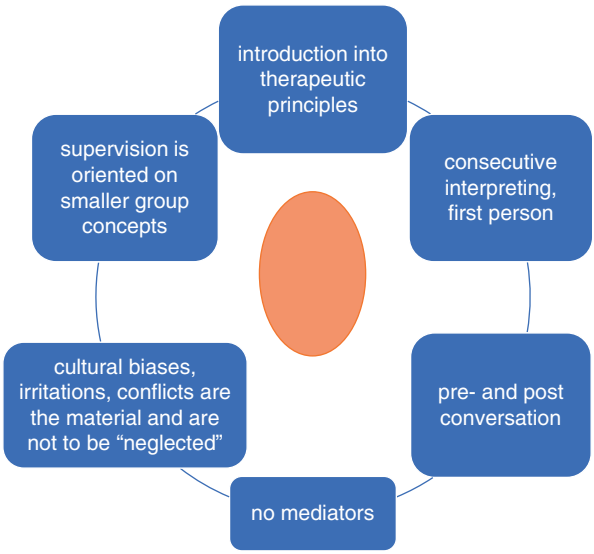

Fig. 7.1 Main aspects on how to work with interpreters in a psychotherapeutic setting [13]

psychotherapeutic approach. Those "languages" need to be transparent; otherwise, it might be confusing for the interpreter.
2. Interpreting should take place consecutively and in the first person. If interpreters are not used to this, it is important that we as therapists remind them to do so. Therapists might realise while working with interpreters that moments of (unconscious) switching to the third person usually indicates difficult, challenging, conflicting situations for the interpreter or the therapeutic situation, where the interpreter distances her- or himself by rejecting the ego-form in the interpreting process.
3. Interpreters should not understand their role in the setting as mediators in the sense of creating understanding between patient and psychotherapist.
4. Their role is to guarantee a smooth interpreting process, which includes allowing conflicts or misunderstandings between patient and therapist to arise. Interpreters have to be aware of this, as such situations are the "working material" that is needed to create a relationship and understanding with all conflicts and dynamics included between the therapist and patient.
5. Reflection and supervision processes should be based on a small group understanding of the triadic setting.
6. Building a reliable working alliance between interpreters and therapists necessitates all the above-mentioned issues. Pre- and post-session conversations between the two are also necessary. Especially at the beginning of a shared process, time for those need to be scheduled, but the necessary time will be reduced after a shared working process is started [5].

For detailed recommendations on how to implement and work with interpreters, follow the five-phase model of Salman [14]: (1) planning of the interpreting service, (2) the pre-conversation, (3) the therapeutic session, (4) the post-conversation between therapist and interpreter and (5) the analysis of the session for the therapist him- or herself (see [5]).

Additionally, we have to be aware that the interpreting process takes place in several dimensions [11] which will be mentioned here briefly: (1) the complex interpreting process between the three itself, (2) the kind of interpreting: verbal and also non-verbal (see [15]), (3) the content of the conversation, (4) the interpretation and transfer of intrapsychic processes during the interpreting process by the therapist (ebd.)

Due to the fact that interpreters are part of the therapeutic processes, they are also part of transference and countertransference processes. These need to be understood and worked with. For instance, any kind of "splitting" of transferences can have either stabilising or destructive impacts on the therapeutic processes. Therapists might realise that the affect they would assume to emerge in the patient, such as anger or fear, is not perceptible in the patient, while a certain corresponding reaction can be detected in the interpreter. Hence, it is important to reflect on any confusion, developments and stagnation in the therapeutic process against the background of the triad. In certain conflictual situations, therapists might realise that they do "deposit" issues which are not yet understandable in the interpreter. This needs to be

reflected and understood as the therapeutic process. In a transcultural setting, it is therefore essential to explore the various levels of the non-understandable, to differentiate whether moments of confusion have a linguistic, cultural, psychodynamic or group-dynamic origin, or whether they are due to the therapeutic triad.

All this said, as psychotherapists, we should be aware that in settings where we rely on language and cultural interpreters, we often realise at a certain point that we have been losing our mastery of our main working tool: language. This changes the therapeutic relationship as well as power relations between patient and psychotherapist (see [16]).

This might be one reason why the setting is considered by some psychotherapists as an *impossible* setting.

In working with language and cultural interpreters, we might sometimes feel some uneasiness or sometimes even adverse feelings towards interpreters, without being able to understand or contextualise those sensations. Apart from transference and countertransference dynamics, one possible reason might lay in the fact that interpreters become symbols of this phenomenon, namely symbols of our incapability to use our main "working tool"—language—in its full richness. Being reminded of that, we might feel restricted in our competence and effectiveness. Additionally, we might start feeling like the 'alien Other': the other Two in the room share a language and perhaps also the respective cultural background. This might result in feelings of being excluded, causing anxiety, uncertainties and mistrust on the therapist's side. At the same time, the psychotherapist in its role of running the session has to act in a professional frame, being aware of language and differentiated articulation to be able to understand. Experienced differences and feelings of alienation arise commonly in such settings, and are an integral part of the dynamics. We might be overwhelmed and feel they are increasing the complexity of the triadic setting, but instead of neglecting them, they should be focussed on and worked with (see [10]).

The inclusion of interpreters therefore provides incredible insights in intercultural encounters, including misunderstandings, biases, exclusion phenomena, etc. An understanding of these can be gained by discussing these in the post-session conversation with interpreters. The relevance and necessity of pre- and post-conversations is discussed by Kießl et al. [17].

Structural Dimension

The topic of professional interpreters in psychotherapy and in clinical practice is closely linked to structural issues. In the German context, for example, the main obstacle to provide and use interpreting services is the funding of interpreters in the health care system [18]. So far, there are only local solutions for funding as well as for standardised qualifications. The goal should be a nationwide strategy, for Germany ideally through the health insurance system. As long as interpreters are not part of the general health care delivery, job profiles as well as standards for different medical and therapeutic disciplines such as psychotherapy are difficult to implement.

To stay with the German example, due to the different local solutions, different standards are implemented, including different concepts and terminologies.

In recent years, it has become widely understood by experts in this field that we need professional, qualified interpreting services [19, 20]; just as important, however, is training for professionals on how to work professionally with interpreters [5, 21]. The appropriate competence to work in those complex triadic settings is therefore needed on both sides.

Having neither standard regulations nor quality criteria or funding policies all results in a lack of standardised procedures, recommendations on training and qualification, and regulations; this also affects research. As long as there are no standards and qualifications, research on the efficacy and performance of interpreters is difficult to carry out.

Research on the Availability and Difficulties and Chances in Working with Interpreters

This said, fortunately over the last years, there has been an increasing interest in clinical work and research on professional interpreting services, as is obvious in the quoted recent publications. Nonetheless, the results of a European study carried out between 2008 and 2010 showed that, for example, in Germany (an immigration country), interpreting services had been available in only 3 out of 15 services (mental health services, general practitioners and A&E departments) [22]. At the same time, experts interviewed in the study already stated at the time that one of the main obstacles was the language and cultural barrier [19]. Despite this, if we look into practice 10 years later, there has not been a remarkable change in the meantime.

Nevertheless, for a long time, most of the research and publications on the topic of interpreters in medical and mental health settings has focussed on the disturbances, challenges and struggles arising in settings with (non-professional) interpreters (e.g. [23, 24]). Marcos [23] already suggested how to overcome these barriers and what qualifications and developments would be needed to increase the quality of such settings. More recent publications, however, show an interesting shift in the sense of pre-supposing professional interpreters and their necessity and discussing from there more elaborated concepts and approaches how to work interpreters in the most appropriate, reasonable sense. This shift in the scientific discourse on interpreters signals a change.

To touch upon Bauer and Algería one more time: it is not a question anymore, if we should work with qualified interpreters, but how we should and could work with them [4].

First, we would need regulations on financing interpreting services, establishing standardised training and qualifications for interpreters as well as therapeutic professionals. From there we should emphasise research on the efficacy, outcomes and user satisfaction, which should include a differentiation in regard to different approaches, methods and tools of interpreting services in relation to the respective fields and settings. For example, in emergency care, low threshold telephone

interpreting services are reasonable, whereas for psychotherapy, face-to-face and video interpreting seem more appropriate; on the other hand for certain standardised medical procedures, apps might be the tool of choice. It is only to be hoped that with the professionalisation of the health care system and its movement towards intercultural opening, the future will see a system of multilevel interpreting services for the benefit of its users from various cultural backgrounds.

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The Patient–Therapist Relationship in Intercultural Psychotherapy

8

Hans Rohlof

To write prescriptions is easy, but to relate to people in other ways is difficult.—Franz Kafka (1919): A country doctor.

Introduction

In psychotherapy, a good relationship between the patient and the therapist is more important for the effect of the treatment than any other issue, including the techniques the therapist uses. This was already mentioned long ago by researchers such as Sol Garfield [1], and has been confirmed by research more recently [3]. Nonetheless, it remains somewhat unclear as to what a good relationship may be. Is it a friendly relationship as between good old friends? Or should it be a more benevolent teacher–pupil relationship, in which the pupil learns behavioural skills by listening to his or her teacher, and modelling this teacher? It seems that there are different answers for different patients [4].

A recent Dutch study among more than 300 therapists showed that 80% of them have the opinion that a good patient–therapist relationship will have a positive influence on the effects of the therapy [5]. Also, researchers have found a strong correlation between a positive relationship and the effect of treatment [3]. They estimated that non-specific factors in psychotherapy, among which the relationship is the most important, have an impact of around 30% on the effect of psychotherapy.

On the basis of different research findings, the American Psychological Association decided to establish a working group to collect and publish information on empirically supported psychotherapy relationships. Norcross published a book about this with the title: Psychotherapy relationships that work [6], of which a largely revised second edition was published in 2011 [7].

In the scientific literature, the real relationship, as opposed to the transference relationship, has become a more important object of research. According to Bordin, the patient should ideally be able to establish a real relationship with a therapist [8]. This relationship is founded on agreements, communication in the here and now,

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and sympathy and respect for each other. Depending on the personality of the patient, the proportion of real relationship and transference relationship are changing. According to Bordin, there should be a balance between the two; this is important because the strength of the real relationship, and indirectly the way in which the therapist handles the transference, defines the effect of the treatment. Bordin's motto is: 'bonds sustain the alliance whereas transference ultimately strains it'. Only very vulnerable patients with serious and chronic illness are not able to construct an effective relationship, given the right support.

Bordin constructed a holistic theoretic vision of the relationship, valid for all kinds of psychotherapy. He went further than Rogers, who spoke only about an emotional bond between patient and therapist [9]. According to Rogers, this bond would offer enough safety to talk about unfriendly feelings towards other people, and to change them. Guilt feelings about this would then become more normal, and acceptable, which would encourage the patient to eventually change them. To Rogers, the emotional bond was sufficient in therapy.

Bordin has the opinion that there should also be an agreement about the goals and the tasks in therapy. His view is that there are three rather independent issues at stake in therapy: (1), the bond, (2), the goal and (3), the task.

The bond includes aspects such as sympathy, respect, reliability and feeling a 'click'.

Furthermore, making goals for the therapy is important, and a task of its own. At the start of treatment, explicit attention should be paid to this. It is important for every patient, but certainly for vulnerable patients, in whom transference patterns will usually be stronger. A clear consensus about therapy goals is a buffer for eventual cracks in the alliance. In ideal cases, the patient can already mention some problematic interpersonal patterns at the beginning of the therapy. If these patterns become clear later on in the therapeutic situation, and there is consensus about the need to change them, the threshold to discuss them is considerably lower.

The therapeutic task is mostly determined by the therapist, but always together with the patient. The patient has to understand the rationale behind the intervention. Bordin stresses the fact that the therapist should not appear as an all-knowing guru, who knows the patient better than the patient knows him-/herself. Transparency of the therapist is therefore quite important.

Intercultural Psychotherapy

Creating a relationship with patients is more challenging if patients and therapists differ culturally or experience cultural differences [10]. There will be different idioms of distress, as well as different expectations about the clinical encounter, about the course of the treatment, and about the possible treatment effects; it is also likely that there will be a lack of trust at some point during the course of therapy. Treatment of patients with a different cultural background has shown to produce a less favourable outcome than with patients of the same cultural background [11].

Building Rapport

The patient–therapist relationship is an ongoing object of study of therapists and researchers in cultural psychiatry. Kleinman (41) pointed at the necessity to develop strategy, so the expectations of the patient and the possible solutions of the clinician may meet. If the so-called explanatory models of the patient and of the clinician are too apart, treatment will fail. Kortmann [12] added that different phases of treatment require different distances to the patient. He distinguishes between:

1. an elementary–sympathetic stage, in which the clinician tries to establish a beneficent and confidential relationship with the patient that facilitates trust and treatment adherence.
2. a diagnostic–therapeutic stage, in which the clinician has to make a proper diagnosis and treatment plan, according to his professional standards.
3. a personal stage, in which the clinician tries to integrate his observations and analysis in a tailor-made treatment, which makes sense for the patient.

The therapist should be aware that a smooth transition through the sequence above will be favourable for the course and the outcome of the psychiatric and psychotherapeutic treatment. If he or she stays too long in the first stage, the patient may feel trust, empathy and understanding, but will miss the professional judgement of the therapist. If the second phase is too long, the patient may admire the therapist in his or her professional role, but will miss the personal touch, that motivates him or her to be compliant and change behaviour. The relationship which is built during early first diagnostic and treatment sessions is therefore of crucial importance for the ultimate outcome.

Cultural Aspects of Every Clinical Encounter

As in other situations and contexts of human interaction, patients and therapists produce, reproduce and transform culture in the process of providing and receiving mental health care, in making contact, in diagnosis and treatment. In other words, psychological knowledge is cultural too and mental health care can be seen as production of culture [13]. In addition, clinical interaction is influenced by differences in power between patient and therapist in the consultation room, and between the social and cultural groups they are part of. Notably, health care professionals have the power to define the worries and complaints of the patient and label them according to a classification system such as DSM-5 or ICD-10 in a way that gives the patient access to scarce social resources.

Attention is often focused on linguistic and cultural differences, and these are generally seen as blocking communication and the health care process. However, in every clinical encounter, psychology culture (terminology, views, therapy choices) and lay culture interact, even when patient and therapist share the same cultural or

ethnic backgrounds or speak the same language [14]. Meanings of distress, complaints and symptoms are negotiated in a continuous process of interpreting, defining, communicating and redefining, with as objective a shared understanding of the patient's mental health condition and agreement about diagnosis and treatment, as much as possible.

Lacking objective biomarkers of mental disorders, diagnosis and treatment, the treatment depends on therapists' interpretation of the patients' interpretation of bodily and mental sensations, and related social reactions by the patient. This two-phase process of interpretation is complicated in a dyadic therapeutic relationship, yet even more complex when a third party is involved, especially in situations where relatives or professional interpreters are present [15].

Culture and attitudes are co-constructed in the interaction between patients and therapists. Lewis-Fernández (46) locates culture not in the minds of individuals, but between people, in the medium of intersubjective engagements. Patients' attitudes towards clinicians are affected by factors such as patients' prior experiences with health care, culture, transference and countertransference reactions, but also other social and individual factors. This influences their views about what is seen as 'proper' to communicate, how to communicate, and expectations of care and interaction with the clinician.

Different Models of Clinical Encounters

Globally, there is a great variety in models of clinical encounters within health care systems, but the essence of all is that one person is in need of help and another is in a helping position. A range of factors such as social and cultural traditions, history, economy, ideologies, politics and local contexts affect the organisation of health care systems. In Western-industrialised societies, clinical encounters shifted in half a century from rather authoritarian relations between (the medical) clinician and patient towards a more egalitarian person-centred approach. The latter entails the therapist becoming more of a medical consultant and guide, while the patient has more decision-making power. The focus shifts to working towards the patient's self-management, and increasing his or her responsibilities.

In Western-industrialised societies, clinicians in both primary and psychiatric care have several roles when carrying out a psychiatric assessment. They are medical expert, helper, guide, pharmacologist, potential psychotherapist and gatekeeper of health care. In multicultural environments, these clinicians encounter patients who are socialised in different (mental) health care systems, which they use simultaneously. Migrant patients' expectations of the role of therapists are diverse, as are their levels of trust in health care and providers. Especially patients with a refugee background may have experiences of mental health care being a part of a repressive state, and even of health professionals participating in torture.

Emotional Reactions Between Patient and Therapist

Therapists need to know that all kinds of emotions may occur during transcultural treatment. Some speak of transcultural transference and countertransference [16]. Clinicians should be aware of their own ethnocentric reflex on the one hand, and of their feelings of discriminating, or of overidentification, which can become an obstacle in the diagnostic evaluation and in treatment. In the unequal relationship of the therapist and the patient, it is difficult to express these feelings, but denying them is worse still. Therapists should already try to identify their own emotional reactions during the first encounter.

The Role of Reflection in Understanding Culture

A reflexive stance means trying to see oneself through the eyes of the other. Self-reflection, or reflexivity, is a prerequisite for anthropological comparative study of culture and society [17]. It is a structured approach to try, to some extent, to take a step back from one's own cultural framework. Reflexivity can also be a useful approach in clinical work in multicultural environments when trying to understand more of the perspective of the other.

Reflecting in situations of ongoing clinical activity may be difficult. To enhance one's capacity for effective actions in complex social situations, Rudolph et al. [18] address the value of reflections on our thoughts, feelings and actions, after activity. They take the view that off-line reflection gives distance in time and space to analyse and re-experience feelings, thoughts, actions and results that have been confusing. This approach can be helpful for identifying blind-spots in the assessment situation, possible misunderstandings, miscommunication and neglect of alternative diagnostic understandings. Additionally, self-reflection is a way of identifying reactions of transcultural countertransference, and raising cultural awareness.

Clinical Tools

Communication and Diagnostics

Mental health workers regard the communication with non-Western migrants often as problematic. In the Netherlands, ethnic minority groups show a high no-show and drop-out rate, often more than twice the numbers of native Dutch patients [19]. Migrants therefore have a lower profit from mental health care than native patients [20–22]. The pathway to adequate care is often not found because of language barriers and a poor knowledge of the existence of and access to care [23]. This applies especially to refugees, who show a large prevalence of mental health problems but

seem rarely to find the road to adequate mental health care. Researchers in the Netherlands have found high numbers of mental health problems among refugees, but low numbers of refugees who went to a mental health professional [24, 25].

When migrants are referred to a mental health institute and arrive there for an assessment interview, the next problem is often efficient *communication*, often made possible only through the use of interpreters [26].

Furthermore, if the communication problem can be dealt with, the professional has to start with a *diagnostic procedure*. This diagnostic process is designed to give credit to the many divergent symptoms of mental illness, to the complexity of the psychosocial situation of the refugee, to the way the person understands his or her problems, to personal coping methods with problems, support from family and to personal history, including formative experiences and former ways of handling problems.

In all, the findings which are mentioned above do account for a more sophisticated way to perform the diagnostic procedure in migrants. We will now elaborate more on the use of clinical interviews which can improve the relationship between therapists and patients in an intercultural setting.

Outline for a Cultural Formulation and Cultural Interview

In this chapter we will describe the use of a cultural interview in the first meeting with a migrant. This is not only because we think culture is important, but also because we think a more profound interview is better suited for the complex nature of complaints and problems a migrant offers in his or her first contacts with a mental health professional.

We have considered the Outline for a Cultural Formulation (OCF) (Lewis-Fernández 1996) as a quite useful concept in the diagnostic procedure. This OCF was published in DSM-IV as a guideline to diagnose the mental health problems of migrants and refugees in a more sophisticated way [27]. The OCF was operationalised in the so-called Cultural Interview and the Cultural Formulation Interview, the first being a Dutch instrument designed by us, and the latter being an internationally used instrument designed by a group of people, within which we made a contribution. This is shown in later sections.

Cultural Identity

At first, migrants bring along their cultural identity. Cultural identity has been defined '… as a multifaceted core set of identities that contributes to how an individual understands his or her environment. Ethnic identity is often a crucial facet of an individual's overall cultural identity, but many other facets may contribute to it as well. The greater the amount of detail a clinician is able to ascertain about the individual's cultural identity, the better understanding he or she will have of the individual's perspectives on health, illness, and the mental health system' ([28], p. 10).

In the new OCF of the DSM-5, this cultural identity has been given a detailed definition (see note[1]).

Symptom Presentation and Treatment Seeking

Secondly, there is much research on differences in symptom presentation and expression of emotions between persons from different cultural backgrounds. Although basic emotions are identified across cultures, thus universal, the value of these emotions may be different in various cultures [29]. Emotions that help people to be a good and normative person in their culture, such as happiness, or in some cases anger, are better appreciated in that specific culture. Also, assertiveness, or on the other side humility, is viewed as more desirable if they are appreciated in a specific culture. This means that persons who migrate will meet a different validation of their emotions. Not only are emotions different—cognitions also vary, since meanings, expectations and views differ between cultures [30]. This could lead to misunderstandings in mental health care, where therapists follow the preference of emotions and cognitions from the host country, and patients the preference of their culture of origin. As a consequence, therapists could be wrong in setting goals for treatment which are not accepted in the cultural view of their patients [31].

Thirdly, there is a difference in treatment seeking, and in expectations about the effect of treatment between persons from different cultures and from different regions of the world. This was shown by a survey on Turkish immigrants in Germany, as well as by a survey on Arab Australians [32, 33]. Barriers to help seeking were identified primarily as poor mental health literacy and stigma. In a large systematic review in the UK, it has been shown that black patients show higher rates of in-patient and compulsory admissions than white patients, with more complex pathways to specialist care [34].

Furthermore, refugees from different parts of the world show different idioms of distress. As Hinton and Kirmayer [35] showed, there is a multiplex model of symptom generation in traumatised refugees, including cognitive, social and physiological mechanisms. They showed that there is also a healing effect of certain rituals and interventions which are not part of the Western evident-based medicine. The OCF has reformulated this.[2]

[1] Cultural identity of the individual: describes the individual's racial, ethnic, or cultural reference groups that may influence his or her relationships with others, access to sources, and developmental and current challenges, conflicts, or predicaments. For immigrants and racial or ethnic communities, the degree and kinds of involvement with both the culture of origin and the host culture should be noted separately. Language abilities, preferences, and patterns of use are relevant for identifying difficulties with access to care, social integration, and the need for an interpreter. Other clinically relevant aspects of identity may include religious affiliation, socioeconomic background, personal and family places of birth and growing up, migrant status, and sexual orientation ([38], pp. 749–750).

[2] Cultural conceptualisations of distress: describe the cultural constructs that influence how the individual experiences, understands, and communicates his or her symptoms or problems to others. These constructs may include cultural syndromes, idioms of distress, and explanatory models or perceived causes. The level of severity and meaning of the distressing experiences should be assessed in relation to the norms of the individual's cultural reference groups. Assessment of coping and help-seeking patterns should consider the use of professional as well as traditional, alternative, or complementary sources of care ([38], p. 750).

Stressors and Support

Because migrants are being confronted with different culturally determined psychosocial stressors, and may have different cultural features of vulnerability and resilience, clinicians have to put more effort into determining those. Clinicians may have difficulties with identifying stressors in the lives of migrants, including fear for the future. Stress occurs if an individual appraises a situation as being a threat to his or her well-being and believes that he or she does not have the resources to handle it [36]. As well as other stress factors such as post-traumatic stress, migrants often have to handle so-called acculturative stress. Acculturation is a complex phenomenon, with effects on both a cultural, and on a psychological level [37]. Acculturative stress can be divided into perceived discrimination, intercultural contact stress, cultural bereavement and bicultural identity stress. In a survey among 321 Muslim immigrants to the Netherlands it was shown that successful contact and participation in Dutch society, and maintenance of heritage culture and identity were moderately associated with less psychological distress. Also, improving mastery of the dominant language in host societies, and allowing migrants to preserve their traditions, might be effective measures in improving the mental well-being of migrants [38]. In the OCF, this has also been included in the OCF.[3]

Patient–Therapist Relationship

The relationship between the patient and the therapist is at stake in the last part of the OCF. This relationship should be based on mutual trust and respect, and is a condition that promotes patients' willingness to discuss their thoughts, emotions and behaviours. The lack of a good relationship will result in challenges to formulate a proper diagnosis, and problems in cooperation, with negative effects on treatment outcomes. The OCF has tried to give attention to this relationship in the last part.[4]

[3] Psychosocial stressors and cultural features of vulnerability and resilience: identify key stressors and supports in the individual's social environment (which may include both local and distant events) and the role of religion, family, and other social networks (e.g. friends, neighbors, coworkers) in providing emotional, instrumental, and informational support. Social stressors and social support vary with cultural interpretation of events, family structure, developmental tasks, and social context. Levels of functioning, disability, and resilience should be assessed in light of individual's cultural reference groups ([38], p. 750).

[4] Cultural features of the relationship between the individual and the clinician: identify differences in culture, language, and social status between an individual and clinician that may cause difficulties in communication and may influence diagnosis and treatment. Experiences of racism and discrimination in the larger society may impede establishing trust and safety in the clinical diagnostic encounter. Effects may include problems eliciting symptoms, misunderstanding of the cultural and clinical significance of symptoms and behaviors, and difficulty establishing or maintaining the rapport needed for an effective clinical alliance ([38], p. 750).

The Supplementary Module on the Patient–Clinician Relationship

Why and When to Use the Supplementary Module

The Cultural Formulation Interview (CFI) facilitates exploration of cultural aspects of the therapist–patient interaction by looking at the present relation and context. In the CFI there is one question on the Patient–Clinician Relationship, namely question 16. The supplementary module includes suggestions as to questions for a further and more comprehensive exploration. Addressing cultural aspects of the interaction in the assessment situation enables both the clinician and the patient to improve understanding of the communication and attribution of meaning.

The objective of the supplementary module 'Patient–Clinician Relationship' is to assess the role of culture in the therapeutic relationship. More specific, it is about the way patient *and* clinician experience, interpret and shape their cultural toolkits or repertoires, and how this influences the development of the relationship (Gregg and Saha 2003). The module, therefore focusses on the *individual* experience of culture (Lakes et al. 2006)—culture as it is experienced and performed by its agents. The term 'culture' in this context is broadly referring to "all the ways the individual understands his or her identity and experience in terms of groups, communities or other collectivities, including national or geographic origin, ethnic community, racialized categories, gender, sexual orientation, social class, religion/spirituality, and language" [39].

This supplementary module addresses the mentioned two-step process of interpretation in mental health care. The questions try to unveil the thoughts and beliefs framing interpretation and to assist the clinician reflecting on both interpretational processes. The module consists of two separate sets of questions. One set is to be used during the clinical encounter, and the other facilitates reflection by the clinician afterwards. The first set can be used in case the CFI question 16 gives rise to further exploration. It is recommended that the second set is kept in mind in every phase of treatment.

An Overview of the Patient-Clinician Module

The supplementary module has 12 questions. Five are questions for the patient; seven support the therapist in finding a self-reflexive stance. The first set of five questions evaluates four domains in the clinician–patient relationship: experiences, expectations, communication and collaboration. These questions are designed to:

- Probe the thoughts and beliefs of the patient about (mental) health care in general, and (mental) health care professionals in particular, that may influence the therapeutic process in a positive or negative way.
- Bring to surface past experiences that may impede or can be helpful in establishing an effective therapeutic relationship.
- Elicit the patient's thoughts about the present and future relationship with the therapist.

These questions furthermore implicitly strengthen the therapist's presentation as thoughtful and open, express his or her willingness to respect the patient, listen to their experiences, take them seriously and underscore the relevance he or she attaches to the patient's point of view.

The first two questions of the module intend to explore the patient's experiences of health care. The presentation of complaints is contextual, depending on prior clinical experience, present needs and cultural traditions and expectations. Negative experiences in the past for instance may explain the patient's reluctance to inform the therapist in an open way.

Expectations which the clinician cannot meet may also be identified, for instance fast recovery of a chronic psychiatric illness, or obtaining scarce social resources or assistance in a juridical affair, and can be addressed in an early phase of therapy. The other way around, the therapist can take into account in his treatment plan what the patients experienced as helpful or difficult in the past, culturally patterned expectations and sometimes discover unexpected cultural and contextual resources of the patient.

The following three questions focus on the present situation, and look for impediments in establishing an effective therapeutic relationship. The third question explores the patient's preference for a therapist. The golden rule is not to assume anything about the patient's preferences, but to inform oneself about them openly. If present, the patient's preference concerning the interpreter has to be included. The influence of racial differences in therapeutic relationship is well known, but differences in gender, age, ethnicity or religion may or may not also play a role. It is important to keep in mind that matching is not always obvious or preferred. Differences, furthermore, are not facts, set once and for all. The initial preferences and the initially experienced differences may diminish as the therapeutic relationship unfolds in a positive way.

The forth question aims to open a dialogue about patients' doubts about being understood in the diagnostic phase. For example talking about homosexuality may be blocked if patient and therapist share a religious background that does not approve of a homosexual orientation. The fifth question aims to promote a discussion about further collaboration.

The second set of questions offers guidelines for the clinician to reflect on after the interview. These questions are designed to:

- Help the therapist to increase their own cultural self-awareness and gain insight into the framing by medical culture: the translation of problems into medical terms.
- Help to gain insight into practices of stereotyping.
- Help the therapist to become aware of the effects of the treatment context on patients' behaviour.
- Illuminate the limitations of the routines that therapists develop and use in clinical practice to assess patients and plan treatment.
- Be used in the clinical encounter, as well as in discussing the patient with colleagues.

The first two questions aim to promote reflection on feelings that may occur in the patient–clinician relationship. Discrimination and social exclusion often play an important role in the narratives of patients from minority groups. Being part of the dominant social group, and not having personal experience with discrimination and social exclusion, may unintentionally hinder clinicians to adequately assess their impact on the life of the patient.

Furthermore, the therapist can easily misjudge a patient when only guided by his or her appearance. Wearing a headscarf or being dressed in an assumed 'traditional' way, may hide a surprisingly 'modern' worldview.

The third question explores the impact of the presence of an interpreter on the communication. The presence of an interpreter may cause the patient to be less open about his thoughts, or may cause the opposite, improving trust and understanding. For instance, is the interpreter to be trusted, and how does he or she deal with confidential information? In small communities, the fear of gossip is often present. Occasionally, especially in the case of refugees, the patient may even wonder about the allegiance of the interpreter to conflicting parties in their country of origin.

The fourth question aims to encourage the therapist to engage in overall reflection about how the patient's cultural background may influence the diagnostic categorisation and evaluation. For example, this includes thoughts about uncertainty on diagnostic interpretation of signs and expressions of distress.

The fifth question supports a reflexive stance towards the therapist's own suggestions for treatment and routines. This includes considering if the treatment plan and recommendations were made with concern about the patient's conceptualisation of the problems, or checking that assumptions about the patient and his or her cultural orientations have been sufficiently integrated when evaluating therapeutic possibilities.

The sixth and seventh questions promote thinking about the therapist's own prejudices and stereotyping that may have been played out in the encounter with the patient.

Obstacles and Caveats When Using the Module

The patient may wonder why the therapist is asking all these questions, some of which seemingly have little or nothing to do with his or her complaints. Patients may not be used to being asked these kinds of questions, take a passive stance and expect the therapist to act. As stressed in the guidelines, it is important to introduce the questions in a proper way.

Secondly, patients may not understand the questions, or be unwilling to disclose their thoughts about therapy or about the therapist in a context of dependence. Sometimes, the patient discloses his or her thoughts more easily by talking about past experiences than about the actual situation. Besides this strategy, the therapist can present examples from his or her clinical practice in order to inform the patient that he or she is acquainted with the situation the patient is in.

Thirdly, the 'culture' pitfall should be mentioned. The culture pitfall refers to a focus on the culture of the group instead of on individual patient as a cultural agent [40]. It also refers to an operationalisation of culture as a set of static properties of patients instead of as a fluid intersubjective system of meaning and practice [42]. Above all, patients do not usually like to be treated as a representative of an ethnic group instead of an individual [43].

Patient *and* therapist may also use talking about culture as a defense mechanism. This may happen so that the patient can avoid talking about personal affairs and to legitimate his choices; for the therapist, it may be a way of arguing that any problems occurring in the treatment have external causes, and are not therapist-related. It is important to avoid talking about 'culture' in general, or using culture as an argument. Instead, the clinician should focus on factual behaviour and the patient's beliefs and social system in everyday life. Finally, there is a commandment that every clinician should always have in mind according to Arthur Kleinman [44]: "First, do not harm by stereotyping".

Conclusions

In an intercultural therapeutic setting, the general aspects of the encounter are at stake, as mentioned in the first paragraph: bond, goals and tasks of the therapy. However, there are also other aspects that have to be taken into account, since intercultural transference and transference are at stake at the same time. Clinical tools such as the Cultural Formulation Interview and the Supplementary Module on the Patient–Clinician relationship are therefore important to use. With good preparation and a constant focus on the difficulties which are described, the relationship will be more effective, which will in turn enhance patient–therapist cooperation and the outcome of treatment with persons from a different cultural setting, whether the therapist is of Western or of non-Western background.

Supplement (Freely Downloadable at https://www.psychiatry.org/)

Supplementary Module of the Cultural Formulation Interview

Patient–Clinician Relationship

Related Core CFI Question 16 Some of the core CFI questions are repeated below and are marked with an asterisk (∗). The CFI question that is repeated is indicated in brackets.

Guide to Interviewer The following questions address the role of culture in the patient–clinician relationship with respect to the individual's presenting concerns and to the clinician's evaluation of the individual's problem. We use the word *cul-*

ture broadly to refer to all the ways the individual understands his or her identity and experience in terms of groups, communities or other collectivities, including national or geographic origin, ethnic community, racialised categories, gender, sexual orientation, social class, religion/spirituality and language.

The first set of questions evaluates four domains in the clinician–patient relationship from the point of view of the patient: experiences, expectations, communication and possibility of collaboration with the clinician. The second set of questions is directed to the clinician to guide reflection on the role of cultural factors in the clinical relationship, the assessment and treatment planning.

Introduction for the Patient I would like to learn about how it has been for you to talk with me and other clinicians about your [PROBLEM] and your health more generally. I will ask some questions about your views, concerns and expectations.

Questions for the Patient:

- What kind of experiences have you had with clinicians in the past? What was most helpful to you?
- Have you had difficulties with clinicians in the past? What did you find difficult or unhelpful?
- Now let's talk about the help that you would like to get here. Some people prefer clinicians of a similar background (for example, age, race, religion or some other characteristic) because they think it may be easier to understand each other. Do you have any preference or ideas about what kind of clinician might understand you best?
- ∗Sometimes differences among patients and clinicians make it difficult for them to understand each other. Do you have any concerns about this? If so, in what way? [RELATED TO CFI Q#16.]

Guide to Interviewer Question #5 addresses the patient–clinician relationship moving forward in treatment. It elicits the patient's expectations of the clinician and may be used to start a discussion on how the two of them can collaborate in the individual's care.

- What patients expect from their clinicians is important. As we move forward in your care, how can we best work together?

Questions for the Clinician After the Interview:

- How did you feel about your relationship with the patient? Did cultural similarities and differences influence your relationship? In what way?
- What was the quality of communication with the patient? Did cultural similarities and differences influence your communication? In what way?
- If you used an interpreter, how did the presence of an interpreter or his/her way of interpreting influence your relationship or your communication with the patient and the information you received?

- How do the patient's cultural background or identity, life situation, and/or social context influence your understanding of his/her problem and your diagnostic assessment?
- How do the patient's cultural background or identity, life situation, and/or social context influence your treatment plan or recommendations?
- Did the clinical encounter confirm or call into question any of your prior ideas about the cultural background or identity of the patient? If so, in what way?
- Are there aspects of your own identity that may influence your attitudes toward this patient?

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Cultural Competence in Psychotherapy

9

Adil Qureshi

In this increasingly globalised world, mental health practitioners are ever more called upon to provide services to people from many distinct cultures, religions and races. The reasons for this have been reiterated throughout this book, two of which are particularly worthy of contemplation: the first one has to do with the considerable displacement of people across the globe due to war, strife, famine and poverty, amongst other reasons. The second, perhaps related to the first, is the increasingly recognised need that displaced people have for mental health services. This latter point is important because it emphasises not only the diversification of client bases, but also the increased demand for psychological treatments and the need for greater practitioner awareness of diversity related mental health related issues.

The upshot of all of this is that standard practice in psychotherapy will simply not do, for both cultural and racial reasons. This problem has been recognised for quite some time in North American psychology, so much so that over the past 40 or so years, a significant body of literature has developed under the general topic of "cultural competence" or "culturally adapted" psychotherapy. As we consider how to best respond to our diverse service users, it can be rather overwhelming and indeed confusing to contemplate the existing body of literature, in large part due to the heterogeneity of sources, contexts, conceptualisations and so on. This heterogeneity reflects in part the very diversity of the populations contemplated, as well as an enriched understanding of what constitutes psychotherapy.

A Couple of Caveats

One of the tremendous challenges facing any model of cultural competence in psychotherapy is that all of the terms and concepts are at once over- and underdetermined. Thousands of articles, books and so on have been dedicated to the broad

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theme of psychotherapy across cultures, and yet there is very little in the way of general conclusions about the topic. Indeed, there is little in the way of agreement as to what exactly constitutes "psychotherapy". To that end, I would like to start with the caveat that this chapter is very much a function of a particular perspective, informed by the areas of multicultural counselling psychology, theoretical psychology, hermeneutics and transcultural psychiatry.

The second caveat relates to the notion of "psychotherapy", and although the argument can be (and is) made that almost any sort of healing of psychological distress can be termed "psychotherapy", this chapter will adopt a narrower perspective, one consistent with Kirmayer's excellent 2007 [1] article, which delimits psychotherapy as a modernist project predicated on a Eurocentric understanding of the self (this will be developed further below). This clearly invokes a serious conundrum: can a modernist, and by definition Euro-American project, be adapted for use with people who do not share a modernist self?

Nomenclature Complication

Although "cultural competence" is perhaps the most widely used frame to address effective responsiveness in the face of diversity, it remains problematic for a few reasons. One is that the term "cultural" underdetermines the topic at hand; that is, most approaches to cultural competence, and certainly the one presented here (see [2]), include diversity related power dynamics best exemplified by race. The other is that "competence" runs the risk of being construed as a reachable skill set with a quantifiable endpoint, as if one can "become" culturally competent. This perspective has been rejected, with good reason, by a number of commentators [3–5] to the point that Tervalon and Garcia [6] proposed the notion of "cultural humility" to inoculate practitioners against the hubris of believing that they have indeed attained "cultural competence".

Background on Models of Cultural Competence in General and as Applied to Psychotherapy

Cultural competence has gained considerable popularity in recent decades, especially among professional psychologists and other mental health practitioners and organisations concerned with multicultural practice. However, the construct remains controversial because of concerns about its purportedly atheoretical nature, its limited empirical support, its questionable feasibility and its possible association with cultural essentialism (see, e.g., [7–9]). As a result, several scholars are beginning to rethink cultural competence in an effort to remedy these concerns while retaining a substantive focus on cultural difference [10]. The model presented here shares these concerns, and is consistent with the seminal work of Sue, Ivey and Pederson [11], which holds that cultural competence is a *metatheory*. It is more of an orienting paradigm, or a perspective, than any specific approach, theory, or set of techniques.

Thus, the model presented here should be complementary to most approaches to psychotherapy (given the caveat mentioned above).

Cultural competence, at its most basic definition, consists of steps required to overcome the barriers that impede diverse patients from receiving quality mental health care. A variety of research reports have identified that the bulk of disparities in care derive from what can broadly be termed cultural and racial sources. 'Cultural' is largely related to interpretive paradigms whereas 'racial' is essentially a function of power differentials between the therapist and the patient. Both of these will be explored briefly below.

Models of Cultural Competence

Much of the research and theory on the topic of cultural competence has been developed in North America, where multiculturalists faced considerable resistance to the introduction of diversity into mainstream psychology and psychotherapy, to the extent that much of the fight centred around a binary/polarity of "White Western European" on the one hand, and minorities on the other. Although there is no question about the deleterious impact of especially implicit racism in psychotherapy, cultural differences are not simply a handful of interestingly different behaviours or thought processes, but rather can have a profound impact on the therapeutic project.

Race (and Power)

At this time we are faced with a world in which racism can be lethal, and there is no shortage of research that shows that racial differences can have a powerful impact on both mental health [12, 13] as well as psychotherapy [14–16]. As noted elsewhere, the entire relevance of race is racism; for the purposes of psychotherapy, race as a biological phenomenon is entirely uninteresting [2]. What is of considerable relevance is racism and how sociodemographic characteristics situate individuals differentially in the overall power network. To begin with, the client or patient has less institutional power than the therapist. If the client is an immigrant, a refugee, a religious or racial minority (etc.), and the therapist is from the majority/dominant group, the power differential is even more pronounced. Although at first glance one might argue that most therapists are "colour-blind", i.e. not impacted by such differences, research indicates that "aversive" racism [17] or indeed unconscious bias [18] can have an important impact on the therapeutic process.

Implicit racism and unconscious bias mean that racial difference can have an impact on the therapist without her or his awareness. A number of theorists argue that therapists may respond to the discomfort evoked by racially different patients through cognitive [19] or psychodynamic processes [20, 21]. Thus, in their efforts to be "colour-blind" and treat all people the same, they are in fact only doing so in

their conscious, explicit behaviour, while their implicit and unconscious responses are rather different.

Further, given that many immigrants, refugees, religious and racial minorities have been subjected to discrimination on a regular basis [22–24], it is not unusual for them to approach mental health professionals with some degree of vigilance, what Terrell and Terrell [25] term "cultural mistrust" and has been shown to negatively impact the therapeutic process.

The upshot of this is that the clinician must have the capacity and interest in exploring and managing her or his unconscious racial bias, not from a position of defensiveness but rather that of an openness [2].

Culture

One of the tremendous challenges is the differentiation of "culture" from the person. Given research carried out in the neurosciences, we can conclude that the brain is indeed cultural: the newborn brain requires human care for the required synaptogenesis and related synaptic pruning. Thus culture is not simply an after the fact add-on through which we interpret experience, but rather is constitutive of experience itself, although how this is so is very much a function of the complex interaction between nature and nurture. That is, there is no a priori way to determine the specific "impact" the culture will have; however, it is inevitable that it will have an impact. On this front the challenge is to be aware of the various ways in which culture can affect a person and their way of being in the world, with the awareness that what is "normal" for us may not be at all for another, and vice versa.

An interpretive or hermeneutic approach to culture emphasises that culture functions as a sort of filter through which we experience the world [26]. From the hermeneutic perspective, culture is important not as a "thing", (thinking about, for example customs and norms, etc.), but rather in the context of how we engage with and make sense of the world around us [27]. To that end, various models of cultural dimensions have been proposed which can help in this process [28–30]. Taken from another perspective, these differences may be epistemic and as such categorical rather than dimensional [31]. At any rate, Table 9.1 represents a synthesis of existing models, which are discussed elsewhere [32], and shall be briefly addressed here.

Table 9.1 Cultural dimensions (adapted from [28–30])

Humans	Centre	Divine
Individual; independent	Identity	Collectivist; interdependent
Task	Priority	Relationship
Sequential	Time	Synchronic
Neutral	Expressiveness	Affective
Inner directed	Environment	Outer directed
Direct	Communication	Indirect
Collateral	Power	Hierarchical

Although there is no doubt that shoddy application of such models run the risk of cultural reductionism, they can also function as tools to help practitioners differentiate between what might appear to be odd behaviours that could be taken to be indicative of psychopathology, resistance, etc. and what may simply be culturally normative behaviours. There is a tendency for the components on each pole to be related to each other, and as such it is tempting to label each column with a specific geocultural region; the goal here is to help make sense of a given patient rather than classify entire communities.

In her excellent discussion of cultural variation of attachment, Keller [33] differentiates between those cultures in which the infant has an intense dyadic relationship with one or two adults and spends time in individual play, and cultures in which the infant has lower intensity interaction with a network of people, and is rarely if ever alone and almost always in contact with another, whether this is in parallel play or on the back of the mother while she is working. Keller argues that the former is very much predicated on a cultural system which values the individual and emphasises individual desires and needs. This is in large part geared towards facilitating the developing person's capacity to define her or his own life goals and pursue them in the process of individuation. Conversely, in the extended family context, the primary goal is fitting into the larger system, and one is valued not on the basis of expressing and developing individual goals and desires but rather of fulfilling the responsibilities to enable the larger group to function effectively. This differentiation speaks loudly to the degree to which psychotherapy is predicated on a certain sort of self.

Psychotherapy (and Culture)

Culture in general and the above dimensions in particular can be understood to impact experience (in large part deriving from the cultural brain), the ways in which we express ourselves in general and our distress in particular, the explanations we provide for our distress, and finally what we expect from psychotherapy. Thus an interculturally competent psychotherapy will simply need to adapt itself in accordance with these four Xs. This makes sense as long as we have "commensurable selves".

As per the differences expounded between an independent versus interdependent self, it may well be the case that some degrees are structural. If we take Keller's [33] position seriously, then it follows that brains develop differently in these different developmental contexts. That being the case, simply "adapting" psychotherapy may not be an adequate response.

In a brilliant article, Kirmayer [1] defines psychotherapy as pertaining to an individualist, independent self, one that roughly corresponds to the right side of the column. In a nutshell, psychotherapy is predicated on an intimate one-on-one conversation in which the patient is invited to reflect upon and share his or her thoughts and feelings and to identify plans of action that can be taken to forward her or his personal objectives. The cause of distress is generally understood to be some

combination of genetics, neurochemistry, lived experience (especially early childhood and family dynamics) and possibly environmental factors (as opposed to supernatural forces such as witchcraft, God's will or the movement of the planets). This means that an important focus of therapy is the individual's agency such that she or he can adapt behaviour in such a way to achieve desired goals. In the process, the individual is expected to explore and share her or his thoughts and especially feelings. We can see how many of the dimensions on the left side of the table come into play in this process, and how complicated, if not untenable psychotherapy will be with patients who live primarily on the right side of the table. In fact, Kirmayer argues that individual psychotherapy only makes sense with individualistic-independent selves, with other modalities such as family therapy more coherent for a more sociocentric self.

There are many accounts of poor results of psychotherapy as applied to "selves" that are not fundamentally on the left side of the above table. For example, Balkir and Barnow [34] explored the notion of emotional expression in the context of the poor results of psychotherapy with Turkish immigrants. Specifically, what they argue is that expressive suppression is associated with wellbeing in Turkish women whereas the opposite in German women; and, indeed, the vast majority of therapeutic approaches thematise emotional exploration and expression, indicating that some complications may ensue should standard psychotherapy be used on Turkish women. This is not at all to argue that Turkish women will not be amenable to or benefit from emotional exploration, but rather to underscore the degree to which cultural and/or epistemic differences can render psychotherapy ineffective with some patients.

Psychotherapy Across Cultures?

As a response to the recognised limitations of conventional psychotherapeutic modalities for the culturally different, "culturally specific" psychological treatments have been developed [35] that draw on "indigenous psychologies" such as Morita Therapy [36] or Cuento Therapy [37]. This raises some important questions for the therapist who strives for cultural competence: do psychological treatments predicated on indigenous psychologies constitute psychotherapeutic treatments worthy of learning?

One of the assumptions, it would seem, of the very notion of culturally competent psychotherapy is that it is reasonable to consider that psychotherapy can be applied across cultures and epistemes, an assumption that is of questionable validity. It must be admitted, however, that this derives in large part from what we understand "psychotherapy" to entail. If we follow Kirmayer [1] then the scope of psychotherapy is rather on the narrower side and corresponds to the modernist context in which it was derived. On the other hand, a broad understanding of psychotherapy expresses less concern for specific modalities or techniques and more for the "common factors" [38, 39]. According to the common factors account, there is no interesting difference between "healing" and "psychotherapy", and as such, any treatment approach that involves the common factors and alleviates mental distress can be considered to be "psychotherapy". Relatedly, it has been argued that the only people interested in

theory concerning psychotherapy—that is, this or that approach—are psychotherapists; patients are interested in feeling better [40]. From that perspective, differentiating between "psychotherapy" and "healing" would, presumably, be relatively meaningless; facilitating client change, on the other hand, is key.

Anything Goes?

We have seen so far that the cultural side of cultural competence can either require modifications in the treatment approach to adapt to cultural dimensions, or, indeed, can challenge the therapist to find a response to a self that is categorically different from the one on which psychotherapy was developed. The dimensional reality generally makes sense in the context of communities in which the populations representing sociodemographic difference have a longer term presence in the community in question. The categorical difference is present in the face of greater "cultural distance" [41], usually related to more recent movements of people common during refugee crises. It is here where psychotherapists are presented with tremendous challenges given that even adaptations of standard psychotherapies will likely be ineffective due to the very different sorts of selves in question.

If an individual is collectivist/interdependent, with an external locus of control, and with the divine at the centre of the universe, for whom fulfilling one's role within the community is the highest order, engaging in talk that focuses on their individual feelings and desires may appear pointless and discomfiting. It is precisely here that a healing approach predicated on indigenous psychologies would make a lot of sense. At the same time, this raises two important questions that are not entirely unrelated. The first one has to do with "who" will provide the treatment. Within most healthcare systems, psychologists and psychiatrists are legitimised to provide psychotherapy predicated on their training and certification. In most parts of the world this training may include a focus on intercultural competence, but not, for example, Morita Therapy or Shamanism. Whereas training in generic approaches to psychotherapy can be transferred to more specific psychotherapeutic modalities, this is hardly the case for healing approaches based on indigenous psychologies as they require specialized and indepth culturally sanctioned training. Thus the logical option, in such cases, would be to refer the patient to a traditional healer, which may however be problematic because in few countries is there any oversight/credentialing of indigenous healers [42].

Culturally Competent Psychotherapy

Traditional models of cultural competence encourage therapists to develop the knowledge base, the skill set, and adopt an attitude that will best facilitate effective treatment of all patients, regardless of their background. In this next section these three components will be addressed, and the chapter will end with an overview of what culturally competent psychotherapy might look like.

Knowledge

The knowledge component concerns what it is that a therapist needs to know in order to effectively treat culturally, racially and religiously different patients. At the cost of sounding simplistic, a therapist needs to know that culture matters. How it matters, of course, is impossible to know a priori, which is precisely where the skills component comes in, which has to do, amongst other things, with a detection of the way(s) in which culture matter. What this means is that any prescriptive approach ("psychotherapy with Arabs") runs a very serious risk of losing sight of the individuality of the patient and succumbing to stereotypes, the very reason that Tervalon and Murray-García [6] warned against arrogance in the intercultural encounter.

It is important to know that culture impacts experience, expression, explanation, and expectations, and clinicians are encouraged to make use of models of cultural difference such as the ones presented earlier as a means by which to help make sense of our culturally different patients. One of our ever present challenges in therapeutic (and diagnostic) work is to identify abnormality and dysfunction, which can only be done against the backdrop of what is normative in a given cultural context. In order to effectively make use of the cultural dimensions, however, the clinician must be aware of his or her own culturally characteristics, must be aware of the ways in which culture informs how he or she experiences herself or himself and the world, how she or he expresses herself/himself, how culture influences expression and finally, how culture impacts expectations, particularly surrounding the psychotherapeutic process, the therapeutic relationship, the therapeutic goals and expected outcomes.

Skills

One of the key critiques of "competence" as applied to intercultural psychotherapy is the notion that one can never achieve competence (in the way one can in car mechanics, for example). Tervalon and Murray-García [6] remind us that we never become fully culturally competent, and as such are always in the process of improving, like the asymptote. What this means is that we never "achieve" the necessary skills, knowledge or attitudes, but are always in the process of developing them. In a brilliant article, Sue and Zane [43] remind us that knowledge is distal from any therapeutic interaction; knowledge is an abstraction, and the real art is in its application to this particular patient in this particular situation, such that we can be responsive to the specific needs of the specific patient.

Central in this process is the capacity to be fully present to the patient, minimising the degree to which difference (and the associated implicit biases) blurs our experience of the patient. Thus we at once need to be able to be present to the patient as an individual without losing sight of the patient as a cultural, racial and/or religious being (or indeed to be present to the patient as a cultural, racial and/or religious being, without losing sight of their individuality), while at the same time having the capacity to monitor our own biases (especially implicit ones) and minimise their negative impact.

More concretely, the skill component is one of intercultural communication and the capacity to build a therapeutic relationship across any sort of difference (for an in-depth discussion of the challenges and some strategies, see [32]).

Attitude

For all that we know and all that we can do, none of it will make any difference at all unless we are willing to fully engage with a process that can be very challenging. Being fully open to all cultures, races, and religions, on the one hand, and, on the other, being willing to challenge and confront our own biases is extremely demanding in multiple ways, and even the best meaning of therapists may succumb to psychodynamic and cognitive strategies that help avoid such demanding work. As previously mentioned, all clinicians are situated in a relative position of power vis-à-vis their patients, which is all the more the case the more marks of privilege (SES, race, gender, sexual orientation, etc.) one is fortunate enough to be privy to. In the face of this privilege, especially for liberally minded folk, many may well feel guilt or some other reaction and will then take steps, often unconsciously, to justify their privilege (e.g. a racial or ethnocultural countertransference stance that diminishes the other by viewing them as inferior ("poor thing"; "they come from a primitive culture" "they do not know any better", etc.)). Thus clinicians need to be willing to challenge their own biases, a process which can be very threatening for many of us when we find ourselves confronting our own racist attitudes.

Conclusions

There are hundreds if not thousands of articles, book chapters, books, reports and conference presentations on the topic of intercultural competence in psychotherapy. To that end, there is no one "correct" model; indeed, there are many excellent models that parse the topic in multiple different ways. In this chapter I have attempted to add a little to our understanding of this process by exploring in some detail the impact and role of culture and race in the therapeutic process, as well as to suggest some ways in which we can develop the domains of knowledge, skills and attitudes. The model presented here is a metatheory; my hope is that it can act as a stance and as a perspective that can be incorporated into the work of any clinician regardless of their particular therapeutic commitment or client population base.

One of the biggest challenges that is particularly poignant in this day and age of mass migration and movement of refugees is that we will often encounter people in distress who are not at all psychologically minded, as per Kirmayer [1]. This in no way is meant to cast aspersions against anyone, but rather simply to recognise that culture informs the self, and there are selves that may be incompatible or at least not well served by a treatment modality that is predicated on a particular kind of individualist-independent self. The clinician is invited to be cognisant of her or his limitations and do their best to develop a network of healing professionals who can

respond to those "other self" needs. Clinicians are also invited to push their own limits to areas that may leave them uncomfortable but are well within their purview and could be helpful, such as discussion of spiritual matters (from a place of authenticity).

Finally, clinicians are invited to heed Tervalon and Murray-García's [6] call to work from a place of cultural humility.

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Adopting an Intercultural Perspective in Mental Healthcare

10

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Migrants and Refugees in the World

In 2013, the International Organisation of Migration (IOM) estimated that there were 232 million migrants worldwide [1]. According to the United Nations Refugee Convention, a person who, 'owing to a well-founded fear of being persecuted […] is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country' is a refugee [2].

Migrants and Refugees in Sweden

In Sweden, the number of immigrants has increased rapidly since the mid-1990s. In the first 15 years of the twenty-first century, the number of asylum seekers in Sweden was stable, with about 30,000 asylum seekers per year. The war in Iraq meant a peak, with 36,000 asylum seekers in 2007. Since 2012 there has been a slow increase in the number of refugees seeking safety in Sweden, but in 2015 the war in Syria meant a substantial but temporary peak, with

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163,000 asylum applicants, of whom 33,000 were unaccompanied refugee minors. In 2017, around 24,000 people sought asylum in Sweden, which means a return to previous levels [3]. UNHCR estimates that the global number of refugees is approximately 7% of all migrants [4]. In Sweden, however, the proportion of refugees among migrants is double [5]. Migration policy in Sweden has shifted over time. In 2018, the Swedish population reached ten million people, of whom 17.8% were born abroad and 12.7% are children of one or two foreign-born parents [6].

Social Determinants of Health, Pre-migration Factors, Migration Factors and Post-migration Factors

Socio-economic conditions, living and working conditions and social networks are among the general social determinants that influence health [7].

Numerous studies have described the positive association between socio-economic status and health and longevity which Marmot and Wilkinson termed the 'social gradient' [7]. Mental illness has also been found to be positively associated with social adversity [8]. Apart from the general social determinants that affect all, there are migrant and refugee-specific social determinants of mental health, often separated into pre-migration, migration and post-migration factors [9]. Pre-migration factors refer to the person's circumstances prior to migration, such as income level in region of origin and the reason for migration (such as need of protection). Migration factors focus on what happens during the migration process. For refugees this refers, for instance, to living in refugee camps or being smuggled across borders. Post-migration factors refer to the migrant-specific situation within the new country, such as length of time in the new country, language, socio-economic position, status loss, labour market attachment and experiences of discrimination or racism, etc. There are also refugee-specific post-migration factors, referring to asylum procedures, worries about family members who have been left behind, restricted working opportunities, etc. WHO highlights the specific difficulties faced by refugees, asylum seekers and migrants, including stigma, and the stress of acculturation and dislocation [10].

Mental Health Among Refugees, Asylum Seekers and Undocumented Migrants

There have been few epidemiological studies of refugees' mental health, although this situation is now changing [11, 12]. Even fewer studies focusing on asylum seekers' mental health are to be found, although this field of study is also growing [12]. Studies of undocumented migrants are still very scarce, hence the relative lack of knowledge about the mental health of this group. However, it goes without saying that there is a high risk of mental illness due to the severe social adversity this group faces in all high-income countries [12, 13].

Post-traumatic Stress Disorder (PTSD)

Due to refugees' increased likeliness of exposure to traumatic experiences, the refugee mental health literature has often focused on PTSD [14]. In a systematic review of 181 surveys, Steel and colleagues reported a PTSD prevalence of 30.6% among refugees and other people subjected to traumatic events in conflict areas [15]. Similarly, Fazel and colleagues found refugees who had resettled in Western countries to be at ten times higher risk for PTSD compared to the background population in those countries in similar age groups [14].

Studies of disaster sites show that the experience of wars and disasters is not necessarily associated per se with severe psychological reactions; rather, it is the individual's personal experience and vulnerability that matters [16]. Cumulative exposure to trauma has a clear connection to PTSD [17]. Torture and PTSD are also found to have a strong correlation [17]. Victims of human-made trauma and organizational violence are more likely to result in PTSD than accidental/nature made traumas [18]. The criteria for PTSD and depression partly overlap [19]. There is an overlap of PTSD and depression in trauma-affected populations [11, 14, 15, 17]. Refugees also run a high risk of depression without PTSD [11, 14, 15, 17].

PTSD has been hypothesised to be a risk factor for schizophrenia and other psychoses. Recently, this has been supported by a register study from Denmark on the broad diagnostic group of traumatic stress, including both PTSD and acute stress reactions [20]. Whether the risks for such a transition from PTSD to psychosis differ due to migration status has never been investigated. Little is known of PTSD diagnoses as a risk factor specifically for schizophrenia, or other non-affective psychotic disorders, and if the hypothesised risk would differ between groups, such as refugees, migrants and native-born.

Schizophrenia and Other Non-affective Psychotic Disorders

Schizophrenia and other non-affective psychotic disorders are serious and long-lasting mental disorders that often start in early adulthood. These disorders are characterised by periods of exacerbation and remission, substantial residual symptoms and functional impairment. Psychoses and PTSD are different in many ways, but have some similarities in terms of symptoms. Avoidance behaviours in PTSD resemble safety-seeking behaviours or negative symptoms in psychosis [21], such as problems with motivation and social interactions. Suspiciousness in psychosis has aspects in common with hypervigilance in PTSD. Hallucinations in psychosis correspond to the experience of flashbacks and intrusive images and bodily sensations in PTSD [21]. Despite these similarities, there are many clear differences between the disorders. For instance, delusional thinking, cognitive disorganization and negative symptoms seem to be more specific to psychotic disorders [22]. PTSD often pre-dates psychosis [20]. However, sometimes psychosis pre-dates PTSD. Non-affective psychoses were

found to be 60% higher amongst refugees than amongst non-refugee migrants from similar regions of origin who, in turn, have a significantly higher risk than the Swedish-born population [23].

Psychiatric Care Utilisation Among Refugees, Asylum Seekers and Undocumented Migrants

Pathways to psychiatric care refers to contacts made during the period from the onset of illness until treatment. *Utilisation of psychiatric care* refers to seeking professional help in primary care or psychiatric care, voluntary and compulsory use of in-patient and psychiatric emergency services. The literature regarding minority-background populations has mainly focused on *ethnic minorities* (including both indigenous groups, migrants, the descendants of migrants and other groups not identifying with the ethnicity of the majority population). However, the pathways to and utilisation of psychiatric care among migrants, including refugees, might be very different from that of ethnic minorities with a longer history in a country. For example, Somali refugees in the UK and the US have a high level of need but a low level of use of mental health services [24]. In Europe, refugees, asylum seekers and undocumented migrants encounter barriers to accessing mental healthcare [12]. WHO argues that promoting social integration, developing outreach services, co-ordinating healthcare, providing information on entitlement and available services and training professionals to work with these groups would lower these barriers [12].

In Sweden, all migrants with a residence permit (i.e. with the right to live and work in Sweden) are entitled to the same healthcare as the Swedish-born population. However, migrants with another legal status, for instance asylum seekers and undocumented migrants, are not entitled to the free universal healthcare. Asylum seekers and undocumented immigrants are only entitled to healthcare that cannot be postponed, the meaning of this being interpreted by the relevant healthcare personnel. All children have full access to care.

Utilisation of psychiatric care also differs between migrants depending on whether or not they have a permanent residence permit. Migrants in Sweden with a residence permit underutilise psychiatric care and psychotropic medications after initial settlement [25, 26]. The group with the lowest proportion of utilisation is that originating from Sub-Saharan Africa. This is in line with the study of Somali refugees in the USA and the UK, in which Somalians have been identified to have low levels of utilisation (but specifically high needs for psychiatric care) [24].

Hypotheses of Differences in Pathways to, and Utilisation of, Psychiatric Care Among Refugees, Asylum Seekers and Undocumented Migrants

Individual factors that might drive differential pathways to care and service utilisation between migrants—including refugees—and the background populations, include health literacy, stigma and prejudices, cultural differences and socio-economic

differences. WHO [27] defines health literacy as "the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health". Unfamiliarity with the health system and low language proficiency both contribute to lower health literacy among migrants than among the native-born population. Studies in Sweden have confirmed lower health literacy among refugees [28].

Persons with low health literacy need more guidance to access appropriate care, and a study in Denmark found that although all patients benefit from person-centred healthcare, it is particularly helpful to migrants [29]. In a review of mental health literacy interventions, Na et al. [30] conclude that the barriers to psychiatric healthcare include: stigma of attending mental health services or receiving a psychiatric diagnostic label; limited knowledge of the types of services available; lack of availability of culturally sensitive services; and language barriers. Additionally, Na et al. stress that many studies have shown that these barriers could be addressed by mental health literacy interventions if these are culturally sensitive and take cultural diversity into account.

Stigma and prejudice regarding mental illness exist everywhere, but are more pronounced and repressive in some areas of the world, and in certain cultures and contexts. Both stigma and prejudice can affect an individual's pathways to, and utilisation of, psychiatric care. Cultural differences between patients and staff may magnify the impact of stigma and further impair mental healthcare utilisation [31]. However, socio-economic factors cannot fully explain the different pathways, or the differences in utilisation [32]. In the UK, ethnic differences in help-seeking behaviours in a crisis have been found to explain ethnic differences in rates of compulsory admission.

Structural factors which might drive differential pathways to care and service utilisation include geographic area-level (geographical) differences, transcultural awareness among staff and institutional racism. Studies show how area-level differences have an influence on pathways to, and utilisation of, psychiatric care. In the UK, associations have been found between compulsory admission and local area deprivation and ethnic density (i.e. the proportion of persons of one's own ethnicity living in the area) [33]. Recent studies in Sweden have found area differences in proportion of population being foreign born regarding utilisation. ADHD medication among children were those living in areas with a large proportion foreign born having lower levels [34].

Additionally, patients' explanatory models of their symptoms can differ markedly from those of the treating clinician, and this difference can profoundly influence utilisation. For mental health professionals, different cultural variations in the presentation of psychiatric symptoms contribute to the risk of being misdiagnosed [31]. Transcultural awareness among staff can bridge cultural differences between patients and care. In the UK, there has been an open debate about institutional racism in psychiatry.

Despite full access to mental healthcare in Sweden for both child and adult migrants with a residence permit, this group still faces several barriers to care, such as: stigma attached to mental illness, language problems, lack of knowledge about mental healthcare, lack of trust, fear of being misunderstood, lack of clinical models responding to cultural diversity, economic and social problems with access to care and geographical distances to clinics. This creates new challenges for the mental

healthcare system and mental health promoting strategies. Interventions to improve intercultural accessibility of mental healthcare include special attention to refugees and asylum seekers from ongoing war and conflict zones.

The Importance of Working with Culture

The Swedish context, now globalised in many ways, includes a large number of refugees, thus requiring mental healthcare to employ a flexible approach towards people with mental distress. It also requires flexibility and willingness to adopt a self-reflexive stance towards existing models of working, research priorities and training. As health is inseparable from a culturally influenced perception of well-being, the Lancet Commission of Health highlights the importance of paying attention to culture in healthcare [35]. The Commission further argues that systematic neglect of culture in health is the single largest barrier to attaining the highest possible standard of health worldwide and that all settings need to understand the relationship between culture and health, especially factors that affect health-improving behaviours.

Culture is an abstract concept, given several meanings, and has to be transformed into concrete development in clinical practice. The Lancet report (2014) recommends defining culture in a broad way, and stating that it "embraces not only social systems of belief as cultural, but also presumptions of objectivity that permeate views of local and global health, healthcare, and healthcare delivery" (p. 1607). With regard to the future of psychiatry, a WPA-Lancet commission [36] emphasises human elements such as cultural sensitivity and the ability to form a strong therapeutic alliance with the patient. These aspects should remain central, and in psychiatry there will be demographic shifts towards older, more urban and migrant populations. The commission also states that the current wave of migration will mean that the importance of cultural factors will grow.

In the globalised multicultural society, mental health professionals encounter patients with different explanatory models of illness and ways of expressing distress. One way of describing this, according to the medical historian Edward Shorter [37], is that people at a given historical time and place have a limited number of symptoms to use, a sort of "cultural symptom pool for models of illness" (p. 320). Culture and context then influence how symptoms of mental disorders are expressed, understood and whether they are conveyed from a somatic or a psychological frame of reference. In multicultural environments, professionals encounter patients influenced by diverse "symptom pools" and medical traditions.

Culturally Sensitive Psychiatric Assessment

Psychiatric assessment and diagnostics are key in understanding both the patient and treatment planning. Psychiatric assessment includes evaluating if a person's expressions, symptoms and behaviours differ from sociocultural norms, and this

requires knowing what these norms are. The psychiatric diagnostic manual, DSM-5, has introduced the importance of paying attention to culture [19]. The role of culture in relation to mental disorders is defined as follows: "Culture provides interpretative frameworks that shape the experience and expression of the symptoms, signs, and behaviours that are criteria for diagnoses" ([19], p. 14). Culture is described as being transmitted, revised and re-created within the family and other social systems and institutions. The DSM-5's core definition of mental disorder (p. 20) refers to the importance of considering culturally approved responses to stressors, losses and socially deviant behaviour, when determining if a condition is to be considered as a mental disorder.

DSM-5 includes information about culture-related diagnostic issues, and these are added to the diagnostic criteria of the mental disorders. For example, it states that the risk for, and onset of, post-traumatic stress disorder (PTSD) may differ across cultural groups due to variation in type of traumatic exposure (e.g. genocide). Meaning attributed to a traumatic life event, the current sociocultural context, and other cultural factors, such as acculturative stress, have an impact on disorder severity. It is stressed that cultural syndromes and idioms of distress influence expressions of PTSD and of comorbid psychiatric disorders. Cultures are described as providing a behavioural and cognitive framework that links traumatic experiences to specific symptoms. There are also alternative ways for individuals to interpret experiences, distress, symptoms and behaviours. Interpretation is influenced by cultural cognitive models of making meaning, cultural traditions, as well as context, language and individual experiences.

DSM-5 includes the anthropological concept of "idioms of distress". This was originally coined by Nichter [38] to describe how culture and context affect expressions of distress. He defined idioms of distress as a socially and culturally resonant means of experiencing and expressing distress in local worlds. Idioms of distress may convey signals and information about past traumatic events, memories and present stressors. In DSM-5, the term 'cultural idioms of distress' refers to linguistic terms, phrases or ways of talking about suffering among individuals from a cultural group, using shared concepts of pathology and ways of expressing, communicating or naming essential aspects of distress.

To facilitate implementation of cultural awareness in psychiatric diagnostic praxis, DSM-5 has included information about culturally related/culture-related issues in relation to psychiatric disorders and has introduced a Culture Formulation Interview (CFI) [19].

Cultural Adaptation of Psychotherapy and Models of Care

Another important example of developing culturally-sensitive methods of working is the cultural adaptation of CBT (cognitive behavioural therapy) for severe mental illness [39]. Aaron Beck [40], a founder of CBT, suggests that CBT needs to be adapted to different beliefs and traditions of diverse communities. Further, he emphasises the importance of the service provider's awareness of the cultural

influence of presentation and care. When adapting CBT, it is stressed that the therapist has to move from the universal human experience to the specifically individual experience. Understanding the worldview of the patient helps the therapist to adjust and modify the therapy.

In clinical care, there is presently an urgent need for the translation and evaluation of screening instruments, including evaluations of cultural validity, and for research evaluating methods and tools aimed at improving cultural sensitivity. To use methods and tools aimed at responding to cultural diversity, clinicians have to be introduced to new fields of knowledge, such as cultural psychiatry, ethnography, and intercultural communication. Hence, this should be a part of basic professional training, supplementary training and training to become a psychotherapist. Existing international [41, 42] and local guidelines for care are supportive in this re-orientation process.

Working with Displacement Factors and Social Determinants of Health

For immigrants, and particularly refugees, post-displacement factors and social determinants are important for mental health and well-being. Several displacement factors, including temporary versus time-limited permission to stay in the new host country, family reunion and housing, are often outside the scope of the individual clinician's control. However, there are factors that clinicians may have an impact on, for example offering information about available social support and educational opportunities. Given that improvement in the social determinants of health has a potentially beneficial effect on the well-being and mental health of the individual, McGregor and Holden [43] emphasise that it is critical that mental health professionals in clinical settings explore strategies for reducing stress and improving coping among patients. This includes assessing risk factors such as unemployment, underemployment and other social determinants.

Sathcer and Shim [44] exemplify how clinicians can address the social determinants of mental health in the clinical setting. They give concrete examples, such as using the Cultural Formulation (CFI) in DSM-5 for evaluating discrimination and social exclusion, screening for adverse early life experiences, implementing supported education in clinical practice and creating local resource lists at clinics to support individuals experiencing poverty and financial crisis (see p. 247). They suggest that when a clinician treats a patient suffering from PTSD, the health-damaging effects of the neighbourhood and community should also be addressed. Addressing patients' ongoing stressful life situations could have a positive impact both on the mental health of the individual, and on the attitudes of professionals. Disregarding these social determinants may contribute to poor treatment outcomes, limited to trying to evaluate and treat de-contextualised symptoms, particularly among newly-arrived immigrants and refugees. An example of such a novel clinical approach is ROT, "Resilience-Oriented Treatment of traumatized asylum seekers and refugees". This model attends to displacement factors, social determinants of health and

strengthening resilience among asylum seekers and refugees, combining the concepts of vulnerability and stress with resilience, personal strengths and that of working with social support [45].

Targeted Culturally Sensitive Mental Health Promoting Strategies

Targeted mental health promoting strategies supporting resilience and healthy resources among minorities and displaced persons are essential for promoting mental health and well-being. One example of this is the suicide prevention strategy, "End Your Silence, Not Your Life," directed towards women of Turkish origin in Berlin, Germany [46]. This strategy was invented in the light of a greatly increased risk of suicidality in different ethnic minority groups and immigrants in Europe [47]. The specific project in Berlin was initiated in response to the high suicide rates among girls and young women in Germany. A public awareness campaign, including a telephone hotline, was combined with training important local persons in contact with the Turkish community about typical signs of emotional (suicidal) crisis among Turkish women. This culturally sensitive public awareness campaign succeeded in reaching young women of Turkish origin.

For newly-arrived refugees and asylum seekers, knowledge about migration stress, available social support and help for mental distress may support their well-being and facilitate access to mental healthcare and different treatment options. One example of conveying this type of information is the work of "health communicators" implemented in Stockholm and some other parts of Sweden. The health communicators meet groups of newly-arrived refugees and asylum seekers in local communities. They maintain an interactive communication in the language of the refugees, informing them about health and mental health promoting behaviours, and about the Swedish healthcare system. They discuss topics such as trauma, and what types of support and help are available for mental ill health, including care for post-traumatic distress. The health communicators challenge stigma connected with mental ill health and give basic information about treatment options, including psychotherapy.

The health communicators usually communicate with the refugees and other newly-arrived migrants in their native language, and the information they provide is adapted to the culture, educational level and knowledge base of the refugees. Although some are illiterate while others have a university education, and finding the right level can be difficult, all face the same types of daily stressor in their exile situation, such as housing problems, language difficulties and, for most, worries about family members and friends left in the war and conflict zones.

Human Rights-Based Care

In line with the Declaration of Universal Human Rights [48] and the World Medical Association [49], the Swedish Health and Medical Services Act ([50], p. 763)

stipulates that the goal of the healthcare system is good health and healthcare on equal terms for the entire population. Moreover, healthcare is to be given with respect to the equality of all individuals and with respect for the dignity of the person. Those in most urgent need should be given priority. This means that everyone with a residence permit in Sweden has full and equal access to health and mental healthcare.

For asylum seekers, undocumented migrants and especially for uninsured migrants from EU countries who have the right to stay in the country for a certain time but with access to the universal healthcare system, there are restrictions to mental healthcare in Sweden, as in many other countries. This is a problem for those in need but also for mental health professionals, who are guided by professional ethics and the international convention of human rights prioritising according to the need of the patient and not due to their legal status. Professionals may face additional ethical dilemmas in situations where the medical status has an impact on the asylum application. This could be, for example, in situations of suicide attempts, and mental disorders affecting detention or the possibility of deportation. In Sweden, the age of the asylum-seeking refugee minor is often questioned by migration authorities. Health professionals are expected to use unreliable medical examinations to determine the age of the minors, the outcome affecting the asylum process and permission to stay in the country.

Migration authorities also expect health professionals to take part in the detention and deportation of asylum seekers and irregular migrants. Such situations may cause ethical dilemmas for the health professionals. For those working in diverse communities with many asylum seekers, this may lead to feelings of "ethical stress". In regard to situations where there is an ethical conflict between the health of the individual and expectations of the migration authorities, the World Health Organisation (WHO) stipulates that: "From a human rights perspective, governments should be fostering the independence of the health profession. Its allegiance should first and foremost be to uphold health as a human right" [51].

Providing poor quality care may cause specific ethical dilemmas for clinicians. If communication, assessments, methods and support strategies are not responsive towards patients with minority and displacement backgrounds, it is hard for clinicians to uphold standards of equality and respect for human values.

Ethical Dilemmas with Politicised Healthcare

When migration policy collides with healthcare ethics, in terms of who is given treatment and who is denied, this can affect the healthcare environment severely as colleagues with different political opinions can find it increasingly difficult to agree on a course of action. Furthermore, working with patients who are harmed by the conditions of the migration system can be confusing and stressful and, additionally, when clinicians are legally prevented to care for some patients in the same way they would treat others with similar needs, they feel inadequate. Therefore, when

healthcare is politicised and provided on the basis of legal status rather than need, there may be consequences not only for the patients but also for the healthcare staff, which affects the healthcare at an organisational level.

A regrettable strategy among some clinicians in Sweden who find themselves in these situations is to avoid the patients altogether. For instance, patients might be referred within a clinic to a few colleagues, or just the one, who have taken a special interest in refugee patients and who have expertise gained from working with them. However, to refer patients to one specific person usually means longer time to treatment and possibly a limited range of methods. Sometimes healthcare professionals and clinics avoid these patients by referring to practical limitations—"this clinic does not work with interpreters"—or claim that trauma treatment cannot be done with an interpreter [52]. Patients living in an unstable situation (such as an asylum seeker pending residence permit, someone with a temporary residence permit, or with a permanent residence permit but an insecure housing situation) can be regarded as not receptive to or capable of participating in demanding trauma treatment. Asylum seekers and newly arrived refugees may also be avoided by therapists because they ask for various kinds of additional administration, such as documentation and attestation to various authorities, and has a greater need for psychosocial support.

Clinical Experiences and Challenges in the Mental Healthcare of Traumatised Asylum Seekers and Refugees in Sweden

Case

A 30-year-old man from an African country arrived in Sweden as an asylum seeker. He visited a healthcare centre for a routine check-up and was diagnosed with post-traumatic stress disorder (PTSD). He was not recalled to the centre or offered treatment. The psychologist assumed that most refugees are traumatised as a natural response to war. Considering that most asylum seekers are in a state of crisis and many suffer from mental health problems brought on by the actions of Swedish migration authorities, he concluded that the patient's mental status was inevitable, not an illness to treat. Even if the psychologist would have liked to offer support, adult asylum seekers in Sweden are only entitled to healthcare that cannot be postponed, and stabilising efforts and trauma treatment is often denied with reference to this legal limitation.

But far from simply being an understandable response to potentially traumatic events, PTSD is a clinical condition which only a minority of trauma survivors meet the criteria for [14] and the responsibility of the healthcare system. The asylum process does create illness [53], but regardless of what type of external trigger causing a patient's crisis, the patient is the responsibility of the healthcare professionals. Refusing this patient treatment affected his long-term health. Shortly after his visit at the healthcare centre, his PTSD symptoms got worse and intrusive flashbacks, concentration difficulties, avoidance of memories, hyperarousal and lack of sleep affected his abilities to make a reliable claim for asylum. He did, despite this, get his

residence permit, and his condition continued to affect his possibilities to learn Swedish and apply for employment. He did not contact any healthcare services for his symptoms for many years; as he had once been rejected, he concluded that there was no help available.

(To protect the anonymity of the persons involved minor details have been changed.)

Treatment of Post-traumatic Stress in the Context of Exile

PTSD itself is a well-known diagnosis among refugees and asylum seekers, and there is much knowledge, evidence and experience regarding treatment of PTSD [14]. However, the complexity of asylum seekers' and newly-arrived refugees' situation is rarely considered in healthcare planning. In order to be accessible to people with vastly different backgrounds, healthcare systems need to broaden. Consequently, trauma treatment cannot be designed exclusively for people with a stable life situation, or for patients familiar with the healthcare organisation, who speaks and reads the country's language, have access to a computer, knows his/her or hers rights, have a social support system, etc. It should not be possible to overlook the responsibility to make treatment accessible by placing the need to change with the patient. It should not be an accepted practice to decide, like the psychologist in the case example, that the trials of the asylum process in itself prevent trauma treatment. Nor should it be possible, as clinicians in the examples regarding ethical dilemmas do, to claim that treatment cannot be done with interpreter or is made impossible by a range of other life circumstances common among asylum seekers and newly arrived refugees. When conditions are far from optimal, it is the competence and conditions in the organisation that need to change—for the patient cannot change his/her situation. Since treatment is possible in unstable countries, countries where war is raging on the other side of the border [54], it certainly can be adapted and effectively provided in peaceful countries, putting to rest all discussion regarding the need for a fully stable life before engaging in trauma treatment. For example, treatment methods such as narrative exposure therapy have been developed to be effective during short, unstable care contacts [55], and more research on exposure therapy indicates how it could be designed more efficiently [56]. For those who do not respond satisfactorily to classic prolonged exposure—up to 40% [57]—there are several interesting complementary methods, such as compassion focused therapy. Peer-to-peer meetings—to start a treatment by meeting a person who has taken part in trauma treatment (a person who perhaps even shares the patient's language, country of origin or culture), who can describe what the treatment entails and instills hope—have shown good results [58]. It is important to constantly develop effective methods for a patient group this vulnerable. Ensuring that resources produced for other patient groups—for example aid and protocols for cognitive impairments—are accessible and used should also be a natural part of working with traumatised refugees.

Practical Considerations for Availability

However, no matter how much methodological development can enhance treatment, no matter how carefully treatment plans are made to account for issues regarding language, culture differences, living situation—the most important reform is still to adapt the healthcare organisation to the chaotic life situation of asylum seekers and newly arrived refugees. We need to make sure healthcare is actually, realistically, accessible and possible to engage in. This remains the most urgent issue for ensuring competent trauma treatment for migrant patients in Sweden. For example, there will be occasions when a traumatised refugee patient will not be able to prioritise their health due to a crisis in their lives, i.e. treatment-disturbing events. To plan for such occasions and maintain patients' contact with the clinic, rather than terminate the treatment, lowers the threshold for the patient to restart therapy and avoids having to end a therapeutic relationship, which could be experienced as rejection or loss. Such arrangements could have the form of open voluntary drop-in group activities for all patients at the clinic—trauma sensitive yoga, movement-, art- or music therapy groups etc. Groups are relational and effective in themselves, and especially for cognitive impaired patients, body-centred treatments can provide an opportunity for stabilisation. Regarding one common problem among PTSD-patients—difficulties with being on time—which often leads to terminated therapy contacts, this should not be penalised, but instead seen as an indicator of important symptoms (sleeping difficulties, concentration issues) which could indicate a powerful direction of treatment and be a part of the empowerment process. Other reforms for availability could be:

- It is preferable if the traumatised patient can choose between several healthcare providers. Having more than one healthcare clinic is important (even though the PTSD-patient's capacity to make a well-informed decision can be reduced) since patients subjected to torture, persecuted by their government, are not always capable of seeking help from publicly run care centres. Other advantages of choosing between several clinics are that if the therapeutic relationship is damaged in one clinic, there are more options available for the patient. This is also desirable when a patient wishes to avoid encounters with, for example, a family member or a perpetrator who is also receiving treatment.
- Language should not be a barrier to treatment. There need to be a professional interpreter service, of course, but it is also a great advantage to have both therapists and administrators who speak different languages, both for regular patients who, for different reasons, oppose the use of an interpreter and for drop-in patients. Drop-ins are seldom encouraged, but they do still happen, especially for patients with chaotic lives. With long-term patients and people who wish to become patients alike all meetings with the clinic, should be a good experience for the patient, so good communication should be prioritised.
- Specialised clinics for traumatised refugees should, as far as possible, allow patients to seek treatment without referral from other healthcare professionals, since patients without knowledge about how the healthcare system is organised

easily can get discouraged by not receiving care in the first clinic they visit. It is better to let clinical staff working with PTSD-patients make the initial clinical assessment and, if necessary, refer further.

– Engaging civil society for community based interventions is an important part of strengthening the patient's ability to reconnect to people, to create a sustainable context for recovery that, after treatment, prevents relapse. Preferably, co-operation should be developed with already established, stable organisations. Such organisations can become a fixed point in the patient's life, even if the volunteers themselves come and go. Healthcare needs to be economically accessible, preferably free of charge. Refugees often have a small budget and even small costs (or the risk thereof) are too threatening and deter patients from seeking help. For patients who take part in employment programs, treatment becomes most effective if healthcare is made to be a part of the employment plan, so that the efforts do not collide and create conflicts and anxiety, but instead strengthen each other. Treatment should always be adapted to the patient's reality—starting a new internship, for example, could be planned for in therapy with adapted exposure exercises in co-operation with the employer.

It is important to consider that all patient contact is either relationship-building or relationship-damaging. Performing services outside your professional capacity, translating letters, etc., for the patient and thereby stepping outside your role is often discouraged, and the risk of clinicians becoming overworked by trying to help patients too much is well known; however, as a planned part of treatment, it can strongly benefit the therapeutic work. It shows understanding of the patient's strained life; it can model problem-solving skills, put some of the patient's acute worries to rest and make the patient able to focus on the planned treatment interventions for the session. If the purpose of doing something outside of the professional duties is clear, it is not, in real terms, outside the professional role.

It is also essential to pay attention to clinical staff's own stereotypes. Individuals who have been traumatised do not react in the same way and different types of treatment must be available. The PTSD-patient is frozen in fear and time, rigid—and must not be met by a rigid care system. There is no one-size-fits-all solution for traumatised individuals. Each relationship that is initiated with the patient should also be designed with regard to the patient's difficulties with trust so that the clinician models care and compassion in all he/she does.

Shared Decision-Making

There will always be a power imbalance between patient and therapist, and if not addressed it could be a constant reminder of the lack of control the patient has felt during traumatic events, or the inequality he/she feels in her everyday life in exile. A UNHCR report about mental health and Syrian refugees stresses that refugees have little influence over most aspects of their lives, so to design interventions to support the patient's capacity to regain control can facilitate a sense of empowerment. An

important way of doing this is to actively involve the patient in decision-making on intervention plans [59]. Providing knowledge about mental healthcare and models of care may, for patients in a migration situation, facilitate shared decision-making in treatment situations. Good patient care for war and torture survivors is always built with the assistance of survivors and strives to empower all patients made to feel powerless by violence, encouraging them to take responsibility and have freedom of action and options. In the beginning of treatment, this will concern small things—choosing when to meet, choosing interpreters or therapists. These are practical arrangements commonly kept from the patient since it makes the planning of the healthcare organisation more difficult and, in the short term, less effective—but seeing the choice itself as a treatment intervention, a behavioural experiment, can motivate organisational change.

In dealing with treatment goals, it is the patient's own individual goals (initially perhaps drastically over- or under ambitious) that matter. Patient goals will, and should, change during treatment, as the patient sees his/her abilities and strengthens them. Research, based on this, may therefore need to be designed to focus on single case studies to illustrate true treatment success.

Treatment Available to the Whole Family

Not all survivors of potential traumatic events develop PTSD, but the situation does occur where more than one person in a family is affected, or when a relative's traumatisation also causes illness in a partner, parent or child. Co-operation with schools, for child and youth care, and network meetings on family-related issues in adult psychiatric care are important for identifying other "patients" around the patient. Another effective method may be to invite family members to meetings about PTSD symptoms, psycho-educational meetings held either in groups with other patients' relatives or individually. It is not uncommon with a conscious division in the family, whereby one person is allowed to focus on their illness (show symptoms) while others must be strong, keep the family together, organise and work (act healthy). Showing an interest in and welcoming the family increases the probability that other family members seek healthcare for themselves, which in the long term strengthens the patient's everyday life and creates sustainable health.

PTSD is not an inevitable consequence of war and traumatic events; mental health issues brought on by the asylum process should be taken seriously—and both treatment methods and organisational surroundings need to adapt to the traumatised individual to guarantee accessible healthcare. Most preferably, treatment for traumatised refugees must be characterised by both sharp clinical skills and a holistic vision [60], a multimodal model. A trauma clinic should be a miniature world. Patients with concentration difficulties and language deficiencies as well as trust issues should be protected from being referred to several different clinics and authorities and people who they do not know. Since the pathway to recovery already is rough and filled with obstacles, we need to seriously lower the thresholds to successfully connect with healthcare providers.

Conclusion

Mental healthcare is a humanitarian issue, supporting the well-being of the individual in need, and of a healthy work force that can contribute to the development of society. In globalised societies, mental healthcare is one of the institutions that can contribute to an inclusive, tolerant and diverse society. A key issue in increasing accessibility for minorities, refugees, asylum seekers and so-called irregular migrants to mental healthcare systems and therapeutic models such as psychotherapy, is to introduce the concept of culture into applied methods, to enhance cultural sensitivity and institutional awareness.

Clinical work has to pay practical attention to the specific social determinants of mental health for displaced persons. For victims of torture and persons suffering from post-traumatic stress, methods need to address cultural variety and the migration situation. Resilience-oriented clinical approaches are important for strengthening patients' resources and capacity. Tailored mental health promoting strategies and social support may reduce mental distress and facilitate interaction with mental healthcare.

The re-orientation of the mental healthcare systems requires policy discussions, guidelines, education, training, supervision and support. Pre-orientation can be an important step towards a flexible healthcare system that is inclusive and responsive towards a diverse and historically, continually shifting population.

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Intercultural Balint Work

11

Volker Haude

Introduction

Since before the recent influx of refugees into the EU, there had been ongoing discussion about multicultural topics in therapy, supervision, medical treatment, coaching and so on. Among healthcare professional in Western societies there is a common understanding that diversity and multiculturalism must be taken seriously if healthcare is to be effective; cultural adaptation deals with just how this can be implemented. It is not enough to have institutions labelled as multilingual; rather, healthcare professionals must see cultural competence as a major necessity and make steps to build this competence [1]. Hayes et al. [2] underlined that cultural competence makes a difference in treatment outcomes for racial ethnic minority patients and, thus, that "cultural competence can be distinguished from general therapist competence". Developing such competencies may be unfamiliar to physicians, whereas therapists or counsellors have encountered supervision and other reflection on the therapeutic relationship during their education and professional pathway. Balint groups fill in the gap as they provide a well-developed technique of reflection adapted to the physician's reality to enlighten difficult aspects of the "doctor–patient" relationship [3]. Given the long history of Balint groups, the lack of relevant studies on how the dimensions of culture influence the process of Balint groups, as well as on how these groups can be used as an instrument to explore cultural characteristics in the physician–patient relationship, is quite astonishing. At present, such exploration is limited to some anecdotal reports concerned with transcultural Balint groups that address the adaptation of these groups in different cultural settings [4, 5]. As Rosenberg et al. ([6], p. 237) state, in Balint groups, "the physician's ethnocultural identity is not routinely addressed". However, there does not seem to be any obvious reason as to why cultural topics could not be tackled

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within the Balint method. Therefore, this chapter will explore the relevant aspects of how multicultural issues can be implemented in the Balint reflection method.

Classical Balint Groups

Balint groups were developed by Michael and Enid Balint [7–9] and were derived from their earlier group work with social welfare care workers in the late 1940s. Balint himself had a history of migration, as his family originated from Hungary, but he migrated to Germany for his psychoanalytic training before moving to England for political reasons [10]. The Balints labelled their groups for physicians as "training cum research", thereby underlining the research aspect when studying the "doctor–patient relationship". Later, Balint groups became increasingly generalised, especially in Germany where there was a long tradition of specialist training (internship or residency) which featured obligatory Balint groups in their curriculum.

The classic Balint group, according to the *Deutsche Balint Gesellschaft* (German Balint Society), consists of 8–12 participants, i.e., doctors led by an experienced leader (and co-leader). Any physician–patient encounter is welcomed for presentation. Following this, the group leader will allow for a few questions before the presenter is asked to step back while the group is invited to share his or her ideas, feelings, fantasies or impressions without addressing the presenter directly [11]. The group leader (and/or co-leader) will then attempt to observe and understand the group's process, focusing on the unspoken aspects or the group's dynamics. The leader will then go on to clarify or interpret these observations at certain stages of the group session; thus, they try to enlighten aspects of the physician–patient relationship by revealing the hidden wishes or expectations of the patient, along with the role of the physician, the context factors, the hidden affects and so forth. All the while, it is held that group containment is necessary for the group members to achieve an output that helps the presenter to better understand what produced the entanglement and to instil the necessary distance for being medically and or therapeutically helpful.

In therapy groups, the same group dynamics as in Balint groups can be seen; Foulkes and Anthony [12] describe these as "group specific factors" and "group phenomena". Some of these regularly observed dynamics in the Balint group processes are described as mirror and condenser phenomena, resonance, support and subgrouping. The most important factor is the mirror phenomenon, which implies that the group process reflects relevant aspects of the physician–patient relationship; to reduce complexity and minimise personal therapy, Balint excluded the personal peculiarities of each group member's character. Often, if the group members reach an intensive working atmosphere, group resistance loosens, and deeper, primitive affects condense and characterise the group process; this indicates that the collective unconsciousness is discharging, which may lead to subgrouping when the group splits into smaller fractions and members unite in defending each other's arguments or feelings. The group leader must be aware that this will neither be "an obstacle to the progress of the group" ([12], p. 155) nor, in the Balint sense, obstruct

the goal of finding insight into the physician–patient relationship. At this point the group leader may intervene supportively and remind the group participants of their acting "as if" in the Balint group. Support and resonance are factors that help the group to function on a productive level.

To the best of the knowledge of the author, the impact of intercultural issues has yet to be explored or mentioned by Balint, perhaps because the diverse reality which societies face today was not found in Britain at the time when the Balints experimented with this training program.

Outcome Research

Data on Balint group outcomes is scarce, as found by van Roy et al. [13]. While strong empirical data is missing, qualitative studies on the effects of Balint group have, for example, found increased self-awareness, changes in interaction with patients and competence in the physician–patient encounter by using a new perspective. A recent study by Flatten et al. [14] among participants of Balint groups throughout Germany showed the effects on all three questioned scales: reflection on the physician–patient encounter, emotional and cognitive learning, and identifying the group dynamics as case-induced (i.e., mirrored). Thus, we may assume that Balint's original goal, set more than 50 years ago, namely "a limited though considerable change in the doctor's personality", may too be achievable through Balint group sessions nowadays. Nevertheless, we must acknowledge the limitations of Balint group work, as Kjeldmand and Holmström [15] did: the effectiveness of the Balint group depends on (1) the individual's needs, vulnerabilities and defences, (2) the group (including the leader) having hidden agendas, (3) rivalries and secrecy needs, as well as (4) the surrounding environment that defines the conditions of the group. Group dynamics can be malicious and are often exposed to tough environmental conditions. Participants can even drop out of Balint groups for cultural reasons ([15], p. 811) if the group is ignoring this agenda. Kutter [16] reports on reversed mirroring in the sense that group dynamics (in the case of a supervision group) can be destructively influenced by adverse countertransference reactions of the participants; these may obscure the presented physician–patient relationship and impose challenges to the techniques used by the group leader whether the dynamics are linked to the case report or to other circumstances.

Intercultural Aspects

According to my personal experience, having visited many different Balint groups, I have found that intercultural topics are very rare in the case presentations. These findings contrast with the intense and vehement discourses of everyday clinical work which is often concerned with the issues of migrant patients, given that more than 20% of the German population have a migrant background [17]. Balint stated that "[the doctor's] blind spots, short comings and mistakes have to be brought out

quite clearly and discussed as frankly as possible" ([7], p. 116). In this sense, we need to focus on the blind spots concerning intercultural topics. If it is assumed that it is not a coincidence which themes do or do not (for reasons of individual or group resistance) occur in a Balint group session, who decides which themes or cases are discussed? A Balint group with members of different cultural backgrounds may be predestined for intercultural topics due to the Foulkesian group matrix ([18], p. 292); i.e., the common cultural, social and linguistic denominator [19] is yet to be formed. Scholz depicts basic dimensions as the understanding of cultural groups, gender relations, the relationship between generations and the entire social structure, including social class, history, power and non-verbal aspects, all of which comprise the communication seen in groups. However, can we assume that the group process founded on this common ground will eventually be successful, bearing in mind the above limitations of Balint groups in terms of negative group dynamics or dropouts? That is, will a culturally mixed group naturally deal with the topics of the otherness? We cannot be sure, as Balint groups with mixed cultural composition may be faced with other challenging group dynamics, as shown by the example below. In a multicultural Balint group, one is typically aware of subtle culture-bound gestures and movements when observing the groups process, if referring to group participants with different cultural backgrounds, as well as the mirror phenomena in situ if referring to a migrant patient being discussed in the group session. In every Balint group it is important who presents a case and who feels the need to present something of his personal entanglement with a patient; this may collude with the (unspoken) wishes of the group and their desire to be open to specific topics and avoid others. Thus, in joint resistance, difficult topics can be left out. Usually, the group leader is not in a position to decide which cases will arise. Instead, it is the group dynamic that induces certain case presentations after a period of silence [20] and this elicits what the group can tolerate. If the group is to be capable of tackling difficult intercultural questions, which according to Baecker [21] imply dissent and consent, acceptance and rejection with predestined contradictions, the group participants must have an idea of their own cultural values to be aware of the strains patients face with acculturation. Does an interculturally aware Balint group have to be constituted by experts from different cultures, or should the group be homogenously looking at other cultures from a distance? Aside from the fact that the composition of the Balint group is given, i.e., can't be changed along the specific (intercultural) cases which are to be discussed, most group leaders will not be in a position to select from a large pool of "suitable" group member candidates. In my opinion the question is how the leader can influence the group dealing with the clinical reality of the everyday practice of its participants in a culturally sensitive way.

Examples of Intercultural Balint Group Topics

Migrant patients are faced with the ongoing confrontation of assimilating to the majority culture or being marginalised. The aspect of inclusion and exclusion—as mirrored in the Balint group—may be illustrated by the following example:

> During a three-day Balint group seminar, a group participant asked twice to present a case concerning a patient with a history of asylum seeking and the concomitant problems arising within the collaboration of different institutions, including the medical care hosting hospital. At first, the case was not deemed to be "that important". On the second occasion, when the participant suggested his case again, the group participants were asked to choose between this and another case in a vote. The voting rejected the migrant patient topic and the group decided to hear the story of a schizophrenic patient.

I mention this anecdote to point out that whatever the reasons were which led to the turning down of this case presentation, the above group participant is likely to have left the session with a feeling of being disvalued and excluded. This may as well be the countertransference feeling that we are exposed to as therapists when working with clients of migrant history. Perhaps the group could not assimilate "the stranger"—that is, the asylum-seeking patient—as a real group member and were fearful that the questioning would be driven towards the topic of otherness [22], thus leading to a rise in anxiety and insecurity. So, given the chance to pick, the group chose a safe option. As Balint group leaders, we should be mindful when encountering those situations as they can be highly valuable for gaining an insight into unspoken (i.e., hidden) agendas not only concerning the physician–patient relationship but also the doctors' experiences about dealing with an unwanted stranger in his clinical practice environment and group based rejection as described above.

When taking part in a Balint group session that presents an intercultural case, can we expect a relevant change in personality of the case-presenting doctor concerning those intercultural attitudes? As an example:

> At a Balint seminar in Germany, a female gynaecologist presented an encounter with a young Turkish woman who was regularly bothering her in the Emergency Room of the clinic during nightshifts. This young woman had no serious illness, but had abdominal complaints underpinned by her boyfriends' pressuring to do something. Within the Balint group process, feelings of anxiety, threat and guilt were expressed by the members. It seemed as if the physician, being put under stress during nightshifts, had to cope with her own confusing attitudes towards cultural differences when this patient expressed complaints and helplessness in a "hysterical way". The Balint group's containing of negative feelings arising from this interpersonal relationship with the patient eased her discomfort and may have offered a chance for the physician to look behind the noisy pressing behaviour of the patient. At the end of the Balint session though, when making a final comment, the presenting physician tried to convince the group that the patient was not in a position to put pressure on her to receive specific medical treatment.

It seemed as if the physician was not ready to look at the personal factors that lead to her feeling pressured, and this prevented her from exploring those negative attitudes which made the physician–patient relationship complicated. Although the Balint group process aims to look at the unconscious aspects of the "doctor setting out his case in its relationship to the patient and to the illness, and more broadly to the medical sphere as a whole", Oppenheim-Gluckman [23] cites Balint and states that "our interpretations, therefore, are hardly ever concerned with the hidden motivation of the doctor's therapeutic behaviour, a sphere which we have come to call his 'private transference'. This remains untouched…" (p. 70). This may explain,

why the group leader in this case chose to accept the outcome of this Balint session as a good enough result. In Balint groups on a regular basis though, we would expect to follow Balint's recommendations in reevaluating the previous case discussion, thus creating a basis for substantial emotional and cognitive learning through continuous Balint group attendance [14].

When observing a cross-cultural physician–patient relationship, we must consider the difference of power which is depicted by the asymmetric power distribution. "Power is an inescapable aspect of all interpersonal relationships" ([24], p. 449) and on both sides, the doctor or patient may use or misuse power in the realms of money, knowledge or social authority: "How power is used and exchanged is influenced by the personal qualities of the doctor and patient" (p. 452). Özdaglar [25] in her report on a psychoanalytic treatment of a Turkish patient asks very relevant questions: What kind of therapeutic relationship can be established with a German therapist while feeling ashamed because of the other social background, an educational backwardness and the past history of violence? How can the humiliatingly ascribed non-European identity be integrated or transformed (p. 1112)? The migrant patient must adapt and expose himself to receive the benevolence of the doctor. Patients with a history of migration who have experienced privations and the loss of the containing function of their "mother culture" [26] face an existential struggle to recreate the concept of the self with the integration of their new culture. The subordination to the host culture and the price to pay for the loss of individual freedom makes it vital to suppress aggressive impulses. The physician, on the other hand, is one who deals in the helping and serving field and who is less concerned with dispute and confrontation either way. Thus, the resulting collusion in the physician–patient relationship may lead to exploitation on both sides. A Balint group can help clarify the situation of the patient and the hidden motifs of the physician to maintain a positive and helpful relationship; this may become more complicated if the topic of power difference is enacted within the Balint group itself (i.e., the dominance and helplessness determines the group dynamics, whereas the actual patient case recedes to the background). This finding may be illustrated by the following example:

> A few years ago, at a Balint seminar for professionals in Germany, a participant belonging to an Eastern European professional delegation was also in attendance. During the small group session within the larger seminar group, he was attempting to follow the group process with an interpreter. From the onset, the participant criticised - with depreciating remarks - the others for missing the point and lectured them in Freudian terminology. The other small group members felt offended and, as the group conflict tension rose, the interpreter stated that she could not translate at the speed of the group's comments. At this time, the Balint group process seemed to break down and come to a sudden halt. It was only when the group leader advised the group members to speak slowly and to give time for the interpreter to translate that the group process went on falteringly because the group members seemed to hesitate giving spontaneous remarks. The actual Balint case presentation, concerning a woman suffering from dizziness and an uncertain gait, became insignificant.

In this case, understanding the case dynamics and gaining insight into the doctor–patient relationship did not seem possible, as group tensions were high, and the

group members failed to dive into a role and act as part of the patient system and recover from it or change roles. It seemed that the colleagues from Eastern Europe found themselves under pressure to demonstrate their professional expertise and, presumably as such, sought to humiliate other Balint group members. The group leader missed the chance to name the struggle for power by relating the negative group dynamic to the physician–patient relationship; i.e., the case presentation. The native German group participants exhibited a latent, unspoken opposition leading to a near disintegration of the group.

> At the end of the three-day Balint seminar, the native German participants were confronted with a notice that the visiting Eastern European delegation had departed abruptly, leaving the rest of the large group with feelings of bewilderment, anger and guilt. The initial small group process had escalated during the seminar and, as tensions rose, accusations and injuries had led to an intolerable group climate. The large group was vehemently discussing the whys and wherefores about the abrupt departure, but finally reasoned that "we should not have to endure those hurtful remarks by the Eastern Europeans".

Weinberg [27] gives another example: "processes in the large group represent unconscious dynamics in the organization in which the large group is working or in society at large. For example, if in a particular group psychotherapy association conference there is a harsh conflict between two subgroups in the large group, we can conclude that either the association is split into two conflicting subgroups or that the external society is in a conflict situation with different groups fighting one another". He goes on to state that, "in the large group a person feels the pressure of representing his/her country, religious orientation, culture, etc. Perhaps this is why people in large groups feel a threat to their identity and of losing their individuality" (p. 258).

This large group at the Balint seminar was not able to contain the "strangeness", because "the persistence of strangeness is intolerable to the group" ([12], p. 159) and it chose to extrude the strangers. Thus, when minding small group processes, we must understand larger group processes, as they can show adverse development/occurrences if the containing function of the external large group—i.e., society—is missing.

As mentioned above, there may be a natural tendency to avoid facing the unfamiliar that is the intercultural topic in Balint groups. As in any group process, the members resonate and drive towards coherency in "[…] a sense of understanding what is going on, that it makes sense and becomes increasingly meaningful" ([28], p. 53). When looking at the unfamiliar though, everyone in the group must question their common denominator to tackle anxiety-provoking differences between group members.

Given this difficulty in Balint groups, we set a working variable when starting our intercultural Balint group:

> At the congress of the DTGPP,[1] the author conducted an experimental Balint group workshop with an intercultural focus. In addition to the standard introduction when starting the

[1] IX. Congress of the Turkish-German Association for Psychiatry, Psychotherapy and Psychosocial Health, Hamburg 2016.

group session, the leader (male) invited the group members (only women) to think for a moment about his or her own background, values, attitudes and spiritual beliefs, as well as those of the participant's parents and grandparents. After a short period of silence, the presented patient case by a therapist with a migration background about a young migrant woman with sexual dysfunction seemed to initiate a benign discussion about how to support female clients with a history of migration. However, the underlying intense effect of shame was not initially brought up. As the group leader noticed subtle attacks on the presenting therapist and disapproval about what was said and what was not, the shame affect was suddenly prominent. It was then possible to relate this to the patient's context and to utilise the group dynamics to clarify interpersonal emotional experience and, thus, to highlight hidden aspects of the therapist-patient relationship within the same cultural background.

Many clients in medical, therapy or counselling situations with a history of forced migration have experienced traumatic incidents; during the healing process, those affects accompany this process. "Women's cultural role, greater sociability, and lower aggression, coupled with their second class citizenship, increase their tendency to experience shame" ([29], p. 129). Shame relates to the "embodied performance of identity in relation to cultural norms [... and] denotes social rejection which is either based in reality or imagined" ([30], p. 46). Although studies show that racial ethnic matching within the physician–patient relationship results in a more positive outcome [31], collusive moments can include conjunctive and avoiding culturally shaped negative feelings. In the implicit agreement in the context of the patient, "it [the sexual dysfunction] won't be talked about" was revalued, and offensively, openly talked about. Social rejection was suddenly apparent and perceptible, mirroring the emotional experience of the patient with a migrant history. The here and now moment of what was going on in the group between the male group leader and the women group members though was not talked about and the sexual aspects in this context remained hidden behind the shame affect. In the case of consolidated group coherency, e.g., in a Balint group on a regular basis, Balint group leaders should try to verbalise those scenic moments as they provide insight into unconscious motives on either side of the doctor and patient relationship.

Conclusion

This paper has attempted to describe various aspects of intercultural Balint group work and offers a proposal for Balint group adaptation with respect to the multicultural reality in medical treatment, therapy and counselling. For a Balint group to function interculturally, group members must be sensitised to differences in beliefs, attitudes, values and traditions by being aware of their own background. A Balint group can become a container for cultural issues relating to the migrant patient–therapist relationship and, thus, is capable of tolerating any negative effects, such as humiliation, shame or guilt. Inherent in the Balint technique, the case-presenting group member stays safe during the discussion process and may experience a group containing those negative feelings. It is important to be aware that the tendency to avoid these difficult topics can be found in Balint groups and society alike. Among

other reflective processes, the Balint method is one with a long history, yet is sparse in terms of scientific research on intercultural topics, so more systematic research should be done on leading techniques in Balint groups which emphasise intercultural awareness. Furthermore the agendas of the various training curricula for becoming a Balint group leader should include this subject.

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Religion and Spirituality in Intercultural Therapy

12

Limore Racin and Simon Dein

Introduction

Pargament [1] noted a religious dimension to coping when studying major life stressors ranging from illness to war to the Oklahoma City bombing. Pargament explained that there are certain types of religious expression that can be either helpful or harmful. Individuals who embrace what could be called 'the-sinners-in-the-hands-of-an-angry-God' model have poor mental health outcomes. For example, feeling angry towards God believing they're being punished for sins or perceive a lack of emotional support from their church or synagogue usually results in more distress, anxiety and depression. In contrast, individuals who embrace the 'loving God' model suffer less and enjoy more positive mental health outcomes. These individuals perceive God as a partner who works with them to solve difficulties, which, in of themselves, are opportunities for spiritual growth. Further, they believe their religious leaders and fellow congregation members are supportive.

Stanley et al. [2] noted that 77–83% of patients over age 55 wish to have their religious beliefs integrated into therapy. Keating and Fretz [3] reported that clients who have a religious affiliation are considerably dissatisfied when working with a clinician who is not religious. Belaire and Young's [4] study had similar findings; Christian clients with no previous therapy experience having a preference for religious counsellors. Interestingly, if Christian clients have previously had therapy, their preference was for a secular counsellor. An explanation given was that religious counsellors were less open; patients felt that their values and feelings were not equally being met or fully understood. The findings suggest that practitioners may not be well equipped to use religion effectively within therapy if they are either more religious than clients or more secular [4]. Tan [5] proposed another explanation; therapists can be in danger of 'abusing or misusing' religion or spirituality in counselling. This hints at ethics; ethical considerations need to be met; otherwise,

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the boundaries of a therapist's professional competence can be mismanaged and can lead to terminations or unsatisfied clients. We begin with a case study treated by SD illustrating the role of religion in intercultural therapy.

Case Study

Jasmin was a 30-year-old woman, married with two young children. Born in Pakistan, she came to live in the UK at the age of 15 and had been a devout Muslim for all of her adult life. Her General Practitioner referred her to my clinic because of marital problems, feelings of depression and frequent suicidal ideation. She attended her first visit together with her sister and her youngest child Ahmad who was crying in the background. SD remembered being struck by the fact that Jasmin was almost silent when she first met me. Her sister did all the speaking until after about an hour when Jasmin spoke up. She recounted the following story:

She had a happy childhood in Pakistan and moved to the UK during adolescence with her family because of her father's job. Although she initially felt unsettled in London, she soon adapted and made some friends. At the age of 18 she entered an arranged marriage to her husband Mohammed and this is when her problems started. Her husband was nearly 15 years older than her. She quickly found that he held a very traditional attitude towards women. He was very controlling and critical towards her and was extremely reluctant to allow her to go out of the house by herself. This fact caused immense friction between the couple and soon she felt trapped. At times, she stated, he became very angry towards her and although she was reluctant to discuss this, he had hit her on several occasions. She felt ashamed and guilty that she could not be a perfect wife, after all this is what she felt Islam expected of her.

She attended the mosque and regularly prayed to Allah. I enquired about the content of her prayers. Predominantly, they had focused upon asking God to make her husband more accepting towards her and that he should change his personality. She felt unable to discuss her marital distress with her husband and hoped that God would miraculously change their relationship. She stated on several occasions that what Allah did, he did for the best. Her trust in God meant that it was not necessary for her to try anything else and she was extremely reluctant to engage in any form of counselling with her spouse. Furthermore, she maintained that divorce was sinful in Islam and that Allah did not favour divorce and encouraged the continuation of marriage at any costs.

Following advice from an imam, SD explained that from a Muslim perspective even though Allah was held to be in control of everything, individuals were still expected to seek help for their problems and that it was acceptable from an Islamic perspective to undergo couple counselling. After several sessions of individual therapy her confidence increased and she was finally able to confront her husband about their relationship. An imam in her Mosque arranged to meet with the couple to discuss their marriage.

R/S in Intercultural Therapy

The case study above emphasises the role of R/S in intercultural therapy. There were two aspects of this case that concerned me. First, SD believed that her coping style of deferring responsibility to God was not helping the problem or was even exacerbating it. Through therapy SD attempted to give her a sense of agency in her life. Second, she had a limited understanding of the rights of women in Islam. SD attempted to facilitate a process by which she could come to understand that humans have a responsibility to take some action in the world to change their lives and not to defer all responsibility to God and to help her understand that Islam teaches the importance of mutual respect in marriage.

We now examine religion, spirituality in psychotherapy before moving on to the role of R/S in intercultural therapy. We start with the seminal work of Freud.

Religion, Freud and the Birth of Psychoanalysis

> God is dead!—Nietzsche
>
> Religion is an illusion and it derives its strength from the fact that it falls in with our instinctual desires.—Sigmund Freud, 1932 cited in *New Introductory Lectures on Psychoanalysis*, 1989

Freud defined psychoanalysis as 'als Wissenschaft wom seelisch Unbewussten', 'as the scientific pursuit of the psychic unconscious' (p. 227), and devoted his entire lifetime developing a theory of knowledge and an ontology of the human condition. Freud favoured the quantifiable and measurable aspects of reason and science and had little interest in the practice of religion; for Freud, there was no place for religion in the consulting room.

Freud's marginality as a Jew played a role in his developing his ideas. He held ambivalent feelings concerning the Jewish connections of psychoanalysis, ranging from pride in the idea that psychoanalysis might be an extension of Jewish intellectualism, through anxiety because it may then jeopardise the safety of his creation, psychoanalysis, to discomfort due to the belief that psychoanalysis should extend beyond one (Jewish) people or share any ideology [6]. Over time, and in the context of ever more extreme anti-Semitism, Freud became more assertive concerning his own Jewish identity. He made it known that he was a steadfast atheist and never accepted the 'Jewish science' label for psychoanalysis as a whole.

Over a span of nearly 40 years, Freud produced different ideas on religion, yet, in many ways, they were interconnected. In *Obsessive Actions and Religious Practices* [7], Freud states that religious practices, like prayer and religious rituals, bear a strong resemblance to the obsessive acts of the neurotic. Freud describes, 'obsessional neurosis as a pathological counterpart of the formation of religion, and to describe that neurosis as an individual religiosity and religion as a universal neurosis' [7]. For Freud, neurosis is nothing more than a private religion and is '[…] a

travesty, half comic, half tragic, of a private religion', implying religion is a parody of a neurotic ceremonial and that it is nothing more than a collective obsession to neurosis. The implication is that if the obsessive neurotic can give up his private religion, his neurosis, in favour of a public religion, then he doesn't need a private religion anymore.

In his second development of his theory of religion, Freud tries to explain the origins of religion. In his 1913 book *Totem and Taboo* (subtitled 'Some Points of Agreement between the Mental Lives of Savages and Neurotics'), Freud outlines the tendency of primitive tribes to gravitate towards 'totemism' in place of religion and social institution. He subdivides each tribe into various clans with a different 'totem', usually an animal that fulfils an organising function for the individual; his relationship to it defines his social obligations, even overriding both tribal and blood relationships. Upon further reflection, Freud traces even further back to a primal, savage tribe that existed before the rise of society and law when a violent and cruel father drove his sons away from the hoard so that he could keep all of the females for himself. The banished brothers joined forces to kill the father. To celebrate the accomplishment of their task, the brothers threw a feast and ate their murdered father. Freud interpreted this cannibalistic act as the sons attempt to symbolically take his strength and power for themselves. This feast, the primal crime, was significant. Freud explains that after their identification with their father, and satisfying their hatred of him, tender impulses they harboured surfaced, and became remorse. They attempted to assuage their guilt and create reconciliation with the dead father by creating a father substitute, a totem, and forbade the killing of this totem [8].

This primal murder marked the beginning of all religions. Here the Oedipal theory of religion and its various prohibitions and atonements are found. Freud argues that the primal murder was significant in defining a key characteristic of every religion, namely the guilt that resulted and the attempt to alleviate these feelings. Having slain an old man, who was both their protector (and oppressor), there is both a loss and a problem: who will take over dominant position? The only way to avoid this is to establish law, namely to establish an incest taboo. This is the dawn of civilised society and, as time went on, humans created the various gods of the various faiths in the world today. All of these gods remained at their core an exalted image of the father. It was to this image that one could offer conciliations as apology for the long forgotten but psychologically embedded murder [8].

Freud's best-known work on religion is his 1927 essay, *Future of an Illusion*. Here, Freud makes a shift in his theory, defining religion as an 'illusion', not just an obsessive neurosis, and not only rooted in Oedipal guilt. He adds an element of human helplessness when facing forces of nature outside and instinctive forces within. Religion, for Freud, emerges at an early stage of human development, when man is daily tormented by dangerous, uncontrollable and incomprehensible outer and inner forces; hence, man must repress them or manage them with the help of other affective forces [9]. Freud introduces an existential element; since we are born helpless, and are faced with an impending death, we generate a wishful illusion, a longing for protection by a stronger, more powerful force, typically a father figure,

a god who is omnipotent, omniscient and benevolent. Religion is a repetition of an experience in childhood when we felt protected by a father we admired and whose love and protection we received when obeying his commands and refrain from his prohibitions. In essence, people formulate the idea of god as a defence against feelings of helplessness and existential anxiety, much like when a child learned to cope with his own insecurity by relying on and admiring and fearing his father. Freud then concludes that 'Religion would thus be the universal obsessional neurosis of humanity; like the obsessional neurosis of children', [10]. Religion is a fantasy structure and man must be set free from religion if he is to grow to maturity.

Three years later, in his 1930 essay, *Civilization and Its Discontents*, Freud responds to the French writer and critic Romain Rolland's viewpoints regarding his 1927 essay. While Rolland agrees with Freud about the illusory nature of religion, he also upholds humans share a common feeling of innate religiosity, which he refers to as 'oceanic' feeling. It is a sense of oneness, boundlessness, limitlessness where the individual feels bonded with the entire world and human race. Freud begins his essay with an examination of the idea that religion is based on an 'oceanic feeling of connectedness'. While he acknowledges the existence of this 'oceanic' feeling, he does not associate it with an innate religiosity. Instead, the oceanic feeling was a regression to a primitive state of ego feeling. He explains it by turning to psychoanalytic experience in our early lives when we have this boundlessness, oneness, a sense of union with the entire world. Freud identifies this eternity kind of experience with infantile narcissism, a period in the womb and after birth. Freud asserts that the 'oceanic' feeling is a psychic remnant of our narcissistic ego, from a previous stage of our psychic development, an echo of this infantile state of oneness and of 'bliss'. Freud also alters his view from religion as an illusory remedy against feelings of helplessness to religion as a mass delusion. 'The whole thing is so patently infantile, so foreign to reality, that to anyone with a friendly attitude to humanity it is painful to think that the majority of mortals will never be able to rise above this view of life' [11].

In *Moses and Monotheism* (1939) Freud attempts to elaborate his ideas on religion (as religious symptom) by examining the history and beliefs of the Jewish people, taking into account a historical and psychoanalytic framework. Freud asserts that Jews derive their identity from the belief that a covenant was established between them and God, creating a sense of being the 'chosen' people. Yet, while this uniqueness elevates them, it is also the reason for deep jealousy among others, resulting in hostilities and persecutions. Nevertheless, the Jews persevered; throughout history, the Jews defend their identity with resoluteness. Their religious belief constitutes their identity [12].

Overall, Freud opposed religion and maintained a hostile attitude towards it. However, it is also important to note that Freud separated two aspects of religion. While he admires the ethical instruction religion provides, namely the achievement of knowledge, brotherly love, reduction of suffering, independence and responsibility, he is critical of the pathological-theistic and supernatural components of religion [9]. Freud highlighted a positive attribute of religion, namely that it provides, what he believes, a necessary and positive social function. To live in society we have

to repress our aggressive drives and religion offers us various compensations. If you hold the belief that religion will get you access into heaven, essentially you will reap reward in heaven, it makes it easier to bear and to cope with the pains of this world. Indeed, Marx points out 'religion is opium of people'.

Carl Jung and Contemporary Religion/Spiritual Thought in the Therapeutic Room

When Freud and Jung met in 1907, the two men became close friends. Yet, by 1912 profound differences in ideas relating to sexuality, religion and the supernatural were so significant that it led to a painful split between the two. Carl Gustav Jung, almost 20 years Freud's junior, and son of a pastor, perceived religious beliefs and behaviours in a positive light, believing it leads to good mental health. The absence of religion was the central cause of adults psychological disorders.

Jung looked at the psyche from a religious point of view, equating God with the collective unconscious. For Jung, all humans are born with a religious instinct and the universality of religion led Jung to posit that religious practice and religious experience were manifestations of the collective unconscious, shared by all of humanity.

Jung presents his views on religious experience; 'It seizes and controls the human subject which is always rather its victim than its creator' [13]. He then proceeds to interpret the concept of the unconscious as being a religious phenomenon whereby it is not only a part of the individual mind, but is also a power beyond our control, intruding our minds [9]. Jung then argues that religious dogma and the dream can be considered as religious phenomena; both are expressions of our being seized by a power outside ourselves. According to Jung, religious experience offers a specific kind of emotional experience, one that is numinous in nature. In these instances we surrender to a higher power, regardless if this higher power is called 'God' or the unconscious. When we are able to recognise some higher authority than the ego, can we detach ourselves sufficiently from sexuality, the will to power and all the other compulsions of the world. Jung believes that without a God, a person will make a God out of something else—sex, power or reason itself. '*The soul must contain in itself the faculty of relation to God,* i.e. *a correspondence, […] in psychological terms, the archetype of a God-image*' [14].

For Jung, manifestations of the unconscious are found in dreams, the technique he developed, active imagination, myths, fairy tales and religious symbolism. Jung believed religion could never be replaced by science because religion provides the language of the archetypes, the deep patterning of the collective unconsciousness, found across the world's religious cultures. The archetypes are expressed as fairy tales, myths and the symbols of religion and art and, at a personal level, in dreams and visions. Jung's concept of individuation, what Jung considered as the goal of an individual's life, can also be considered as a religious process. It is about uniting a person's conscious and unconscious minds so that their original unique promise can be fulfilled. It is about wholeness and totality, which are also the goals of religion.

In essence, to realise the uniqueness of each person, we had to go beyond the personal self to understand the workings of this deeper collective wisdom.

Cognitive Behavioural Therapy

In more recent years, cognitive behavioural therapy (CBT) has become more welcoming to the subject of religion and spirituality. For instance, Asian spiritual practices have become an important element of the 'third wave' cognitive behaviour therapy represented by acceptance and commitment therapy (ACT) [15] and dialectical behaviour therapy (DBT) [16]. Buddhist meditation and yoga has inspired mindfulness-based stress reduction (MBSR) [17] and mindfulness-based cognitive therapy (MBCT) [18]. In 2000, Albert Ellis, founder of rational emotive behaviour therapy (REBT), reassessed some of his earlier (negative) views on religion and reformulated his ideas; religious and nonreligious beliefs do not make a person 'healthy' or 'unhealthy'. Rather, it is absolute, dogmatic devotion to beliefs that create emotional disturbances. Ellis then presents 12 philosophical principles of REBT and their compatibility with religion-based precepts [19].

CBT holds the fundamental principle that one's thoughts and beliefs are the fundamental determinant of one's emotional and/or behavioural responses to life events [20, 21]. CBT is an information processing model that professes that our reactions to situations are influenced by how we cognitively process and interpret (i.e., meanings, attributions, judgments, etc.) those situations. Furthermore, those immediate and fluid interpretations of life events are influenced by a set of core beliefs [22] that represent the more central, stable, fundamental and definitive views the individual has about the self, others and the world at large. Hence, within the framework of CBT, we see that one's belief system is key to shaping responses. It has been argued that CBT, due to its focus on clients' beliefs, meanings and practices, is a good approach to work with religious and/or spiritual individuals [23].

Researchers have begun to recognise the importance of the patient's value system and world views, with reference to their notions of magic, healing ceremonies and religious rituals on the psychotherapeutic success [24]. The treatment approach for depressed medically ill patients from major world religions (Christianity, Judaism, Islam, Buddhism and Hinduism) indicated that these patients benefited when assisted to develop depression-reducing thoughts and behaviours informed by their own religious beliefs, practices and resources [25].

Spiritual-Based Therapies

Several spirituality-based therapies have also been developed, such as the spiritual self-schema therapy for treatment of addiction and HIV risk behaviour [26]; mindfulness, the combination of Buddhist and Western psychological principles and practices used for improving mental health (e.g., [27, 28]); mindfulness-based cognitive therapy for depression [29]; and spiritual coping groups for those with HIV

[30]. Spiritual interventions have also been used when treating individuals with generalised anxiety [31] and posttraumatic stress disorder [32, 33] and eating disorders [34]. In 2011, a meta-analytic review of 46 spiritual intervention studies performed by Worthington and colleagues' [35] concluded that patients holding spiritual beliefs in spiritually integrated psychotherapies had greater improvement than patients treated with other psychotherapies. Further, these individuals showed greater improvement on spiritual outcomes and similar improvement on psychological outcomes when compared with patients receiving the same type of therapy in secular form.

Williams [36] posited that the main concerns for Muslims in therapy are the fears of not having their religion understood or judged incorrectly. This can have a detrimental effect on the client's state of mind which can lead to a weaker alliance between the therapist and client, which can contribute to ruptures in the client–therapist relationship and early termination of the counselling [37].

The Inclusion of Religion and Spirituality in Psychotherapy

Freud firmly believed that religion should be left out of the consulting room, to replace illusion with reality in therapy [38]; psychological maturity necessitated renouncing one's religious beliefs [39]. However, more recent writers have addressed the inclusivity, and vicissitudes, of religion and spirituality in psychotherapy [38].

In some instances, there is a discrepancy between the client's and therapist's beliefs.

Clinician members of the American Psychological Association (APA) were surveyed and findings from a survey [40] indicated 72% of clients supporting the statement 'my whole approach to life is based on my religion', while only 35% of psychologists endorsed this statement.

Being aware of the content of your client's beliefs as well as your own is important; problems arising when a therapist is unable to deal with the religiosity of the client [41]. If therapists are less religious than their clients, and more likely to reject the belief in God, issues may arise within the counselling context.

Interestingly, while the issue of religiosity is a concern among qualified therapists, who believe they have not had sufficient training in these areas, Hage et al. [42] asserted that trainee therapists do not receive enough education including 'religious/spiritual diversity and interventions'. Dwyer [43] surveyed 126 practicing master's level social workers in America; findings revealed that although 35% of the sample affirmed that religion and spirituality were included in their graduate coursework, less than 5% had actually taken a class on these topics or had received significant training. Hoffman et al. [44] found that trainee therapists do not believe they need training on these topics and that one would be able to appreciate different ideologies if therapists spent time in their training learning about them. For example, Hoffman indicated that in Buddhism there is a concept of 'no-self' and 'non-attachment to self'. Buddhists find this deep level of thinking to be quite liberating and isn't to be confused with the psychotherapeutic term of 'mindfulness'

which regards increasing the sense of self-worth, confidence, love, care and insight. Hoffman et al. emphasised that if therapists are not able to value and appreciate diversity then, ethically, they ought to avoid working with particular groups that may arouse negative possibilities. The therapist must respect and be able to value differences. It seems that a lack of training in how to incorporate religion and spirituality in therapy may contribute to a therapist's reluctance to use religious and spiritual techniques [23]. Similarly, Rosmarin et al. [45] reported that over 70% of members of the Association of Cognitive Behavioral and Cognitive Therapies indicated they had little to no clinical training in how to assess and address religious and spiritual issues in treatment, 36% expressed a fair degree of discomfort in addressing these issues and 19% indicated they rarely/never inquired into these issues in therapy.

Although there have been attempts to open the dialogue between psychoanalysis and religion [46, 47], there still remains a gap on the actual facing of the issue or religion as illusion, as Freud used the word, in clinical work [38]. The question regarding the scientific status of psychoanalysis has nagged the discipline since the beginning; Freud was adamant to affirm his credentials as a scientist. Subsequently, the secularisation of therapy has helped acknowledge it as an objective 'hard science' [48]; spiritual therapy techniques, meditation, praying with a client or utilising spiritual texts are difficult to study objectively [49]. In what is seemingly a secular age, religion plays a potent force in many people's lives, not only operating explicitly but also through the unconscious [50].

Hathaway et al. [51] reported that 'over 80% of professionals in the United States felt that religion and spirituality was a necessary component for improving mental health, yet only 18% reported to have raised the topic of religion or spirituality in a client's session'. The use of religion in psychotherapy has been disputed; those who recognise and value incorporating this aspect into a treatment, and those opposed. For example, Fingarette [52] believes that although religion and spirituality provide meaning and significance, it should not be enmeshed with therapy, particularly within traditional psychoanalysis; psychoanalysis cannot comprehend the deeper and meaningful concepts of life, for example, being, spirituality, etc. According to him, psychoanalysis reduces these deep ideas and philosophies into a psychologically understandable point, thereby losing the potency of its original entity. Similarly, Bordin [53] maintained that religion should not be included in the therapeutic context and that the strength of the working alliance exceeds any other aspect of the therapeutic relationship. For him, the greatest therapeutic change comes about when three aspects of the working alliance are established, namely goals, bonds and tasks. The first, a mutual recognition for the goals of the therapeutic work, second, is the understanding of how these will be achieved within the therapy and, third, necessitating and developing a bond between the therapist and client. For Bordin, religion, culture, differences or any other subject matter is irrelevant due to the importance of the interactional relationship, which sets the foundation for implementing change in the client. Here, we have Fingarette and Bordin both underlining those opposed to bringing in religion into the therapeutic context.

In contrast, a number of writers have stressed the potential of therapeutic value when attending to a client's religious beliefs. Rizzuto [46] suggested that

understanding God's psychic role in an individual's life can illuminate information about the patient's developmental history as well as his private (conscious and unconscious) elaborations or parental imagos. Lovinger [54] recognises that a patient's religious beliefs and experiences can impart important meanings about past experiences, which can denote the quality of the patient's relationships with others.

Hill et al. [55] described religion functioning as a means of armour. For example, acts of worship such as prayer and meditation are strategies to alleviate distress. They noted Freud's claim—that psychotherapy is a substitute for religion whereby religious practices such as praying can be replaced with a talking remedy [56]. Although Freud's views of religion as a 'neurosis' and as something that can be 'cured' have been criticised, some professionals insufficiently recognise, explore and harness religion when treating people with mental illness, especially those from ethno-cultural minorities [57]. Crossley [56], like Freud, also believed religion holds little value, maintaining it encourages individuals to become dependent on it in a disconcerting manner. Sanders [58] made a comparison between psychotherapy and Christianity, highlighting the similarity. According to Sanders, Christ was painted as the 'great psychiatrist', viewed as a healer, similar to the psychologist, healer of the mind. Sanders [58] also associated a kind of transference 'in the love, respect and trust the followers had for Christ'. Believers would visit Christ, and speak of their concerns to him, for support. In counselling, transference also occurs. If positive, then clients will also begin to love, respect and trust the therapist. Clients uncover their life stories and stresses in the search for meaning, and the ability to change for the better. Thus, Sanders argues that Christianity and psychotherapy are two differing approaches with the same underlying goal, improving 'an individual's state of being'. Here, we have an ideology that refutes Freud's conception of religion as 'neurosis' and an indication that ideas suggestive of the 'talking remedy' by going to seek advice and support has existed before Freud.

Cox [59] proposed that incorporating religion and understanding culture can lead to a more responsive society that is sensitive to multiculturalism. Yet, this is not always reflected in the therapeutic rooms. Therapists may not be well equipped to use religion in sessions or may refrain from using it [4]. Tan [5] deliberated that therapists can be in danger of 'abusing or misusing' religion or spirituality in counselling. Ethical considerations need to be met; otherwise, the boundaries of a therapist's professional competence can be disrupted. This could also explain early terminations or displeased clients. This could suggest that a more inclusive training is needed for trainee therapists in order to use religion appropriately in sessions.

People suffering from mental and physical illness often engage in psychotherapy and religion/spirituality [25]. A proliferation of research has indicated a new relationship between psychotherapy and religiosity/spirituality [60]. Some researchers advocate a biopsychosocial model to be expanded to include the religious–spiritual dimension [61]. The need to integrate religion/spirituality into treatment has been emphasised [62–64]. Kizilhan [24] advocated the importance of including the patient's value system and world views, with reference to their notions of magic, healing ceremonies and religious rituals on psychotherapeutic success.

The treatment approach for depressed medically ill patients from major world religions (Christianity, Judaism, Islam, Buddhism and Hinduism) indicated that these patients benefited when assisted to develop depression-reducing thoughts and behaviours informed by their own religious beliefs, practices and resources [25].

Religion, Spirituality and Intercultural Therapy

In the past few decades, the impact of culture in psychotherapy has been gaining attention [65–67] especially as the diversity of the population seeking psychological services grows. When working with varied patients, a foremost concern for both clinicians and clinical researchers is achieving effectiveness of therapeutic interventions [68]. Regardless of theoretical orientations and treatment modality, therapeutic alliance remains a critical constituent to determine a favourable outcome from therapy [68]. Our pluralistic society is increasingly demanding providers of mental health services to be both culturally sensitive and culturally competent.

Cultural sensitivity often begins with self-assessment. When working in a multicultural context, it is important that therapists are aware of their own frame of reference and world view; 'how an individual sees the world from a moral, social, ethical, and philosophical perspective. It is the source of a person's values, beliefs, and assumptions' [69].

The values that therapists bring to the counselling setting may be incongruent with those of many of the clients and families that they serve. In societies such as the UK and USA, the individual is viewed as unique, independent, active and in charge of his or her own destiny [70, 71]. Self-awareness, self-determination, self-actualisation and self-improvement are thus important goals [72]. The Western counselling culture also prizes individualism as one of its core values [73]. Chiu and Kosinski [74] noted differences between individualistic and collectivist societies in therapy; counselling promotes autonomy, the 'I' in the client, and individual success, yet many collective cultures (e.g., Chinese and Korean) promote interdependence and prioritise the goal of the group. In other societies such as African, Asian, Mediterranean-European, etc., the notion of respect for autonomy may be discordant with the value placed on family and community [71]. Perderson [75] recognised that a good therapeutic alliance is one in which the therapist is aware of the various cultural networks and uses it within the sessions to add context with the client.

The British Association for Counselling and Psychotherapy emphasises that therapists have a duty to 'equality and diversity'. Lago [76] stressed that therapists should recognise and value diversity and not to view difference as problematic or outlandish. Nonetheless, this can be problematic. Although there is a recognition that everyone be treated with fairness and respect, some counselling therapists are reluctant to work with those that are quiet, ugly, old, indigent and dissimilar culturally [77, 78]. Others have begun using the acronym HOUND (homely, old, unsuccessful, nonverbal and dumb). Bhugra and Becker [79] assert that religion is a component of culture and that, in most cases, the two are inseparable. We can

therefore infer 'culturally dissimilar' includes religion, spirituality as well as culture. Religion and spirituality (R/S) are important factors in the lives of many individuals [23]. In a study performed in 2006, findings indicated that the main domains discussed by Americans in individual psychotherapy included work, family, friends and sexuality. Religion and spirituality were seen as equally important subjects and clients thought that therapists were open to discussing these domains [80]. According to Barrett and Johnson [81], 90% of the world's population is involved in some form of religious or spiritual practice.

Pargament [64] contends that the therapist's personal religiosity or spirituality does not automatically help a therapist to conduct spiritually based psychotherapy. Of more importance are the therapist's qualities: openness, sensitivity and willingness enquire what role spirituality plays in the lives of his client. This attitude is relevant to both spiritual and nonspiritual therapists.

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Gender-Specific Aspects of Intercultural Psychotherapy for Traumatised Female Refugees

13

Marianne C. Kastrup and Klement Dymi

Introduction

Women and men have different life conditions, as well as a different biology. They are exposed to different traumata and may cope in different ways with life adversities. They also show differences in the prevalence of mental disorders [1] and when it comes to treatment, have different thresholds for entering treatment and may be offered different types of treatment. These factors therefore justify a focus on gender-specific aspects [2] of intercultural psychotherapy, and this chapter concentrates on certain dimensions of this broad topic.

We are aware that mental health problems and the need for treatment hereof is not solely an issue of importance for women, and will begin by giving an overview of some of the particularities and adversities related to women and their role in certain cultures, explaining our focus on traumatised female refugees and asylum seekers.

Women's physical and mental health is inextricably linked to social, cultural and economic factors that influence all aspects of their lives, also having consequences for the well-being of their children and the functioning of their households [3, 4]. Historically, most societies have placed women in a subordinate position, and philosophers, scientists and clergy have often justified this behaviour (https://en.wikipedia.org/wiki/Women%27s_rights, 2017). In many cultures, women are still under the control and scrutiny of their husbands, fathers or brothers, and seen as inferior (https://en.wikipedia.org/wiki/Women%27s_rights, 2017). Gender stereotypes often reduce the role of women primarily to being a wife and mother [3], while literacy among women has remained low in many countries [5]. Culture, customs, beliefs and traditions, including traditional practices such as mutilation, have fostered various forms of violence against women [3, 6].

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According to statistics, around 35% of women worldwide have been subject to some form of physical and/or sexual violence either by an intimate partner or a non-partner [7]. At least one in five women suffers rape or attempted rape in their lifetime. Most violence against women takes place in the private domain. Such violence is often accompanied by a feeling of shame and frequently remains hidden [8].

Nonetheless, an increasing awareness of gender discrimination in the domestic setting, schools, educational institutions and the workplace is occurring, and there is a global recognition of women's basic human rights [5]. While the situation may be improving on a global level, migrant women often carry a triple burden linked to their sex, their class and their ethnic background, and prejudices and discrimination may be part and parcel of their daily life [9].

In recent years there has also been an increasing recognition of the problems of trafficking and abuse [10, 11].

Efforts are therefore needed to treat both the causes and the symptoms of the specific mental health challenges faced by female migrants and refugees.

The Trauma Refugee Women Are Subjected to: Violence Against Women

The traumata that many refugee women are exposed to are manifold and may include both the forms of violence mentioned above and forms of violence specific to their biography as refugees. While some of the latter are common for both sexes [12], others represent a particular threat to women [13].

Significant changes in the character of war have occurred during the last century [14]. Civilians currently comprise up to 90% of war victims, and at least half of these are women and children.

It is increasingly recognised that many women undergo sexual humiliation and harassment not only during war and migration, but also in the refugee camps which are supposed to represent a safe haven [15]. Such harassment may include providing sexual services in exchange for food or access to services or sexual violence including rape. Women may have little protection in camps or detention centres, living in cramped conditions alongside men who are not members of their family [10, 16].

Mental Health Problems in Women

In general women and men show consistently different patterns regarding the kinds of mental illness they may develop, which is important for therapeutic interventions [17]. Depression is the most common women's mental health problem worldwide and tends to be more persistent in women than men [1]. In many cultures, depressive traits, also severe depressive reactions may be interpreted as a natural sign of grief, preventing adequate treatment, so the interaction between culture and depression needs to be considered when interviewing a depressive patient [18]. Anxiety disorders and psychological distress are consistently reported as being higher in

women than in men, and represent a larger illness burden in women [19]. Women on the other hand are less likely to develop problems related to substance abuse.

PTSD: Of the Problem

Refugees and asylum seekers are likely to have experienced a range of traumatic events both in their country of origin, during migration and in the country of exile [20], and while there is no indication that males and females have different lifetime prevalence of exposure, women exposed to a given trauma are four times as likely to develop PTSD than men [21]. In general, we see a higher prevalence of PTSD in women [22–24].

The above findings have been questioned, countered with suggestions that findings are related to hormonal differences, to greater exposure to interpersonal violence or explained through the observation that women are more likely to seek professional help [25]. Women are more likely to have a chronic mental health condition, the proportion of total life years lived with a disability (DALY) among women with PTSD being 6.6% compared to 3.2% among men [26].

However, among persons with a non-Western background exposed to political violence, findings are not consistent. While some studies found a larger risk of developing PTSD among female refugees, for example, among Tamil women [27], or female refugees from Kosovo [28], some show no gender differences, for example, among Bosnian refugees in Sweden [29] and among Cambodian refugees in New Zealand [30].

Socio-Demographic Aspects

Marital Roles/Family Roles

Gender role conflicts may precipitate anxious and depressive disorders in women. Women are particularly vulnerable to mental health problems postnatally, and very young mothers run a higher risk of mental distress [31]. Irrespective of culture, the majority of women who are also mothers fulfil the role of nurturers and carry the main responsibility for caregiving, meaning that they often have insufficient time to consider their own needs. When exposed to severe adverse life events, women's capacity to cope may as a result be overloaded [15]. On the other hand, women's traditional roles may offer an advantage and a protective function in finding a role in the country of settlement as wife and mother, daily life being filled with traditional caregiving activities in contrast to their male counterparts, who may be without work or other useful activities that would usually mean the fulfilment of their roles as husbands and fathers [32].

Many women are faced with a life situation as single provider, the destiny of their husbands unknown and new and unfamiliar responsibilities placed on them. Furthermore, life in exile may not provide the shelter and personal security they had

hoped for, the reality often being overcrowded asylum centres and unsafe sleeping facilities [33]. A study of Cambodian refugees found that women who were without husbands showed the most severe impairments to mental health; these women reported that they felt socially and culturally isolated [34]. Sexual violation of women often results in feelings of betrayal and guilt [35], and many may be overcome with shame which prevent them reporting sexual violence; they may also fear the reactions of their husbands [36]. Living with a partner may also have some drawbacks, as living in the new environment may result in more control by the male partner. Single refugee women with young children and pregnant women need attention as they have an increased vulnerability to stress [16, 37], and PTSD symptoms among mothers have been found to predict the children's mental ill health [38].

Case Study: Z Z is a 26-year-old Kurdish woman who got married at the age of 15 and initially lived with her in-laws, who treated her very roughly. She never went to school. She now lives with her husband in their country of exile and has given birth to five children in 6 years. She was in a state of severe exhaustion during her last childbirth and the couple agreed that she should be sterilised to avoid more childbirth. She was then referred to a psychiatric department after a suicide attempt during which she took an overdose of Paracetamol. She has been diagnosed with depression and feels that it was not the right decision to be sterilised as she no longer feels like a real woman. She finds that taking care of her five children and ensuring that they receive a good upbringing is not sufficiently fulfilling. When discussing her options in the new host country, communication is not optimal, despite the presence of an interpreter who also acts as culture-broker. It becomes apparent that no one has ever asked her what she wanted and that she gets confused when faced with different options. She feels frightened in the large city and is longing for her village life.

Resilience

There is a lack of research regarding the life of mentally healthy refugees, their choices of coping strategies, and cognitive styles permitting female refugees to adapt to a new context. Existing research shows that in cases of resilience, it is the result of individuals' ability to interact with their environments and the processes that either promote well-being or protect them against the overwhelming influence of risk (https://en.wikipedia.org/wiki/Psychological_resilience, 8 Nov 2017). Resilience factors have been shown to modify the consequences of trauma [39]. Studies on adaption following disasters revealed that women were associated with a lower level of resilience [40]. Protective factors include political involvement, spirituality, emotional disclosure to others and other factors [41–43]. Around 91% of women from the Za'atari refugee camp stated that safe spaces for women help them to recover their self-esteem and sense of identity [44]. Factors that have a negative impact on recovery include prior individual or family trauma and dysfunctional personality traits [45].

Empowerment

When arriving in a new country with an unfamiliar language and way of life, many female migrants are in a state of disempowerment which does not disappear over time. Integration may leave them feeling even more disempowered if they experience discrimination and marginalisation, as life in exile is faced with a diversity of challenges [46], many of which continue for years [47]. Empowerment is an important goal of a therapeutic process, helping women to gain control over their lives. Women need to acquire changing roles in post-war settlements [48].

Empowerment may take place on many levels: legislation may focus on the rights of female migrants and educational initiatives specifically on their problems, while the establishment of self-help groups, health promotion, "neighbourhood mothers" groups, etc. may contribute to personal empowerment [49]. Therapeutic intervention may begin by letting the women define their own problems and support their own proposals to solutions. Extended family, spirituality and the availability of community social support services may all empower women during the process of resettling [50].

Case Study: A A is a 40-year-old woman of Syrian background married to a severely traumatised man with whom she has three children. The couple was referred to a centre for treatment of traumatised refugees, but due to the husband's inability to leave the house, the therapist visits the couple at home with an interpreter. The husband is almost constantly bedridden, and the entire household depends upon the wife. She is illiterate and has never worked in her homeland. Having arrived as a refugee, A soon realised that she must learn the language and become active in order to support her children. Thanks to her children, who go to school, she gradually learned the language and soon found a cleaning job. Through supportive counselling, she became increasingly self-sufficient, having initially relied on her children for all paperwork, and was able to support her daughter to become part of an elite football team. Her anxiety disappeared, and she began to take classes to become the manager of the cleaning team.

Intercultural Psychotherapy for Traumatised Groups

Therapeutic programmes directed towards traumatised refugees are commonly based on a multidisciplinary approach with a combination of medical, psychiatric, psychological, physiotherapeutic and social aspects [51, 52]. In recognition of the increasing number of refugees requiring care, there is often an emphasis on community-based interventions and a request that mainstream health systems should be able to address the specific needs of the traumatised individuals [53].

Today, we see a large variety of psychotherapeutic approaches including cognitive behavioural therapy, psycho-dynamic therapy, counselling, EMDR, individual and group therapy; psychoeducation is also receiving recognition as a treatment strategy [51, 54]. Psychopharmaceutic drugs also play an important role in particular due to

the high levels of co-morbidity [55]. The supportive part of therapy should be kept in mind and the therapist needs to provide support to physical, medical and social needs as well as religious beliefs [56]. Safety and survival issues can be crucial in some cases and need to be addressed before therapeutic interventions take place.

Rather than general therapeutic aspects, this chapter focuses on therapeutic issues of particular relevance to women.

Therapeutic Issues of a Gender-Specific Nature

Culturally Different Views on Health and Illness

When working with refugee women, therapists face cultural differences in the perceptions of health and illness.

Belief Systems Should Always Be Considered

As Patel and co-workers pointed out in their overview, gender, cultural issues and belief systems are all commonly insufficiently considered [57].

Challenging Our Own "Majority" Attitude

Working with this population demands cognitive flexibility, empathy, human understanding attitude and challenging our own "majority" attitude. As therapists we must listen, contain and support the proposals to solutions that these women bring forward, question our own prejudices and stereotypes and scrutinise whether they in fact reflect a sense of superiority or even racism.

Therapists Must Listen and Support the Women's Proposals

We need to be aware that the proposals may not coincide with our own ideas and thinking, but we should discuss their solutions in a therapeutic and open manner without any preconceived notions and try to understand the cognitive and emotional world view of the women and attempt to build a bridge over cultural incongruence [15].

The Significant Language Difficulties

Apart from the issues mentioned above, the therapist may also be faced with significant language difficulties, negative stereotypes and expectations of treatment that cannot be fulfilled [17].

In the book Broken Spirits [58], Kastrup and Arcel [15] provided an overview of some of the aspects that, according to their clinical experience, are important to take into consideration in the psychotherapeutic intervention with refugee/migrant women. These aspects also pertain to the therapeutic approach and are therefore summarised below.

Always Consider Cumulative Trauma

Many women have been repeatedly traumatised—in their country of origin, refugee camps, asylum centres and country of resettlement. The women have often experienced numerous losses, including the loss of family members, native country, social status and network. Consequently, their symptomatology will not only be due to a single traumatic experience but several, acting cumulatively. They accept referral to therapy as they suffer from physical and psychological problems. It is often a third person who takes the initiative and not the woman in question. Frequently, somatic complaints prevail, and the woman may look for a physical explanation for which there is a physical treatment.

Psychotherapy Is Not Known or Is Perceived as Stigmatising

Knowledge about psychotherapy is limited if at all existent and issues related to mental health are often perceived as stigmatising. There may be a resistance to disclosing traumatic experiences and instead a wish to bury unpleasant memories. Here, the therapist needs to approach delicate topics very carefully, leaving sufficient time for the woman to reflect.

Expectations of Treatment That Cannot Be Fulfilled

We often encounter women with a lack of knowledge about psychotherapy, who demand a rapid cure equivalent to receiving medication. Adherence to the therapy may also be influenced by this hope for a rapid improvement, as the woman gets impatient if she experiences no change in her condition. To avoid this, it is crucial that the therapist clarifies at a very early stage what the woman's expectations are of the therapy. Why did she come? And what does she hope to gain?

Resistance/Family Involvement, etc. Demands Time for Reflection

In this initial phase, any misunderstandings may be removed, and the therapist can inform the woman about what in fact can be offered. Many women may express an initial scepticism, and "how can it help just to talk?" is a frequent question. Therapists from a Western training background should be very clear in explaining

what their limits are with respect to the kinds of intervention available. There is an increasing emphasis on evidence-based interventions and in most settings, interventions involving, for example, exorcism or black magic will not be acceptable. The women may seek such a traditional therapy outside the institutional setting, and whether there is collaboration or not with these treatments depends upon several factors including the policy of the institution. But with or without collaboration, the therapist should show an openness and interest in learning more when informed about such therapies.

It is not just the woman who may express scepticism, family members may also view psychotherapeutic interventions as inappropriate or suspicious. They may see it as too slow or fear that the woman will be negatively influenced, such as becoming too "Western", too independent and no longer respecting the values of her family. As pointed out, the social control of women in refugee groups is often prominent in the process of acculturation. Males in the family network may feel as though their position is being threatened and emphasise the need for maintaining the traditional lifestyle.

Case Study: B B is an 18-year-old high-school pupil of Iraqi origin who has visited the psychiatric emergency unit several times due to Paracetamol intoxication. She is in conflict with her father, who believes she should quit school and get married. She is gifted and wants to enter higher education. The therapist suggests a family intervention. Here, the father expresses his wish to see his daughter well off and married as, in his view, any good father would do. He is afraid that education will distance his daughter from the family. The therapy focusses on what it takes to be a good father in the new country, and gradually the father cognitively understands that the wish of his daughter does not go against the family values and ends up accepting her wish to continue her education.

Scrutinise Our Own Prejudices and Stereotypes

Awareness of the different positions of the therapist and the patient is a prerogative for a good therapeutic alliance. There may be differences due to language barriers, level of education, socio-economic status or religion.

Attempting to Build a Cultural Bridge

Therapists may also have preconceived ideas about different cultures that intervene and create obstacles in creating a respectful therapeutic relationship. Large educational differences can be difficult to overcome, such as if the woman is illiterate and has recently arrived from a rural background with no knowledge of Western urban lifestyle. Even when qualified interpreters exist, such educational differences can pose a major challenge for the therapist, and there may be further obstacles due to religious differences such as, for example, the conviction that the woman's problems are caused by demons.

Case Study: D D is a 55-year-old Moroccan woman with few years of schooling and no working experience. She was referred to psychiatric services due to strong anxiety, and asked her neighbour to accompany her in order to confirm her story. She was convinced that she had disturbed the djinns living beneath her in the sewage system by pouring boiling water into the system late at night as she was preparing food at Ramadan. She reported having seen a djinn, which then left the kitchen by breaking the window, and the neighbour confirmed that the glass was broken. The woman feared revenge, and sought help to pacify the djinn, but despite adequate interpretation and discussion of her anxiety and how to overcome it, she decided to seek the help of a traditional healer (unknown to us) instead.

Immigration and efforts to integrate into a new country is stressful and is often accompanied by multiple insecurities. Such social adversities may easily reactivate traumatic symptoms or create additional ones. The therapist may have a difficult task as the woman sees the professional as a high-status person. The therapist wishes to help the woman to solve these obstacles, but legislation and institutional policy may limit what the therapist can achieve, thereby leaving the woman in a situation of despair. To avoid such an impasse the therapist should at an early point clarify the boundaries of the setting. At the same time, it is also crucial that the therapist does not neglect the socially pertinent problems the woman presents; these should be prioritised, and solutions sought for the most acute ones which impact the woman's overall situation. She may express a natural wish to receive support from the therapist in her endeavour to solve these problems rather than talking about trauma. A sustainable relation between therapist and patient that allows her to reveal her traumatic experiences requires the therapist to pay due attention to the extent to which the woman's state of mind and expression of her symptoms is influenced by her current life situation which may involve discrimination or a devalued status in society. Indeed, some therapists suggest that the main objective of therapy should be to focus on increased functionality in daily life and in achieving personal goals [15].

Cultural Aspects

Cultural norms determine to a large extent what is an acceptable behaviour and how illness is expressed [17]. Respect for traditional values and customs may prevent refugee women from adapting to new norms and lifestyles, and therapists should aim for a delicate balance for respecting between the cultural values of the woman and their own wish to empower the woman by supporting her more assertive sides. Cultural norms define what is acceptable behaviour for, for example, a widower/divorced man, and what may however be unacceptable for a widow/divorced woman [59]. Therapists in Western settings are trained to work in an individualistically oriented society which allows a high degree of autonomy to the individual and encourages self-sufficiency [20]. This means that a certain amount of adaptation can be required when working with people who have been socialised in another context. Applying culturally sensitive approaches to health education improves people's

access to information and enhances health literacy [60]. Findings suggested that basic information on rights and sexual health is best delivered in same-sex groups to ensure its uptake.

Access to Care

In many places, the benefits of health services and access to care are not distributed with equity, irrespective of gender and ethnic minority [61]. Minorities may often receive a lower quality of health care. Stereotyping, uncertainty on the part of health care providers, linguistic and cultural barriers all contribute to these disparities [62]. Differences in access to services depend upon several factors, including political and economic, but even if care is distributed with equity, inequity may still prevail if the populations concerned have different needs. WHO [63] has recommended that primary care providers develop sensitivity to both gender and migrant issues.

In most cultures, women show different behaviour than men in terms of actively seeking help, women having a lower threshold for seeking care [64]. That could partly explain the apparent higher occurrence of chronic health problems and PTSD among female victims of violence [25]. However, this presumes that women have equal access to care. Different cultures have different approaches to the need for women to be referred to treatment decisions that are taken by the head of the family who should "give permission or approve the need for referral" and refugee women often have limited knowledge about the available services and how to access them.

Communication and Cultural Competence

In Western psychotherapeutic practice, mutual respect and levelling out previous paternalistic attitudes are part and parcel of daily practice. However, many migrant women come from cultures where communication between health professionals and female patients is authoritarian, emphasising the distance between them. In such a setting, a woman may find it difficult to disclose experiences of violations or even family conflicts. In the new country, the woman may be under the social control of male family members and reluctant to inform the mental health professionals about family matters. Mental health professionals need to be sensitive to cultural and contextual aspects of communication [65].

Differences between the therapist and patient such as in age or authority may also play a role in the therapeutic relationship. Working with a male therapist can also represent a challenge, and some women may refuse to reveal more intimate problems [17]. It is recommendable to clarify this a priori. Cultural matching is another issue where opinions differ [17]. Some find it preferable that the cultural background of therapist and patient are as close as possible, while others have experienced that there are advantages in having a therapist from the new country who may be better able to introduce the women to the lifestyle and values of the new environment. Many women are not used to answering questions that open up choices

or to being asked their opinion, and may try to please the therapist by answering in the way in which they think is expected. This is more pronounced if the woman has little or no schooling. The therapist has a crucial role to play in helping the patient to overcome the barriers met when trying to integrate into a new environment, ideally providing tools that are in accordance with the woman's level of education and cultural background.

In all therapeutic work we need to assess thoroughly the extent to which the patient's problems are related to cultural factors and adjust our interactions to the cultural background of all stakeholders involved. In a pluralistic society there is increasing demand for providers of mental health care to be both culturally sensitive and culturally competent [66].

Several attempts have been carried out in developing guidelines for a cultural interview. The DSM-5 cultural formulation [67] is one of the most frequently used, but has no emphasis on women's problems. The EPA guidance paper [62] states the importance of cultural competence for staff working with patients of different cultures. While gender was not a focus, the key principles outlined are useful for both sexes; these include listening carefully to the patient, eliciting the psychopathology in a culturally appropriate manner, assessing needs and suggesting changes in management. Cultural competence involves professional values which must include sensitivity, non-discrimination and responsiveness to the psychiatric needs of any patient.

Using interpreters may be essential in order to avoid misunderstandings if the woman has difficulty expressing emotional details in the language of the therapist or lack terms for key concepts. But there are pitfalls even in work with professional interpreters, including the reluctance of the woman to work with a given interpreter due to their ethnic background or their being of the opposite sex which may hamper her willingness to disclose her problems [20].

Perspectives

As female migration is on the rise, and women now outnumber men in the current migrant situation [16], it is high time to recognise the problems that refugee women are facing in the country of settlement. A recent report from the European Parliament emphasises that policies aimed at guaranteeing the rights of asylum seekers and refugees' rights cannot be gender-neutral, as women face gender-specific challenges in the host country [68]. Consequently, reception and integration policies are unlikely to succeed if they are not gender-sensitive. Legally, human rights include everyone and comprises all cultural settings.

Therapists treating female migrants play an important role in helping these women to develop strategies to overcome feelings of helplessness, using therapeutic interventions that provide patients with a recognition of their own resilience. Faced with challenges of becoming self-reliant and empowered, refugee women must learn how to find an appropriate balance between retaining the moral and cultural values they have grown up with and coping with the new environment [15].

We also have to support the women in making realistic plans, in acquiring a positive self-image, and learning how to cope.

The primary factor in protecting women against the development of mental problems is to have relationships providing emotional care and support, and offer encouragement, both within and outside the family. Having sufficient material resources to manage and cope with adversities and having a feeling of being in control when facing difficulties is also important. A project in Sweden providing health literacy training demonstrated how information opens opportunities to challenge these norms that oppress women [60]. A topic that deserves more scientific attention is the prevention or treatment of gender-based violence and the resulting health consequences [69].

Conclusion

Female migrants and refugees commonly bring with them not only traumatic experiences and current stress, but the whole context of her social relationships which affect how she is coping with trauma. Therapists must learn to differentiate between suffering from the original traumatisation and suffering as the result of gender discrimination.

If we want to fulfil the needs of traumatised refugee women, we must recognise the complex interrelationship of traumatic experiences, social relationships, gender roles and expectations and how these factors interact and influence women in their attempts to overcome trauma [70].

Certain refugee groups such as single women travelling with children, adolescent girls and elderly women are among those requiring coordinated protection. The current response to women's needs by governments and humanitarian actors is insufficient, and human rights organisations, including the United Nations High Commissioner for Refugees and women's rights organisations, have called for immediate action [16]. This is a challenge also for the psychiatric profession.

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Ethical Aspects of Psychotherapy in Forced Migrants

14

Solvig Ekblad

Introduction

Impacts of Globalization: Diverse and Fast Growing Population

The United Nations estimate that over 65 million persons worldwide are currently displaced by war, armed conflict, or persecution, meaning that on a global scale, 1 in every 100 humans is a refugee. In total, 16.5 million people fall under the mandate of the UNHCR and more than 80% of refugees have even been internally displaced or have fled across national borders to neighboring countries, the majority being located in low- and lower middle-income countries. However, during 2015–2016, European countries (particularly Sweden and Germany) received the largest inflow of refugees since WWII, with over a million Syrians and others from the Middle East entering the region. As a result of a new law in Sweden, the influx then halted, "indicating the lack of preparedness of even advanced nations to deal with this humanitarian crisis" ([1], p. 139).

The United Nations has integrated a human rights perspective (from the Universal Declaration of Human Rights, 1948) into the 17 global aims for sustainability development to ensure healthy lives and promote well-being for all people of all ages. "Leaving no one behind" is a central principle in the Sustainable Development Agenda, and one which is supposed to guide all aspects of life including access to healthcare/the structuring of health services, but those most likely to be "left behind" are *unique people* with diverse backgrounds and barriers to health services in the context *of their host country*. Guideline 9 on ethical issues in public health surveillance [2] describes that surveillance of individuals or groups who are particularly susceptible to disease, harm, or injustice is critical and demands careful scrutiny to avoid the imposition of unnecessary additional burdens. For the time being, the

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international literature lacks examples of elaborated ethical guidelines for cross-cultural psychotherapy. We require an ethical code for psychotherapy, which is based on the principle that to discard the human rights of the other is to reject our own humanity.

The aim of this chapter is to provide an overview of psychotherapeutic ethics towards forced migrants with traumatic life events and to increase understanding of how they are adversely affected by globalization, pre- and post-migration stress, and limited access to ethical psychotherapeutic interventions.

Cultural Diversity

Vulnerable Groups

According to Wenzel et al. [3] "protection for vulnerable groups and human rights standards must be supported in different settings including asylum procedures" (p. 405).

Special attention has to be taken to the particular problems of female refugees in terms of security and access to health services (e.g., [4]) as well as former child soldiers, unaccompanied and orphaned minors, and persons with physical and mental disabilities—all face exceptional levels of ongoing stress. Women and children comprise up to 80% of the population in refugee camps and reception countries and are at particular risk of abuse and assault, as they are frequently without providers or social support. The UNHCR and WHO have approved guidelines to prevent gender-based violence. However, field cases continue to show that domestic violence is usually hidden, sexual assault is routinely carried as in the name of "ethnic cleansing," and women are often forced into "sexual services" to secure survival for themselves and their dependents and/or become victims of human trafficking [5]. Migrant women's health literacy varies [6, 7]. The WHO [8] has recommended that primary care providers develop sensitivity to both gender and migrant issues. Those forced into sexual services are often at risk of HIV and other infectious diseases as well as anxious and depressive disorders. Whether or not this is the case, social control over women by men is often strict since male relatives may feel threatened by the Western lifestyle and autonomy among women [9]. A report from the European Parliament [10] concludes that "policies aimed at guaranteeing asylum seekers and refugees' rights and wellbeing cannot be gender-neutral, because women have to face gender-specific challenges in the host country, as a consequence, reception and integration policies that are not gender-sensitive are destined to fail" (p. 10).

Migrants with mental health needs therefore often experience not only scarcity and inequitable distribution of services, but also barriers to accessing care even when services are available, and persisting stigma associated with being both a forced migrant and mentally ill [11]. Human beings with particular vulnerability to illnesses and diseases, harm, or injustice may also be at increased risk for further burdens, such as discrimination and stigma. For example, forced and undocumented

migrants with a higher disease burden may be misdiagnosed when the cause of the symptoms is misinterpreted as being related to external factors/misinterpreted, ignoring the relation to external factors.

During the present global refugee crisis, an increased number of forced and other migrants have fled due to inhuman or degrading treatment (IDT). In this globalizing process, health care professionals and organizations increasingly experience cross-cultural challenges in care relationships which give rise to ethical questions regarding "the right thing to do" in such situations. Physical and psychological sequels, such as torture, which is defined by the UN Convention Against Torture (CAT, Article 1, Box 14.1), quite often require holistic treatment including both medical treatment and psychotherapy. However, this resource is scarce for the majority of the affected, due to limitations both in economic resources and clinically trained staff [12].

Forced migrants who have exposed either directly or indirectly traumatic life events during migration including torture (Box 14.1) are often at risk for a range of physical and emotional troubles and as such are a vulnerable group. Severe human rights violations may lead to long-term sequels which influence not only the survivor but also family members, also transgenerational [13], as well as society at large.

It is quite common that after resettlement in a safe environment, these and new challenges remain, due to post-migration stress [14, 15].

Asylum seekers and undocumented people are in more tenuous situations due to worries about their immigration status, lack or absence of basic needs including medical care, and ongoing family separation [15]. Ethical dilemmas for those involved in health care for asylum seekers include long waiting times for permission to stay, the perceived lack of future, the non-fulfillment of basic needs, and situations in which the host society is threatened, e.g., betrayal trauma. Often, immigration status influences not only a person's willingness to seek services such as psychotherapy, but also the availability of needed services [16]. Psychotherapists have the ethical obligation in legal proceedings and to deliver informed, sensitive, culturally competent psychotherapy and other services considering as much as possible of the person's multiple needs [16].

Dauvrin et al. [17] concluded that "while legislation might help to improve health care for IM (irregular migrants), more appropriate organization and local flexibility are equally important for improving access and care pathways" (p. 1). Practical issues continue regarding the effectiveness of proposing counseling to persons forced to live under such restrictive conditions [18]. Pathogenic, social context, help-seeking behavior, stigma, mistrust, and lack of knowledge about services "may limit the extent to which refugees access mental health service, even if available" (p. 132).

Consent to Treatment

The globalization process is irreversible on individual, local, regional, and national levels. The culturally based ethical dilemmas in psychotherapeutic services to forced migrants are around various themes, including informed consent to therapy.

Therapists must address the patient's expectations about the duration and nature of therapy, just as with other populations. Psychotherapy is usually a new and unfamiliar concept, meaning that the first part of the session should take time for psychoeducation regarding the type of treatment which will be given, the duration of time, the psychotherapist's expectations, and possible improvements, all of which form a significant part of Informed Consent to Therapy [16].

The extent to which Western diagnostic tools and psychotherapies can be adequately performed with refugees coming from outside Western countries has been discussed in the literature (e.g., [19]). The literature shows that with time, a process of adaptation to the major culture of the host country generally takes place, and this change may also be connected to variations in health literacy among the new-comers in the host country [6, 20]. Ekblad and Kastrup [21] have paid attention to the extent of cultural competence and cultural tailoring needed in the rehabilitation of refugee and other traumatized patients from non-Western cultures.

Confidentiality When Working with Traumatized Forced Migrants

Due to globalization, many professionals—including psychotherapists—may be born and/or educated in different cultural contexts than their patients, and practice with diversity of patients and in diversity of contexts [22]. In carrying out our psychotherapeutic work as clinicians, we need according to Kastrup [5] "to weigh different values and take into account the different views in the multicultural work of today" (p. 75). Okasha [23] expresses this in a similar way, saying that we may no longer base our findings on norms of the past, but instead have to rebuild our worldview and find perspectives we can live with in the present. Speaking for myself, trust in the fundamental rights of all of us has been the guiding principle in both my professional and my private life.

Psychotherapy in this chapter is defined as the treatment of mental or emotional disorders or of related bodily illness by psychological means (https://www.merriam-webster.com/dictionary/psychotherapy). Similar benefits and challenges to reflexivity as quality control in research settings under three types may be useful of psychotherapist's position (social position, e.g., gender, age, race, immigration status, sexual orientation, personal experience, and political and professional beliefs) and illustrated by means of the following case examples: (1) reflexivity when the clinician shares the experience of the patient, (2) reflexivity when the clinician moves from the position of an outsider to the position of an insider in the course of the therapy, and (3) reflexivity when the clinician has no personal familiarity or experience with what is said in the therapy ([24], p. 219).

Crosby [25] recommended the following approach to receiving the trust of a force migrant patient: the situation "…. requires attentive listening, communication, empathy and respect (p. 525)." Communication styles of forced migrants may be unfamiliar to Western clinicians (e.g., lack of direct eye contact, inappropriateness of shaking hands with the opposite sex). Further, there may be a perceived power differential whereby forced migrants do not feel comfortable initiating conversation

topics. According to Crosby [25], forced migrants may have reasons to perceive mistrust and discrimination and it is important to discuss the following issues directly:

- their immigration status,
- previous negative experiences with the health care system,
- potential fear of getting bills (refugees have revealed fear of arrest when receiving hospital bills they are unable to pay),
- mistrust of clinicians or hospital workers as they may report to the government,
- reluctance to disclose information if they do not understand the confidential nature of the patient–physician relationship,
- fear of arrest and deportation during the asylum process,
- suspicion that physicians may have participated in the system of oppression or torture in their home country, or belong to an ethnic group in conflict with their own.

The path towards addressing many different persistent and emerging health issues for this group, such as establishing access to care/therapy/psychological support as a human right, is a long and arduous one, which needs much attention.

Box 14.1 Torture

The main aim of torture, using physical and psychological methods, is to dehumanize, degrade, destroy or debilitate, and render the individual helpless. Torture has no geographical or ideological boundaries. There exists a global crisis of torture, with short- and long-lasting broad impact across physical, psychological, social and existential/spiritual boundaries [26]. Its complex and diverse effects interact with gender, economic hardship, self-esteem, and sense of agency, quality of life, ethnicity, and the refugee experience. Health workers, including doctors and psychotherapists, may have been present at the torture to assure survival of the individual. Methods of torture will not be described here as Amnesty International has this updated information (www.amnestyinternational.org).

The Detection of Torture Survivors Survey (DOTSS) consists of four questions with good psychometric issues to identify individuals who have been exposed to torture in heterogeneous populations attending ambulatory care clinics ([27], p. 636):

1. (In your former country) did you ever have problems because of religion, political beliefs, culture, or any other reason?
2. Did you have any problems with persons working for the government, military, police, or any other group?
3. Were you ever a victim of violence (in your former country)?
4. Were you ever a victim of torture (in your former country)?

Mental Health Problems Among Refugees: Epidemiological Studies

According to Silove et al. [1], mental health problems among refugees prior to the 1970s lacked vigorous epidemiological scientific data detailing the nature, prevalence, and determinants of these mental health problems. It was not until 1980 that the version of the DSM (DSM-III, 1980) included post-traumatic stress disorder (PTSD) the first time. Mollica et al. [28] performed the first study among South-East Asian refugees in a refugee camp for Cambodian survivors of the Khmer Rouge autogenocide and found that half of the respondents met threshold criteria for depression and 15% for PTSD. For every traumatized man, three women have a lifetime prevalence rate of PTSD [29].

During 1980–1990, an increased number of epidemiological studies and systematic reviews of refugees and other conflict-affected populations in Western countries were carried out, finding an average prevalence of 9% for PTSD and 5% for depression. According to Silove et al. [1] "these findings provided a corrective to the tendency to regard all refugees as "traumatized" in the need of counseling" (p. 1). Porter and Haslam [15] conducted a review based on studies that included comparison groups, and showed that refugees had a modestly elevated risk (effect size of 0.41) of a range of adverse mental health outcomes. In their review, factors associated with poor mental health among refugees included socio-demographic characteristics and stressors in the post-displacement phase. In a recent review of more rigorously designed studies (e.g., Priebe et al. [30]) lower prevalence rates were found, reducing the estimate for PTSD to 15%. There is also evidence now that cases in which PTSD is associated with psychotic-like symptoms or frank psychosis among refugees and post-conflict populations compared to other migrant groups resettled in high-income countries and host populations [31].

Recent studies on the impacts of the post-migration environment on the mental health of displaced populations (asylum seekers) show that "prolonged detention, insecure residency status, challenging refugee determination procedures, restricted access to services, and lack of opportunities to work or study, combined in a way that compounded the effects of past traumas in exacerbating symptoms of PTSD and depression" ([1], p. 132).

It therefore becomes clear that *ethical issues* must be carefully considered in the policy and planning of psychotherapeutic programs for these subpopulations. Interdisciplinary and bio-psycho-social rehabilitation approach has been reviewed using the WHO International Classification of Functioning, Disability and Health (ICF) [32].

Culturally Appropriate Psychotherapeutic Interventions

The Adaption and Development After Persecution and Trauma, ADAPT, model [33] identifies five core psychosocial pillars disrupted by conflict and displacement, namely systems of safety and security, interpersonal bonds and networks, justice, roles and identities, and existential meaning and coherence. These pillars form the

basis on which stable societies are grounded and on which civilians depend for their mental equilibrium.

The major theories in psychotherapy are still based on Western worldview norms, while large and increasing numbers of forced migrants are arriving in these Western countries from non-Western backgrounds, with general, specific, and unique needs. Psychotherapists therefore have the task of providing flexible psychotherapeutic programs using holistic approaches which makes use of positive social support and community factors wherever possible, in turn enabling the development of new social support networks and resilience. Thus, when determining therapeutic directions, methods, and models, these need to be well matched to the problems and needs presented by the forced migrant. Here cultural issues such as ethnicity, gender, or religion may be critical components, issues which may be behind forced migration. Some forced migrants may have different ways of understanding illness and health care compared with Western psychotherapists. One example may be that they attribute their symptoms to fate or Allah's will rather than seeing them as a result of trauma which is treatable. Injections might be seen as more effective than pills, and by not being prescribed an injection, the forced migrant may feel that he or she is not getting the best treatment.

In the 2010 and 2016 amendments of the DSM, the American Psychological Association includes ethical principles and a code of conduct for psychologists. The five general ethical principles are:

- Beneficence and non-maleficence
- Fidelity and responsibility
- Integrity
- Justice
- Respect for people's rights and dignity

"Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status, and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices" (www.aga.org/ethuics/code).

When entering into therapeutic alliances with migrants, in particular those experiencing poverty and social exclusion, or facing intersecting and compounding barriers, ethical issues must be taken into account. Silove et al. [34] concluded that "the medical profession has a role in educating governments and the public about the potential risks of imposing excessively harsh policies of deterrence on the mental health of asylum seekers" (p. 604).

Inequalities in Access and Unique Challenges of Psychotherapy with Forced Migrants

Inequalities in access and use of health services including psychotherapeutic services by forced migrants, lower quality of care received, and lower health outcomes are

increasingly being exposed by research (e.g., [35]). These authors concluded according to the international academic literature that "primary causes are language and communication problems between practitioners and patients, lower health literacy in migrant patients, cultural differences and professional uncertainty, negative attitudes and distrust among professionals and patients, higher socioeconomic stressors in minority groups, difficulties in arranging care for undocumented patients, and issues during the hospital stay." (p. 38). It is a challenge due to possible miscommunications and confidentiality.

A systematic review [36] of migrant attitudes towards seeking psychological help ascertained that the following factors increase the likelihood of help-seeking: "stronger identification with host than heritage culture, fluency in host country language, psychological attributions of distress, higher educational levels, higher socioeconomic status, female gender, and older age [36, p.94]."

In a qualitative study, ethnic minority patients were interviewed to assess their perceptions of cultural issues in their recent therapy with a white therapist. The majority believed that their white therapists could not understand key aspects of their experiences and that the patient/the therapist subsequently avoided proposing racial/cultural issues in therapy. However, many felt that cultural differences were minimized if the therapist was compassionate, accepting, and comfortable discussing racial, ethnic, and/or cultural issues. Results suggest that patients' construction of cultural issues are multidimensional and support recommendations that psychotherapists acquire skills for addressing cultural perceptions that may impact upon the therapy relationship [37]. Gurpinar-Morgan et al. [38] came to similar conclusion in their study, namely that psychotherapists do not need to share the same ethnic background to work effectively with patients but must be able to demonstrate empathy.

A meta-analysis of 12 studies examined the effectiveness of psychosocial interventions for PTSD among refugees and asylum seekers who had resettled in high-income countries, finding that these provided significant benefits in reducing PTSD symptoms. However, more rigorous trials should be concluded in the future [39].

A systematic review through providers' lens on challenges in the provision of healthcare services for migrants showed the contradiction between professional ethics, on the one hand, and laws that limit migrants' right to health care, on the other [40].

A patient may expect a therapist to act authoritatively and present explicit advice, whereas the therapist's orientation may involve respecting patient autonomy. The therapist needs to balance both views in order to develop "appropriate boundaries that facilitate a productive alliance" ([41], p. 160). For instance, transference and countertransference is related to culturally influenced power dynamics and empathic understanding. However, this cultural clash may also happen when the therapist and patient share the same cultural background but not the same social class.

Cultural Competence Among Therapists

At the individual level, there is a constellation of characteristics that define the "culturally component" practitioner (awareness, knowledge, and skills); these involve a clinician who:

- "Is aware of their own personal and professional values and biases, and how these may influence their perceptions of an "other," their problem, and the therapeutic relationship.
- Has acquired or knows how to acquire cultural knowledge relevant to the client.
- Has the skill to intervene to alleviate distress of the client in a culturally responsive way" ([41], p. 163).

Delivery of Different Kinds of Psychotherapies

Evidenced-Based Interventions for Forced Migrants

Trauma-focused cognitive behavioral therapies (e.g., [42]) are described in the literature as a series of low cost, time-limited, structured, manualized psychotherapeutic sets among forced migrants. According to the literature, the strengths of these newer programs are that they can be adapted to local cultures, allow rapid training of front-line personnel, and facilitate task-shifting, i.e., the transfer of skills from professionals such as psychologists to lay or community workers where educated mental health personnel are scarce and there is therefore advantage in increasing the possibility of dissemination of these interventions in practice [1].

eHealth

In recent years, an increased access to and use of the internet in health care and psychotherapy has led to the development of a new field called eHealth. Hilgart et al. [16] have highlighted the ethical issues associated with providing psychological interventions over the internet in the context of delivery of clinical services. These authors take up both the ethical benefits and challenges surrounding the delivery of eHealth. The benefits according to the same authors are wider access to treatment, increased options of communication, increased convenience, and possible cost savings. The challenges are informed consent, privacy and confidentiality, appropriateness of online treatment, online assessment, identity verification, data validity, communication, competence, crisis intervention, and legal concerns. Both the benefits and challenges are required to be evaluated regularly to be transparent, and discussed in ethics codes for eHealth.

Language Barriers

Forced migrants with culturally and linguistic different backgrounds than psychotherapists rely on competent, professional trained interpreters to enable communication during psychotherapeutic sessions.

One systematic review suggests that optimal communication, increased patient satisfaction, best outcomes, and fewest errors occurred when patients with Limited

English Proficiency (LEP) have access to trained professional interpreters [43]. To maximize the quality of the psychotherapeutic encounter and to minimize the risk of errors, bilingual psychotherapists or certified professional interpreters are recommended to be involved in all encounters with patient with LEP or with limited host language proficiency. Further, attention ought to be given to present use of anonymous phone interpreter when delicate subjects are discussed. An "in-person" interpreter may be a member of the local community, and patients may be reluctant to discuss sensitive topics such as torture/trauma or sexual and reproductive health because of fear of disclosure or stigma. Gender concordance of the interpreter may be important in some cultural groups. Ethnicity or tribal affiliation of the interpreter should be paid attention to, as well as earlier associate with persecution of the patient or patient's ethnic group.

Conclusion

As the global picture changes, a paradigm shift is needed to a world of health care, which is more compatible with the needs of diverse populations. Psychotherapy with forced migrant patients who have experienced trauma requires an understanding of the trauma history and the trauma-related symptoms. Successful treatment requires a multidisciplinary approach that is culturally acceptable to the forced migrant patient, and if necessary facilitated by an interpreter. Incorporating mental health services into primary care clinics may decrease stigma and normalize mental health care as part of routine services. A bio-psycho-social model that is based on the Universal Declaration of Human Rights and utilizes a humanist theoretical framework is recommended.

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Psychotherapy Using Electronic Media

15

Davor Mucic and Donald M. Hilty

Introduction

Over recent decades, the upsurge in migration of immigrants, asylum seekers, and refugees has transformed most EU countries into multicultural societies. However, the transformation of mental health care had not followed these sociocultural changes. Improving the accessibility and availability of appropriate (psycho)therapeutic approaches is key in the establishment of effective care. Nevertheless, the structure, distribution, and costs of mental health care (including psychotherapy) make it unavailable for a significant proportion of the world's population, especially refugees, asylum seekers, and migrants [1].

Accessibility and availability may be significantly increased through the use of telecommunication technologies. e-Mental health (eMH) is the term that covers the use of telecommunications technologies in the provision of mental health services to individuals in communities that are underserved due to geographic, linguistical, and/or cultural isolation. The use of mobile devices such as an iPad, mobile phone, web-based applications, and conventional videoconference equipment is finding its place within assessment, (psychotherapeutic) treatment, (psycho-)education, and the monitoring of psychiatric patients. Telemedicine and Internet-enabled clinical systems are already widely available and are starting to have an impact on the doctor–patient relationship, and will increasingly do so in the future. Telemedicine consultations are now so common that they are undertaken on broadband Internet

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systems, and professionals from all areas of mental health (from psychiatrists, psychologists, marriage and family therapists to career counsellors) can now deliver therapy from a distance.

Across telemental health clinics, clients tend to present with the same concerns as seen in traditional clinic settings [2]. The choice of who will be provided such services depends on developmental and diagnostic considerations, reasons for seeking care, the patient's illnesses/disorders, and the therapist's comfort with the technology. This treatment option may cause participants to feel less self-conscious and lessen any confidentiality concerns, as the therapist is usually located outside of the local community. No category of patients has been excluded from mental health services over a distance, but adolescent patients may adapt particularly well. When we speak about participants/patients/clients in further text of this chapter, we also include refugees and migrants as e-MH applications enable remote contact/assessment/treatment via respective mother tongue as well as via interpreter if needed.

Remote (Psycho)Therapy

When telecommunication technologies are used in provision of psychotherapy, they may be referred to as e-therapy, e-psychotherapy, online-psychotherapy, telepsychology, web counselling, distance counselling, cyber-therapy, distance therapy, Internet therapy, web therapy, or even other terms. These experiences and/or services vary in many regard: (1) focus of education, support, and/or formal therapy; (2) individual vs. group participation; (3) synchronous vs. asynchronous interaction; and (4) participants as people, patients, caregivers, family/loved ones, and providers/clinicians across interdisciplinary teams. Most research has been based on patient satisfaction, psychotherapeutic interventions, and the therapeutic alliance comparing remote (videoconference based) and in-person delivery [3, 4]. This includes effectiveness with therapeutic types/formats, populations served, satisfaction, feasibility, and outcome data [5].

Types of Interventions/Treatments

Depending on which medium is in use, remote interventions may be divided as follows:

- Web-based intervention is a primarily self-guided intervention programme that is executed by means of a prescriptive online programme operated through a website and used by consumers seeking health- and mental-health related assistance [6]. An app-based intervention is essentially the same as a web-based intervention except that it is operated through a mobile phone application using phone memory and/or the Internet.
- The intervention programme itself attempts to create positive change and/or enhance knowledge, awareness, and understanding via the provision of sound health-related material and the use of interactive web-based components.

- On the basis of this broad and inclusive description of web-based interventions, three additional sub-categories have been delineated. These are: (1) web-based education interventions; (2) self-guided web-based therapeutic interventions; and (3) human-supported web-based therapeutic interventions. Although each of these categories aims to support or direct cognitive, emotional or behavioral change, they differ primarily with regard to their level of interactivity, support, structure, and directiveness [7].
  - Web-based educational resources are popular with the public, patients, and providers in order to access information, decide whether or not to seek advice/consultation with a professional, and seek self- or provider-directed treatments (e.g., cognitive behavioral therapy or telemental health care). Social networking has been defined as "web-based services that allow individuals to (1) construct a public or semi-public profile within a bounded system, (2) articulate a list of other users with whom they share a connection, and (3) view and traverse their list of connections and those made by others within the system" [8]. A meta-analysis shows that health behaviors change with this medium [9]. Young people with developmental challenges feel more comfortable receiving support anonymously or at a distance [10]. Patients migrate to sites such as PatientsLikeMe (http://www.patientslikeme.com/), a consumer-driven site where individuals log on to connect with others experiencing similar problems. Some use role-playing games (such as "Second Life") as an educational tool, which may improve understanding of psychotic symptoms (i.e., auditory and/or visual hallucinations) [11]. These patients use the Internet as a source of information about the illness and any potential side effects of medication, as well as in the hope of finding better medication with fewer side effects [12]. Anxiety or trauma patients (e.g., military personnel with PTSD) may also prefer the Internet or distance options [13].
  - Self-guided web-based therapeutic interventions are highly structured, derived from theory (e.g., CBT, interpersonal therapy), and modelled on standardized or manualized in-person psychological therapy [6]. The interventions also typically provide automatically generated feedback or a means by which people can monitor their progress as they complete stages of a programme. The main purpose of self-guided web-based therapeutic interventions is to support consumers to make cognitive, behavioral, and emotional change to address particular problems they experience. Self-guided web-based interventions have been developed for conditions such as mood disorders, anxiety, and insomnia, typically by a team of web-designers and consumer representatives led by psychologists within a university setting [7].
  - "Human-supported web-based therapeutic interventions" incorporate a human (usually a health/mental health professional or, in some cases, peer supporters) to provide support, guidance, and feedback" [6]. The human support complementing the web-based material can vary in terms of mode (i.e., video, e-mail, chat), frequency, and whether or not it is synchronous or asynchronous. Human-supported web-based therapeutic interventions differ from self-help web-based interventions and online counselling interventions by specifically combining the human support/feedback with the

self-help material. The feedback and guidance provided by the mental health professional is seen as an additional, active, and critical component of the programme tailored for people with moderate to severe levels of distress compared with self-help web-based interventions which support people with mild to moderate levels of distress.

- Online counselling and therapy refers to the provision of a psychological service directly between a psychologist and client via the Internet. The communication between psychologist and client can be through a variety of modes including e-mail, synchronous "chat," i.e., in real-time, video and/or phone services such as those mediated by a secure online video chat/conference service, and might be between individuals or shared within a group.
- When videoconference in real-time is in use, we speak about "synchronous telepsychiatry." The term "asynchronous telepsychiatry" or "store and forward model" covers the transmission of recorded clinical-related material, i.e., assessment, psychiatric interview/consultation between referring physicians and specialists. Telepsychiatry offers a useful alternative to psychotherapy provision when in-person therapy is not accessible. The most commonly studied type of video-conferenced psychotherapy was CBT.
- Internet-operated therapeutic software refers to "therapeutic software that uses advanced computer capabilities such as artificial intelligence principles for (a) robotic simulation of therapists providing dialogue-based therapy with patients, (b) rule-based expert systems, and (c) gaming and three-dimensional (3D) virtual environments" [6].
- Simulation of therapists through programmes such as "Eliza" (http://www.manifestation.com/neurotoys/eliza.php3) was developed originally as a test of the development and ability of artificial intelligence to simulate human interaction rather than to necessarily represent a genuine therapeutic interaction between a client and therapist.

Depending on the nature of the interaction between mental health professionals and consumers on the Internet, this interaction may be divided into four types. Two types of interaction take place entirely via the Internet, while the others combine Internet communication with in-person treatment.

1. e-Therapy—psychotherapists form ongoing helping relationships that take place solely via Internet communication.
2. Mental health advice—psychotherapists respond to one question in depth, again with communication taking place solely via Internet.
3. Adjunct services—psychotherapists use Internet communication to supplement traditional, in-person treatment.
4. Behavioral telehealth and telepsychiatry—mental health professionals (typically psychiatrists) use sophisticated videoconferencing systems to work with patients in remote locations, as an extension of traditional clinic or hospital care.

The Approach to Psychotherapy at a Distance

The intersection of the patient–clinician relationship with technology may impact the therapeutic frame, trust/safety issues, and expectations. The patient's requests, needs, and preferences among indicated clinical care options should be the clinician's first priority and s/he should consider technology or technologies based on the many factors that determine its suitability. The suitability of such technology—whether it is appropriate to assist in the process and whether it "fits" the circumstance—is a discussion which is held ideally at the beginning of an evaluation as part of the consent process (and at times, discussed before this by the clinician and/or her/his proxy e.g., telemedicine coordinator, staff) [14, 15]. The choice of technology is subsequently considered. The therapeutic frame also includes preparing for emergencies, for example, by gaining familiarity with the availability of community resources and emergency resources where the patient is located.

The clinician also explores with the patient how the use of technology may differ from in-person and/or use in a personal relationship: boundaries (e.g., whether they will use their personal or work e-mail, or not responding to e-mail messages at all hours of the day and night), privacy and confidentiality, the pros/cons specific to the technology selection and use of telecommunications, and therapeutic issues (such as not benefiting from the services provided or the option of calling instead of posting suicidal thoughts). Response to such interventions varies. Some sub-populations may be more comfortable with it than others: children in general report novelty, while those with significant behavioral/conduct/chemical dependency issues report feeling less stigmatization and anxious patients report less anxiety [16]. However, as within in-person therapy there will always be patients who are not motivated for treatment, having ongoing drug or alcohol abuse, etc. In such cases we may not expect better results via remote approaches.

Historically, communication via text and e-mail suffers from the phenomenon of "cluelessness" [17], which leads to a task-oriented focus where depersonalized content may occur [18]. These asynchronous technologies (e.g., text, e-mail, or social media posts) affect and require special effort to create telepresence as they do not include facial expressions and emotions [19]. Examples are eye contact, gestures, posture, fidgeting, nods, grins, smiles, frowns, and lip-reading [20].

Boundaries, technology, and clinical care are complex to manage, too, and clinicians must attend to boundaries with tele-behavioral health (TBH) technology-mediated options (e.g., video, e-mail, telephone, text messaging, apps) just as they do with in-person care [15]. Usually this means being in agreement on reasonable expectations, consistency, triaging concerns (e.g., suicidal thoughts in person or by phone rather than text), and professional responsiveness (e.g., not responding to an e-mail until the next day if received at 4.50 p.m. or after hours). For new technologies, though, this may include dealing with terms/symbols with multiple or ambiguous meanings (e.g., sentence/thought fragments, acronyms, emoticons). The use of text messaging and apps particularly affects boundary, privacy, and security issues, as participants may be disinhibited and overly responsive. The flow of conversation,

the impact of the medium, language, and culture (e.g., across time zones) may also shift communication. Creating and maintaining a distraction-free virtual environment is key, and here, there are two types of problem that may arise. First, there are the obvious things like avoiding interruptions due to the location (e.g., roommates or children around), telephone calls, noise, and positioning of equipment/devices—arranging this should be part of the consent process. As above, participants should not be multi-tasking with traffic while driving, typing notes on the computer, or checking their e-mail during a session. Preparation and ongoing fine-tuning of the environment are suggested. The second issue is that when care is provided at a distance such as in telepsychiatry, there is a multiplier effect of "little things"—non-ideal in-person components plus non-ideal technology plus "minor" distractions may negatively affect the ambience. The bottom line, again, should be a focus on the clinical objective(s) and therapeutic impact. Being overly responsive could be therapeutically negative and may not be appropriate for those already struggling with boundaries (i.e., those with personality traits and disorders) to create obstructive chaos. Indeed, those patients may need more literal education and clinicians should approach that care with caution, as such patients already require significant time and energy.

Historical Background

Remote communication between therapist and client is not a new concept. Sigmund Freud utilized letters extensively to communicate with his clients.

- Use of radio and TV in psychotherapy was described in the 1950s [21, 22].
- In 1959, the Nebraska Psychiatric Institute used early videoconferencing to provide group therapy, long-term therapy, consultation-liaison psychiatry, and medical student training at the Nebraska state hospital in Norfolk.
- Telephone sessions were pioneered in the 1960s with the advent of suicide hotlines, and have expanded to cover many areas of mental health counselling.
- In 1969, Massachusetts General Hospital provided psychiatric consultations for adults and children at the Logan International Airport health clinic. During the 1970s and 1980s this became increasingly common, expanding to most diagnostic and therapeutic interactions.
- By the 1990s, it spread further across the world, particularly in Australia, and research began on its ability to facilitate access to care, overcome geographical obstacles, and how it compared to in-person care.
- Within the EU, leading pioneer countries developing remote mental health services are Norway and England, who have been developing remote services since the early 1990s.
- Telepsychiatry has been tested and established on a small scale in Denmark since 2000, as well as in Sweden, Spain, and Greece within the last decade.
- One of the first demonstrations of mental health care via the Internet was a simulated psychotherapy session between computers at Stanford and UCLA during the International Conference on Computer Communication in October 1972.

- The earliest known organized service to provide mental health advice online was "Ask Uncle Ezra," a free service which has been offered to students of Cornell University in Ithaca, NY, since 1986.
- Fee-based mental health services offered to the public began to appear on the Internet in 1995. Most were of the "mental health advice" type, offering to answer one question for a small fee.
- Telepsychology was first described in 2000 [23, 24].
- Videoconferencing has also been used in supervision and psychoeducation [25].
- With the expansion of the Internet, a number of web-based services offering online therapy have enabled increased accessibility and availability of care, ranging from self-help groups and psychoeducation to ordinary therapy usually based on CBT principles.
- The use of mobile technology to support various aspects of health care delivery has been on the rise for more than a decade, and is now commonly referred to as "mobile health" or simply "mHealth" [26]. The first mobile software application ("app") became available for use in 2008 [27]. However, the usage of mobile phones to provide psychotherapeutic services is at a relatively early stage of evaluation.

e-Therapies are now recognized as an integral constituent of future health care solutions in Australia, the UK, and New Zealand, with such therapies also common in many other regions, including the USA and other parts of Europe [28, 29].

Building Bridges over Barriers

Psychotherapy enhances quality of life and promotes adaptive functioning. However, common obstacles such as long waiting lists [30], perceived social stigma [31], and high costs [32] may discourage many individuals with a psychiatric disorder from seeking relevant professional help. Internet-based interventions provided via use of mobile devices (i.e., smartphones, i-pads), computers, and/or stand-alone videoconference equipment offer potential solutions to these barriers. Immediately accessible and usually less costly, online interventions may offer a valuable alternative to in-person therapy. Therapeutic interventions provided via the Internet are often combined with individual and group interventions in person, but may also be used as a stand-alone psychological service. e-Mental health interventions, usually CBT based, are available and effective approaches in the treatment of various psychological health problems for majority of mental disorders [33, 34]. These are considered to be especially suited for offering early intervention after the experience of stressful life events that potentially trigger adjustment disorder [17, 35]; they are effective for panic disorder [36, 37], social phobia [38], depression [39–41], and substance misuse [42, 43].

The treatment of PTSD is particularly interesting for professionals who deal with cross-cultural populations, i.e., asylum seekers, refugees, and migrants. Studies on the use of e-mental health applications (e.g., telepsychiatry) in the assessment and/

or treatment of PTSD show a highly significant decrease in the symptoms of PTSD, depression, and anxiety [44]. Furthermore, quality of life was also higher at post-treatment [45]. Although telepsychiatry is the most researched and oldest of all e-mental health applications, it represents a novel and understudied mode of treatment in conflict zones. The use of telepsychiatry in the Syrian conflict presents a promising solution to addressing mental health needs in complex humanitarian emergencies [46]. In a study of veterans with PTSD which compared in-person to video-conferenced CBT, it was found that both groups improved and were satisfied. However, outcome data was lacking for many studies reported in the systematic review [47]; research using more rigorous methodology would therefore be useful in order to better understand the effectiveness of telepsychotherapy.

In addition, e-therapies have been identified as particularly suitable for use by marginalized populations [48, 49] such as persons living in rural areas [50] or members of the LGBT community [49]. When the only options are no therapy or therapy provided via interpreters, then individuals with limited language proficiencies (i.e., refugees, asylum seekers, and immigrants) tend to prefer a videoconference with clinicians who speak their language rather than therapy provided in person by someone who does not speak their language, via an interpreter [51].

Finally, while the majority of patients benefit from psychotherapeutic treatment, many fail to maintain their treatment gains following discharge. Technology-enhanced interventions such as Internet chat groups can be successful in preventing relapse following inpatient treatment [52] as well as offering transdiagnostic Internet-based maintenance treatment in combination with "treatment as usual", effectively enhancing the long-term outcomes of inpatient cognitive behavioral therapy [53].

Advantages vs. Disadvantages

e-Therapy utilizes the power and convenience of the Internet to allow synchronous and asynchronous communication between patient and therapist. e-Therapies are an attractive option because they are relatively cost-effective [54–58], accessible, and able to maintain user anonymity [54, 55, 58]. e-Interventions offer several advantages such as ease of use, independent of time and place at a self-determined pace, and low cost of delivery to large populations [34, 59]. Further, e-mental health has been associated with benefits such as anonymity and reduced barriers such as stigma.

A further advantage is the disinhibition effect, where people feel more comfortable opening up and discussing problems when they are online. It might be due to the fact that the client does not have to deal with social and non-verbal cues, embarrassment, shyness, and other behavioral barriers that can sometimes impede progress in a traditional counselling atmosphere.

The downside of remote contact is that there is less chance to develop a strong relationship with a therapist. Finally, it is important to underline that e-therapy is not an alternative treatment, but a resource that can be added to traditional psychotherapy.

In particular e-therapy can facilitate access for people:

- in remote locations;
- with specific cultural or language needs;
- seeking specific services that are not broadly available;
- who, by reason of psychological or other impairment, are unable to leave their homes;
- who have limited time availability for appointments;
- who prefer the convenience it provides; and
- for whom high levels of confidentiality or anonymity are important [60].

As services can be accessed online via a computer, smartphone, or tablet, digital mental health can be used for anyone who doesn't want to work in person with a therapist, or anyone who finds it difficult to leave their home (i.e., because of agoraphobia or social phobia). As talking therapies can often have long waiting lists, these services can be used while waiting for in-person services. Rather than replacing traditional services, e-mental health resources can offer support during these waiting times. Being online means that services can be offered to people in rural areas who may find it difficult to access services in person due to long distances. Online or blended approaches are likely to be cost-effective, and can possibly reduce the direct costs of treatment compared to treatment as usual.

Potential disadvantages related to remote therapy (especially non-videoconference provided) are the possible absence of verbal and non-verbal cues due to no in-person contact. The lack of visual cues may reduce a sense of accountability to one's conversational partner, as both parties can engage in other tasks without the other being able to see this occurring. Even for therapists, this can foster a sense of disconnectedness. Confidentiality could be breached (hacked) depending on level of connection and/or the security of the software programme used.

When using non-video media, there is a greater risk of misdiagnosis occurring. Therapist credibility might be questioned as anyone may offer an online service without necessarily being approved by the relevant municipality. If/when absolute anonymity remains, how is a quality service ensured? If a practitioner does not know where a client is, how can they call for help, such as suicidal threats? Psychotherapy at a distance precludes smelling alcohol on the patient's breath, as well as noticing auditory and visual subtleties such as a quiet sigh or dilated pupils. Micro-momentary facial expressions, implicated in unconscious interpersonal communication, may be overlooked.

iCBT

Research shows that online mental health interventions are as effective as traditional in-person therapy for disorders such as depression and anxiety [61–63] (e.g., CBT for panic disorder and agoraphobia) [63]. Based on a 30-month follow-up study for treatment of social phobia, research showed that the long-term effects of in-person

delivered cognitive behavior therapy (CBT) were comparable to the results of Internet-based treatment [62].

Internet-based CBT (iCBT) is most often used for patients with depression and anxiety. iCBT appears to be effective when delivered in clinical practice when guided by a qualified therapist [64, 65]. Results indicated that effect sizes and recovery rates were comparable to, or somewhat superior than, those observed in previous controlled trials, and similar to those of in-person CBT [66]. iCBT approaches may be unguided and/or guided and self-help interventions vary in terms of degrees of therapist contact [59] (e.g., people with PTSD symptoms benefit from a cognitive behavioral treatment provided entirely via the Internet [67], while depressive patients seem to need remote support in addition to in-person treatment). Some iCT may be combined with monitoring by text message (mobile cognitive therapy; mCT) with minimal therapist support (e-mail and telephone). Preliminary results indicate mCT as an acceptable and feasible approach to both patients and clinicians [68].

Mobile Health and Smartphone-Based Approaches

With improvements in design, methodology, and innovation, mobile phone-based psychotherapeutic applications technology have the potential to play an important role in transforming the healthcare delivery process. The emerging literature highlights the potential benefits, feasibility, and acceptability of the applications across a range of psychiatric conditions. However, effectiveness trials are scarce [69]. Nevertheless, the reviewed evidence provides hope that mobile phone technology will prove to be a useful adjunctive, if not a stand-alone treatment for psychotherapy in a broad range of mental health conditions, e.g., anxiety disorders [70–73], depression [74–76], bipolar disorders [77], substance use disorders [78–81], schizophrenia and psychotic disorders [82–86].

Specific target interventions show promising results [14]. One trial compared a brief mobile-based intervention to treatment as usual among suicide attempters and found significant reductions in suicidal ideations and depression in the mobile phone group [87]. Stress reduction programmes using a mobile phone app has attracted a large number of potential users and may economically impact a community [88]. Many of these have been adjusted so that various patient groups may benefit also via their mother tongue. “FearFighter” is a computer guided self-exposure approach to treat phobia/panic developed at the end of last century [89]. Exposure therapy may be effective for phobia/panic but qualified and trained therapist resources are scarce. Computer-guided approaches provide patient and clinician benefits by saving time and enhance health care efficiency [90].

Psychiatric apps support the drive towards more individualized medicine—rather than epidemiological and consensus-driven algorithms—and are supported more by informatics, laboratory medicine, and testing [14]. Mobile apps offer portability for care anytime, anywhere, regardless of patient geography and transportation barriers and represent an inexpensive option versus traditional desktop computers; they also

offer additional features (such as context-aware interventions and sensors) [91] with real-time feedback. Overall, psych apps are used for many functions, including to: (1) communicate with other patients, caregivers, social supports, or providers; (2) (smart) monitor, that is, use tools that automatically predict relapse behavior or worsening affective symptoms, through sensors and data activity; (3) to practice self-care by equipping patients with new ways to self-assess and reflect about their symptoms; (4) make learning more interactive than traditional paper homework; and (5) organize, track, and thus monitor long-term their activities, moods, and therapy homework [92, 93]. Patients often forget key events between visits, so logging real-time experiences helps with reporting of symptoms; this is known as ecological momentary assessment; (EMA) [94].

Psychometric measures such as the Patient Health Questionnaire (PHQ-9) and other military population measures have been found to have good reliability and validity, but soldiers have preferred using the iPhone rather than paper or computer due to its interface, portability, and convenience [95]. The US National Center for PTSD and the National Center for Telehealth and Technology have created an app called PTSD Coach [96]. The app features information on PTSD and treatments, tools for screening and tracking symptoms, tools to manage stress and direct links to support and help. While such apps are not designed to act as a substitute for treatment, this technology may become an important tool for managing and even initially detecting PTSD symptoms.

Virtual Reality

One of the applications that is being increasingly widely adopted and used for mental healthcare education and clinical purposes is virtual reality (VR) [97]. VR is the concept of being virtually but not physically at a specific place. Some VR platforms involve three-dimensional imaging and surround audio that make the user feel as if they are in the real world. The user can go or do certain things that might be difficult or impossible in real life. Virtual reality exposure therapy (VRET) is an extension of traditional exposure therapy. In a VRET treatment protocol, an individual is immersed in a virtual environment that allows for sensory exposure to the feared stimuli via computer-generated displays. It permits the individual to face their triggers in a safe environment and allows the therapist to control the intensity and duration of the stimuli, based on their clinical appraisal [98]. The environments can be tailored to represent the individual's fears as well as to recreate a traumatic experience, e.g., in the treatment of PTSD [99]. VRET is usually delivered via a head-mounted display, which tracks the users' head-movements and allows for real-time updating of the scenes they can see [100]. Initially designed for the treatment of phobias, the use of VR in behavioral disorders has expanded for other mental health conditions [101].

Systematic reviews of the studies of VR in mental disorders found that the main conditions investigated were anxiety disorders, schizophrenia, substance related disorders, and eating disorders [102]. Another review focusing specifically on the

potential use of VR in interventions for mental disorders [103] demonstrated that overall, VR has been shown to be superior to treatment as usual or waiting lists and as having similar efficacy as conventional CBT or in vivo exposure. Two different randomized, controlled trials [104, 105] have shown at 1-year follow-up that VR had a higher efficacy than the gold standard in treatment of eating disorders, i.e., CBT. The effectiveness of VRET is now well-established: four independent meta-analyses have concluded that such interventions lead to significant decreases in anxiety-related symptoms [106–109].

Prolonged exposure therapy, which has been proved to be highly efficacious in the treatment of PTSD, aims to access the traumatic memory, including information about the traumatic situation and related emotions, thoughts, and behaviors. It helps the patient to understand the context of the traumatic experience as well as its impact in the patient's life. It also enables the patient to achieve a realistic perspective on the traumatic event and its aftermath [110].

VRET can be particularly useful in the treatment of PTSD that is resistant to traditional exposure because it allows for greater engagement by the patient and, consequently, greater activation of the traumatic memory, which is necessary for the extinction of the conditioned fear. The sense of presence provided by a virtual environment that is rich in sensory stimuli facilitates the emotional processing of memories related to the experienced traumatic event [111]. Technology allows gradual exposure to the feared environment which can be tailored to the needs of each patient. Additionally, it can be used in situations where time is limited, as well as in situations that are difficult to control or unpredictable [112] or that could put the patient at risk if the exposure were performed in a real situation. Finally, exposure in a virtual reality environment allows for greater methodological rigor in clinical studies as it allows for the standardization of the duration and type of exposure for all patients [113].

Despite the fact that exposure therapy stimulates emotional engagement during imaginal exposure, some patients find it difficult to immerse themselves in the traumatic scene and, therefore, may quit the treatment. However, dropout rates do not seem to be lower than in traditional exposure treatment [114]. VRET proved to be as efficacious as exposure therapy.

Avatars are digital self-representations which enable individuals to interact with each other in computer-based virtual environments. They are increasingly being utilized to facilitate online communication between clients and therapists. As a flexible and creative platform, avatar technology holds significant potential to engage a broad range of clients in need of psychological support who may otherwise be unable or unwilling to participate in traditional treatment. In particular, avatars may foster the development of a strong virtual therapeutic alliance, overcome communication barriers experienced by individuals with various disabilities and mental disorders, offer an anonymous means of seeking treatment, and support clients to explore and extend their identity.

Several studies have utilized various forms of avatar technology to facilitate or augment treatments that are delivered with the in-person support of a therapist. Two models of these avatar-assisted therapies have been implemented: (1) applications

that require the client to "embody" or represent themselves as an avatar in order to participate in the therapy and (2) applications that do not require the client to embody an avatar, but rather require the client to interact with another avatar, be it the therapist or an "other."

Five psychotherapeutic key applications of avatars are identified (1) in the formation of online peer support communities; (2) replicating traditional modes of psychotherapy by using avatars as a vehicle to communicate within a wholly virtual environment; (3) using avatar technology to facilitate or augment face-to-face treatment; (4) as part of serious games; and (5) communication with an autonomous virtual therapist [80].

Across these applications, avatars appeared to serve several functions conducive to treatment engagement by (1) facilitating the development of a virtual therapeutic alliance; (2) reducing communication barriers; (3) promoting treatment-seeking through anonymity; (4) promoting expression and exploration of client identity; and (5) enabling therapists to control and manipulate treatment stimuli [115].

One of the leading more popular VR applications is Second Life (www.secondlife.com). It is a VR platform that is open to the public and can be accessed free of charge. Every user is given an avatar that can be customized to reflect one's own physical appearance or character. Avatars can walk, run, or fly from one island to another. Some can go shopping, visit museums, or even go on a date. It all depends on the user's preference and liking. Consequently, Second Life has strong potential to replicate models of individual and group-based treatments, but conducted entirely online, with both client and therapist interacting with each other in a virtual environment. To date, this model has been trialled in two uncontrolled studies using individual [116] and group formats [117]. Participants reported that they appreciated the convenience of being able to participate remotely in a virtual programme and also commented that the anonymity of participation made the intervention material more approachable.

Using Second Life, Kandalaft et al. [118] delivered a manualized social skills training programme to eight young adults with high-functioning autism spectrum disorder. During sessions, the therapist—represented as an avatar—directed participants to various virtual spaces (e.g., cafes, parks, shops) where they met with a confederate clinician—also represented as an avatar—to practice social interactions in diverse role-playing situations (e.g., attending a job interview). Clinician-administered neurocognitive measures of verbal and non-verbal emotional recognition significantly improved, suggesting that the programme may improve elements of social communication typically impaired in people with autism.

A novel component of (embodied) avatar use in online psychotherapeutic interventions is the capacity they provide for clients to express, experiment with, explore, and construct a virtual, visual representation of their identity and provide therapists with greater control over treatment stimuli that involve an element of exposure or skills training [115].

Virtual reality programmes/environments have been successfully developed and applied to treat, for example, specific phobias and other anxiety disorders. Therapeutic games, though primarily designed to have health, cognitive,

behavioral, or educational benefits, are also intended to be entertaining for the user. The games are often based on research findings and are generally designed for a specific target group (e.g., children with moderate to severe autism) or a broad (commercial) market. Many video games require that the player embodies an avatar to interact with other players or to interact with automated non-player characters. In "serious games," such game-like elements are incorporated into computerized psychotherapies to achieve a serious health-related goal (e.g., to reduce depression symptoms) [119].

Cross-Cultural Populations

Cross-cultural patient mental health-care demands a high standard of communication between the patient and the provider, since linguistic and other differences may influence it and consequently affect quality of care and satisfaction. Unfortunately, both access to relevant culture-appropriate care and availability thereof are often limited due to: (a) a shortage/lack of respective qualified resources; (b) linguistic, cultural, and even racial barriers to addressing the mental health care needs of cross-cultural patient populations.

Narratives from daily clinical work may significantly increase the understanding and acceptance of e-mental health among professionals with no e-mental health-related experience or professionals that are still in doubt, so we share the following story (Davor Mucic's case):

> NN is a 28-year-old female, refugee from my Bosnia-Herzegovina, ex-Yugoslavia (home country of DM). In Bosnia, during the war, NN was unfortunately raped several times while her husband was in the army. After immigrating to Denmark, NN was referred to a psychiatrist due to occurred posttraumatic stress disorder symptomatology. As her Danish language abilities were poor, the communication was provided via an interpreter. Consequently, she received psychiatric treatment with medication and psychotherapy via interpreter for around 3 years prior to our first telepsychiatry session. The video equipment was installed at psychiatric department where NN used to come and speak with her psychiatrist in-person. I was in Copenhagen while NN was located 245 km away in outskirts of Denmark. At the first consultation via telepsychiatry, the first question NN asked was, "Can all of Denmark see us now?"
>
> When assured that no one follows our conversation and that the session will not be recorded, NN replied, "Then I have a secret I would like to disclose" and so she started her story about traumatic events, i.e., rape and torture in home country. NN cried while spoke in a stream without a break except to wipe her tears and blow her nose. She said that it was not possible for her to speak about it with her past psychiatrist as all communication runs via the interpreter. The presence of the interpreter for her changed the dynamic of the interview and more tangibly, it increased the risk that her husband would find out about the rape and consequently divorce her.
>
> While NN spoke about her painful experiences, the Internet suddenly disconnected. When that happens, the last frame remains on the screen as a frozen picture. So NN could see me as a still image and I could see her frozen in the middle of a movement…and of course we could not hear each other. I panicked, thinking what she would say to this, or fearing that

> she probably would never come again (i.e., use the video). My technician was in the office next door, so he restored the connection. The break varied about 30 seconds in total, but it felt like much longer. To my surprise, when the connection was restored, I could see and hear NN who spoke in a stream and cried at the same time. She didn't even notice that I was gone for a while.
>
> Personally, it was an experience that shaped the next 15 years of dedicated work on developing of the "cross-cultural telepsychiatry concept", whereby the treatment of ethnic minorities de-emphasized use of interpreters. Further, we realized that telecommunication and information technology has the potential to increase the exchange of expertise across national borders without need for travel.

Perhaps the most significant changes in approach to culturally competent care over the past three decades are: (1) shifting from knowledge to skills as central to training; (2) moving from a specialized clinician based on a single culture (e.g., matching his/her own to training that provides flexibility/versatility to help many diverse populations); and (3) team-based collaboration across disciplines [120]. This work is shaped by many disciplines including cultural anthropology, psychology, social work, and other BH/social sciences. The gold standard for clinical care is linguistic, cultural, and racial concordance—but this requires training.

In all, eMH can play an enormous role both in leveraging mental health expertise around the world and in providing hope to patients in accessing healthcare. This is particularly important, since the boundaries of normality and pathology vary across cultures for specific types of behavior. Thresholds of tolerance for specific symptoms also vary across cultures, social settings, and families. A judgment of a behavior depends on norms internalized by individuals, family members, and clinicians. Mistaken interpretations may contribute to vulnerability, suffering, and missed opportunities for care. Traditions affect others' responses to mental illness, too, though some coping strategies may enhance resilience in response to illness, and increase access to care and patients' engagement of alternative care. Of course, differences between the clinician and patient have implications for accuracy, mutual understanding, acceptance of illness, treatment planning, and prognosis.

Stories are perhaps more important in the field of healing than in any other field, both in conveying abstract meaning (myths), moving people to change (politics), and teaching learners to apply knowledge and learn skills [121]. Stories are sometimes the only way to understand a patient's path and constitute a less hierarchical approach by facilitating a patient to tell his/her story in his/her own words.

It is a common practice to use "interpreters" on-site where the patient is, but family members, nurses, or untrained interpreters sometimes miscommunicate medical complaints [122] or de-emphasize information [123, 124]. In one study, primary care providers and staff rated the importance of valuing cultural differences and being able to speak (or use an interpreter). Enabling the conversation in the patient's primary language was rated at 5.4 on a Likert scale from 1 to 7 (not important to very important) [125]. Ratings of the importance of quality of care were at 4.9, access to care better with videoconferencing at 4.5, and the availability of a competent trained interpreter at 4.4 [125]. A subanalysis showed that those surveyed did

not think providers and patients must share the same ethnicity, culture, or language, but they thought more interpreters were needed. A review of the available scientific literature shows that the presence of a third person (i.e., an interpreter) in a confidential relationship (such as within psychotherapeutic treatment) affects patient satisfaction, as it influences both transference and countertransference between the individuals involved, with unavoidable consequences for the therapist–client relationship [119].

eMH applications offer new possibilities for reducing disparities in access to relevant mental health care to vulnerable patient groups, such as refugees, migrants, and asylum seekers worldwide. For asylum seekers, refugees, and migrants access to mental healthcare is a problem due to lack of clinicians who understand their language, culture, and special needs. It is well known that patients who do not speak the language of respective care providers report feeling discriminated against in clinical settings, whereas communicating with health professionals in a common language is associated with increased trust and confidence. That is probably why "ethnic matching" appears to be the most desirable model used in addressing language barriers and cultural disparities in mental healthcare provision. The use of eMH applications enables opportunities to build bridges over cultural and linguistic barriers by connecting patients with professionals that "match" culturally and linguistically [126].

The Little Prince Treatment Centre in Copenhagen, Denmark [127], was the first to use the medium of videoconference in order to connect patients with culturally competent bilingual clinicians, thereby side-stepping the need for interpreters (www.denlilleprins.org). Since then, different approaches have been described to deal with the specific needs of Hispanics/Latinos, Asians [128–132] and Native Americans [133, 134]. Patients report preferring to receive health care from a provider who speaks their native language rather than through interpretation, citing concerns about confidentiality and the accuracy of translations [135, 136]. The large majority of patients accepted the cross-cultural telepsychiatry model regardless of the type of service setting [135].

Only few international eMH services have been described so far: (1) Videoconferencing provided psychoanalytic clinical care and training to psychoanalytic candidates in China by US psychoanalysts, and this involved 40 psychoanalytic and 30 psychodynamic psychotherapies [137]; (2) The Little Prince Treatment Centre in Copenhagen connected bilingual clinicians from Sweden with non-native patients in Denmark in order to provide care (including psychotherapy) by professionals with cross-cultural skills, including clinicians who spoke Arabic, Polish, Kurdish, and ex-Yugoslavian languages [138].

Most European countries have established rehabilitation and research centers for torture victims providing assessment, medical and/or psychotherapeutic treatment mostly via interpreters. eMH mediated collaboration between the centers will enable the international exchange of expertise and enhance research in the field. Such a network could, by the use of various eMH applications, improve assessment and/or treatment of primarily asylum seekers, refugees, and migrants within the EU. National and international cross-cultural eMH services may contribute to reduce stigma and improve the quality of health care for these groups in their host countries.

Ethical Issues in Providing Online Psychotherapeutic Interventions

Online psychotherapy offers new ethical challenges for therapists interested in providing online psychotherapeutic services. The differences between interactive text-based communication and in-person verbal communication create new ethical challenges, and ones not previously encountered in face-to-face therapy. Ethical and legal issues in virtual environments are similar to those that occur in the in-person world. For example, individuals represented by an avatar have the same rights as any other individual and should be treated as such [139]. The American Psychological Association advises that psychologists " … take reasonable steps to ensure the competence of their work and to protect [participants] from harm" [140]. Consensus guidelines encourage transparency, dialogue with patients as part of the informed consent process, and discussion of the risks/benefits of therapy overall. Other treatment options—in the community or by travel—are discussed to encourage patient choice, although this is difficult when there are few local options.

A new tele-behavioral health (TBH) competency framework [15] includes the following domains: (1) Clinical Evaluation and Care; (2) Virtual Environment and Telepresence; (3) Technology; (4) Legal and Regulatory Issues; (5) Evidence-Based and Ethical Practice; (6) Mobile Health and Apps; and (7) Telepractice Development. There are three levels of competency (?)—novice, proficient, or authority. For the domain of Legal and Regulatory Issues, the four competencies are: (1) Adheres to TBH-relevant laws and regulations; (2) Practices in accordance with and educates others on adherence to TBH-relevant legal and regulatory requirements; (3) Applies/adapts in-person standards to TBH; and (4) Attends to TBH contextual and overarching jurisdictional issues in a reasonable fashion, with adaptations made for atypical practices that facilitate "good enough" care and attend to requirements [15].

Legal and regulatory issues affect TBH practice internationally. Using the USA as an example, this includes federal laws and benchmarks from regulatory agencies, related to privacy, confidentiality, data protection/integrity, and security (e.g., Health Insurance Portability and Accountability Act (HIPAA)), Health Information Technology for Economic and Clinical Health (HITECH), inter-jurisdictional practice and prescribing (e.g., Food and Drug Administration, the Ryan Haight Act). Likewise, state/provincial laws and regulations for TBH practice may be further defined, implemented, enforced, and interpreted (e.g., inter-jurisdictional practice). Again, in the USA, there are licensing boards for medicine, nursing, pharmacy, behavior analysis, counselling, marriage and family therapy, psychology, and social work. Relevant state/provincial and federal laws and regulations may also overlap.

Non-governmental regulatory requirements and recommendations from professional organizations, agencies, and other authorities in other countries may also apply to TBH practice. Examples of such entities include the Joint Commission, Council on Accreditation (COA), Commission on Accreditation of Rehabilitation Facilities (CARF), Utilisation Review Accreditation Commission (URAC),

American National Standards Institute (ANSI), and Healthcare Information and Management Systems Society (HIMSS) in the USA and according to other authorities in other countries.

Conclusion

The Internet is providing a bridge across some of the barriers that keeps people from getting the help they need. As psychotherapists have ventured into cyberspace, more and more people who would not otherwise have been helped are finding a path to healing. One may conclude that psychotherapy is on the verge of a technology-inspired revolution. The concurrent maturation of communication, signal processing, and machine learning technologies begs an earnest look at how these technologies may be used to improve the quality of psychotherapy. While research supporting the use of the Internet and other telecommunications technologies is emerging, in many instances, the research base remains behind practice. Therapists involved in e-therapy may ensure that they evaluate the effectiveness of their interventions. Furthermore they may keep up to date with developments in this rapidly moving area. Online counselling clearly does pose some unique problems, but also some unique possibilities for both clients and therapists. As such, both mental health practitioners and potential clients must be informed of both the benefits and limitations of remote therapeutic approaches.

Ultimately, psychotherapy is a decidedly human endeavor, and thus, the application of modern technology to therapy must capitalize on and enhance our human capacities as professionals. Online therapy introduces new pitfalls, and it is wise to be aware of these before choosing to practice in this way. While face-to-face treatment remains the gold standard, remote contact allows the creation of therapeutic situations where they might otherwise not have been possible, and may even be preferable to in-person contact in certain situations.

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Measuring the Outcomes of Intercultural Psychotherapy

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Introduction

Both carrying out a thorough assessment before commencing psychotherapy and measuring its outcomes are an integral part of clinical practice in mental health. Baseline assessment serves several purposes. It can be used to identify the needs and goals of the patient, as well as to plan the treatment accordingly. Baseline assessment also gives both the patient and the psychotherapist an idea of the level of emotional distress at baseline and enables them to measure changes over time. In order to track treatment-related changes as they occur, repeated measurement is required. Integrating outcome measurement into daily clinical practice offers a means to monitor treatment outcomes, which in turn may provide feedback to treatment in an attempt to improve these outcomes. Using measurements in clinical practice may also serve as a platform for doing research, ultimately allowing results to benefit other clinicians. When studying treatment outcomes in research, it is not merely a question of using appropriate measurements but also of designing a scientifically sound study. This chapter will focus on specific methods for measuring rather than on the design of research studies.

Measuring the outcome of psychotherapy presents particular challenges in an intercultural context. In this chapter we will first present some of the main questions to consider when choosing an instrument for measuring change in intercultural psychotherapy, either for clinical or combined clinical and research purposes. We will then go on to provide an overview and brief evaluation of specific instruments for measuring outcomes in psychotherapy.

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Questions to Consider When Choosing Measurement Tools in Intercultural Psychotherapy

A typical question when considering assessment tools in transcultural psychiatry is whether they are "transculturally validated". This is arguably an overused term, as there are many facets to validity and many populations for which these tools have not been evaluated. The term "validity" designates the ability of a scale to actually measure what it is intended to measure. When choosing a scale, then, the consideration of validity is whether there is a good indication that the scale will measure as intended in this particular sample. Furthermore, a tool needs to be assessed for reliability, i.e. the degree to which an assessment tool produces stable and consistent results.

Traditionally, psychometric studies have capitalised on criterion validity as well as reliability. Both the scope and approach of this tradition have carried over to transcultural research and are only recently and gradually being supplemented by more detailed and sophisticated validation approaches. Studies of criterion validity have typically evaluated the ability of a scale to predict diagnostic cases vs. non-cases based on a cut-off score. The ability of the scale to provide an accurate prediction also indicates that it measures the intended construct, although the observed accuracy may fluctuate from population to population. Much less is generally known about the validity of the individual items in the scale, e.g. their ability to discriminate degrees of the assessed phenomenon, and about potential bias in their measuring properties across languages, cultures, gender, etc. Ultimately, a measurement tool with good scalability comprises items which, when used together, discriminate well across the whole severity continuum of a phenomenon and have no deviations in their measuring precision across, for example, languages, cultures, and gender—the former being especially important in culturally heterogenous populations. These aspects of validity and reliability are sufficiently evaluated only with item response theory (IRT) measurement models, although the method is still new in intercultural studies. The advent of these new validation approaches along with changes to the major diagnostic classification systems mark a transitional period in the field of mental health measurement, in which previous consensus has been disrupted, while new recommendations are still somewhat immature.

The validity and reliability of a given instrument need to be established in relation to the intended purpose and the specific population. Neither can be assumed to be generalisable across populations. Assessment tools can thus be valid in one setting but less valid in another. This presents a special challenge to measurement in intercultural psychotherapy, where cultural heterogeneity in the population is frequent, while most measure are developed in homogenous, typically Western settings.

Only few instruments have been validated for several different cultural settings, including non-Western. This is also the case for many of the measure that are frequently used in cross-cultural studies [1, 2]. In a review of instruments used to measure refugee trauma and health status, Hollifield et al. conclude that the majority of articles about refugee trauma or health are either descriptive or include quantitative data from instruments that have limited or untested validity and reliability in refugees [2]. Although Hollifield's review focused on refugee populations, the lack

of valid and reliable scales is also a challenge for cross-cultural studies in general. Therefore, when choosing an instrument not previously tested in the target population, there is a need for a thorough examination regarding both the cultural equivalence and testing of desirable psychometric properties.

Flaherty and colleagues have suggested a stepwise validation model to secure cultural equivalence when developing scales [1]. The model is however also of interest when choosing between already existing assessment tools. The model includes the following steps:

1. Content equivalence: ensuring that the content of each item of the instrument is relevant to the phenomena of the culture being studied.
2. Semantic equivalence: ensuring that the meaning of each item is the same in the other culture after translation into the language and idiom (written or oral) of the other culture.
3. Technical equivalence: securing that the method of assessment (e.g. pencil and paper or interview) is similar in each culture with respect to the data it yields.
4. Criterion equivalence: examining whether the measurement of the variable remains the same when compared with the norm for each culture studied.
5. Conceptual equivalence: examining whether the instrument measures the same theoretical construct in each culture.

On a practical level, choosing measurement tools will always be a balance of careful considerations regarding general validity and reliability, cultural equivalence, as well as other aspects discussed below. When choosing which measurements to use either in clinical work or research, the following questions might be helpful.

What Do We Want to Measure and Are Existing Assessment Tools Appropriate for the Specific Purpose and Population?

This question relates to most of the steps in Flaherty's model, namely content validity, semantic equivalence, criterion equivalence, and conceptual equivalence. When deciding on an assessment tool, a decision needs to be made regarding whether we are interested in symptoms, quality of life, functioning, or in patient-centred or process-oriented measures. Are we interested in a global coverage of, for example, depression, or are we carrying out psychotherapy focusing on specific aspects of depression and therefore want to focus on these aspects in the assessment? Are there reasons to believe that specific cultural factors influence the phenomena we wish to measure? As mentioned above, most standardised tools used today have been developed in Western cultural settings—we therefore need to make sure that existing tools actually capture the phenomena cross-culturally. These preparations may require both qualitative work, such as focus groups, as well as psychometric analyses.

Although there will often be weaknesses in existing tools and no previous usage of the tool in a similar population, it will nevertheless often be advisable to use an

existing tool rather than inventing one's own. If considering developing a scale of one's own, this implies taking on a very large work load in developing a scale as well as carrying out initial validation studies. Furthermore, another disadvantage is that it will be difficult to compare the results with others.

It is worthwhile emphasising the importance of correct scale translations. Apart from a literal translation, the translation needs to be culturally informed so that the translated items make sense in the new language (i.e. securing semantic equivalence). It is important to follow guidelines such as those developed by WHO for proper translation of questionnaires, and to invest sufficient time in this process [3].

Finally, scales should preferably be accessible and free of charge. A worthwhile consideration here is that the fee spent per copy of a licensed scale is only part of the investment in a scale; published results, growing awareness of the scale through word of mouth, and feedback into the optimisation of the scale constitute a collective investment in the long term. By investing these resources in scales in the public domain, the return will ultimately benefit counsellors and clinicians in low-income settings.

How Many Measurements Do We Wish to Use?

When choosing measurement tools, the end product will usually be a battery of complementary instruments to obtain a nuanced and broad representation. At the same time, it will be important to limit the extent of the battery so that the assessment does not become too demanding and time-consuming for the patient and clinician. To make the best compromise, the exact purpose of each measurement needs to be carefully considered. As part of this consideration, it may be useful for researchers to define specific hypotheses to each of the chosen outcomes. Finally, relatively short scales may sometimes suffice. In some areas, traditional consensus dictates the use of scales which have been kept lengthy mainly for the sake of reliability, and possibly a wide content coverage, while in turn sacrificing construct validity. We provide a few examples of this below, such as with the Hamilton Depression Rating Scale. For this reason, we also advocate caution in choosing between alternative scales based on published reliability coefficients alone, particularly if it comes at the expense of lengthy administration and multidimensionality.

How Should the Measurement Be Administered?

This question is related to the technical equivalence in Flaherty's model. What would be the most informative or appropriate way of gathering the desired information? Assessments can consist of structured or semi-structured interviews, self-report questionnaires, or open-ended interviews. In some cases the patient needs an interpreter and this has to be taken into consideration when choosing a method which allows for as many people as possible to utilise the measurement. "When it comes to self-report questionnaires, it will often be a choice between pen and paper versus computer-based questionnaires, and in the case of observer ratings, a choice between structured and semi-structured interviews". Computer software, such as

MultiCASI [4] and MAPSS [5], allows questions to be read out loud and for patients to respond through a touch screen interface. This is particularly useful in populations with low literacy and where access to trained translators is limited [6].

Is the Scale Sensitive to Change?

If a scale demonstrates valid and reliable measurements, it will also show some ability to reflect changes between two points in time and be able to distinguish change from random variation. However, certain aspects of validity and reliability are particularly relevant to consider in this regard. First, it is important to promote variability in the responses. This entails that clients do not generally score extremely high ("ceiling effect") or extremely low ("floor effect") on the scale (i.e. good scalability in the target population). If this is the case, a scale with either more or less severe symptom should be chosen. Information about a tool's ability to scale appropriately in the target population can be obtained through IRT analyses, but short of validity studies with this sophistication, simply evaluating the items based on clinical insight from the relevant sample (i.e. face validity) will give a rough indication.

Most importantly, if individual items feature poor validity and reliability, they will detract from the sensitivity to change of the scale. For most of the scales relevant to this chapter, validation has not been carried out with IRT, but to illustrate the above principle, in the following we occasionally point out potentially irrelevant items based on face validity, as well as clinical and cultural observations.

Furthermore, in a recovery process the alleviation of symptoms does not always predict increased well-being, and this needs to be taken into account in the timing of the administration. If using a scale which has not previously been tested cross-culturally, it is also worthwhile considering that the sensitivity to change might differ between populations.

The difference in sensitivity to change across populations might also be related to using either observer ratings or self-ratings and symptom-based measurement or measures of functioning. In a meta-analysis from 2010, Cuijpers et al. [7] compared observer rating with self-report measures of depression and found a tendency towards larger improvement in depressive symptoms in the clinician-rated instrument. To our knowledge, similar studies have not yet been carried out to ascertain whether the same tendency applies cross-culturally.

The most relevant phenomena measured in intercultural psychotherapy encompass symptoms of mental health, disability and/or quality of life, and patient-generated outcome measures. Some of the most frequently used tools are presented below. Importantly, just as a psychotherapeutic approach may be effective even if still not supported by evidence, so too do a range of scales appear relevant for use in intercultural psychotherapy, even if most are lagging behind in terms of validation. Ideally, the introduction of key psychometric principles combined with clinical and cultural insight will allow the reader to make a competent choice of tools, even in a previously untested cultural context.

Symptom-Based Measures

This section considers measures of mental health symptoms. We focus on Post-Traumatic Stress Disorder (PTSD), depression, and anxiety, as these are some of the most predominant mental disorders treated with psychotherapy, and these phenomena have undergone at least some psychometric research in culturally heterogenous populations.

PTSD

Self-Ratings

For self-ratings of the diagnostic symptoms of PTSD, most cross-cultural studies have used the Harvard Trauma Questionnaire (HTQ; [8]). *The HTQ is a relatively comprehensive questionnaire, including event checklists as well as symptom ratings. We will be concerned initially only with part four, which includes 16 items corresponding to the 17 symptoms of cluster B-D of the DSM-IV.* Part 4 of the HTQ also includes additional culture-specific items, which we will consider later. Although numerous studies have used only the 16 DSM-related items, no official name is given to this subscale of the HTQ part 4. We will refer to it as the HTQ PTSD scale.

The PTSD Checklist [9] and the Post-Traumatic Diagnostic Scale [10] have also been used in a number of cross-cultural studies. They are based on the same DSM symptoms as the HTQ PTSD scale, and the item content is very similar across the scales. However, the updated PCL-5 [11] and PDS-5 [12] versions reflect DSM-5 PTSD symptoms, whereas the HTQ has not seen such an update yet. Yet more options are introduced in the 11th revision of the International Classification of Diseases (ICD-11), which introduces a more narrow definition of PTSD along with the new and extended diagnosis of complex PTSD (CPTSD; [13]). A self-rating scale has already been developed to cover both of these diagnoses, the International Trauma Questionnaire [14]. While a discussion of the particular relevance and validity to transcultural psychiatry of each of the diagnostic frameworks exceeds the scope of this chapter, we will point out some potential strengths of each of the four rating scales.

The PCL, PDS, and HTQ all inquire into how much or how often each symptom has manifested within a given time frame. For the PCL and PDS, the time frame is the last month, while for the HTQ it is the last week. The PCL and HTQ both focus on subjective distress caused by each symptom, i.e. how much the respondent was bothered by each symptom during the period in question. The PCL uses five response categories: not at all, a little bit, moderately, quite a bit, and extremely, while the HTQ uses only four, dispensing with the category moderately. The latter reduction reflects arguments that a 4-point scale is more comprehensible across cultures [15, 16]. Rather than subjective stress, the PDS focuses on the estimated frequency of each symptom. Response categories are (a) not at all, once a week or less/a little, (b) 2–3 times a week/somewhat, (c) 4–5 times a week/very much, and

(d) 6 or more times a week/severe. While on the surface this may appear a more objective measure, what qualifies as a significant occurrence is still subjective. Also, it is generally easier to keep count of occurrences when the frequency is low. All in all, the simplified time frame and response categories of the HTQ may be relevant in many cross-cultural settings. If using other rating scales, it would be relevant to adapt them to avoid excessive complexity.

Another simplification in the HTQ is the combination of physical and emotional distress from being reminded of the traumatic event(s) into one item. In the authors' clinical experience with other PTSD rating scales, the ratings of these two symptoms typically coincide, thus supporting the decision to combine them in the HTQ.

The item content is generally similar, and occasionally identical, across the three scales. This is not surprising, given the direct relationship to the diagnostic criteria. Perhaps the most notable difference concerns the two avoidance symptoms, which in the diagnostic manual cover both avoidance and efforts to avoid. Here, the PCL and HTQ assess only actual avoidance, and conversely, the PDS assesses only efforts to avoid. In our experience, severely affected refugees will often try but fail to avoid upsetting reminders. With these populations, it may be more relevant to assess efforts to avoid, as in the PDS, rather than actual avoidance.

The International Trauma Questionnaire (ITQ) resembles the format of the PCL in referencing the last month and featuring the same five response categories. The PTSD subscale also asks respondents to rate how much each item has bothered them during this period. In accordance with the ICD criteria, it covers less content in the PTSD subscale (no inclusion of numbing symptoms) but includes new content in the complex PTSD subscale, such as items relating to interpersonal disturbances. Like the PCL and HTQ, the ITQ only assesses actual avoidance, not efforts to avoid.

The ITQ has been used to inform the ICD-11 diagnostic criteria, and neither the scale nor the diagnostic criteria have been officially finalised as of the time of writing. Thus, the specific items and their wordings may change in the final version. However, if the proposed time frame, number of response categories, and the formulation of avoidance items are retained in the final version, it may be relevant to subsequently adapt them for application to transcultural psychiatry.

While most of the scales mentioned here are available for free, the PDS is commercial and requires purchase of each scoring sheet. The HTQ is widely circulated but is only officially available through purchase of a CD-ROM. The PCL is explicitly in the public domain. The PCL-5 has also been widely translated, e.g. into Arabic, Farsi, Armenian, Russian, Cambodian, Vietnamese, and Chinese. As such, the PCL-5 is highly relevant to those who wish to use a free, DSM-5 updated self-report questionnaire for the assessment of PTSD in transcultural psychiatry.

Culture-Specific Symptoms of Trauma

While all of the scales covered here relate to diagnostic criteria, the HTQ part 4 also includes allegedly culture-specific trauma symptoms. The original intention behind the HTQ was that these items should be formulated and validated for each cultural setting [17]. After 25 years, however, this part of the scale has only been

officially adapted to six settings [18]. Also, the different versions of the scale vary in length, and no psychometric studies have compared the psychometric properties across these scales. As such, it is difficult to fully rely on the extended scale when comparing measures across cultures or settings. To promote transparency and replicability, we recommend that outcome studies relying on the HTQ always publish the results of the 16-item PTSD scale, regardless of whether the full-length scale is also used. Another limitation of the full-length scale, even if used only as a supplement, is its apparent multidimensionality and overlap with other constructs. The Bosnian scale, for examples, contains 14 culture-specific items, of which some are somatic (e.g. bodily pain; troubled by physical problem(s)), some are dissociative (e.g. finding out […] that you have done something that you cannot remember; feeling as if you are split into two people […]), and some relate to cognitive performance (e.g. difficulty concentrating and feeling unable to make daily plans). Such symptoms may be more appropriately assessed with separate subscales and accordingly separate total scores. This would promote the transparency and specificity of the outcome results and may reduce item overlap with other scales in the study. A unique contribution of the extended scale, however, is represented by items relating to the interpersonal nature of the traumas suffered by most refugees, e.g. feeling humiliated by your experience, feeling someone you trusted betrayed you, feeling no trust in others, and feeling a need for revenge. Some of these items may be relevant to include in outcome measurements in refugee samples across cultural settings.

While less aligned with the diagnostic PTSD symptoms, an additional scale deserves brief mention here. The Impact of Event Scale—Revised (IES-R; [19]) contains 22 items, of which 14 correspond with DSM-IV symptoms of PTSD. While the scales described above were all conceived with the diagnostic criteria in mind, the original form of the IES-R predates the diagnosis of PTSD. Its most unique feature is a thorough coverage of avoidance. Avoidance, intrusion, and hyperarousal can be measured with subscale scores, based on 6–8 items. The scale features the same five response categories as the SCL, allowing for easy administration as part of the same battery.

Interviews

When resources allow, measures of PTSD can be obtained with a semi-structured interview. The Clinician-Administered PTSD Scale (CAPS; [20]) is the most comprehensive and time-consuming of these, providing ratings of both the frequency and the intensity of each symptom, as well as ensuring a relation to the trauma, either in terms of content or time of onset of symptoms. The PTSD Symptom Scale (PSS-I; [21]) was intended for easier administration. It has been suggested that the CAPS can be administered in 30–60 min, while the PSS-I takes as little as 15–25 min. Longer administration time should be expected in transcultural psychiatry, however, to ensure proper understanding, particularly if relying on a translator. Also, clarifying the relationship to traumatic episodes can be challenging in cases of complex trauma histories, with unexpected material potentially surfacing during the administration. In our experience, it is important to have a flexible time

frame and an ethical commitment to sparing the patient from excessive exposure in such situations. In accordance with the relatively resource-demanding administration of these interviews, we have mainly seen cross-cultural studies use them for baseline ratings. For a simpler interview administration, an interview could also technically be based directly on a questionnaire (e.g. [22, 23]). However, if the content is not clarified based on an interview script, the inter-rater reliability may be compromised.

The International Trauma Interview (ITI; [24]) currently still exists as a draft version undergoing psychometric evaluation, and its results are intended to inform the choice of final diagnostic criteria of complex PTSD. At the time of writing, we are not aware of any cross-cultural studies evaluating this scale.

Trauma Event Checklists

When initially administering any of the scales presented above, a trauma event checklist should preferably be administered first. Responses to the checklist create a frame of reference for the subsequent symptom rating. The Life Event Checklist [25] presents a common and generic checklist, while part 1 of the Harvard Trauma Questionnaire lists specific events based on the cultural setting. The CAPS, the PSS-I, and the PDS all explicitly require respondents to settle on a single index trauma and assert that symptoms relating to other potential traumas should be disregarded in the subsequent rating. As refugees are typically characterised by an extensive trauma history, it is often difficult to single out a primary trauma as the primary cause of current distress.

As a final note on PTSD scales, we would advocate that researchers consider whether trauma-induced psychogenic amnesia clearly relates to PTSD in the sample under study. In the HTQ this item is phrased “Inability to remember parts of the most traumatic or hurtful event”. It is disputed whether this symptom is a likely or even possible result from traumatic experiences [26, 27]. Furthermore, a recent large cross-cultural study of PTSD symptoms showed that amnesia had very low associations with all other PTSD symptoms [28]. More importantly, however, it is not obvious how this symptom relates to perceived distress. Refugees will often state that it is the involuntary frequency with which the memories present themselves which bothers them and not amnesia. Thus, while it is important to a DSM-based diagnostic evaluation, it may be relevant to exclude this item from the total score when evaluating treatment outcomes.

Finally, in the new psychiatric nomenclatures, the ICD-11 and DSM-5, new trauma-related disorders (dissociative and complex PTSD) are introduced along with new measures. These concepts or measures have however not yet been tested in culturally heterogenous populations.

Anxiety and Depression Scales

Depression and anxiety are not diagnostically clustered, which allows for simpler scales with more narrowly defined constructs, relative to PTSD scales. This is an

attractive feature, both in terms of scale validation and total score interpretation. As we will illustrate, scales vary in the degree to which they take advantage of this.

Perhaps the most widely used scale for measuring anxiety and depression in transcultural psychiatry is the Hopkins Symptom Checklist 25 (HSCL-25) [8]. This is often administered alongside the HTQ, with which it shares its four category response format and one-week reference period. While the HSCL-25 can be used as a 25-item scale of psychological distress, it is more commonly used as a 10-item anxiety scale and a 15-item depression scale. Accordingly, we will consider these separately.

Anxiety Scales

The total score of items 1–10 of the HSCL-25 provides a measure of anxiety. While these items are typically presented as anxiety items carried over from the HSCL-58, two of the items—"Faintness, dizziness, or weakness", and "Headaches"—are in fact clustered as somatic items in both the HSCL-58 and the SCL-90. The content validity of these items is not clear, and researchers and clinicians may consider excluding them in outcome measures if a specific measure of anxiety is preferred over a more general measure of distress.

The SCL-90 and SCL-90-R (revised) anxiety subscales offer slight alternatives to that of the HSCL-25. Eight symptoms are identical across the three scales, i.e. the non-somatic items of the HSCL-25 anxiety subscale. Instead of the two somatic items, the SCL-90 includes "feeling that familiar things are strange or unreal" and "feeling pushed to get things done", while the SCL-90-R includes "feeling something bad is going to happen" and "thoughts and images of a frightening nature". While the latter two items arguably feature a clearer relationship with anxiety, the SCL-90-R is a paid scale. One of the attractions of the HSCL-25 is indeed that it has been available for use in low-income settings. As per our recommendation above, it may be relevant to exclude the somatic items of the HSCL-25 anxiety subscale, thereby assessing the eight shared items of HSCL-25, SCL-90, and SCL-90-R anxiety subscales.

Two alternative paid scales, the Anxiety Sensitivity Index (ASI; [29]) and the State-Trait Anxiety Scale (STAI; [30]), have also occasionally seen use in cross-cultural studies. They cover more symptoms than the SCL family of anxiety subscales, which is desirable in terms of reliability and symptom coverage, but also entails multidimensionality [31, 32]. The latter means that the indicated treatment outcome is less specific in these scales, as it may reflect improvements in different underlying constructs. The same applies to the Beck Anxiety Inventory (BAI) and the observer-rated Hamilton Anxiety Scale (HAS).

When evaluating outcomes of intercultural psychotherapy, it is relevant to consider the role of anxiety in the symptom profile and the corresponding target of the treatment; if anxiety is mainly trauma-related, the 8-item (H)SCL-anxiety scale offers a widely translated, easy to administer questionnaire with a general, yet

consistent focus on anxiety symptoms. On the other hand, if specific aspects of anxiety are particularly salient and a particular focus of treatment, it may be relevant to consider one of the remaining scales mentioned above. If symptoms of panic disorder are of relevance, then the ASI and BDI offer more coverage.

Depression

Items 11–25 of the Hopkins Symptom Checklist-25 are devised as a depression subscale. All 15 symptoms are carried over from the SCL-90; 13 from the depression subscale and two items (poor appetite and sleeping difficulties) from other parts of the SCL-90. A simple advantage of this scale is the shared response categories with the HTQ. Administering these scales together provides a seamless progression.

The Beck Depression Inventory—Second Edition (BDI-II; [33]) is one of the most commonly used self-report scales for depression in the general population, and it has also been used in a few cross-cultural studies. It features four response categories, each with specific reference to the content of the item, e.g. "I do not feel sad", "I feel sad", "I am sad all the time and I can't snap out of it", and "I am so sad and unhappy that I can't stand it". The BDI-II is copyrighted.

The observer-rated Hamilton Depression Rating Scale (HDRS) is considered a gold standard in measures of depression and has seen relatively wide use in cross-cultural studies as well. The scale has received criticism for lacking content validity and being multidimensional [34], and subscales with 6 and 7 items have been suggested for a unidimensional measure [35, 36]. The melancholia subscale [37] has received support across a number of non-Western countries, indicating that all six items contribute to a unidimensional construct.

Disability and Quality of Life (QOL) Measures

An addition to symptom-based outcome measurement is the measurement of disability caused by psychiatric (or somatic) illness and quality of life (QOL). The most common definition of disability is that of the WHO, where disability is defined as impairments (deviations in physical or mental abilities) in daily activities, and the resulting limitations on societal participation [38]. Disability should not be ascribed to a specific disorder, but is a characteristic of specific impairments and individual contextual factors such as age, education, motivation, cultural norms, family support systems, public laws, and available services [38]. WHO defines disability as the objective performance (what the individual does), while QOL is the individual's subjective feeling of satisfaction about their performance in different life domains [39].

As already implied, culture plays an important role in either hindering or supporting adaptive coping with mental illness. We therefore suggest that in cross-cultural treatment settings, it is vital that a disability assessment is sensitive to important contextual factors of both the majority culture (typically represented by

the therapist) and the patient's minority culture, and how these interact to shape the patient's specific adaptation to illness. Especially if the disability assessment is to guide the choice of psychotherapeutic interventions, these contextual factors need to be well-understood. A comprehensive review of disability measures is beyond the present scope. Thus, the focus here will be on disability and QOL measures, which have known psychometric properties, or have been used in the treatment outcome literature in culturally heterogenous populations. Further, we discuss the sensitivity of the tools in assessing contextual factors in the majority and minority cultures. In general, there is a lack of studies which specifically address disability measures as outcomes of intercultural psychotherapy. Hence, most of the cited studies have measured outcomes in intercultural multidisciplinary treatment (often involving psychotherapy).

One disability measure with unknown cross-cultural psychometric properties, but which is used in intercultural psychotherapy outcome studies, is the Global Assessment of Functioning (GAF; [40]). The GAF is an older measure, but one which has not undergone the thorough research-based development that the modern disability scales have [41]. In general, it has issues with basic conceptualisation and psychometric properties [41]. To name a few, the GAF has one scale for function and one for symptoms, but the mutual relationship between the two scales is unknown. It is a 100-point scale with 10 anchor points (key word examples to aid scoring), the validity of which is generally questionable [41]. Finally, the GAF combines assessment of function with specific impairments/disorders—for example, a rating of less than 50 on the GAF requires the presence of psychotic symptoms. The generally questionable psychometrics of the GAF make its use in intercultural psychotherapy questionable as well. Regarding the intercultural disability assessment, the GAF assesses disability only from the point of view of the majority culture. Thus, its rating in intercultural psychotherapy is highly dependent on the intercultural sensitivity and cultural competences of a given clinician performing the assessment.

The Health of Nation Outcome Scales (HoNOS) is a routine observer-rated measure of psychiatric disability [42]. It has been validated using IRT analyses in a mixed population of trauma-affected refugees in multidisciplinary outpatient treatment in Denmark [43]. A revised 10-item HoNOS had good scaling properties, in which culture, gender, and need for translation did not exert serious bias on the measure. However, assessment of problems with occupation had some cultural bias, in that clinicians were probably rating refugees from countries with higher levels of education, and where women are better integrated into the labour market, as having fewer occupational problems, even though they had the same levels of psychiatric disability as individuals from other countries. Furthermore, the revised 10-item HoNOS retained its scaling and cultural properties upon retesting [43]. Although no formal study of clinical utility was undertaken, the HoNOS was in general found to be meaningful amongst the clinicians. Some intercultural issues included inadequate information during pre-treatment regarding the items "activities/daily living" and "living conditions" in the outpatient setting [44], and the longer rating time needed due to interpretation needs. This was mitigated by asking direct questions

about specific disability aspects (instead of standalone observer rating), and allowing a time frame of up to three sessions for the initial HoNOS rating. This is a large deviation from the 10–15 min spent in non-intercultural settings.

Like the GAF, the HoNOS only captures disability according to the majority culture. However, due to detailed item-level analyses, the HoNOS is cross-culturally applicable in the sense that if the HoNOS favours the majority culture, it has a global cultural bias, and not one which favours or disadvantages individuals from certain minority cultures. Being a global (one-item) disability measure, the GAF cannot be subjected to IRT analyses, but it is presumably more susceptible to cross-cultural rater bias, compared to the better structured HoNOS. However, because the HoNOS is rated on the grounds of routine clinical observations, the lack of dialogue, which is present in interview formats, might make the clinicians less inclined to apply their intercultural sensitivity skills.

Finally, an IRT-validated disability measure which has been developed in a cross-cultural study across 19 countries is the WHO Disability Assessment Schedule 2.0 (WHODAS 2.0; [39]). The WHODAS 2.0 has good scaling properties across cultures and different types of patient populations. It has good test–retest reliability and sensitivity to change, which is unaffected by sociodemographic factors and culture, and also has good convergence with similar measures and clinical ratings [39]. The WHODAS 2.0 is available in 36- and 12-item versions, which can be self-, interviewer-, or caretaker-administered in 30 different languages. As the development of WHODAS 2.0 included cross-cultural study of health-related terminology, concepts of disability, and areas of daily functioning, the measure is claimed to apply universal disability concepts [39]. This universality should in principle apply across intercultural therapist–patient dyads. However, we are not aware of any studies which have directly tested whether the WHODAS 2.0 retains its psychometric properties in case of cultural disparity between the interviewer and the respondent (or between the respondent's/caretaker's culture and the culture of the health care system). So far, good clinical practice in intercultural assessment with the WHODAS 2.0 should in our opinion still involve a good amount of clinical intercultural sensitivity. This is accomplished, for example, by asking the patient whether the same impairments are present across his/her minority and majority cultural contexts; ratings are then made in reference to the context which affects the patient the most. Despite some unresolved issues in the intercultural use of the WHODAS 2.0, this measure is still by far the best validated measure for cross-cultural use in general.

Finally, in a recent review, Dronavalli and Thompson [45] thoroughly summarised the properties of QOL/well-being measures according to test–retest reliability, sensitivity to change, numerous validity criteria, clarity of questions, costs of use, and—not least—cross-cultural use. They identified 27 measures, five of which had superior properties across the above parameters. Four of the measures cut across the dimensions of either health (impairment according to WHO) or disability and well-being. In other words, four of the superior measures capture both disability and QOL, and one measures only QOL. These are the Quality of Life Scale [46], Personal Wellbeing Index [47], WHOQOL-BREF [48], and the Health Related Quality of Life from the WONCA charts [49]. Importantly, although the review

assessed whether the measures were *used* cross-culturally, it is unclear to what extent their psychometric properties were *tested* cross-culturally as well.

Another relevant measure in intercultural settings which was not featured in the Dronavalli and Thompson review (perhaps due to the review's requirement that a measure includes a global health or well-being item) is the WHO-5 Well-Being Index [50]. This short 5-item measure assesses psychological well-being, is IRT-validated, widely used, and has been translated into 30 different languages. It has good scaling properties, sensitivity to change, convergence with clinical ratings, and European population-based norms. Although the measure is used in many languages, its psychometric properties have formally been tested only in a few non-European countries, including China, Bangladesh, and Lebanon [51–53].

Regarding cross-cultural use, the QOL measures are defined from the view of the majority culture as well. However, the inherent focus on the subjective feelings in QOL measurement is likely to make them somewhat more sensitive to aspects of the minority culture as well. As long as the cross-cultural generalisability of the psychometric properties of the generic health and QOL measures are somewhat unknown, a useful recommendation in cross-cultural settings is that the WHODAS 2.0 is used as a primary disability indicator, and if necessary, supplemented by a standalone QOL measure.

Patient-Generated Outcome Measures in Intercultural Therapy

There is an increasing interest in ideographic measurement in psychotherapy. Ideographic measurement focuses on capturing the unique elements of a subjective phenomenon—in case of therapy, these are the psychological concerns of individual patients as formulated by themselves. In contrast, nomothetic measures, which have been presented thus far, focus on the common or generalisable aspects of the human experience (e.g. psychiatric symptoms, general definitions of quality of life, and disability).

Ideographic measures in psychotherapy are known under many names. Most commonly used terms are patient-generated outcome measures (PGOMs), patient-centred outcome measures, or individualised patient-reported outcome measures. Throughout this chapter the term PGOMs is used to refer to all of the above. A recent review on the use of PGOMs [54] identifies the three most common PGOMs as the *Simplified Personal Questionnaire* (PQ; [55]), the *Psychological Outcome Profiles* (PSYCHLOPS; [56]), and possibly the most well-known *Goal Attainment Scaling* (GAS; [57]).

While there are examples of PGOMs devised for specific studies and contexts, many are used only once, and their psychometric properties are unknown. In contrast, the three above-mentioned measures are known to have acceptable or good reliability, validity, clinical utility, and sensitivity to change [54]. It is worth noting that the reliability and validity of PGOMs are mainly documented in terms of test–retest reliability and convergent validity (i.e. whether scores on measures of related constructs correlate with a given PGOM in a predictable manner). As PGOMs

usually consist of a few items, which are purposefully *ideographic*, they are neither statistically nor theoretically suitable for psychometric analyses using the latent variable paradigms (i.e. factor analytic or IRT techniques). Instead, the PGOMs are an important supplement to the nomothetic measures in documenting aspects of outcomes which are not usually captured by the former.

Returning to PGOMs in intercultural therapy, a thorough search for PGOMs and the keywords intercultural/transcultural, minority, migrants, refugees, as well as Hispanics, Afro Americans, Arab, Balkans, etc., did not return any results at all. This indicates that there is no scientifically documented use of PGOMs within intercultural therapy, and more importantly, the psychometric properties and the *clinical utility* in this setting are unknown. The search thus mirrors the general situation of cross-cultural outcome measurement, which is lagging behind measurement in mainstream Western populations despite the fact that there are compelling reasons for developing and using PGOMs in intercultural therapy. The most important of these is the cultural discrepancy in therapist–client pairs, making it highly likely that there will be disparities in values, expectations, and priorities between the patient and the therapist. Eliciting patient-generated goals and monitoring their progress over time is a natural part of therapy, but doing so in a structured manner, with a valid PGOM, gives more focus to this area. It can thus prevent that important patient-generated outcomes are overlooked in intercultural therapy.

It can also be theorised that using PGOMs might strengthen the treatment motivation and the therapeutic alliance in intercultural therapy, given that inviting patient-generated outcomes in the context of intercultural therapy also means actively inviting the patient's culture into the therapy room. Patients may therefore feel better understood and respected by a therapist who is interested in formulating treatment goals in full accordance with his/her cultural preferences. These, however, are unresearched topics which warrant attention.

Also, the emergence of PGOMs is closely linked to the concept of personal recovery in mental illness [54], the idea of giving patients a voice and empowering patient perspectives. Furthermore, as outcome measurement is increasingly used to support political decisions on the funding of treatment services, PGOMs become an important supplement to the documentation of treatment effects. It is not unthinkable that effects on the nomothetic measures (symptoms, disability, etc.) and the PGOMs might differ, especially when taking into consideration the challenges of cross-cultural outcome measurement that have been presented so far. Thus, the PGOMs which are naturally more closely "case-tailored" could give voice to important patient perspectives in cross-cultural treatment contexts.

Finally, some challenges to PGOM use in intercultural therapy should be mentioned. The GAS was used for approximately 2 years at the Competence Centre for Transcultural Psychiatry in Denmark. The clinical experience in this setting, working with severely trauma-affected refugees, was that although some therapists reported acceptable utility of the GAS (i.e. positive effects such as the strengthening of their intercultural sensitivity, the treatment motivation, and the therapeutic alliance), this pertained to refugee patients with a low level of disability. For patients with a high burden of comorbidity, symptom chronicity, and high disability, clinical

experience showed that the GAS had low utility. This was especially salient when coupled with low educational and literacy levels. In such cases, many patients did not understand the GAS' structured format, had great difficulty in identifying GAS appropriate goals—some felt that concretising their problem belittled their "true" problems (which subjectively felt much larger and more complex), while others forgot what the purpose of the GAS was from one session to the other, etc. The psychotherapists' general experience was that GAS took much time away from other psychotherapeutic processes. However, it should be kept in mind that these clinical experiences are presented as preliminary insights in lieu of better evidence for the utility of PGOMs in intercultural therapy. Importantly, these concerns apply to any kind of outcome measurement where it is important to match patient characteristics with the measure requirements. We have good reasons to believe that the above-mentioned trauma-affected refugee patients represent some of the most severely affected amongst the internationally studied trauma-affected refugee populations, hence making high demands on any kind of measure. This report should thus be used to point out the need for systematic use and development of PGOMs in intercultural therapy, especially to gain the kind of knowledge which nuances our understanding of which PGOMs are appropriate for which types of patients and which clinical contexts. PGOMs are in general not used as standalone measures, but in combination with nomothetic measures [54]. The same recommendations naturally apply to their use in intercultural therapy.

Conclusions

Outcome measurement in intercultural psychotherapy is complex due to population heterogeneity as well as difficult access to study populations. It is therefore lagging behind the standards of outcome measurement in mainstream Western populations. However, the emergence of new psychometric paradigms such as IRT is for the first time enabling direct testing of the cross-cultural validity and reliability of measures and items. Cross-cultural IRT-validated measures are currently only available within the measurement of disability and QOL, but the spread of this methodology is expected to advance other areas of cross-cultural measurement as well. We can only hope that more combined international efforts such as WHODAS 2.0 will emerge in the years to come to the benefit of minority patients. Furthermore, the IRT-related focus on item-level functioning is bringing back the intuitive concept of face validity into cross-cultural measurement. This chapter thus also demonstrates the important principle that items whose content or severity description is clinically counter-intuitive are unlikely to have superior IRT-scaling properties. Therefore, with a combined knowledge of chief psychometric principles and a good amount of clinical cultural sensitivity, one can come far in choosing appropriate and pragmatic tools for outcome measurement in intercultural psychotherapy. Finally, with a renewed focus on personal recovery in mental illness, empowerment, and the documentation of patient perspectives, the development of PGOMs with good cross-cultural clinical utility remains an important and worthy endeavour for all practising in the field of intercultural psychotherapy outcome measurement.

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Global Perspectives on the Teaching and Learning of Intercultural Psychotherapy

17

Renato D. Alarcón

Introduction

In a period of history characterised chiefly by mass globalisation, a pervasive series of migratory phenomena and increasingly sophisticated technology [1, 2], the medical and healthcare fields are critical components of such complex times. This is even more evident in the field of mental health, where psychopathological and clinical realities are framed by an unavoidable set of social and cultural factors [3], all of which demand innovative diagnostic, therapeutic and preventive resources and actions. The mental health professions have faced these realities, particularly in the last few decades, with significant didactic developments (theoretical and curricular updates, teaching techniques, instrumental assistance), and specific treatment strategies which go beyond purely pharmacological interventions. This includes psychotherapeutic approaches which, in the context which has just been described, entail several facts: the growing clinical severity of a variety of diagnoses, increasing patient demands, the scarcity of human and material resources, and the inadequacy of treatment and assistance settings [4, 5]. The statistics on damage to mental health due to migration in all its various forms (legal, economic or political reasons, refugees, displaced populations, etc.), affecting more than 200 million people across the world, are the most eloquent testimony.

In spite of clear advances in the deployment of policies and human resources to face these needs, the management of migration-related psychopathologies requires a reasonable convergence of well-trained individuals and efficient therapeutic tools. A primary feature in this process is the notion of intercultural psychotherapy, a concept basically structured by four components: effective

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patient-provider communication, the identification of common objectives, an appropriate *dossier* of pertinent therapeutic interventions and the recognition of cultural strengths and weaknesses triggered by the process [6]. Intercultural psychotherapy deploys and uses these features, but cannot be seen as a specific technical skill, it is mostly a set of principles, a catalogue of concepts applied in the practice of clinical attention to patients from different backgrounds, across the cultural divide. As such, it possesses a pedagogic tradition based on the rich interaction between culture and human behaviour, culture and psychopathology, and culture and psychotherapy [7, 8].

The following sections will offer different perspectives on these aspects of intercultural psychotherapy, emphasising their conceptual and epistemological cogency, heuristic evidence and applicability in both educational and clinical practice areas.

Psychotherapy and Mental Health Education

Unquestionably, the multifaceted phenomenon of globalisation has complicated the logistics of all aspects of psychiatric and mental health education. In the field of psychotherapy, the hegemony of psychoanalytical/psychodynamic approaches which was evident during the first half of the twentieth century has ostensibly decreased, giving way to a variety of other techniques and approaches for which there is more research evidence of positive outcomes [9]. This has induced significant and often/sometimes difficult changes in the curricular focus of psychotherapy training, not only in the didactics of these new approaches (i.e. moving from the traditional, long-term, individual, Freudian-inspired style towards cognitive-behavioural techniques, brief psychotherapies, and couples, family and group psychotherapy) [10, 11] but also in the teaching settings (seeing a massive switch from long-term hospital units to outpatient clinics, public institutions, schools, campuses, etc.) and in evaluation procedures (i.e. supervision, case assignments, progress reports and self-assessments) [12, 13].

A crucial distinction between "old" and "new" approaches in psychotherapy teaching is the nature and composition of the trainers' groups: nowadays, a significant majority of psychotherapy instructors are psychologists, counsellors per se, and social workers, with psychiatrists being consistently and systematically diminished in such role [14]. Be that as it may, the greatest current challenge in this field is the consideration of factors and aspects of psychological distress, emotional or mental illnesses that are closely related to cultural experiences: culture as repository of language, religion, traditions, beliefs and practices, a solid set of variables that confer a contextual atmosphere, a unique sense of meaning and a seal of identity to the protagonists of the psychotherapeutic encounter [15, 16]. It can be said that culture is an ever-present factor in each and every kind of human transaction, as firmly established within them as the deepest genetic, neurobiological or biochemical substrates of each and every human behaviour. The theoretical and practical transition to intercultural psychotherapy is, therefore, evident.

Culture and the Teaching and Learning of Intercultural Psychotherapy

As stated above, context and meaning are decisive cultural ingredients of any human experience, and together with identity as expression of genuineness constitute the reality to be dealt with in any given psychotherapeutic encounter. In today's clinical practice, a universally accepted norm is that every case should be treated in a comprehensive, integrated manner, one that requires the combined use of psychopharmacological agents and psychotherapeutic resources. These concepts become more evident when intercultural psychotherapy is definitely indicated, that is, in patients from migrant groups and subgroups, in circumstances in which cultural differences represent more than simple concurrent circumstances. It should not be forgotten that the many different immigrant groups reflect some similarities but also include differences at many levels: ethnic origin, religious traditions and approach to gender/sexual orientation [17]. This implies cultural heterogeneity between immigrants as well as between immigrants as patients and immigrants as therapists.

Furthermore, the unique experience of emotional pain or anguish, the pathogenic chain of events, the explanatory models offered by the patient or his/her relatives about the clinical occurrences, the help-seeking modalities, the contorts of hope and demise, of faith and despair [18, 19] are all culture-related features. Furthermore, in examining intercultural psychotherapy we are addressing not only the cultural "baggage" of the person we call patient but also that of the person we call therapist (or provider) and, even more so, the culture of medicine, of psychiatry and other mental health professions, of the institution where the treatment takes place and of the society where all these transactions occur [20] such is the complexity of the process.

The teaching and learning of intercultural psychotherapy include the following key segments:

1. Basic principles: acceptance of culture as an essential component of psychotherapeutic transactions, identification of fundamental cultural variables and their consideration as one of the fundamental bases of social interactions and pillars of interpersonal communication [14]. These must be substantial and consistent facets of any psychotherapy curriculum in professional schools and training centres [20, 21].
2. Mutualities and distinctions between the cultural legacies of patient and provider: the mutual recognition of similarities and differences in the cultural loads of the protagonists must take place openly and thoroughly, early in the psychotherapeutic encounter, avoiding stereotypes, half-way attempts or evasive manoeuvrings [22].
3. The above may occur in the midst of the more or less spontaneous creation of a "potential working space" following Winnicot's well-known postulate [23]. Independent from the psychotherapeutic theory or school of thought, this step would allow the co-creation of a mutual space for reciprocal support throughout the process, thus facilitating objective-setting and outcome achievements.

Components of this process include establishment of trust, body language interpretation, active participation vs. hidden learning and authority rules [24–26].

4. The cultural concept of the person, implicit in the therapeutic discourse and practice, must be compared and contrasted along individualistic or egocentric vs. sociocentric, ecocentric or cosmocentric views [8, 27]. Points of contact or agreement as well as points of disagreement or of "ongoing discussions" can be arrived at through these mechanisms. Overcoming barriers, minimising differences and accentuating the advantages of mutual understanding and joint actions are important conditions for successful intercultural psychotherapy.
5. In further phases of the process, patient and therapist will be able to point out both strengths and weaknesses of the psychotherapeutic experience, focusing on the former to reinforce their advantages, and on the latter to continue improvement attempts or to accept realistic limitations [28, 29].
6. Similar to many aspects of treatment in clinical practice, the protagonists of intercultural psychotherapy may benefit from a multidisciplinary teamwork perspective, shared by professionals, family members, friends or neighbours. Guidelines for the conceptualisation of intercultural training have been elaborated [30]. The implications in favour of a reduction of stigma (a phenomenon of extreme relevance among migrant populations) are quite significant [31, 32].

Clinical Realities in Intercultural Psychotherapy

The intercultural psychotherapy literature of recent decades offers a great variety of practical examples dealing with specific clinical situations. For instance, the so-called intercultural predisposing and precipitating factors may contribute to the exacerbation and recurrent relapses of psychiatric conditions [33]. Ethnographic inquiries into indigenous conceptions of selfhood, mind, relationships and emotional disturbances allow a fuller grasp of the patient's internal, interpersonal and external worlds [34]. On the other hand, intercultural psychology and ethnopsychiatry have adapted the modality of co-therapy (intervention involving at least two clinicians) to an intercultural context aimed at facilitating the working through processes of mourning and identity in migrant individuals [35].

Leising [36] suggests that there is a "strong resemblance" between intercultural communications from an "overseas traveller", including their habits and internalised values and cultural conventions, and those of individuals diagnosed with a personality disorder. Differential diagnosis implications are, in this situation, as important as the management of different perspectives on health and illness, and social and public events. Expanding the narrative process in these and other situations opens new doors to exploring the origin, apprenticeship, performance and transmission of traditions among the patients, relatives, acquaintances and professionals involved [37]. In fact, it has been proved that cultural sensitivity and effective intercultural communication benefit not only patients but also healthcare providers by reducing their stress levels [38].

El-Awad et al. [39] make relevant recommendations to implement primary support programmes in the context of intercultural psychotherapy: focusing on intercultural competence fosters mutual adaptation, emotional regulation (increased empathy, positive reappraisals) and basic mental health principles; assistance in goal-setting and goal-striving corrects unrealistic wishes and unattainable objectives. Furthermore, organisations such as the World Psychiatric Association (WPA) and the European Psychiatric Association (EPA) have issued well-articulated norms about cultural competence training in order to improve the overall mental healthcare of immigrants, refugees and other minority populations [40].

Discussion

The clinical impact of mass migration in practically all regions and continents across the world is a well-documented fact. Even though media attention is focused particularly on events in the Middle East, particularly Syria and territories disputed by the Islamic State, displacements from South East Asian and North African towards Eastern, Central and ultimately Western European countries affect millions of people [5, 41]. In the American continent, migration from Mexico to the USA has grown, and Mexico is also a passing territory (or even a final destination) for migrants from several Central American, Caribbean and South American countries (the case of Venezuela being the most recent). Furthermore, the so-called internal migrations, that is mass mobilisations within the same country (i.e. Colombia and Peru) due to social crises, terrorism, civil war or narcotic traffic routes, add to the complexity of this scenario [42, 43].

Clinical diagnoses such as post-traumatic stress disorder (PTSD), different forms of depressive and anxious disorders and acute adjustment disorders (including self-harming outbursts) constitute the majority but not all the conditions detected in this context [44, 45]. “Psychosomatic disorders” (including depersonalisation and dissociative problems), triggering or worsening personality disorders [31], age-related medical and psychiatric entities (particularly among children, adolescents and the elderly) and general pictures of malnutrition, infections or chronic diseases have been described [46]. The dramatic circumstances of migration (prompted by political reasons, social instability, poverty, corruption and crime), long journeys through unknown territories, violent and abusive acts sometimes perpetrated by individuals that call themselves “helpers”, prolonged stays in poorly attended refugee camps, anonymising bureaucratic rules and uncertainty as the most concrete characteristic of this cruel separation process are powerful pathogenic factors [47].

There are three basic reasons that justify the consideration of a competent interpersonal psychotherapy as part of the management armamentarium of mental/behavioural conditions among migrants, refugees or displaced persons: one is the noted vulnerability of such populations to a variety of psychopathologies; the second is the essential need of comprehensiveness or integration in the treatment of the clinical conditions; the third is the undeniably different cultural endowments brought in, with or without awareness, by patients and providers to their decisive clinical

encounter. It is this latter feature which requires closest and deepest attention on the side of both protagonists, keeping in mind the implication of the so-called acculturative stress [48, 49]: if done inappropriately, the results may be ambiguous or even counterproductive. According to Gadamer's philosophical hermeneutics [50], the process of each human being "making sense of the world around him" is predicated on culturally given "preunderstandings" that often show in the form of racial and ethnic prejudices, influencing all aspects of the psychotherapeutic process [51].

To the dramatic aspects of an intercultural gathering in, say, a fragile tent located in the midst of a crowded refugee camp, the perception of cultural differences begins with differences in clothing styles, skin colour, language, accents or facial expressions, and continued with the report of symptoms, accounts of the migration experience and relational styles with authority figures (i.e. the therapist); all of this forms the initial stage of the process. It seems clear that the therapist must be the first to bring up these issues for discussion, pointing out the most evident differences and inviting the patient to express his/her doubts, questions, fears or suspicions. Information about the process, the milieu and the expected outcomes must be fluid and transparent; no promises of immediate solutions can be given, but the early planting of seeds of openness and honesty in the description of therapeutic objectives and through the main steps of the journey [52] plays a critical role towards a successful therapeutic path.

A lot has been written about the relevance of cultural factors in the development and conduction of psychotherapy. Although the presence of interpreters may play an indispensable role in some situations [53], the main task is for both patient and therapist, to be aware of their cultural similarities and differences, reinforce the former and understand the latter with a continuous deployment of tolerance and respect. Obviously, this must come, first and foremost, from the therapist's side, using the techniques, capacities and skills he/she has developed professionally; the patient may be initially reluctant, even distrustful, confused or demoralised [54] by his/her hopes and expectations being placed at minimal levels, if not prematurely shattered. Intercultural psychotherapy is, thus, an exercise in both old traditions of decent human contact, and innovative, creative and transparent attempts at overcoming the unknown.

The challenges to intercultural psychotherapy are multiple. The first (and main) ones encompass the identification of points of contact and separation between patient and therapist. There may be "false starts" or assumptions of closeness and agreement that later on can or must be discarded. Similarly, there may be points of disagreement which turn out to be less complicated than initially perceived. The search for exits or solutions can become a very constructive aspect of the therapeutic process, a potential signal of consistency and progress, an "occupational habit" of the two partners of the therapeutic alliance. This then becomes a search for coincidences, in itself a resource of powerful therapeutic impact. Some would say that the cultural exchange allowed by the mutual psychotherapeutic effort becomes a genuine source of successful outcomes [55]. Positive results have also been found with cognitive-behavioural (CBT) and narrative exposure therapy (NET) in intercultural contexts [56].

Thus, intercultural psychotherapeutic processes entail a variety of strengths: collaborative work, identification and commonality of purposes, similarity of tactics, mutual awareness of advances and obstacles, advantages and inconveniences, open-mindedness, creativity, and joint and continuous evaluation of accomplishments [57, 58]. The "anthropologisation" of clinical and therapeutic efforts allows a clearer, more efficient way to address the "universality of psychopathology" [59].

Nevertheless, intercultural psychotherapy also has its own weaknesses: different overall perspectives or conceptual delineations; greater or lesser levels of appropriateness; uncertainties or inconsistencies in issues such as self-esteem or self-potential; levels of tolerance, stamina or resilience (what Western clinical psychiatry may call "premorbid personality"), etc. [60, 61]. As well, the prognostic relevance of the protagonists' (patient, therapist, family, society) cultural legacy or "imprinting" requires further research and discussions in epistemological, measurement and distinctively clinical terrains [62, 63].

Conclusions

The intercultural approach can, indeed, be considered essential to all types of psychotherapies, a defining ingredient of the transactions shaping up the "meeting of minds" represented by and reflected in the process [7, 64]. In a more restrictive sense, intercultural psychotherapy applies to procedures related to the health management of migrant populations in today's world, the main focus of both this volume and this chapter. In either case, it is clear that the teaching and learning of intercultural psychotherapy has become a critically relevant facet of educational and training programmes in all mental health professions nowadays. As such, close attention must be paid to it in curricular designs, theoretical and practical arrangements, and evaluation procedures. It must be part of modern comprehensive training conceptions and of the philosophical basis of multidisciplinary teamwork [65]. Last but not least, systematic research is needed in many contexts, from the effectiveness of increased cultural competence among therapists to the "geohistory of the clinical encounter" or intercultural awareness of institutional, social and global factors [66–68] assessed from international or inter-societal comparative perspectives [19, 69]. The importance of the interviewer's preparedness to explore power imbalances in clinical and research relationships is also evident [70, 71]. Overall, a cogent cultural view "effectively fashions an expanded therapeutic discourse, shifting the focus….from normative prescription for family 'functionality' to issues of intercultural harmony….a peacemaking between conflicting stories that intersect in the client's life" [72].

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Ethnocultural Diversity in the Mind: Psychodynamic Psychotherapy for Non-Western Immigrants in the Netherlands

18

Wouter Gomperts

Introduction

Across the globe, tens of millions of people leave their native countries every year. There have been three waves of newcomers in the Netherlands since World War II, these being immigrants from the former Dutch colonies, migrant workers and their families, and political refugees. Groups previously separated by thousands of kilometres are now living side by side, meaning not only new opportunities but also issues and conflicts that can lead to mental health problems.

The psychological theories on how people function and the idea of psychotherapy as a way of coping with difficulties within and between people are typical exponents of Western culture and society. Common psychotherapy approaches might not always be applicable if people from different ethnocultural backgrounds have different ways of perceiving the world, interacting with others and viewing illness, treatment and recovery. What is more, the notion of *going into therapy* is rooted in the culture and society of the new country and usually not in that of the old one, and the therapist usually has a mainstream Dutch background. This can reinforce newcomers' fear of losing their original culture and identity.

From a Western psychological point of view, migrating or fleeing one's country are developmental achievements that are particularly difficult in combination with traumatisation caused by political violence in the country of origin or intrafamilial violence. Particularly if individuals have undergone trauma in childhood, their basic sense of security is affected. This can be reinforced by the unsafe feeling typical of life in a new country. Separation and loss can intensify already existing problems. Homesickness and loyalty conflicts can make the adjustment to the new country even more difficult. The things once taken for granted are no longer around, the customs and habits are unfamiliar, the finer points of the language and sense of

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humour can often escape the newcomer. In addition, members of an ethnic minority can experience discrimination. All in all, and whether temporarily or even more permanently, migration can cause a high level of stress. The ability to envisage your own inner world and that of other people can be affected. This can be detrimental to an important intrapsychological buffer in the contact with oneself and others.

Migration also has repercussions for the coming generations. The reasons for migration and its effects can detract from the sense of security that should be part of family life. Insecurity in early parent–child relationships and the options and tensions of immigrants in a new country can influence the personality development of later generations. The children of immigrants often grow up with the incompatible realities of their lives inside and outside the home, which are difficult to integrate in their own internal world. This can lead to severe identity confusion.

In short, in first and later non-Western ethnocultural minority generations, the psychological themes and therefore the contents of psychotherapy can somewhat differ from those of members of the background population of the host country. My questions are: What specific aspects are evident among ethnocultural minority patients in the small world of the psychodynamic therapy consulting room? Can this teach us something relevant to the larger world of ethnocultural diversity in society?

The Patients and the Therapy

Up to now, only limited numbers of non-Western immigrants, their children or grandchildren have requested psychodynamic psychotherapy and are receiving it. Single well-educated women around the age of 30 are over-represented. These are often studying or working at high levels in fields such as management, economics, law or medicine. Not only are their high educational and professional levels indicative of successful integration into the new society, so too is their interest in psychodynamic psychotherapy. Their internal integration is however under a great deal of pressure. The patients often come with mood ailments; they feel sombre or empty and have chronic anxiety-related symptoms such as excessive fatigue, chronic pain or an imminent burn-out. Many are prone to considerable identity confusion and trouble with intimate relationships.

Aziza is 29 and has a Moroccan background. Her father came to the Netherlands as a migrant worker. A few years later, the family was reunited in the Netherlands. Aziza was born in Morocco, and came to the Netherlands at the age of 4. She states during the psychotherapy intake interview,

> I am really overdoing it. If I go on like this, I am heading for a burn-out. I really have a problem with self-respect and confidence. People see me in a certain way, as successful, intelligent, with a great life, if they only knew. I come from a family of guest workers. My parents come from a tiny village and never learned to read and write. I saw a television programme about a woman from Turkey who became a lawyer here. She said the generation and cultural gap was just too large and I recognize that. Constantly on the edge. I am exhausted.

Other patients or their parents or grandparents came to the Netherlands as refugees, mostly from the Middle East or former Yugoslavia. In early childhood, the family traumas can impair a child's personality development. Personality pathology can be a reason to receive a recommendation for psychodynamic therapy. In the event of post-traumatic stress disorder in first-generation immigrants or refugees, however, other types of therapy are more suitable. One patient tells me for example, "I was a physical and mental wreck when I came to the Netherlands sixteen years ago. I had six months of therapy at a specialised institute. That was good, but it didn't instill any real confidence". He then began psychodynamic therapy 9 years later. "All kinds of things had happened, relationships broke up, things went wrong at work, I was depressed and a moment came when I was just fed up with it all, I couldn't take any more". He tells me at the end of the therapy,

> Of course we would regularly go back to the period when I was in prison, but we especially talked a lot about before then, the period when I was a child that seemed so far away because I was in prison and because I fled the country. But a lot of things also happened before at home. When we talked about it, I realised that was really what shaped me too, it really bothered me.

The traditional aim of psychodynamic therapy is structural personality change. By acquiring deep emotional insight into unconscious conflicts, an individual's internal resilience is increased and he can develop his identify in a more authentic fashion and explore his potential. This does not mean that fear, sadness, rage, guilt or shame will no longer be part of the person's experience. As painful as they can be, these emotions replace unexplained symptoms, depression or experiential paucity.

To be able to benefit from psychodynamic therapy, it is important for patients to have the inner curiosity to see what is happening inside them and allow someone else (the therapist) to see it too, even if it is difficult and does not immediately lead to positive results. Reflective capacity (self-reflection, reflection on the other person and on what is happening between both) is a pre-condition, instrument and benefit of psychodynamic therapy. So to benefit from therapy, a person has, to a certain extent, to be capable beforehand of the kind of reflection that is going to be its final product.

In modern psychodynamic psychotherapy, there has been a partial shift in focus from promoting emotional insight into unconscious conflicts to developing or reinforcing the capacity to reflect on thoughts and feelings. Mentalisation (realising that having a mind mediates how we experience the world, i.e. how we understand ourselves and others in terms of feelings, thoughts, motivations and desires) ideally develops in the thousands of verbal and non-verbal social micro-interactions inherent in an early attachment relationship which is adequately safe and secure. Traumatic development interferences in early childhood disturb the process of arriving at such mental representations, however, resulting in shortcomings in this ability. This does not necessarily indicate a psychological disorder, but does mean extra vulnerability (Bateman & Fonagy 2004).

Mentalisation presumes a certain type of psychological perspective that may on the whole be more facilitated in some cultures than others. One patient makes it clear how little evidence there is of a psychological perspective in the language and culture of her native country.

> We really did not have the slightest idea that if you weren't happy, you could have some mental problem. In your upbringing, you were not taught to translate your negative emotions into words or attach a certain significance to them. It did not happen. You just did not learn how. You kept your mouth shut about negative feelings. You carried them around in your head, they ate away at you inside, and you started to hate yourself.

A psychodynamic therapist endeavours to focus the patient's attention on his or her inner world, mainly on how he or she experiences emotions here and now in daily life as well as in the therapeutic relationship. One therapist describes the therapy process with a patient with an ethnic minority background as follows.

> On a very small scale based on all kinds of day-to-day occurrences and what I thought was happening inside him or between us, I did my best to look for differences in how he experienced things. So that together, we could look and see what the differences had to do with. And sometimes he would say, 'Wow, I never thought of that.' This is how we managed to add something of a psychological perspective.

Different Times and Societies, Differences in Affect Regulation and Behavioural Control

Over the past century, as a general tendency, social relations in Western society have become more equal. This egalitarian process refers to social norms and ideals and to a certain extent to social reality. Long-held dominance of one party over another, whether it be men over women, the more affluent over the poorer, parents over children, bosses over workers, older adults over younger ones, or white people over other ethnicities, is no longer acceptable, and this is backed up by a legal framework which attempts to ensure the respect of equal rights for all humans. Such changes at a sociocultural level influence affect and behaviour at the individual level, as well as the kinds of themes which patients bring to psychotherapy.

First- and second-generation ethnocultural minority immigrants are often brought up with a repressive sexual moral code, a great deal of religious pressure and a collectivistic perspective, in other words a *we*-orientation focused on the family and community. They often grow up in strongly patriarchal contexts, with inequality in the power relations between the sexes, ethnic groups and generations, and with hierarchic positions. In the internal imagery of many ethnic minority patients, their family, religion and community occupy an important position. Honour, scandal, revenge, violence and coercion can play an important role. As Aziza tells me,

> My father was proud of me. He used to say, 'My daughter is going to be a secretary.' But he would beat me from when I was eight years old and came home late until I was twenty and he scolded me, 'I saw you walking with a man.' He would slap my face. Where were you?

> Why weren't you wearing a hijab? Why were you standing and talking to whatever his name was? So I learned to tell lies. There is an enormous amount of hypocrisy. You have to keep a lot of secrets.

From my own Western perspective as a practitioner, I observe general tendencies among patients with certain cultural backgrounds. For example, people from the Middle East may express their emotions and passions very out in the open, while those from the Far East may tend to be more restrained. Some patients may have less familiarity with a Western perspective to think and talk about emotions and behaviour in terms of individualistic motivations, desires, fears and so forth. When making choices, they may tend to set different priorities than Westerners between their own personal interests and those of their group. Parents and older relatives have a voice in decisions affecting the lives of even adult children, and interference from outside the family is often frowned upon. Women are often expected to go along with the decisions of their husbands and in-laws. As one patient told me, "My mother was bitter. She thought she was going to be married off to a good husband, but he was just a simple peasant". Another patient drew a direct link between her own relational problems and her parents' arranged marriage. "My parents literally did not say a word to each other. They would ask practical questions via the children. It would be like, 'tell your father to do this and tell your mother to buy that'. They didn't exchange a single word. So it was not much of an example of what a marriage should be like".

From a collectivistic perspective, what every family member says and does helps determine the prestige of the whole family in the community. In some cultures, homosexuality, female promiscuity and babies born out of wedlock violate the family honour and can lead to social exclusion or even penalty of death. One patient said, "In our family and community, homosexuality is a disgrace. My family would be put to shame, it would be a scandal. I don't want that to happen to them". For single women, a sham marriage is sometimes the only way to leave their parents' home. Homosexuality and female sexuality outside of marriage may often come up against strict internal and external taboos, meaning that people may only be able to engage in sex in secret and in non-committed relationships which lack intimacy.

Splitting Arising in the Inner or Outer World

Many psychodynamic therapy patients with a non-Western background are successful in their studies and careers but have difficulties navigating the subjects of identity and intimate relationships. Aziza felt that she could not really feel at home with a man without Moroccan roots. She was however no longer willing to have a relationship with a man from her own background for fear of losing the independence it had been so difficult to attain. For years, her parents and other relatives had been exerting pressure on her to finally get married. In secret, Aziza had relations with non-Islamic men of her own educational level. She was often used by them, and sometimes in a violent manner. Frustrated and exhausted, she would go back to her

parents and family, who did not provide any support or containment in the covert new regions Aziza was venturing into. What is more, her family would belittle and disparage her, as she was almost 30 and had no children, calling her a dry branch on the family tree. Paralysing fear and shame, repetitive patterns and vulnerability can all be symptoms of traumatisation in patients as well as their families.

Many ethnic minority patients suffer from direct or transgenerational traumatisation due to political or intrafamilial violence or a lack of primary affective support. First-generation migrants who arrive in the Netherlands with small children are often overpowered by the enormity of the migration process, and this sense of overwhelm may have a strong influence on their parenting. As Aziza, who is from a family of migrant workers, tells me,

> My mother took good care of us but she did it in a mechanical way. She made sure there was food on the table, our clothes were clean and the house was nice and neat. The only time I would see signs of a positive emotion in her was when I was sick. Then I saw the concern in her eyes. She would touch me and give me a kiss. But for the rest … She loved us, but wasn't able to be sweet and nice. She was overwhelmed, I think.

Another patient comments on the domestic violence he experienced. "My father would pick up an ax and threaten to cut off my hand if I ever stole anything again. He took my hand and put it on the table". A patient tells me how his mother was maltreated. "He would tie her hands to her back and blow smoke in her face". Grandmothers-in-law can also play a role in the violence. "If my mother put something on the stove, my grandmother would take it off again. She would tell my father his wife was not obeying, and then he would hit her". Another patient says, "My mother hit us, she learned that from her mother". One patient says, "We were beaten with a belt at home, but in our culture that was the general way of bringing up children, it happened even more at the neighbours' house". Another patient says, "Children were beaten in a lot of families, but with us it went further. It is only culturally determined to a certain extent".

If small children are not adequately protected from physical and mental pain, it blocks the development of their mentalising capacity. Thinking about intolerable feelings or having certain emotions when thinking intolerable thoughts will bring about even more pain than the intolerable emotions and thoughts themselves. Splitting and dissociative mechanisms are activated to eliminate the intolerable. Psychological reality is split into separate parts and detached from external events.[1] Especially in stressful situations, the individual relies on this ingrained mechanism later as well.

[1] Freud [1] speaks of *Ichspaltung* (splitting) if the Ego simultaneously has two different attitudes to one and the same event or person. For example, a child who has lost a parent can know about it and at the same time keep thinking the parent is still alive. Klein [2] describes splitting as the early childhood defence mechanism where the child's sense of good is split off from evil to prevent good from being destroyed by evil. Kernberg [3] refers to splitting as a feature of borderline pathology. One's own personality or the other person's is perceived as totally good or totally bad. There is no capacity to experience ambivalences.

Childhood trauma (among which domestic violence) exists in Western culture too. In my experience in patients with a Non-Western migration background, a tendency towards splitting can also be reinforced from outside by incompatible ethnocultural realities. In first-generation migrants, this can be due to the geographic, temporal and cultural distance characteristic of migration. In second or later generations, growing up in a reality of cultures that are difficult to reconcile can reinforce a tendency towards splitting.

In Western psychiatry, we have learned to associate splitting with severe personality pathology (borderline personality disorder). We can however overestimate the severity of personality pathology if we fail to devote adequate attention to the fact that splitting can also be stimulated from outside by a life in cultural realities that are difficult to reconcile. This may to lead to false diagnosis and psychiatrisation of symptoms which are related to sociocultural factors, with the possible outcome that patients are underestimated in their therapeutic prognosis.

Over-Adjustment, Mummification, Compartmentalisation and Connecting

In my work, I distinguish three inner constellations in migration-related identity problems, these being over-adjustment, mummification and compartmentalisation. All three are characterised by split inner realities derived from experience of both the culture and society of the country of origin and of the Netherlands. The therapy aim is to create or reinforce an inner connection between these split inner realities.

Patients who over-adjust identify very strongly with Western social arrangements and ideals and abandon all their conscious positive identification with the culture of their country of origin. In this form of splitting, one can speak of hyper-identification with the culture and society of the new country and disidentification with the country of origin. Over-adjusted patients ostensibly live in the new country without all too much pain and sadness about what they have left behind. One patient said, “At a given moment I enrolled at the university and completely opted for everything Dutch and abandoned anything related to my own background”.

The opposite can also occur. Some patients (or their parents) adhere rigidly to an idealised picture of the culture and society of their old country and avoid any identification with the new one. This is called mummification [4]. They stick to their idealised and often totally outdated picture of their country of origin and avoid anything to do with the culture and society of their present home. They live in the new country but continue to be focused on what it was like there and then, rather than here and now.

Another form of splitting occurs in second-generation patients who are so disillusioned and contemptful of their own non-Western family background as well as the Dutch culture and society that they reject both of them. As one patient puts it,

> My father worked so hard all those years that he is a physical wreck. He stays home all day, he is crass and he drinks. But what bothers me most is that he allowed himself to be

> exploited all those years as if he was nothing. I went to the university, but I have to do work I am overqualified for. We are essentially not welcome here. I can't get that idea out of my head. I have had my fill of it. I really don't know what to do with myself.

Disidentification with the family's home country as well as with Dutch culture and society can be breeding grounds for depressive narcissistic isolation and lead to rage or inner emptiness. This double disidentification could potentially, also lead to behaviours such as radicalisation, for example via the internet, identifying with religious fundamentalist and ethnic nationalistic ideologies, leaders and like-minded youngsters. There are however no indications of this route in the therapies with which I am familiar, neither as therapist nor as supervisor.

In cases of over-adjustment or mummification, discontinuity resulting from migration is not acknowledged or felt. This can mainly be discerned in first-generation patients, who tend to either overly adjust to the new situation or cling excessively to the old one. Teja and Akhtar (in [5]) refer respectively to counter-phobic assimilation and ethnocentric withdrawal.

The aim of psychodynamic therapy is to restore or create an inner connection between life there and then (childhood) and life here and now (adulthood). Papadopoulos [6] calls this reconnecting. A central issue is the capacity to mourn the loss of what was familiar and loved there and then, and to cope with whatever illusions there might be about it and about a possible return home. There is a dilemma for the therapist in this context. To what extent does talking about and remembering the past intensify the sense of loss and separation and retraumatise the patient, and to what extent does it help the patient cope internally and promote psychological integration?

Therapy is also focused on taking new steps, and coping with the feelings of betrayal, loyalty and fear of expulsion as regards the family, community and traditions that can serve as an obstacle in this connection. The therapist is mainly perceived as someone to lean on, a safe lighthouse in a strange and sometimes hostile world. The de-idealisation of this position can mean a new loss and retraumatisation, and thus be undesirable.

Particularly in the increasing number of second-generation patients, we see that in therapy as well as elsewhere, there is a tendency to keep going back and forth between two separate inner realities. I refer to this as compartmentalisation. In one compartment, the patient solely identifies with the culture and society of the native country, and in the other with Dutch culture and society. The compartmentalised realities are like cats and dogs—they don't combine. Sometimes the switch between the two realities is extremely rapid. At a therapy session, one patient says,

> It really bothers me here, the way everyone is so materialistic with their new kitchen and bathroom. If I stand at a bus stop for ten minutes in Amsterdam, I think, what a bunch of idiots. This is not how I want to live. [And diametrically opposed] Over there it is like a warm blanket wrapped around you. I am very different there, much more open, much more sociable. [But a moment later] It is barbarian over there, a weird world. I happen to bump into someone and right away I get threatened, 'I'll break your bones.' There is no respect for you at all, they tell lies, make everything better than it is. Ridiculous. The choice is easy

> for me, I feel Dutch. It is more down to earth here. [But then] They are much more hospitable over there. Everyone is so stingy here. If you come for a visit there, they take out everything they have. Here you get one cookie with your tea and that's it.

Aziza also oscillates between compartments, but less rapidly than in the example above. In one reality, she is the loyal daughter of her parents, extended family, community and traditions, and in the other she does everything forbidden by Allah and the very same parents, extended family and community. She is not at home anywhere and cannot find satisfaction in anything. Aziza habitually lives in a world of secrets, half truths, shame, surreptitious activities and pretending. In her own words,

> That is what I am accustomed to. In a practical sense, I cannot wear a short skirt or shirt sleeves when I go visit my parents. I have to make sure that when my parents come to visit me, I hide certain clothes and photographs and anything with alcohol in it. It is wrong to have sex without being married, but if he isn't even a Muslim …. I am used to doing things my parents think are horrible and I don't tell them.
>
> For me, that is my everyday life. There are so many things I am used to hiding and lying about. I am almost two different people, I live in two different worlds. It is as if I turn a switch.

When it comes to her therapy, Aziza has great expectations. During the first session, she says, "I would like to take a few weeks sabbatical to analyse it all". The therapy is twice a week and she approaches it with much the same energetic perseverance with which she utilises her talents and opportunities in her studies and work. It becomes clear during the sessions how Aziza goes back and forth between demanding and compelling family relations haunted by traumas on the one hand and self-destructive situations and relations in modern Western life on the other. She is alienated from herself and totally exhausted. In the countertransference, the compartmentalisation is accompanied by a polarisation in my own feeling states. At one session, I experience a sense of powerless despair, and at the next session there is hope. A week later the hope fades away and I have my doubts about the usefulness of the therapy and my own competence.

Therapy is often the first situation where compartmentalised realities coincide. It initially occurs within the therapist, who serves as a non-judgemental, listening witness of the two realities and gives them both empathy and holding. This can create a sense of safety that gives the patient space to experience and express feelings and thoughts the compartmentalisation is warding off.

Aziza now speaks about her friends, relatives, colleagues and acquaintances in a more differentiated way, has a more balanced attitude to traditions and modernity and can find greater coherence and authenticity in herself. In her internal world, a connection is growing between the two ethnocultural realities and she perceives this as an important aspect of her identity. She is able to respond lovingly to her family and background and at the same time commit to her work and relationships in her modern Dutch life without feeling alienated from either of them. She perceives this as something very out of the ordinary, a specific identity that also entails special experiences and a special sensitivity.

Compartmentalisation occurs unconsciously and is connected to a lack of mentalisation. Feeling emotionally linked to realities that are difficult to reconcile in the external world requires a capacity to mentalise and is adaptive. I notice the change in Aziza and also in myself. There is greater tranquillity and continuity in my feeling of countertransference. After 4 years of therapy, Aziza says,

> My parents feel they cannot accept my not living a Muslim life. My mother says, 'It is making me sick, it is torturing me.' What my father says is even worse. He says, 'I pray to Allah every day to give you the faith or to take you to him.' The gap in my life has always been there. I used to just go back and forth like a chicken without a head. But now I have moments when I get tears in my eyes. I see how hard it is for my parents to accept how I live. It makes me sad. My parents came from far away, but I want to go further. For me, therapy is an anchor, a fixed point where I formulate and organise my thoughts and where I experience what I feel and who I am.

Ethnocultural Transference and Countertransference

In non-Western patients of the second or later generations, insecurity in primary attachment relationships can be reinforced by the insecurity an ethnocultural minority position has implied since childhood. Members of a minority can often be very sensitive to even the slightest sign of discrimination. At the intake interview, Aziza talks about how Dutch kids used to make fun of her at school. She had henna on her hands and her parents were traditionally dressed.

> Two Dutch girls who were really losers were the only ones who would sometimes play with me. The isolation was so awful that the teacher decided the kids had to take turns playing with me. It was like alms that in a way I was too proud for but was still happy with so I simply accepted the humiliation that went with it. As a child, you are embarrassed about where you come from. At school because my mother was wearing a hijab and could hardly speak Dutch and the food we ate was weird.

From early childhood onwards, second-generation patients have often witnessed their parents being humiliated by individuals and official agencies. As Aziza puts it,

> I was the bridgehead for the family, I had to read documents and write letters and be the interpreter, and that way I got to hear things I would have preferred not to hear. Like in the hospital when they were talking about my mother, saying 'Why do those guest workers have to keep having children?'

Feelings of inferiority and superiority can start in the small world of family interaction, but also have to do with power relations in the larger world. From early childhood, the sense of self and identity is shaped by how significant others at home or at school think and feel about ethnicity and skin colour, which is related in turn to the significance of these categories in a society at a certain time and place. For generations, white children learned that black people were inferior to them. They learned this as unquestioningly as they learned that trees are made of wood. From one generation to the next, positive or negative emotional associations regarding

specific categories of people are included in the implicit memory system via repeated imprinting and conditioning. This helps create a racialised sense of self in white as well as black people. A patient with a Caribbean background puts it as follows.

> It has not disappeared. It is active. Why? The closer you are to the Dutch norm, physically or mentally, the better you are. The further you are from the Dutch norm, the more inferior you are. It is inside you, in your mind and in your heart. It has been internalised for generations. People think they are ugly and stupid and primitive, and they have a wide nose and thick lips and bad hair and the wrong colour. And they would love to marry a white person, they would kill to be able to do that. Because then they would get better children, with the better colour. With better chances in life. That is how we have been trained!

If from childhood your ethnicity is often approached in a negative way in direct contacts, public opinion, children's and history books, it can evoke deep feelings of shame, fear and sadness. Hurt and rage can play a central role. Simply applying for therapy activates the attachment system, reinforcing an awareness of social discrimination. Does the therapist see you as a person and not as an example of a problematic minority? Do you get the same opportunities for treatment as a Dutch person? When you register for therapy, there is always the possibility of stereotyping and discrimination. In that sense, the therapist, intake team and mental health clinic can be an object of transference and there can also be countertransference. What can happen?

Aziza applied for therapy at an Amsterdam outpatient mental health clinic. At a therapy session, she later says, "Anything less than the very best is unacceptable to me. It really has to do with the fact that I grew up Moroccan here". At primary school for example, her teachers advised her to attend a simple 4-year secondary school, even though she turned out to be a good pupil at a more advanced 6-year secondary school. Due to her fear of not getting the treatment she deserves, at the intake interview she is already standing her ground. The therapist finds her a bit aggressive. Her behaviour feels suspicious, intimidating and transgressive, and irritates him, perhaps also because his own experience of being in the mainstream Dutch majority position leaves him without much familiarity with or sensitivity to people like Aziza and her type of behaviour in a situation of assessment and selection. A consequence of the therapist's irritation is that Aziza stands her ground even more and the therapist feels even more annoyed and so on. His growing irritation makes the therapist less able to use his psychoanalytical stance of empathy and understanding and he reverts back to his basic diagnostic skills as a psychiatrist or clinical psychologist. Aziza's behaviour is subsequently seen as a sign of serious personality pathology (paranoid, borderline, narcissistic). This is why Aziza's therapy prognosis at first is assessed as rather poor, which is a self-fulfilling prophecy.

This ethnocultural transference-countertransference enactment fails to devote attention to the fact that Aziza's behaviour and the therapist's reaction to it—and vice versa—can also be related to the macro-level tension in society between emancipating newcomers/outsiders and the established Dutch majority. Transference and

countertransference in the consulting room can be manifestations of large-scale societal tension. Insufficient acknowledgement of this can muddle the diagnostic judgement and give rise to excessive psychiatrisation.

As well as excessive psychiatrisation, excessive culturalisation can also occur. The therapist, based on his or her own personal or societal disadvantages, for instance as the youngest sibling or black sheep in the family, as a woman, homosexual or villager in a big city, a lower social class background or ethnic minority position, can feel a strong identification with the outsider position of the patient through their post-migration non-Western background. For instance, Aziza's behaviour at the intake interview might be idealized as the vitality of a spirited immigrant. In the case of strong culturalisation, the severity of a patient's pathology can be underestimated, and the therapy can subsequently prove disappointing. Excessive psychiatrisation and culturalisation are both pitfalls in ethnocultural countertransference.

Society in the Mind, Its Past in the Present

In modern egalitarian Western society, ethnocultural differences can have a strong emotional aspect. With echoes of slavery, colonialism and the Holocaust still reverberating, discriminatory behavioural tendencies are coming up against the restrictive effects of shame and guilt perhaps more than ever before, at least among those with an interest in such egalitarianism. Due in part to the fear of behaving in a racist or discriminatory way, which may also be felt by the therapist, there may be a great deal of caution in the therapeutic relation when approaching ethnocultural differences. As one supervisee says, "I think it is a touchy issue to approach in therapy. I would immediately get the feeling 'hey do I think I am so superior?' And that is definitely not what I want to be". If the therapist belongs to the established majority and the patient to an often discriminated minority, there can be an interaction between the two that keeps the subject of discrimination outside the consulting room. *The two of us know there is discrimination, but it does not exist between us, we are above all that*. This kind of narcissistic collusion can reinforce a patient's anxiety. After all, the unconscious message can be that the therapist does not dare approach the subject, so apparently he might otherwise make some comment indicative of a discriminatory attitude. Both of them know this would mean the end of the patient's trust in the therapist, so they don't say anything at all.

Sometimes, if the therapist belongs to a minority too, the patient looks for and emphasises the similarity in their backgrounds. A sense of solidarity and a shared destiny can magnify the connectedness with the therapist, sometimes allowing negative feelings about the majority group to be expressed in a more or less covert way. As one patient puts it, "I wonder if it is all right to ask you something. Your name isn't Dutch, is it? And you have those dark eyes and dark eyebrows and you are so nice, I thought right away you aren't really Dutch either".

Exploration of Ethnocultural Diversity in the Therapeutic Relationship

Smith [7] notes that if the therapist and patient differ in their ethnicity, there is always an awareness of it in the consulting room. So the question is not *whether* the difference in ethnicity is significant or not, but *when* to devote attention to it and *how* to explore its meanings. Aziza mentions during a session that she went to see Astrid's new baby with her sister. Astrid is a friend of her sister's. Astrid is a common Dutch first name. The therapist notes his own focus on the fact that the patient mentions Astrid by name, but continues to refer to her own sister, whom she often talks about in therapy, as *my sister*. He explores what this can mean.

Therapist: You just mentioned Astrid by name. But you don't do that when you talk about your sister. Is that right?
Patient: That's true …
Therapist: Do you have any thoughts about that?
Patient: It's automatic … yes … I don't really know.
Therapist: You don't know?
Patient: In the Netherlands they have a hard time remembering her name.
Therapist: How does that make you feel?
Patient: Not too bad … But if I know someone longer, then I actually do mind.
Therapist: I have known you for quite some time. How would it make you feel if I couldn't remember her name?
Patient: If you didn't remember her name, of course I would get it, or if you mispronounced it. But if you continued to do so … well that's … I would be disappointed.
Therapist: Do I understand you right, that just to be careful you don't mention your sister's name? You want to make sure I won't mispronounce it and disappoint you?
Patient: Yes. I have always tried to not be different from other people. I was born in the Netherlands, but I keep noticing I am still a foreigner.
Therapist: How does that make you feel?
Patient: It makes me feel really angry. I am often seen as part of the Moroccan problem group.
Therapist: I can imagine that you pay attention to whether I am also doing that in one way or another.
Patient: I don't know if I want to pay attention to that.
Therapist: Can you tell me about that?
Patient: If you labeled me Moroccan, I wouldn't be able to talk to you about deep things any more, I wouldn't be able to do this therapy. But since you have gone to the university and learned to speak to people so intensely, I think it is just part of your job to be able to understand that. Otherwise I would be making my feeling of being understood depen-

dent on what you are like as an individual. So I pay attention to what you say. But I have to assume you can understand this, otherwise I can't do the therapy. So I don't personalise you. Or not yet.

Therapist: First you need to carefully examine the extent to which I can understand you.

The acknowledgment of a certain extent of more or less concealed ethnocultural tension in the therapeutic relationship can be crucial to creating a safe setting for the therapy. During the following sessions, Aziza expresses her pent up rage and anxiety about the small and sometimes larger confrontations with discriminating stereotypes in her daily life. In therapy, she also experiences these emotions with her therapist. It is important that the therapist is able to tolerate being identified with the discriminating aggressor. As the therapist has done before with other comments about him as a person, he tries to approach Aziza with understanding and empathy. He examines his countertransference for traces of discrimination in his own functioning and his responses to the discriminating micro-aggression the patient attributes him with. Aziza perceives that her assumptions are not dismissed as being oversensitive, as often happens in daily life, even in her own mind. She can now think, feel and speak with greater freedom and acceptance about her ethnocultural identity, the therapist's and other people's ethnocultural identity. Fixed emotional convictions such as *All Dutch people discriminate* and *That doesn't happen here at therapy* are replaced by greater subtlety and differentiation. Then it can also become clear that the fear of discriminating stereotypes sometimes conceals a different kind of fear. In Aziza's case for example, the fear of emotional closeness and dependence emerges in the transference.

A not-knowing stance means the therapist keeps reminding himself that he or she cannot know a priori what is going on in the patient's mind. This is particularly the case in the event of ethnocultural differences between the patient and the therapist. The therapist should always bear in mind that he or she can only in part emotionally comprehend a world perceived from a different ethnocultural perspective. Sometimes a therapist may try to deal with the fear that not-knowing might lead to, a fear closely linked to a fear of strangers, by reading extensively about other cultures and asking the patient numerous questions. With this countertransference reaction, the therapist can hope to avoid exhibiting a lack of empathy.

A psychodynamic perspective emphasises a different approach. In psychodynamic therapy, the therapeutic relationship is the therapeutic instrument. Faltering in the relationship due to imperfect therapist empathy with the patient's experiential world is inevitable in every therapy, no matter who the therapist is and who the patient is. The restoration that follows is viewed as an active ingredient which is essential to the therapy. If a therapeutic alliance falters after the therapist's failure to understand the patient's ethnocultural experiential world, the restoration of the alliance can have special therapeutic value. It demonstrates the possibility of repair and serves as an opportunity to explore and comprehend the ethnocultural misunderstanding in an emotionally meaningful way.

Whiteness Can Be a Countertransference Blind Spot

The term *whiteness* refers to the complacency automatically experienced by white people who fail to reflect on the meaning of their ethnocultural position and have very little empathy with the position of other categories of people or ability to imagine what it can be like. Whiteness can be a countertransference blind spot [8]. The therapist's sensitivity to the possible impact of his specific ethnocultural position on patients with a different background is reinforced by a deeply felt awareness of his own place in society in light of his family history as well as in a wider sociohistorical perspective. Undergoing therapy himself can be helpful in this connection. Training therapy is a requirement for a Dutch post-M.A. degree in psychotherapy. I am nonetheless concerned that little attention is devoted to this theme in the numerous cases where the therapist-in-training and the therapist running the training both belong to the native Dutch majority and neither of them feel an inner urge to explore the issue. This pitfall is an extra reason to focus on this topic in the psychotherapy curriculum.

A Final Remark

In modern Western society, ethnocultural differences are frequently either stubbornly ignored or expressed in a crude way. For more than a century, therapy professionals have been looking for better ways to cope with difficult emotions than by sweeping them under the carpet or addressing them head on in a coarse way. In the era of Sigmund Freud, difficult impulses and emotions were mainly linked to sexuality and aggression (Freud 1930). In today's consulting room, ways are sought to deal with ethnocultural diversity in a bolder and more natural manner. This requires a high level of empathy and imagination on the part of the therapist. If this is difficult for a therapist trained in self-reflection, reflection on the other person and on the relationship between them, it is even more understandable that it should be problematic outside of the therapy room in the larger world of society. The stronger the regressive and primitive forces in a society for whatever reason, the more alienated larger numbers of people will be from their thoughtful and empathetic side, and the more different segments of the population will be driven away from each other.

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Psychotherapy for Africans with a Migration Background

19

Samuel O. Okpaku

Introduction

The above title is somewhat presumptuous with regard to several factors. Firstly, Africa is a heavily populated and extensive continent with peoples of different historical, economic, and sometimes cultural and linguistic backgrounds, even within the same geographical borders. Anthropologists frequently refer, for example, to the presence of over 500 languages in Nigeria alone [1]. Secondly, driven by globalisation, political conflicts, and a desire amongst young Africans to seek education and prosperity abroad, the African diaspora is very sizable. This group therefore reflects a heterogeneity in terms of reasons for immigration, educational status, age, gender, level of occupation, and adjustment. My comments and observations are thus an attempt to provide a framework and a composite that may be beneficial to any therapist who is likely to work with a sizable population of Africans abroad with a migration background. The application of any aspects of my suggestions and observations will in some instances require adjustments, modifications, and an openness and willingness to be instructed by the client and members of his/her family. These are essential ingredients within transcultural psychiatry. I have previously referred to therapy with a transcultural context as:

> An entity with a dynamic core in which an attempt is made by the therapist to show empathy and respect for cultural differences. In such a relationship the therapist remains open and willing to be informed by the client. The clinical conflicts are defined within the client's cultural context and the goals of therapy are predicated on a dynamic and bilateral relationship between therapist and patient.—Okpaku [2]

At the same time, though, there are instances of universally occurring similarities in human behaviours and beliefs in cultures that are substantially different from our

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own. We should embrace these instances when they occur. I recall as I made my last presentation on a family to my supervisor, he asked me if my family was different from the family I was seeing. My answer was yes and no. In some ways our families were similar and in other ways they were not. So, it is refreshing to know when our families are similar to other families.

Background

Anyone interested in working with individuals from a distinct cultural or substantially different background from his/her own can also benefit from some familiarity with the etiquette, values and beliefs of that society. The observations derived from the anthropological world by studies on culture and personality have perhaps led to the current interest in cultural sensitivity and the need to be culturally informed. Even then, we must not forget the exhortation by Sapir [3].

> We have to deal with the cultures of groups and the cultures of individuals.

Fortes has alluded to the significance and benefit of proper field research. He emphasised the need to engage in a deeper analysis of our observations rather than just a superficial description. He suggested that the field worker should see humanity in the distant cultures that they study. This advice is pertinent to health providers working in transcultural contexts. Clearly it is unrealistic to expect each professional to have first-hand information on every nationality that he/she works with. However, a natural curiosity and inquisitiveness can be helpful. With increased globalisation and trends in global health and global mental health, many individuals have the opportunity to visit the countries of origin of some of the people they serve. However, we should remember the warnings from J.H. Orley:

> There does seem a tendency for some writers, especially psychiatrists, to talk of 'Africa' and the 'African' when, in fact, they are referring only to their own experiences and to their research amongst the clients with whom they have worked. Thus, they give the impression of making valuable generalizations about Africa when they are doing nothing of the such [4].

Access to useful literature can be an asset and good substitute for field research. An example is a basic knowledge of West African religious philosophy. This provides a foundation to the group's traditions, value systems, ideals, and etiquette. In regard to this issue I could share an experience which I had many years ago. Dr. Renee Fox was an eminent medical sociologist who had worked in the Congo. She was Jewish and I a Methodist/Episcopalian. At one point in our conversation she stated that I was speaking as an African. This was in spite of me having spent over a decade abroad. I was puzzled by her remark, wondering what I could have said that pointed to or betrayed my value system. I am also reminded of a statement I came across which emphasised that an individual may behave in a certain way without being

fully cognisant of the origin of that behaviour or the tradition that has sustained it. In other words, an Irish Catholic may behave in a certain way consistent with Catholic beliefs without being fully knowledgeable of the Catholic Catechism. How then can we gain insight into some of the personality structures, value systems, and behaviours of an "African"? I believe we can glean some answers by reviewing some aspects of the religious philosophy of some West African countries. The following is a brief description of a West African religion, the ancestral worship of the Tallensi. This closely resembles the religions of the Yorubas and Binis of Nigeria.

According to Fortes [5] the Tallensi religion is a monotheistic religion with a supreme being above a cosmology of multiple ancestral spirits or Gods. An individual's destiny and fate are shaped by celestial and terrestrial arrangements. Prior to his/her birth, it is believed that his/her parents' ancestral spirits or Gods volunteer to protect him/her. This group of ancestors is joined by other ancestral spirits who also volunteer to protect the individual. This celestial arrangement is duplicated on earth by similar kinship and lineage arrangements. In return for the protection afforded the individual, he/she is obliged to serve the ancestral spirits in a reciprocal way. Hence an aspect of the religion is ancestral worship. This arrangement provides an opportunity to resolve two major conflicts, the Job conflict and the Oedipal conflict. These two Biblical stories are paradigmatic of the concepts of fate and supernatural justice amongst other West African cultures. The Job conflict has to do with supernatural justice, and the Oedipal conflict has to do with fate and destiny. In this religion they supplement each other. Because of the multiplicity of the ancestral spirits to be served, an individual can only do his/her best. So, in the presence of misfortune, for example the birth of a malformed baby, the cosmological arrangement provides an alibi and an absence of guilt. The fact that an ancestral spirit has been upset can be revealed by divination and relieved by sacrifice and rituals. Parenthetically, the absence of guilt amongst Africans was misinterpreted as reflecting a defective superego and hence the absence of depression in African populations. The obligation that the individual has to his/her heavenly spirits and ancestors also has a terrestrial equivalent of obligations and responsibilities to parents, kinships, and lineage. Sometimes, individuals from the same village will therefore call themselves brothers and sisters, as frequently found amongst the Ibos of Nigeria. Another strand in West African religious belief systems is that everyone will someday become an ancestor. As such, if an individual does good while on earth, then he/she is likely to be a good ancestor. If on the other hand he/she does poorly, then he/she is likely to be a bad ancestor; from a psychological point of view, then, there is a tendency towards an internal locus of control. Such rudimentary knowledge as observed can be helpful in the full assessment, diagnosis, and treatment of an African with a migration background. It provides the therapists some insights into the family and social structures that are the foundation of the observable social behaviour and ideals of the client and his/her family. Fortes emphasised that it is not that the Tallensis are afraid of death and that their beliefs are superstitious or magical, but rather that the filio-parental relationships provide the foundation for the social organisation in that culture.

Assessment

The proper assessment of an African with a migration background is critical, as is the assessment of anyone with psychological problems, since it sets the stage for further treatment and provision of services. Significant time should be allocated for the first assessment. The client should be put at ease. This may include the presence of a relative in the room and the use of an interpreter. The challenges and opportunities associated with the use of interpreters are well known. However, for the sake of completeness these will be reviewed. In the field of mental health service delivery, some models of interpretation have been identified. These are:

1. The approximate interpreting mode.
2. Tele-active model.
3. Bilingual worker interpreter model.
4. Volunteer interpreter pool model.
5. Staff interpreter model.

The "approximate interpreter" is one in which the nearest person available is recruited. In the tele-active model, the migrant make responses to telephone or audio visual prompts. In the "bilingual" worker model, the interpreter interviews the migrant with or without family and summarises the interview to the health care provider. The "volunteer interpreter pool model" has a pool of volunteers to assist upon request. Some relief agencies or ethnic community groups may provide such services. In the "staff interpreter model", the agency or hospital has paid bilingual or multilingual individuals who may be called upon. Clearly, each model has its advantages and disadvantages in terms of its application depending on the context, cost, efficiency, and ethics. It is suggested that for optimal results, the interpreter should be trained. In addition, there is a set of guidelines provided by the Royal Children's Hospital in Melbourne to serve as a framework for setting up an interpreted session. To achieve competency in interpreting, some suggestions have been made with respect to technical, cultural, ethical, and interpersonal considerations [6]. The use of family members is problematic for a variety of reasons. The family member may be a source of the stressors leading to the individual's emotional problems. If the family member is a child, their role of interpreter may lead to parentifying the child. If the issues are of a very intimate nature such a sexual trauma, there may be no opportunity to broach the subject. In all interpretation, the issue of fidelity is essential. The interpreter may decide to screen what he or she hears because of family or ethnic pride and therefore withhold useful information. The setting and the nature of the first encounters may also be significant, especially when there is a strong history of trauma. The client should not be exposed to a situation that is reminiscent of an interrogation.

The therapist should have an idea of which phase of migration and acculturation the client is currently in and of the source and circumstances of the referral. Is the client a grandmother who has migrated from Nigeria to live with her family in

Canada or the USA? Is the referral an adolescent who is having problems at school or is the referral from the local law enforcement agency because of domestic violence by a depressed man from West Africa? In the early settlement phase the individual may have anxieties about his/her immigration status, housing, and employment. These issues may not be relevant in the late resettlement or acculturation phase as the immigrant may have the same legal benefits and protection as a citizen.

During screening and assessment, the provider should attempt to supplement the traditional psychiatric interview that includes demographics, family background, presenting symptom and present history, past psychiatric and physical health history, school education, employment, and legal history with information or reason for the migration of the individual or his/her family, the level of social and community adjustment, and participation in ethnic community organisations. For refugees, taking a history of the pre-migratory and early resettlement phases is important. Was the individual subjected to trauma or other hardships? The use of traditional herbs, e.g. Khat use by Africans from the Horn of Africa, may be useful information. Establishing whether the onset of the illness was pre- or post-migration is significant. Taking a history of previous treatments can also be helpful. Has the client sought treatment or is she/he receiving current treatment or consultation from a minister, Iman, or a native healer? Caution has to be exercised in the diagnosis of psychosis or schizophrenia, especially in the presence of severe language barriers. The use of common psychiatric scales and instruments may be considered in the absence of language barriers and when the client is fluent in the test language and the instrument has been validated for that group. The client should be asked to give an explanation as to the causative factors of his/her illness. The provider should be alert to the possibility of misdiagnosis. Kleinman (1980) [7] has suggested an ethnographic approach to the assessment and treatment. For agencies, institutions, and hospitals providing mental health services and consultations to neighbourhoods with large populations of African refugees, the use of the WHO/UNHCR tool kit may be helpful in providing individual assessments and community readiness. The tool kit has various sections for screening individuals who may present with psychological distress and psychosis. Although *useful* (easy?) to administer, the tool kit carries a risk of misdiagnosis or over-diagnosis of psychosis. The community readiness and perceptions of needs can be a helpful survey when administered to community leaders city officials. Lastly, Rogler [8] has indicated that culture can impact psychiatric assessment and diagnosis on three levels. The first level comprises the expression of the subject's symptoms, as well as the readiness to express the symptoms. The second level is the clustering of symptoms into ethno-psychiatric diagnoses. This may include the readily identifiable culture-bound syndromes. The third level gives consideration to the interpersonal context in which the client is engaged by the therapist. It is suggested that the greater the distance between the client and the therapist due to language barriers and other factors, the greater the chance of misdiagnosis. The term ethnography was coined by George Devereux [9], who emphasised that we should give intensive consideration to cultural aspects in the assessment and treatment of clients. This is to be achieved by paying attention to the

views of the client as we try to understand his/her world. The psychiatric interview should be followed by a full physical examination because of coexistence of mental and physical illness.

Psychoanalytically Oriented Psychotherapy: Supportive–Expressive Psychotherapy for Africans with a Migration Background

The provision of treatment and services to any psychologically distressed individual should be holistic, comprehensive, and eclectic. A distressed individual's condition may be described as minimal, moderate, or severe. The individual with minimal severity of illness may not require as comprehensive an array of services as that individual with a moderate level of severity. The severely distressed individual often requires all services that are available. These may include individual psychotherapy, marital therapy, family therapy, and when indicated the use of biological approaches to include medications and ECT. For the African with a migratory or refugee background, the therapist has to pay close attention to aspects of culture that may include the presence or absence of traditional beliefs, some aspects of family dynamics, and the particular idioms of distress as well as the need to be pragmatic and eclectic. When the individual displays severe symptoms there is likely to be agreement across cultures that something is wrong. The agreement may decrease when the condition is less severe. Differences in opinion as to this severity may be attributable to cultural influences. With that background we can now address the central issue of this chapter which is the psychotherapy for Africans with a migration background. The significance of migration is most likely to be influential when providing psychotherapy to an individual in the early phase of resettlement or early adaptation or acculturation phase. This is not to suggest that cultural factors automatically disappear with full acculturation. Based on my training, research, and clinical practice, I have chosen to focus on the form of psychotherapy described as psychoanalytically oriented psychotherapy or supportive–expressive psychotherapy. This type of psychotherapy is derived from classical psychoanalysis. In 1980, Parin [10] published the results of his studies to explore whether psychoanalytic concepts and terms were applicable amongst the Anyi of Ghana. He published his results in the volume 'Fear thy Neighbor As Thyself'. His results were in the affirmative. What, then, is the potential of using classical psychoanalysis with Africans with a migratory background? Classical psychoanalysis no longer enjoys the earlier prestige it once enjoyed, and its practicality in dealing with large numbers of people is not only very limited but also raises an ethical issue considering the amount of suffering and mental pain that abounds in contemporary times. However, some of its important concepts, strategies, and techniques have been modified and modernised by such workers as Ferenczi [11], Fenichel [12], Malan [13], and Mann [14]. The principles of this approach are well illustrated by Luborsky [15] in his volume 'Principles of Psychoanalytic Psychotherapy—A manual for Supportive-Expressive Treatment'. There are two main prongs to this approach. One is a supportive prong, which as its

name implies, is directed at supporting the individual; the other is an expressive prong in which the therapist encourages the client to express him-/herself within a context of a helping alliance. Luborsky defines this helping alliance as the degree to which the client experiences the relationship with the therapist as helpful in achieving his/her goals. Luborsky has identified the following core elements of supportive–expressive psychotherapy. These are the elements of "transference, the supportive and expressive aspects, and a lack of reliance on advice giving". The last factor may present an issue initially for psychotherapy with an African who relies on the therapist as he/she would rely on a doctor to provide direction and give direct advice. A central aspect of this technique is the requirement to listen carefully to the client. For the majority of the clients in my outpatient clinic the major reason for them to see me is conflict, in the interpersonal, occupational, and economic domains.

These conflicts may overlap, so in terms of listening, I use a music metaphor. All music is based on a melody or theme. This is so whether we are listening to a symphonic poem or a simple children's round. The task is to identify the major themes and corresponding conflicts, reflecting them to the client. Let the client agree as to the major themes and hence the goals to be achieved in the treatment. This technique is not haphazard, but rather a disciplined approach, and fidelity can be obtained through supervision and use of taped recordings of the sessions. Another important aspect of this approach is the creation of a therapeutic (helping) alliance. In the first treatment interview, the stage should be set for a socialising process and the engagement of the client that leads to a helping alliance. The client is socialised along the lines suggested by Orne and Wender [16]. In simple terms the clients should be introduced to psychotherapy as a "talking therapy", and are encouraged in each session to say whatever is on their mind without screening or filtering. As previously suggested, the therapist will reflect to the client what he hears and what the recurrent themes are. In introducing the helping alliance and transference and countertransference issues, the therapist could say something to this effect, "OK, I will do my best for you. I would like you to attend once a week. It is your time. What I would like you to do during the sessions is to say everything that comes to your mind without screening it and I will tell you what I think I hear. If you agree with me, then those will be the problems that we will address. If you have any questions you should ask me and I will do my best to answer them. I will be like a second driving mirror to you. I am not always right but I will require you to think about what I say. If you disagree with me we should talk about it. You may have some strong feelings about me. When you feel that way we should talk about it". If the client demonstrates a palpable anxiety or suspiciousness, the therapist should feel free to ask "do you think I am the type of person that can help you?" This is useful when there is a gender difference between the therapist and the client or when there was a history of sexual or other traumas. Along such lines, the concept of transference and countertransference is introduced; the client will begin to feel some support and an encouragement to express himself or herself. If there are language difficulties, the services of a good interpreter will be required. However because of the expense and lack of available translation services, an interpreter in such circumstances is usually a close relative or a friend. Such services should be used with

caution as the principle conflicts may be due to the relationship with that individual. In addition, in such instances disclosure of sensitive material is hindered. One characteristic of supportive–expressive psychotherapy is the limit of usually 10 sessions and at most 25–30 sessions. However, this may not always be feasible or desirable. Nevertheless, the client should be given some perimeters whenever possible. For example, "I would like to see you for about 4 sessions initially or until you are showing some improvement and then we will cut back to once every 2 weeks and then once a month". If necessary the client may be referred to other services including support groups, 12 step programs, or marital and family counselling. When necessary, especially in the case of psychosis or depression, appropriate medications may be prescribed. The physician who plans to prescribe psychotropic drugs should be at least familiar with basic biological and non-biological factors that are likely to influence side-effects and compliance with the prescribed medications. In the absence of much data on pharmacodynamics and psychotropic effects or psychiatric drugs, common sense explanations may be made from observations on African Americans. An example will be the increased use of Tardive Dyskinesia medications on African Americans vs non-African Americans in the USA.

The use of other forms of psychotherapies such as cognitive behavioural therapy, interpersonal psychotherapy, and values-oriented therapies may be used depending on the training and expertise of the therapist. In low resource areas, the WHO mhGAP can be used by non-specialists and lay persons to bring relief to their clients. There are also possibilities to use computer- or internet-dependent technologies to enhance human capacities in such areas.

Some Common Themes in the Assessment of and Psychotherapy with Africans with a Migration Background

Religion, Sorcery, and Magic

Religion plays a significant role in most cultures. In the USA about 95% of the population espouses a belief in God (Church) (Gallups Report 1985). Many of these may not be practicing Christians if judged by a Church attendance. Religious practice in various parts of Africa is in contrast very active. Church attendance in some parts of Africa is amongst the highest in the world, usually variations of Pentecostal faith. In the USA there are now some major African Churches headed by Nigerians with mainly African attendees. Some of them provide counselling to distressed members of their Churches. African religious practice tends to be eclectic. For example, in the same family there can be Catholics and Protestants, mixed religious marriages between Muslims and Christians, or between Christians and individuals who are simply traditional. A Christian may seek Western treatment approaches but also expose him-/herself to alternative treatments such as healing meetings from native priests and healers. This is more likely when the condition is chronic and the Western type of approach is not bringing any relief. Therefore there is a need for

cultural sensitivity and synthesis. Bartocco et al. [17] pointed to the need for example in Italy to be alert to the coexistence of magic, sorcery, and religion in the presentation and treatment of mental illness. Their comments were based on historical and psychoanalytical perspectives. They illustrated their points using clinical case studies which had one thing in common, i.e. "robbing of the ego". They suggested the main pathways of dealing with one's existence in the modern world can be grouped into two categories.

> Our patient may either turn to the healing hand of humanity or appeal to the omnipotence of God.

Lambo [18] pointed out that the relevance of belief in witchcraft is sometimes a pervasive factor in the explanatory model of mentally ill Africans. He emphasised that it could be relevant even for the very educated. Consider the case of a young Nigerian who is married to a West Indian woman. He was referred to me by a colleague who was aware of my interest. He was initially not forthright as he suspected I may know individuals who know his family. He had been seeing a West Indian Bishop who prayed for him. He was referred for hospitalisation as his condition had worsened with much delusional thinking. He believed his condition was due to the fact that his mother was distressed about his marriage to a West Indian. His mother lives in Nigeria and he and his wife live here in the USA. Although very educated, he believed his mother had cast a spell on him. Another instance of this is when an individual comes from a polygamous home. An evil eye or witchcraft is often cited as the reason for the illness. That religion and spirituality play a significant role in the lives of the average African can easily be attested to by a keen observer who visits any major city in West Africa. He will witness excerpts from the Bible or Quran as mottos on cars and buses, billboards, or on houses. In day-to-day conversations this behaviour can also be observed as people mention the name of God in greetings or discussions. Parenthetically, this behaviour can be observed in countries with African survivals such as Brazil, Cuba, and Jamaica. In Brazil and Cuba many people live in an ancestral spirit world and in Jamaica; one cannot fail to hear the housekeeping staff singing hymns as they go about their work routines.

Idioms of Distress and Somatisation

Since Prince [19] described "brain fag", psychiatrists and anthropologists have been fascinated with that culture-bound syndrome. The name brain fag seems to have been derived from Nigerian students who complained of anxiety, tension, headaches, crawling feelings, and other symptoms of anxiety and depression which usually occurred before school examinations. Since Prince's description, some Nigerian psychiatrists have further explored the phenomenon [20, 21]. Although originally described in Nigeria, there is evidence that the syndrome also exists in other parts of Africa and in Asia. In fact, there is evidence that there were descriptions of "brain fag" in the European and American literature in the nineteenth and early twentieth

century. In terms of culture-bound syndromes we should pay attention to the comments by Aubrey Lewis.

> There is a risk of putting too much stress on the cultural aspects of strange forms of mental disorders.

[Somatic] expressions of distress among Africans are not limited to brain fag. Considering the universality of somatisation in the presence of anxiety and depression, one is intrigued by the previous preoccupation with somatisation amongst depressed Africans. In addition to other explanations for somatisation, perhaps we should add that somatisation is an indication of the severity of distress and expectation of the type of relief that is wished. It is perhaps easier to complain of and demonstrate physical symptoms than to do the same for corresponding psychological symptoms. Also, an individual who is experiencing hot or cold sensations or crawling worm-like feelings in his head would probably expect a physical intervention rather than a non-physical intervention. The more severe the discomfort, the more dramatic the expected intervention. Some Africans refer to a preference for "strong medication", tonic or injections. In Yorubaland, for example, reference is sometimes made to an all-powerful mixture—*gbogboloshe*. Van Moffaert [22] made some additional observations about a blurriness in Africans between mind and body. Her research was on migrants in Belgium. Her sample consisted of farm workers from Tunisia, Algeria, Morocco, Turkey, and Sicily. Although these individuals came from culturally and structurally different backgrounds, their rural communities were similar in terms of social organisation and support systems. In contrast to the state-organised health systems in Northwestern European communities, social support for the villagers was from other members of their communities. According to her, the somatisation process serves to trigger the social support system. In her study, individuals who had lived in Northeastern Europe for less than 5 years were excluded to reduce the chance of contamination of the study results due to issues related to the individuals' adaptation to their host countries. She also referred to issues of misdiagnosis in these cultures because of inattention to the idioms of distress in this population. From an analysis of her data she concluded that when it comes to the conceptualisation of illness in the Mediterranean culture, there is hardly any distinction between the mind and the body and that somatisation is a direct idiom of distress. In addition, for rural migrant workers, integrity of physical health is an economic asset, and any threat to his physical body can be anxiety-provoking.

The Use of Alternative Care

A logical consequence of the above paragraph is the use of alternative sources of healthcare with or without Western-oriented health services. An inclination of the client to use these services can be gleaned during the assessment period. Individuals who have used native healing in their countries may wish to continue this. Individuals and their families may also opt for this in refractory or chronic cases. The client may not disclose this piece of information to the therapist. On the other hand, the client

may ask if the therapist believes in spirits. This can be tricky for a therapist who does not hold this belief. In such a situation, one has to be honest and authentic. For my part I could ask the client for the basis of that question. If he or she persists I could tell him/her that my answer may not necessarily be useful to him or her. Or I could say that it is OK for him/her to have that belief and for me to have my belief. As part of alternative care, perhaps, we should include the intervention of elders, grandparents, granduncles, and grandaunts in settling family disputes. I recall the case of a high school student. Her father was highly educated and was in the foreign service. She complained that she had been sexually molested. Her father did not believe her in the first instance and also remarked that in their home country, such an issue would be dealt with by her aunt. In Uganda such interventions have been formalised and researched upon.

Transference, Countertransference, and Ethnic Matching

Psychotherapy with an African client with a background of migration can be loaded with transference and countertransferential issues. I have pointed to the relief an individual, especially a new immigrant, might feel when seen by a therapist of the same ethnicity or nationality. This experience is not universal for a variety of reasons. The therapist may not meet the expectations of the client. Take for example the reaction of a young African woman who had lost her husband. She had been exploited by some prayer groups. During the assessment I tried to listen intently to her story. She misperceived my focused attention with lack of verbal reinforcement as not being significantly empathetic, stating "you do not ever say you are sorry". There is also the possibility of countertransferential issues, such as when the client feels she/he should be treated differently and accommodated for not showing up for appointments, or asks for prescriptions to be called in after hours.

The result from a study on the racial/ethnic matching of clients to therapists is intriguing. The study examined three aspects of the issue, namely the client's perception of the therapist, the client's preference in therapist selection, and the outcomes of treatment. The average effect sizes (Cohen D) obtained were respectively 0.63, 0.32, and 0.09 for preference for one's own racial/ethnic therapist, preference for one's own racial/ethnic match therapist and for the treatment outcome. With a racial/ethnic match between the client and therapist, the result showed a moderately strong preference. When racially matched client outcomes were compared with not racially/ethnically matched clients, there was no difference [23].

Another treacherous area for the therapist treating an individual with immigration background, especially one who is very traditional, is when there are family disputes. An example is an adolescent girl, whose parents are immigrants, who presented with depression and suicidal feelings, stating the reasons that her parents did not give her the same latitude that her classmates had. To make matters worse, she felt different because she did not have a car like her classmates. The parents were working hard and the father was not able to provide her with one. She began to act out. She tried to manipulate the therapist to put pressure on her parents to meet her wishes. Perhaps a more tricky issue is when there is marital discord and the

marriage is facing dissolution. One partner may ask the therapist to instruct the other partner to behave. In such instances the therapist is often seen as an elder. There are other aspects of family dynamics and conflict resolution in the African family. There is respect and differential behaviour to an elder or chronologically senior person. In international conferences and elsewhere, I have seen young Yoruba men and women prostrating on the floor as a sign of respect to their elders or senior professors. The older person or senior is expected to be accommodating to the misbehaviour of younger ones. In terms of conflict resolution there is a tendency to thrash out the differences and resolve the matter rather than the Western style of emphasis on individual autonomy.

The Stress of Family Expectations and Demands

For an African, the impetus for migration is often, among other things, the chance to have a better life. Witnessing the hardships encountered by Africans attempting to cross the Mediterranean to Europe, they risk death and being sold into slavery. An underlying sentiment for Africans is very often to be able to be of practical help to those left behind. This may take the form of cash transfers or assistance in providing help to siblings to join them abroad. Additionally, a great premium is often placed on educational or economic success. When the desired goals are not met, this may result in disappointment and guilt. One of the major difficulties of living abroad is dealing with deaths of members of the extended family and parents. African funerals can be elaborate, involving a variety of rituals. Individuals who may not be able to participate in these rituals because of being abroad may feel guilty and depressed. The therapist should be aware of these sentiments and encourage the clients to express their guilt and accompanying negative feelings.

Social Support

As is now generally known, social support is a critical factor in mental health outcomes. For the newly arrived individual, the provision of social services information, the presence of ethnic civic organisation and religious bodies, or information such as ethnic restaurants or groceries can be helpful. The access to these organisations and their participation may ease the burden of immigration and the isolation of being in a foreign country.

Repatriation

One last consideration in this section is the painful issue of repatriation. In my career of about 40 years in psychiatry, I have supported the decision of an individual who during psychiatric treatment expressed a wish to return to his homeland. It seemed his decision was based on several factors. This was a graduate student who

prior to his coming to the USA was married and his wife was pregnant. His symptoms consisted of an admixture of anxiety and depression, and there was some somatisation involving abnormal discomfort. He was hospitalised for his psychological distress. He was highly educated and articulate. Although he participated in group sessions, he believed he was not getting enough attention from other group members. He became very adamant about returning to Nigeria and to his wife. I made the necessary referrals to a colleague in his home country. Upon follow-up I was informed that no sooner had he arrived there than his condition improved and he was able to continue his studies. The outcome in this case was positive but I do not believe that all such cases would have such good outcome. Nevertheless, when an individual expresses the belief that they will be better off in their homeland because they have significant adjustment reaction, depression, or brief psychosis, the matter should be given due consideration.

Conclusion

In this chapter, I have attempted to describe some factors that may be influential in psychotherapy for Africans with a migration background. One factor is the position of the client in the migration trajectory. The newly arrived immigrant is likely to have some adjustment problems in addition to other mental health problems. The fully acculturated migrant may be more knowledgeable about health services. In the screening and assessment of the individual, a common sense approach that is culture-sensitive and informed is useful. One must not expect that every case will exhibit a culture-bound syndrome. We should guard against errors of misdiagnosis and a rush to interpretation. However, at least rudimentary knowledge of African religious philosophy, value systems, and sentiments is helpful. If clinical instruments are used they should be validated for that population. The patient should be socialised about what the treatment is about and what their participation should involve. It is emphasised that the therapeutic encounter is basically a transcultural encounter. When there is a language barrier, competent interpreters should be used and when necessary, the therapist may seek supervision and consultation. With the development of psychotherapy manuals and guides it is to be predicted that formal psychotherapy may be more available to psychologically distressed Africans with a migration background. The exercise of working with clients from this background can be a profitable and enriching human experience for the therapist.

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Cultural Psychiatry and the Implementation of Transcultural Psychotherapy in China

20

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Introduction

Cultural psychiatry is a specific field of psychiatry dealing with cultural aspects of human behaviour, mental health, psychopathology, and treatment. In China, as well as in many other Asian countries, there is much to explore about the multifaceted cultural matrix and how it may influence individual psychopathology and psychotherapy, with the influence of both the mainstream society and a diversity of other cultural influences according to specific region, religion, age, ethnicity, and so on. This paper presents a brief overview of the modern Chinese cultural matrix, which is a combination of both the traditional and new trends in today's rapidly changing society. It will then discuss the development of the psychological services in the China over the last 30 years, providing a comprehensive analysis of the "civilisation diseases" of modern Chinese people. This paper is based on transcultural analysis of peer-reviewed articles, classical textbooks, personal oral history, interviews, and clinical experiences, and discusses potential implications for culturally adaptive psychotherapy.

Influences of Culture on Psychopathology and Psychotherapy

Tseng [1] discusses seven kinds of effects, which relate to the influences of culture on psychopathology, including (1) pathogenic effects, (2) pathoselective effects, (3) pathoplastic effects, (4) pathoelaborating effects, (5) pathofacilitative effects, (6)

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pathodiscriminating effects, and the lastly, (7) pathoreactive effects (p. 190). He describes the spectrum of psychopathology as a continuum of six categories, these being organic mental disorders, major psychiatric disorders, substance abuse, minor psychiatric disorders, epidemic mental disorders, and culture-related specific syndromes. Each of these categories can be subdivided according to three types of determinant, namely biological determinants, psychological determinants, and socio-cultural determinants. Each of the seven effects listed above also impact differently on each category. For instance, the pathoplastic effect is most common in culture-related specific syndromes and epidemic mental disorders, but is rarely seen in the other four categories of psychopathology. Pathoreactive effects impact almost all kinds of psychopathology including organic mental disorders (p. 190).

Besides organic mental disorders, most of the psychopathological disorders and syndromes are culture-related or at least treated differently depending on the cultural context, often following traditions that are full of unique meaning to each individual. Culture-related psychopathology calls for culturally sensitive healing practices and psychotherapy. According to Tseng, in terms of its relationship to culture, psychological therapy may be classified into three types, these being (1) culture-embedded indigenous healing practices, (2) culture-influenced unique psychotherapies, and (3) culture-related "common" psychotherapies.

Culture-related effects had been devalued along with the development of the biological–medical model since the eighteenth century in the West. As the biological–medical model faces its own challenges and is pushed to reintegrate a holistic view of human beings into the treatment of psychopathology, the importance of the role of culture is being re-evaluated. As Tseng [1] states at the very beginning of his book *Culture and Psychotherapy,* "Contemporary mental health practitioners widely recognise the importance of cultural issues in psychotherapy (p. 3)." China has a tradition of thousands of years of civilisation and Eastern wisdom to treat people's mental suffering. In the following section we will present a brief view of the mainstream culture and cultural diversity in China, as well as discussing how psychopathology *has traditionally* been treated and healed within the context of the Chinese cultural matrix.

The Modern Chinese Cultural Matrix

The modern Chinese cultural matrix of the psyche is formed through the combination of five dominant philosophies, namely Confucianism, Taoism, Buddhism, Communism, and Socialist Market Economics. Each of these philosophies represents a profound system of knowledge in its own right. Given the limits of this chapter, and bearing in mind the risk of overly simplifying these philosophies, we nonetheless wish to give the reader a taste of each in order to present a rough but accurate map of the Chinese cultural matrix. For instance, Confucianism provides the Chinese ethical value system and the regulation of interpersonal relationships, and emphasises order and harmony. For instance, Confucianism recommends the family head three cardinal guides: "ruler guides subject, father guides son, and

husband guides wife". Chinese people who are influenced by Confucianism are raised to respect authority figures and please others, and tend to suppress their own distressed feelings and dissatisfaction with the aim of paying social respect. Taoism, meanwhile, provides the ontology of cosmology and emphasises the unknown. Chinese people who are identified with Taoism therefore respect supernatural powers more than social authority, and may superficially appear to be more aligned to Western individualism, paying attention to their own inner world; nonetheless, this is still very different from Western individualism. Buddhism provides a sophisticated faith system and emphasises on humility and a circular understanding of life and death, meaning that those who are identified with Buddhism may experience more fear due to assumptions about punishment by identification of the hell-theory in Buddhism. Together, these three philosophies have been dominant in the formation of Chinese culture for over 2000 years.

Communism was introduced from the West into China at the beginning of twentieth century, a new cultural trend which became one of the leading ideologies since the foundation of the People's Republic of China in 1949. When compared with the cultural traditions mentioned above, Communism provides a concept of political equality and respect for the labourers. At the same time, other Western cultural influences including rationalism, science spirit, democracy, and capitalism as described by Karl Marx in his book *Das Kapital (1867–1894)* also present themselves in the cultural matrix of the Chinese psyche. Due to changes in thinking on gender equality, women are also increasingly entitled to more equal political powers and independent interests like men. All in all, a new social order is being constructed in Chinese society.

For a variety of reasons including political and economic ones, the development of the national economics and people's quality of life have become popular public topics and evidently impact on people's behaviours and beliefs in a new way. Social phenomena such as materialism, hedonism, money worship, and the exchange of power and money are increasingly pervasive and have become part of the modern Chinese culture since 1978 when China began to reform and be open to the outside world.

From the observation and analysis of the modern Chinese cultural matrix characterised by the co-existence of multiple mainstreams of philosophies and viewpoints radically challenged by rapidly changing lifestyles, we arrive at the following statements about the generalised image, which we have called the "national character" of the modern Chinese people:

1. It is necessary to understand the mentality of modern Chinese people. They are no longer the people on whom the West based their image of Chinese people decades ago.
2. Generally, they are still worldly oriented, family-centred, flexible, optimistic, peaceful, harmonious, and tolerant most of the time, because they still follow natural and positive views of the world, life, and death.
3. Psychologically, contemporary Chinese people possess more confidence and more archetypally/stereotypically "masculine" traits.

4. Meanwhile, some new trends have also emerged, for example that the Chinese are changing their conception of relationships regarding self and environment, body and mind.

Socio-Cultural Change and Mental Health in China

China is developing rapidly from the societal level and the cultural level. As we have discussed above, the new cultural trends of communism and socialism market economics have landed upon a foundation of Confucian, Taoist, and Buddhist traditions and have led to enormous changes at a socio-cultural level in China. People have had to readjust their behaviour and psychological status in this multifaceted cultural matrix.

Social-cultural changes have inevitably induced radical changes in the individual's inner psychic life. While enjoying the progress in a material sense and experiencing individual growth followed with the more equal power as citizenship, many people have had to pay a high price for such a 'Great Leap'. Phillips et al. [2] did a series of epidemiological studies from 2001 to 2005 to estimate the variables of prevalence, treatment, and associated disability of different types of mental disorders in four provinces of China. They found that the prevalence of mental disorders of any kind was 17.5% (p. 2044). As the most developed city in China, Shanghai, the prevalence of total mental disorders was 18.25% in the year of 2009. According to the findings of Phillips et al. [2], the patients present culture differences in terms of gender and age, such that "mood disorders and anxiety disorders were more prevalent in women than in men, and in individuals 40 years and older than in those younger than 40 years (Table 20.1). Alcohol use disorders were 48 times more prevalent in men than in women" (p. 2041). It is not only the individual, but also society that pays a high price for such rates of pathology.

The prevalence of mental disorders relates significantly but not exclusively to the socio-cultural changes described above. One of the causes of psychopathology among the Chinese people are the "old problems", by which we mean factors that

Table 20.1 [a]12-month prevalence of mental disorders in Mainland Chinese

Classification	Four provinces (2001–2005)	Hebei (2004)	Shanghai (2009)
Mood disorders	6.1	7.3	7.52
Anxiety disorders	5.6	5.3	3.91
Substance abuse disorders	5.9	2.0	5.45
Personality and behavioural problems	NA	NA	4.22
Psychotic disorders	1.0	0.6	0.74
Organic mental disorders	0.3	2.3	0.12
Other mental disorders	0.3	1.4	1.81
Any disorders	17.5	16.2	18.25

[a]Phillips MR, et al. The Lancet, 2009, 373: 2041–2053

have long been playing a role in Chinese society and have changed little despite outside influences. For instance, the general population's attitude towards mental illnesses and disorders continues, on the whole, to be passive and negative. Guilt and shame are still the initial emotional reactions of most modern Chinese people towards mental illnesses, similar to that of their grandparents' generation. Correspondingly, the help and support system for the mentally ill, both on the societal and the familiar level, is weak and fragile. Prevalent negative attitudes jeopardise patients' help-seeking behaviours and consequently interfere with the process of healing and recovery.

According to Phillips et al. [2],

> On the basis of analyses done by WHO, the combined category of neuropsychiatric conditions and suicide accounted for more than 20% of the total burden of illness in China in 2004, making it the most important category of illness or injury in men and women. But only 2.35% of the government's health budget is spent on mental health and less than 15% of the population had health insurance that covered psychiatric disorders (p. 2050).

The increase both in mental health problems and untreated mentally ill population is one of the major problems that the Chinese people and their government are facing. To be more specific, China is facing a huge demand on mental health services, and the dominant model of biological psychiatry is insufficient. A new system of mental health services with a more humane paradigm and techniques is urgently needed. In particular, this new model of services should supplement or even challenge the dominant model of the authoritarian physician–patient relationship.

Psychotherapy in China

Traditional Healing Methods

The term 'traditional healing' refers to non-orthodox therapeutic practices based on indigenous cultural traditions that operate outside official health care systems ([3], p. 7). The situation in China, however, is somehow different. Generally, Traditional Chinese Medicine (TCM) is regarded as one of the orthodox therapeutic practices in Chinese history, but is still categorised as traditional healing when compared with modern therapy.

Traditional Chinese Medicine, along with local religions, superstition, and unofficial healing practices have been the most common methods for ordinary people to deal with their psychological sufferings and improve their mental wellbeing. Increasing numbers of Traditional Chinese Medicine scholars have started to study the psychotherapy methods of TCM and come up with some inspiring findings. For instance, Wang [4] introduces the theoretical system of TCM psychotherapy as including three theories, namely Yin Yang Five Elements Theory, Visceral Manifestation Theory, and Seven Emotions Theory, combined with eight methods of intervention including rationalization, evidence-based convincing, and paradoxical emotions, to name but a few. Rooted deeply in traditional Chinese culture, TCM

still plays an important role in healing, similar to various other forms of folk therapy that TCM doctors use; as authority figures, they utilise their power as an authority figure, therefore are easily able to convince their patients that these methods will be effective.

Meanwhile, superstition is still one of the acceptable healing practices in some rural areas of China such as the Shamanic healing rituals in contemporary Inner Mongolia. Inner Mongolia is home to one of the 55 minority nationalities of China, and one of our students has videotaped two Shaman healing rituals there. One features a young woman presenting severe headaches without an organic cause, while the other is a young woman with depressive moods due to the breakdown of the relationship with her boyfriend. The Shaman dealt with the patients' physical and emotional symptoms by using rituals of dramatic body movements, esoteric language, and symbolic drama settings [5].

Legitimation of Psychotherapy

As Prof. Yu Xin (personal communication, 2013) states, the Chinese people are craving psychotherapy for three main reasons. The first is related to their spiritual needs, as psychotherapy is regarded as a sort of religion or superpower. The second is related to their sense of belonging, wherein the therapists are perceived as mother-like figures. The third is connected to self-value or self-esteem, patients seeking help with their psychological growth and development. Traditional Chinese Medicine, together with other traditional healing practices, may provide some satisfaction for the first and second of these needs, but with the third need often unmet, and with the interplay of the other afore-mentioned cultural elements, modern psychotherapy is becoming increasingly popular in urban areas of China.

There are four types of institutions providing different levels of intensity and different styles of intervention within mental health care in contemporary China. These are: (1) mental hospitals or mental health centres (also called specialised psychiatric hospitals) at province and district levels; (2) departments for psychiatry or psychosomatic medicine in general hospitals; (3) counselling centres in universities, schools, and out-patient services in hospitals; and (4) private clinics. As Tseng and Streltzer [3] states, "the practice of psychotherapy is strongly influenced by the socioeconomic-medical system" (p. 9). Historically in China, "talking therapy" was not valued by people as much as ordinary medical treatment that uses medication or surgical procedures. Furthermore, the acceptance of psychotherapy was also obstructed by political ideology in China during the Cultural Revolution.

Psychotherapy and psychological counselling did not become a focus of the attention of medical professionals in China until the 1980s. The major milestone was the First Chinese–German Symposium for Psychotherapy, which held in Kunming, Yunnan Province, in 1988. Official legitimization of psychotherapy and psychotherapists was historically granted by the *Mental Health Law of the People's Republic of China*, which itself was enforced on May 1st in 2013. This was the first time in Chinese history that psychotherapy was legally acknowledged as a "scientific medical treatment" and psychological counselling as a "useful method to promote mental health".

According to the Law, psychotherapy is endowed with legal status as a medical treatment term, and precisely differentiated from psychological counselling by the identity of the practitioner, the aim, and the location, among other things. For instance, coding from article 51 in Chapter III of "Diagnosis and treatment of mental disorders" states:

> Psychotherapy shall only be practiced within medical facilities. Persons only qualified to provide psychotherapy must not diagnose mental disorders, prescribe medications for persons with mental disorders, or perform surgical treatments. Technical regulations for the provision of psychotherapy will be formulated by the administrative departments for health under the State Council.

Article 51 critically clarifies the different responsibilities of mental health practitioners and promoters, distinguishing between psychiatrists, psychotherapists practising in medical facilities, and psychological counsellors practising in non-medical facilities *for many benefits of policy*. Beside the policy's benefit of regulating the growing market of psychotherapy and setting up boundaries between medical and non-medical fields for the welfare of patients, the policy also encourages the professional development of psychotherapists and counsellors in their different responsibilities as healers.

Adapting Psychotherapy for the Transcultural Chinese Context

Over the past 30 years since the 1980s, the field of psychotherapy has experienced significant change in China, transitioning from being obstructed to being legalised. The main forms or schools of psychotherapy include psychodynamic, cognitive behavioural, humanistic, and systemic, all of which have been imported into China. Thousands of psychiatrists and counsellors have received some sort of professional training of psychotherapy by means of short-term courses of continuous education. Prof. Zhang Yalin conducted a study (2013) in which 1232 psychotherapists in six administrative areas in China were surveyed either by interview or by questionnaire in 2012 and 2013 and were asked about the methods of psychotherapy they applied in daily practice. According to the study, the most frequently used methods by the Chinese psychotherapists are as follows: (1) cognitive (24.0% of frequency by 59.2% of total therapists), (2) behavioural (15.4% of frequency by 38.1% of total therapists), (3) psychoanalysis (11.9%/29.4%), (4) family (6.5%/16.0%), (5) CBT (6.3%/15.6%), (6) humanistic (6.3%/15.6%), (7) sandbox (3.8%/9.4%), (8) hypnosis (3.5%/8.6%), (9) holistic (2.3%/5.7%), (10) Morita (2.2%/5.6%), and (11) others (17.8%/43.9%) [6]. By reviewing the data, we may make the following three assumptions about the methods used by psychotherapists in China. The first is that most of the psychotherapists use a variety of psychotherapeutic methods from different schools. The second is that nearly half of the psychotherapists (43.9%) use methods which cannot be categorised into the most common methods. The third is that cognitive methods are the most popular methods both for therapists and patients in China. Interestingly enough, there is limited research on the satisfaction of the patients who pay for the service of psychotherapy. It may also be a reflection of the unbalanced power position between the psychotherapists and the patients.

A number of culturally related explanations may underlie these three phenomena. Using a variety of methods across different approaches may imply insufficient training in each approach, with psychotherapists trying to maximise the benefits of the therapy by using a collective approach from a variety of relatively superficial training experiences. On the other hand, using methods other than the orthodox ones could imply the creativity of therapists who are trying to compensate for the culturally specific needs of their Chinese patients with tailor-made interventions. Lastly, the popularity of cognitive interventions may imply the psychotherapists' preference for an approach which focusses on symptom reduction; this may also be preferable to patients due to the "practical character" of Chinese people, although it is not clear whether this intervention is truly the preference of the people, or whether the patients defer to the preference of the psychotherapists whom they regard as an authority figure. It is obvious that due to the field of psychotherapy just in its baby-stage, therefore the clients are also young in terms of the judgement of the quality of psychotherapy. As mentioned above, a significant portion of the patients seek for some superior spiritual leader or a sense of belonging in psychotherapy rather than a science-based professional service.

Philosophical and Meta-Theoretical Considerations

No matter which school of psychotherapy is practised, for the field of psychotherapy to develop in modern China, it is important to balance the main contradictions inherent at the philosophical or meta-theoretical level [7]. There are at least five pairs of philosophical contradictions in the process of adapting psychotherapy for use in the transcultural context within China, especially in the process of implanting psychotherapy from the West into the Chinese context. These are as follows:

1. *Universality versus uniqueness*. It is possible for us to develop and use a relatively universal framework to describe, analyse, and solve indigenous and unique problems.
2. *Collectivism versus individualism*. Collectivism is a cultural tradition shared within many Asian countries and was criticised as *over fusion* and inhumane in terms of not giving an individual enough autonomy and independent rights during the Western culture centred era. Now it is possible to value each individual as part of a collective social wellbeing.
3. *Harmony versus Unrest*. Harmony is ideal for a society in the sense of interpersonal relationships, but can inhibit the dynamics of development and growth of society. Unrest, or perturbation induced intentionally by psychotherapy, may relate to stress but can also lead to change. This is true both at a societal level and in the mental health of individuals.
4. *Localisation versus globalisation*. It is possible to import Western theories and practices of psychotherapy into Eastern cultures, and it is also important to introduce the contribution of Eastern wisdom into psychotherapy in the Western world.

5. *The psychology of understanding versus the psychology of explanation*. Jaspers described the subject of psychology about 100 years ago as the psychology of explanation, and saw it as one which was aiming to provide nothing but the truth and facts about the psychology of human beings. He criticised this psychology of explanation, remarking that human beings should be more than *materials or physical existences*. As a philosopher and psychiatrist, Jaspers put forward a new view of psychology as the psychology of understanding, motioning that psychologists should promote understanding the meaningful inner psychic connections. According to Jaspers, it is important for psychiatrists to *yield* the pure biological-orientation but to extend knowledge, skills, and services according to the so-called "bio-psycho-social medical model." Meanwhile, psychologists should develop new working relationships with psychiatrists, while becoming experts in the field of psychotherapy.

In the process of balancing these five pairs of philosophical and meta-theoretical contradictions, our cultural understanding of human nature may be deepened and cultural-specific approaches to psychological problems may be developed. Psychological dilemmas, distress, and disorders are to some extent universal, while the problems in various nationalities have strongly cultural characteristics. Based on the successful introduction of Western psychotherapy into the Chinese context, it is time for Chinese practitioners to contribute to the world [8]. There is much wisdom from traditional cultures, which can play a role in solving problems, pursuing harmony, and dealing with the troubles of rapidly developing societies worldwide. Perhaps the future of psychotherapy will be one in which this Eastern wisdom is integrated with contemporary Western psychological sciences.

To lead the discussion one step further, a paradigm shift is necessary within psychotherapy, moving from the medical model, which is based on linear determinism, towards a moral model and systemic thinking, which focusses on meaningful connection over causality. Theoretically, systemic thinking is useful for us to better understand the relationships between human and nature, individuals and society, and body and mind. Clinically, it can be utilised in clinical practices to deal with problems of various natures. The fact that family therapy has been widely welcomed in China is a good example. Systemic thinking fits in well with Chinese traditions and the "here-and-now" social reality, and Chinese psychotherapists employ it with their own understanding of the cultural context and in creative combination with other methods.

Conclusion: Toward a Culturally Adaptive Psychotherapy

China is a country with a 5000 year-long history of civilisation as well as an incredibly short history of modern psychotherapy, this having developed over the last 30 years. Upon the foundation of the longstanding healing traditions focused mainly around Traditional Chinese Medicine and a variety of folk healing practices as well as the complex Chinese cultural matrix, contemporary Chinese society now

increasingly accepts and welcomes the introduction of Western psychotherapy. Nowadays in China, as the government begins to stress the value of a "Scientific view of development" and "Human-centred governance", the tasks of mental health professionals can be defined as promoting psychological harmony. Psychological services in Chinese society also require a significant emphasis on the multicultural competence of the practitioners given its unique cultural background and the diversity of minority cultures in China.

The Chinese cultural matrix is profoundly complex and each individual who partakes in psychotherapy presents his/her unique belief system and psychological needs reflecting the comprehensive impacts within his/her own cultural matrix. Contrasting the traditional healing practices and modern trends in psychotherapy in China points towards the need for a new system of mental health services with a more humane paradigm and techniques.

China is currently one of the most rapidly developing countries in the world, and the impact of this socio-cultural change influences a population of about 1.38 billion (Statistics in 2017). In stark contrast with this figure, there are only 34,000 psychiatrists, 10,000 psychotherapists, and 1,300,000 counsellors who, often with very limited clinical experience, are responsible for serving the mental health care for these 1.38 billion people. The Chinese government has made significant progress in regulating and promoting the development of the professional field, but much work still remains to be done. It is also critically important for the practitioners to follow well-regulated professional ethical rules.

As a latest progress, China's central government launches a national-wide project to develop mental health service both in medical institutions and non-medical areas including communities, educational institutions, and industrial sectors. For example, in the experimental areas of this project, all the psychiatric hospitals and at least 40% of the general hospitals shall set up departments of clinical psychology/psychotherapy, which is never requested so far. Therefore, the need for qualified psychotherapists with medical or psychological background is very huge. We deserve to be proud for this positive development, because our 30-year efforts to introduce Western psychotherapy into China through the German–Chinese Training Project has laid a good foundation for this progress.

There is also much potential in terms of contribution to the development of the field of psychotherapy in the global context, which may be done by developing, researching, and publishing work on the use of indigenous methods in combination with Western psychotherapy approaches.

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Psychotherapy for Latin Americans

21

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Introduction

Latin America (LA) is a region of the world that shares a number of common historical features and two Latin origin languages, Spanish and Portuguese. Starting from Río Grande all the way down to Patagonia, including 19 sovereign states plus some lands and islands that belong to the Caribbean Ocean, with an approximate area of 19.2 million km^2 and a population close to 640 million people. In spite of these commonalities, one cannot refer to LA as a uniform population from any standpoint, since the ethnic and cultural composition varies greatly from one country to another.

In both the twentieth century and the twenty-first century thus far, the world has provided assistance to a number of different waves of migration. After the First and Second World Wars, Europe exported immigrants to Latin America, the USA, and Canada. Poverty and the remarkable precariousness of postwar conditions affected the pillars of European culture. The fear of famine had devastating effects in the European continent. The general trust in history, reasoning and science, progress and social structure, all became questionable, a process which had started accumulating since the French illustration. In the midst of a number of protest movements

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and the despair being faced, two new utopias arose. The fearful utopia of the Russian Revolution did not produce great migration towards Eastern Europe—instead, the illusion of prosperity in the American continent was much more attractive as a great centre of migration.

The acknowledgement of the heterogeneity in Latin American is as important as the identification of the common constituents when addressing a psychotherapy patient or their family. Recognising *how these integrate the cultural Latin Americans components on the subjectivity of its population* enhances the perspective of the therapist and can lead to greater efficacy in their clinical practice. However, it is equally important to shed light on the stereotyped view that people in Europe and the rest of the world have on Latin America and its people.

Common Problems in Latin America

From the mythical expulsion from Paradise of the first man ever, human chains have followed the trajectory of Adam. Persecution and exile have been consistent in the history of humankind, and during the twentieth and twenty-first centuries, there are overwhelming examples of this.

The problems generated as a result of migration from Latin America to different regions of the world are varied and complex. An approximate inventory includes civil wars, drug traffic, poverty, violence, national conflicts with political and economic instability, persecutions, social inequalities and inequities, as well as a number of crises with different dimensions and transcendences. Typically, displaced people arrive to their destination country in conditions of precariousness, but this is often just the tip of the iceberg of problems they must face. Back in 2014, the High Commissioner from the United Nations for Refugees had calculated the number of displaced people around the world as 54.5 million people, out of which 86% were located in developed countries from the first world. The migratory tendencies from Latin America have now been mainly directed to the United States, where a recent census indicates 54 million Hispanics living in the country, representing approximately 17% of the total population. Although at a lower level, but in no way any less significant, Latin Americans have also migrated towards Europe, especially Spain. The displacement of Latin Americans around the world represents a demographic phenomenon of high proportions, with a background that goes back over a century in history. In general, the displaced persons of this region of the world usually have a lower socioeconomic and educational status, and meet with significant challenges of adaptation and cultural integration into the hosting country. These migrants experience a range of different problems, of which we will focus on those related to mental health. The World Association of Cultural Psychiatry (WACP) has presented an extensive document entitled “Global Challenges and Cultural Psychiatry: natural disasters, conflicts, insecurity, migration and spirituality”; this states that the assistance of migrants in the field of mental health is not possible from a monocultural approach, and has gathered a group of important investigations about the subject in a significant volume [1].

Epistemological Fundamentals

The relevance of the cultural approach in psychiatry has been recognised since Kraepelin published his first observations on the Pacific populations [2]. Ever since, the study of the cultural phenomenon in psychiatry has increased so much that, currently, it is a subject of indispensable consideration. The modern neurosciences are more and more concerned with advances in the knowledge on the neurobiological mechanisms of the cultural pathoplasticity. It is well known that the central nervous system at the same time connects and controls processes that take place in the *biological level* and is also related with the world of symbols that take place within social interaction, and that the reciprocities between the two worlds are so many, that we now know they are much more closely related than we used to think.

It is important to recognise the contribution that philosophy, the social sciences, and the humanities has represented and continues to represent for medicine. The new questions that promote the investigation in neurosciences take their origin from fruitful exchange with the humanities, leading on to conversations about neuroaesthetics, neurophilosophy, philosophy from the mind, and all the way to neurotheology with absolute scientific rigour and allowing the emergence of a new anthropology that permeates all branches of medicine.

In psychiatry, the nomothetic and the idiographic are equally relevant. This is why the Latin American Guide for Psychiatric Diagnosis (GLADP) has boldly suggested an idiographic axis inspired by the qualitative ethnographic investigation, which gives the patient a voice to record his/her own description and perception of the condition, health, and subjective and cultural components that may influence recovery. *The transcendence of this information consigned in history* is enormous, as it prescribes the need for a respectful dialogue with an anthropological dimension. It makes no difference whether or not the opinion of the patient and his/her community coincides with the doctor's—this is about recognising the "other", with his knowledge and his culture, in a fruitful and sometimes tense, invigorating, dialogue which is rich in possibilities to promote health. This is about a remarkable contribution from Latin American psychiatry that must not be unknown and is currently gaining attention in Europe under the name of Narrative Medicine [3–5]. On the other hand, the DSM-5 eliminates the Multiaxial Diagnosis, but suggests an Interview of Cultural Formulation of the Diagnosis (ICF). Even though this is not a Diagnosis axis, the Third Section of the DSM-5 contains an ICF that turns out to be very important in assisting the patient in his/her community of consciousness. The ICF is a questionnaire with 16 questions centred on the person that provides information to the clinic about four different fundamental areas: Cultural Definition of the Problem (questions 1–3); Cultural perception of the Cause, context and Support (questions 4–10); Cultural Factors affecting the coping process in the person (questions 11–13); and Cultural Factors affecting the search for help (questions 14–16). Both the process of carrying out the ICF and the information resulting from it are centred on the subject and aim to improve the cultural validity of the diagnosis, facilitate the planning of the treatment, and promote the commitment and satisfaction of the individual. In order to reach these objectives, the information obtained

from the ICF must be integrated with the rest from the clinical material available in a full clinical and contextual evaluation. One version for the informant from the ICF can be used to collect information collaterally about the domain of the ICF, by interviewing the patient's relatives and/or caregivers [6]. The cultural formulation of the DSM-5 is conceptually right next to the IDIOGRAPHIC AXIS by the GLADP, an axis that had been previously conceived.

Today's medicine recognises and accommodates the anthropological dimension of the illness. A medicine that separates itself from anthropology would not be anything other than "The human province of the veterinarian" [7]. The "Medicine Centred on the Person" suggests recovering that anthropological dimension inherent to the medical practice. The approach centred on the person, recognises that each person possesses an intrinsic dignity, and suggests treating them with respect to promote the health and happiness of the users. Likewise, the approach centred on the person supports their freedom and responsibility to develop a life of their own in personally significant terms, while being respectful to others and the environment of interaction. The evidence suggests that organisations of medical assistance work better whenever they operate in a person-centred way, since this stimulates better coordination, cooperation, and social trust [8].

Some Experiences in Cultural Psychotherapy

The therapeutic systems of the cultures which originated in Latin America could work in their own sociocultural context. William Holland studied the subject profoundly among the indigenous "tzotziles" group from the Altos de Chiapas. Although nominally Catholics, the tzotziles have preserved the ancestral Cosmovision from their ancestors. In its cosmogony, the earth is the centre of the universe, and the other stars orbit in its surroundings, the blue sky is the home of the spirits and benevolent gods, while the underworld is located underneath the ground, where the malignant beings reside. These, in an eternal combat with the benevolent ones, are deeply dreadful, and wander through the nights spreading illness, death, and misfortune. In their beliefs, the spirit (chu'lel) represents the core of the personality, the thoughts, and the impulses. Everything that affects the spirit also affects the physical body and vice versa. The earthly world reproduces itself through the spirits from the mountains. The healing ceremonies of the Tzotzil shamans must influence both worlds in order to achieve the healing of the ill ones [9].

In the assimilation processes of the different ancestral ethnic groups to the dominating cultures of America (USA) or to the *first world (Developed countries)*, different phenomena are produced from the cultural syncretism; however, the meeting of indigenous ethnic groups and majority cultures produces a variety of phenomenon, and while much is lost, there are always remains of the culture of the ancestors.

In any case, looking at it exclusively from a Western and modern perspective, which does not entirely recognise the influence of the ancestral culture of a Latin American individual, it would be very likely that any therapeutic assistance or intervention will be doomed to failure or at most, minimal success. Culture is not a

"factor" that can be statistically isolated to be measured and weighed. It is a component that cannot be isolated at all without producing a severe disintegration of the phenomenon in question. Some valid efforts have been conducted around the world to address a psychotherapeutic intervention with more successful possibilities. The following are some examples.

Bennett-Levy et al. trained an Australian aborigine group in cognitive behavioural therapy (CBT). Their research, designed to address the question on whether CBT "could work" for aboriginal individuals, opens new paths in the literature on aboriginal mental health. The aboriginal counsellors trained in CBT perceived that the technique could be efficient in the treatment of psychological anxiety among indigenous patients from Australia. In particular, they were able to report the value in its adaptability, structure, safety, and the practical utility of techniques. The features of this style of therapy were especially useful to contain complex situations (with resources to focus the therapy work) and to empower the clients as agents of change in their own lives. These specific techniques were considered to be easy to transmit to clients, promoting a simple and collaborative approach to problems for their resolution. The study is particularly significant since it promotes an advance towards best practice based on evidence in aboriginal mental health, as opposed to current practices, which tend to be based on anecdotal evidence [10].

Vicary and Andrews developed a model for therapeutic work with Australian aboriginals. The authors acknowledged that there is no evaluated model on therapeutic approaches from non-aboriginal clinical professionals in work with aboriginal patients. In a study that incorporates theoretical content as well as debate between doctors and the aboriginal population, they were able to develop a model that comprehends seven stages or revealing moments. In the first step, the remission to a mental health service must be thoroughly examined, with appropriate cultural expertise. The clinic must be contextualised within the community of beliefs of the patient. The second place consists of the examination of the patient, including their personal background, which could require written consent if used in any way beyond strictly clinical terms. This would include information both on the most relevant recent events, such as illnesses, the death of family members and other relevant psychosocial traumas, and also more distant events, such as the process of colonisation, the lost generation, problems, and cultural beliefs associated with health, since the collective history is expressed in each individual. The third phase comes with the acknowledgement of the potentially limiting factors from the intervention. These had been previously sensed or observed in the prior steps. The cultural resistance against the treatment and the conceptual discrepancies in relation to the health and the lifestyles must be calibrated appropriately to adjust the objectives of the therapeutic process to the clinical and social reality of the patient. The fourth step consists of (the patient making a commitment or contract with the community or the family, which has implications with several aspects and channels of compliance). In this phase it is extremely critical that the aboriginal collaborators actively participate while relatives and close people are interviewed, but only after the reasons behind the therapeutic interview have been explained, as well as the limitations and possibilities of the procedure to be resourced. The role of the non-aboriginal

therapists must be defined as well as the relevance of some cultural beliefs that could possibly get in the way of the process. In the fifth step, the frequency and the appointments scheduled are established with the patient and his/her relatives. In the sixth stage, we discuss the therapeutic options, particularly those that offer a Western approach to address the health issue in question, as well as those resulting from their own cultural background. Finally, the seventh point is intended to co-evaluate the procedures and results from the therapeutic intervention with the patient and close family/community members. The work could be subscribed in the ethnographic qualitative method applied to the clinical work, given its wide interest on the world of significations, the symbolic order, and the subjective records of a life in society [11]. The result ends up being very similar to what is suggested by Ferraroti as "history of life" for the anthropological investigations [12].

Devereux, both an anthropologist and a psychoanalyst, founded ethnopsychoanalysis in the 1980s based on two principles. The first of these is the psychic universality of the human being, which provides a psychic mechanism to the entire species, but is inscribed in the universality through the particular aspects of the individual's own culture. Secondly, the method consists in the mandatory but not simultaneous use of the anthropological and the psychoanalytical viewpoint [13, 14]. "The therapist must work in the two different levels, the cultural and individual level, without confusing one with the other, as well as on the perspective and interactions between the two of them" [15]. The anthropological level enables the decoding of the cultural frame and the container of the disorder and the causes of the illness, exactly in the same way these are understood in some traditional cultures, where the invisible world is believed to intervene, for example through witchcraft, the genies, and the spirits of the ancestors. Each disorder is the target of the ontological theories of the person (the soul, the souls), from etiological theories and from therapeutic acts. The consultation of ethnopsychoanalysis accompanies the patient and their family members to promote these models [16]. This form of psychoanalysis enables a greater comprehension of the subjectivity, the individual constellation of the conflicts and their manifestation through the expression of the individual. Ethnopsychoanalysis also integrates the historical context of colonisation, decolonisation, migration, colonial and postcolonial wars, or other factors which drive the migrants to leave their country.

On the other hand, during the 1980s, Tobbie Nathan, a student of Devereux, invented and experimented in the Centre Hospitalier Universitaire de Bobigny (France), with a device for consultation intended for migrant patients. This group multi-ethnic device comprises a main therapist, several co-therapists from different origins, an interpreter, and the healthcare professional assisting the family. The migrant patient is received with his family; they can communicate in their native language and work with the logics of their culture of origin [17, 18]. The multicultural and multilingual group reflects alterity and mixing. If requested during the session by the main therapist, the co-therapists could report how similar situations are addressed in the culture of the patient perhaps quoting a proverb, a belief, a ritual, or a story. Implicitly, the group states: "we were able to heal him a little bit like in the country of origin"; "there's a number of us to work together around this difficult situation".

In numerous traditional cultures there is no therapeutic dual relationship, as it is considered fearful and dangerous, since the power of the therapist could be beneficial but also evil. The therapists then work around the patient, speaking more with the environment than with patient.

The agent of evil, illnesses, or disgrace, is often believed to be targeting the group, but only through the most vulnerable members, usually the children. If anyone suffers from some disorder, the entire group is concerned and involved collectively in the search for its meaning. The first sessions at the hospital aim to establish a therapeutic alliance, *giving the patient time to talk about his or her individual and collective history and experiences prior to, during, and after migration*, as well as talking about their place in the culture and relationship to traditional etiologies. This allows the patient to regain part of the cultural environment which he or she may have lost in the process of migration. The consultations are 1–2 h long and there is an interval of a few weeks between appointments.

During the 1990s, Marie Rose Moro *was oriented towards a theory of the culture, founded on the* "*mestizaje*". She sees migration not just as a trauma from which one never really recovers, but also as an opportunity since it increases the freedom of human beings. Marie Rose Moro conducted investigations about postpartum depression among migrant women, who often have to experience pregnancy in great isolation, as well as about the learning challenges faced by migrant children, confronted by their mother language at home and a foreign language at school [18–22].

Ethnopsychoanalysis can produce positive and lasting results. With the therapeutic multicultural group and the presence of an interpreter, it is possible to establish a therapeutic alliance with migrant patients facing difficulties. The reception of traditional etiologies allows us to address the meaning that families give to the disturbance, and in a second time address the family history, which is frequently traumatic and rarely talked among migrant families.

Proposal for Intervention on Mental Health for Indigenous Migrants

Villaseñor et al. have designed a manual to be able to work on the subject of mental health with indigenous migrants. This is a study of great anthropological depth, which examines the beliefs, responsibilities, roles, and knowledge of the physicians, psychiatrists, psychologists, and healers, as well as the worldview of the indigenous groups, an understanding of which is vital for determining which therapeutic approach is appropriate. The authors suggest the following basic elements of the proposal for intervention:

1. An intervention that integrates the three perspectives, the three spheres of the human being appointed, the spiritual, physiological, and that of the experience.
2. Take into account the culture of origin.
3. Respect the person and their beliefs.

4. Eliminate the social, cultural, and even theoretical prejudices.
5. Adapt the knowledge to the case in particular.
6. Consider that the person is part of a collectiveness and the possibility to integrate other people in the process of intervention, mainly their family members, understanding the illness is not an individual condition, on top of being centred on the needs of the patient.
7. The intervention must be short in the majority of the cases and centred on the reason for consultation. In this population, the interest and attachment of the patient gets easily lost if the intended intervention is from medium and long term to reach a profound level in the case or in other related experiences. This is due to the fact they are used to short and targeted interventions, just like traditional physicians would do.
8. Finally, understanding the process of adaptation and the cultural shock that implies their own process of migration in a context of domination and of hypermodernity ([23], p. 97).

A lot can be said about cultural therapy for those who migrate and leave their hometown, while very little attention is paid to those who stay. Both suffer. Over recent years in Venezuela, nearly three million people have migrated from the country. The great majority are middle class professionals and technicians, Catholics, and those belonging to traditional families and stable groups. There are thousands of homes that have been fractured and broken. Just like in the grieving of the survivor who loses someone close, the "presence sensation" (a sense that the person is near, although they are gone) is described among the mothers who have witnessed their children leaving, and we have described the "awkwardness sensation" as being located in the same biological and symbolic niche from which the "sensation of presence" comes from. This situation is often a heartbreaking process of grieving, of profound pain, sometimes with rage and indignation given the socio-economic situation in the country, which makes the chance of reunion difficult or impossible because the brutal poverty in the country makes it simply impossible to buy the flight ticket that would enable that hug so yearned for by both sides. Phones and other electronic devices may make this experience a little easier, but the situation—repeated the world over—nevertheless remains heartbreaking for the countless families torn apart by the circumstances of the modern world. For those who remain at home, the bedroom of the one gone who has left, still filled perhaps with clothes, toys, school notes and other objects which were once filled with tenderness, and now only promote great pain and suffering. The home is perceived as lonely and empty, and the preparation of meals that used to be a way of showing love and affection to the long gone family member becomes a task which is reminiscent only of the loss. Those who leave are often well aware of this, and also suffer. It is important that the psychotherapist understands that it is not only those who have left home who often suffer a great deal, but also those who stay. To understand this phenomenon, it is necessary to get close to the story and listen to the person telling about their suffering in the first person. We have suggested phenomenology and existential analysis as an appropriate route of scientific approach to the problem [24].

The experiences resulting from the use of a culturally sensitive approach in the promotion and recovery of mental health are varied and of remarkable wealth. Communication through online social networks, as well as more traditional ways of information outreach, has effects that the clinical community has paid little attention to thus far.

There's no question that those with a commercial interest insist in turning psychology into a consumable science, but neither can the great need for help be ignored; there is an enormous need for help, and large sectors of the population are looking for the secret to overcome their problems and existential ruptures. This also explains the proliferation of religious groups offering the possibility of miracles, healings, and the end of suffering. *The ill condition of civilisation and its discontent, already a great concern for the early fathers of psychotherapy such as Sigmund Freud and Erich Fromm, should perhaps be retaken by the psychiatry from the lessons from Honorio Delgado and Ángel Bustamante* [25, 26] *because they introduce in Latin America the need to think about the morbid phenomenon in its cultural context.*

Conclusions

The Latin American subcontinent is an extensive territory that begins in northern Mexico and ends in Patagonia. It houses a heterogeneous group of nations and ethnic groups; however, there are some common characteristics derived from the discovery, conquest, colonisation, and independence of each of their countries.

Native cultures of America, very rich and varied at the time of discovery, each with a worldview that permeated the economy, social life, hierarchies, and customs, ended up integrating Christianity and the values of the Spanish and Portuguese colonisers, in a new cultural, religious, and social syncretism that is what is described as Latin American miscegenation (Mestizaje). The product does not end in the great biological crossing, because it incorporates and develops a new culture.

A Latin American emigrant in Europe or the United States will carry many records of that great miscegenation, which has not stopped at any time, but is broadening and deepening with new contributions from other parts of the world.

Among its peculiarities, a psychotherapist should bear in mind the following common characteristics:

1. The majority of Latin American migrants are of Christian religion, which conditions a series of values related to family, social relationships, health, and illness.
2. The family is generally extended, is not confined to the nucleus of parents and children, and plays a very important role in decision-making, especially in the most critical moments of life, such as illness, death, and social adversities. Faith, hope, and religious belief are very important in the approach of misfortune, but also in the moments of important celebrations.
3. The worldview of the indigenous cultures of Latin America still survives in different ways and customs. It cannot be ignored by the psychotherapist because it permeates various activities that include illness and death.
4. The migrant Latin American family usually maintains solid ties with the family that stays in the country of origin. The suffering and adaptation of the migrant cannot be understood without asking about the relatives and friends who have stayed.

5. Latin American migrants will try to adapt to the receiving culture, and the process can be facilitated if some facilitating mechanisms of cultural integration are put in place.
6. The Latin American people have music, food, bonds of friendship, and social participation that can favour a successful integration in the host countries. All this can be used to encourage a process of reciprocal enrichment with the host cultures.

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The Challenges of Interpreting in Psychotherapy

22

Interpreters Stand Apart

Jan Cambridge, Swaran Singh, and Mark R. D. Johnson

Introduction

A crucial element in any intercultural activity, particularly when the use of language is a crucial element of diagnosis, treatment ("talking therapies") or ensuring concordance ("compliance") with a treatment regime, or indeed, "informed consent", is that the language used is understood equally on both sides of the dyadic transaction—or conversation. As this volume notes in its introduction, language while crucial to communication can also present a barrier: "Overcoming these barriers requires certain competencies such as working with a qualified interpreter". This chapter, drawing on the personal experience of an experienced interpreter and trainer of interpreters, and her doctoral research into the use of interpreters in psychiatric interviews [1] uses a number of vignettes or observations of the interpretation process, alongside reflection of the interpreter's experience, to suggest ways in which those working with interpreters may better understand the process, and the situation of the interpreter as a person as well as language-translation "machine". Frequently, the interpreter has only a linguistic knowledge of the languages used in a conversational transaction, and possibly some understanding of the technical issues involved in that discussion, but may be unfamiliar with any other aspect of the experiences of either of the two principal "actors" in that conversation or the

Note: A fuller version of the first author's experiences in Kosovo can be found at: http://publicserviceinterpreting.com/interpreter-training-in-kosovo/.

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technical languages they are using. In relation to mental health especially, the interpreter needs to be advised to attempt to convey the "style" or paralinguistics of the language used as well as the meaning, since often mental distress or some specific conditions may be indicated by particular formulations or departure from "standard" speech patterns.

As Jiminez-Ivars and Leon-Pinilla [2] state very clearly, refugees' experience of interpreting is often negative and frustrating, while many interpreters also express high levels of dissatisfaction with their working conditions. The whole world of "interpreting in refugee contexts" has been largely invisible to scholarship and research, and yet refugee well-being and integration (and particularly, their chances of obtaining reconised refugee "settled status") are jeopardised. However, such attention as there may be seems largely focused on the essential needs within the legal system (cf. [3]; a tendency reinforced by research following the Amsterdam Treaty such as the "Grotius network": https://eulita.eu/wp/grotius-i-project/) providing a right for legal processes to be conducted in a language understood by the plaintiff (i.e. defendant/refugee/asylum seeker, in this case), and providing interpreting training and standards to support that. There is no such EU-wide understanding in health.

While research in the discipline of translation studies has developed a considerable corpus of knowledge, it is only very recently that public service interpreting (PSI) has begun to emerge and develop as a discrete branch of the general discipline of interpreting within translation studies. There is now an emergent body of knowledge concerning public service interpreting and dedicated professional conferences and peer reviewed journals, including The Critical Link conferences, which began in Toronto in 1995 (http://criticallink.org/) [4] and the International Conference on Public Service Interpreting and Translation, Universidad de Alcala, Madrid, Spain (http://www2.uah.es/traduccion). Publications include the International Journal of Research and Practice in Interpreting (http://benjamins.com/#catalog/journals/intp) first published in 1996. Helpfully, interpreting and communications topics are increasingly being included in conferences held in other fields, for example, the European Association for Communication in Healthcare (EACH) (http://www.each.nl/) and the International Conference on Communication in Healthcare series of conferences; the first interdisciplinary conference on Applied Linguistics and Professional Practice in 2011 (http://www.cardiff.ac.uk/encap/newsandevents/events/conferences/alapp/index.html).

Academic and practitioner research has increased our understanding of the field and this body of knowledge continues to grow, but it is centred principally on legal interpreting and more particularly on court interpreting, in no small part because court proceedings are usually public occasions and there are fewer constraints on researchers' gaining access to recorded data than there are for studying police or medical interviews. The fundamental works in this field include those by Cecilia Wadensjö [5] concerning questioning techniques and cross-linguistic challenges in preserving meaning. This research relates to police work but has relevance to all public service situations, as does her work on interpreting as interaction [6] which takes a comprehensive look at all the elements involved in language switching

during authentic face-to-face interpreter-mediated interaction. She develops a framework for examining the structure of interaction across language and culture, and examines the interpreter's role in this.

Relatively little work in this area has looked at the importance and particularities of interpreting practice in healthcare settings. It is easy, but clinically unsafe, to assume greater language skills in those claiming fluency than actually exist. Documented examples of real harm being done have been published by medical practitioners [7–9], as well as others. This harm often occurs when family members and untrained personnel serve as interpreters and may conceal or fail to pass on vital information. For example, the CEMACH report, "Saving Mothers' Lives", identifies language difficulties as a factor in death from maternal causes, sometimes due to spousal abuse and non-reporting [10, 11].

Interpreters exercise their professional skills in other people's work domains. They are, by definition, members of a multidisciplinary team. They use their knowledge, skills and expertise as linguists within many other professionals' fields of knowledge, skills and expertise. For this reason any study of interpreting in the public services requires an interdisciplinary approach involving such disciplines as diagnostic psychiatry; linguistics; interpreting studies; bilingualism; professional ethics; health studies; and social care. For this reason, reflecting the power relationship, an ancient carving from Mohenjo-Daro in the Indus Valley, dated about 2000 BCE, shows the interpreter as a very small being, between two images clearly representing kings or rulers—not a person of power, but essential for the exercise of that power: (http://unprofessionaltranslation.blogspot.com/2017/01/correction-oldest-depiction-of.html)! In sociological terms, this is described as a "liminal" position—between, but not of, groups.

The following vignettes describe the initial impressions of a trainer (JC) of interpreters (health and social) when she was called to support a refugee situation during the collapse of the Former Republic of Yugoslavia, and again in Romania during a second refugee evacuation. These may give a flavour of the life of an interpreter, and the problems of training!

Case Study 1: Kosovo 2000

There was pestilence and internecine war in Priština in October and November of 2000. A WAC (*weapons authorisation certificate*) was only for KFOR (*the armed forces*), but on the streets men were carrying mother of pearl handguns in pigskin holsters strapped to their thigh. That show of bravado (could have) got them a 12-month imprisonment. I had never before been put in the position that I will describe.

Somebody in the city headquarters of the UNHCR (United Nations High Commission for Refugees) had telephoned the Institute of Translation and Interpreting in London. They wanted somebody who knew how to travel out and train the interpreters returning from the airlift. When I arrived(?), chaos reigned and we all got wet! Somebody said that the holes in the roads had been made by tanks

in the streets. It was very dangerous to cross the street; there were too many fox-holes. Anyhow, I got there. KFOR was run by the Swedish military, and it was the end of the tour for them. The handover was picked up by the King's and Cheshire Regiment (an English army group from near JC's home in Warrington)—how comforting is that?? The Grand Hotel was all massive marble columns and far too much gold paint, but with a leaking toilet I had to fix myself.

The headquarters for the OSCE (Organisation for Security and Co-operation in Europe) housed the The Rule of Law Department so I went to work in it. There were innumerable police officers patrolling the streets of the "Golden Triangle" where one may not stop. But these policemen and women, from all over the globe, were each possessed of specific knowledge and I was glad to be escorted. Interpreters are liminal people, apart but embedded; we are impartial aids to clarify complex discussions.

We had 90 h of training to get through, and oh how they struggled. I was struggling in a war zone, training people who rapidly needed to develop language relay skills to a high level and writing new laws at the same time. One of the number saw the Srebrenica massacre, and moved to Priština for safety. I visited and found a heavily guarded front door to the inside of the building. I had brought a gift of oranges which almost made my student cry.

There were many unsafe buildings with evident, vertical deep cracks running upwards to the roof. There were semi-automatic gun fights in the market place. A hand grenade was thrown through the open door to the flats opposite our hotel, and an angry mob outside the Town Hall saw a police officer being dragged from his car and bludgeoned to death. The next day in the street we saw a wedding party making so much noise on car horns that we were happily unable to shout.

Case Study 2: Timišoara May 2013

War never stops. Timišoara was the first Emergency Transit Camp (ETC) in 2008. The Kosovo experience was as real again as could possibly be.

The refugees arriving at the camp are classified as very vulnerable and come from some of the most dangerous places on earth: Uzbeks, Sudanese, Eritreans and Afghanis—a long list. These are known in UNHCR jargon as refoulement countries. Refoulement is a French word meaning "return", but it has been adopted to describe the practice of forcible return of asylum seekers either to their home country or to their country of first refuge, in the full knowledge that they will be tortured and/or murdered there. In order to preserve human life these deeply traumatised people are airlifted out, many arriving at the ETC unable to speak and with dreadful physical wounds. Whole villages, not just individuals, have been airlifted out and all of them receive comfortable accommodation, medical and psychiatric/psychological support and legal assistance. The aim is to be able to permanently resettle people in non-refoulement countries which have signed up to a resettlement scheme. Apart from the major powers in the English-speaking world, such as the USA, Canada, Australia, New Zealand and the UK, there is an ever growing list of Western

European countries joining the list, including France, Spain, the Netherlands, Belgium, Germany, the Nordic countries, among others. Many refugees are resettled in these countries. Some choose to settle in Romania. Some are resettled with new identities.

Timišoara offered a safe haven in the training room at the NGO Generatie Tanara (Young Generation—GTR), a special team working, among many worldwide leaders, to end human trafficking. It was clear from the opening talk of the president of GTR that local interpreters had particular difficulty in terms of the most appropriate mode of interpreting to use during interviews with severely traumatised people.

Both groups were guided through an in-depth look at essential theory, which dealt with what impartiality means in the interpreting setting. An explanation by the interpreter as to his or her role during an interpreted dialogue helps to establish rapport. They were advised on the importance of: not inserting additional, unprompted cultural information; the harm caused by not staying faithful to the message including strong and emotional language; and the risks of not relaying every single utterance by the other parties, which can all do further harm to an already vulnerable victim. In the situation described, in which we found ourselves, the importance of this can be imagined!

Discussion

Nomenclature is a widely contested issue in this academic and professional field. A necessary distinction has to be made between two types of language mediator: "interpreter" and "bilingual advocate". The function of the interpreter is to convey meaning from one language to the other, and facilitate mutual comprehension between the parties; the function of the bilingual advocate is to offer advice, information and support, to the patient as well as interpreting and educating health services about cultural norms. The two concepts of bilingual advocacy and interpreting have become entwined to the extent that in parts of Britain the term "advocacy" is a used as a hypernym, with the word "interpreting" as a hyponym of advocacy [12, 13]. El Ansari and colleagues limit the work of interpreters to acute situations and ascribe the linguistic model to their activities. Unfortunately no description of this model is available in the text, neither do the authors elaborate on what they mean by an acute situation. It might be, perhaps, that they are thinking of a child brought to the emergency department of a hospital and the most pressing immediate need is to establish what he (or she) had swallowed to make him so ill. It is clear however that the authors looked on interpreting as a function within bilingual advocacy:

> Service delivery models that balance 'interpreting' and 'advocacy' functions are able to respond to wide ranging and changing physical and mental health needs. On the one hand, the availability of professional interpretation (linguistic model) services is vital and particularly pertinent in acute conditions where timely decisions by care teams rely on an accurate understanding of an individual's symptoms ([13], p. 643).

In order to represent and explain the activity of interpreting for the public services, a number of performance models and names have been developed throughout

the world, but with relatively few areas of agreement. The principal performance models used in the UK are usually described as the impartial model, the community model and the advocacy model. The impartial model was developed over more than a decade of consultation with interpreters, service users and service providers, to enable public service providers and their clients to speak to one another directly and develop as nearly as possible a normal service provider–client relationship. It recognises the linguistic and cultural expertise of the interpreter and also the interpreter's lack of training or expertise as, for example, a doctor or lawyer. It states clearly that interpreters relay messages fully and faithfully in as closely as possible the style of the original, without addition, omission or distortion; they do not give personal advice or opinions; they will intervene only to prevent or repair misunderstandings or to point out missed cultural references which may lead to a misunderstanding.

For years it has been (JC's) practice to teach interpreting students about common ground; politeness, face and interlocutor roles; transaction versus interaction. The importance of register, and its accurate relay, may be even more significant in mental health care than anywhere else, given that the style and type of language chosen for emotional outbursts is a factor in assessing patients' condition. Propositional cursing can be a symptom:

> Emotional language and verbal aggression are oral behaviours symptomatic of obscene phone calls (OPC), conduct disorders, anti-social personalities, and schizophrenia. All of these disorders are characterised by abnormal verbal aggression and emotional language. […] Surprisingly, the role of cursing in these disorders has not been researched. The use of terms such as "emotional language" or "verbal aggression" in DSM IV needs to be operationalized and described, and the emotional and/or aggressive cursing lexicon that is considered symptomatic remains to be defined ([14], p. 71).

Cursing is deeply embedded in memory along with other automatic speech such as counting.

> Swearing is a significant issue in a mental health context. It plays a prominent role in various neuropathologies of language. For example, it is one of a small set of speech functions – automatic speech – selectively preserved in the severely aphasic patient (Van Lancker and Cummings 1999, cited in [15]).

Ideas about the linguistic pragmatics of cursing arose from discussions with students and colleagues over time and led to the development of a theory of the interpreter's location within the interpreting triad. These ideas about the pragmatics of strong emotional language and the interpreter's management of the message are briefly set out in The Translator [16]. I describe below a further development which occurred while working with students and finding that many of them were unwilling to relay strong emotional language in a form that reflected its original expression. A paradigm for relaying curses was included in training. The students needed a cognitive framework within which to understand how strong emotional language can be interpreted and which allowed them to fulfil their duty of fidelity to the message. We explored what cursing is, and they discovered how to avoid using blasphemy or expressions that were abhorrent to them while still properly conveying the

emotional weight of the locution. The paradigm was based on three pragmatic features of cursing: emotional weight, semantic equivalence and pragmatic function. Pragmatic function further divides into three groups: descriptors, exclamations and name calling. The "rudeness register" [17, 18] became my principal tool for overcoming students' reluctance to relay curses rather than "tidy them up" with an arch little description. "You bloody bastard!" is not equivalent to "give my regards to mademoiselle, your mother". To divert the emotional power behind the speaker's intention by referring to the listener's mother as unmarried, using a French word, is likely to damage the speaker's credibility. Real harm can be done by subverting a speaker's need to express strong emotion, especially if the chosen replacement phrase causes amusement.

It is obvious that the interpreter relaying messages between a doctor belonging to one set of professional, linguistic and cultural speech communities and a patient who belongs to a wholly other set of speech communities will need the knowledge and skill to access both. Limited knowledge of a language's idioms and social formulae can bring risk to communication. In the gynaecology clinic the question "Is your family complete?" is ambiguous in English, could be wrongly rendered into the other language and may elicit the "wrong" answer. It may be taken to mean "Do you have relatives who will support you and your baby?" It could also be taken to mean "have you finished wanting more babies?" Indeed, in the migrant/refugee situation, it also may mean "Have all your family escaped to be safe with you?" If the patient answers "yes" to the wrong understanding of the question she could find herself unable to conceive in the future. "Is your family complete?" "Yes" can lead to: No more babies, due to clinical sterilisation. "Do you have relatives who will support you and your baby?" "Yes" can lead to: More babies, which may have been unwanted. In the questioner's mind this question had a clear, single meaning. Did the interpreter notice the ambiguity in time to check it prior to relay? The difference is subtle and only applies in limited circumstances.

In some cases a doctor and patient may know one another quite well from previous encounters, while the interpreter is new to the triad. There are many possible changes in the group but there is not always shared knowledge, both communal and personal common ground. This explains what interpreters are doing when they introduce themselves to their two clients and start to try and create some rapport between them, as will be seen below.

Face, Politeness and Interlocutor Roles

Face is a key theoretical concept in this setting, by which we mean the interpreter's face-saving needs and the techniques they sometimes employ. This theoretical concept is supported by discussion, in monolingual settings, by many researchers especially Goffman. In his theory of footing Goffman [19] describes the interlocutors' constant negotiation of their footing within an interaction, in order to preserve face or status. In their seminal work on face and politeness, Brown and Levinson define face as the public self-image that everyone wants to preserve for themselves. The

term has two related aspects. One is negative face, which is the basic right to freedom of action and freedom from imposition. The second is positive face which essentially consists of self-esteem and receiving the positive regard of others. Again, in the situation of the migrant or refugee, this issue is easy to overlook, and yet dignity may be their only resource. Maintaining equity within an encounter is a matter of balancing the speaker's and hearer's face "wants", which demands that speech acts which threaten face be mitigated by some threat-reducing strategy. Negative politeness uses mitigation strategies such as indirectness, questions and hedges, impersonal and passive constructions. If face is damaged by a face threatening act (FTA) some redress must be found; though the extent to which this is true is influenced by power and distance, particularly relevant in clinical consultations. Essentially this is "respect behaviour [and] performs the function of minimizing the particular imposition that the FTA unavoidably effects" ([20], p. 134). Positive politeness offers redress in a wider sense by acknowledging others' wants, asserting reciprocity of wants and "gift-giving". Gifts of praise or help are often offered in conjunction with joking or familiar behaviour. Negative politeness is the more conventionally courteous of the two.

Politeness is described as being designed to protect one another's face, as a universal factor in human societies, but with differing manifestations from one culture to another [20]. In interpreting settings, Knapp and colleagues concern themselves with the idea *that* "*differences in ethnic conversational style which the participants are unaware of very frequently give rise to misunderstandings in intercultural communication*" [21]. Later, Berk-Seligson [22] looked at cross cultural communication in American federal, state and municipal courts, a situation which routinely challenges the face of people under cross examination, and shows how interpreting style can influence jurors' evaluations of a witness's intelligence, competence, convincingness and trustworthiness.

Face is closely bound to our identities, and sense of self. In her editorial, called "Identity, face and (im)politeness", Helen Spencer Oatey says that all self-aspects of identity either individual, relational or collective are both cognitive and social in nature. People have a fairly stable and lasting idea of who they are but they also construct and negotiate their identities during social contact and interaction

> people's concerns about face, (im)politeness, and the (mis)management of rapport are closely interconnected with the identities that people claim and/or (co-)construct in interaction ([23], p. 637).

H. H. Clark took the work of Goffman and further developed the concept of interlocutor roles in "using language" [24]. Taking Goffman's concept of the roles people occupy when speaking and listening, but using Clark's nomenclature, a speaker occupies three roles in almost overlapping succession. Firstly he or she acts as "principal", in which they have an idea they wish to convey and which they own as an expression of the whole self (personality, beliefs, preferences, prejudices, needs and wants). Secondly they act as "formulator", arranging a form of words that they believe will carry their idea into the mind of the listener, and be understood. Thirdly,

they must speak, in "vocaliser" role. Meanwhile the listener, if they are paying attention, will receive the stream of sound in "attender" role. If they are hearing a language they understand they will move into "identifier" role in which they identify units of meaning within the stream of sound. As the talk flows backwards and forwards each speaker has to wait only one turn in order to correct any misunderstandings. The third role the listener occupies is the role of "respondent". In this role the listener attributes overall meaning and intention to the speaker's words. The attribution of overall meaning and intention expresses the listener's personality, beliefs, preferences, prejudices, needs and wants. Interpreters are responsible for facilitating communication between people who cannot do more than "attend" to one another, without the help of an external attender/identifier and formulator/vocaliser. They are engaged in relaying messages for other people; they may not alter, distort or in any way damage the message during the relay. They may not "own" messages or responses. If they engage as full interlocutors, their "principal" and "attender" functions will be fully operational and their own personality, beliefs, preferences, prejudices, needs and wants will inevitably colour the message that is delivered. The interpreter therefore is acutely aware of her own identity or "personality functions", constantly alert in restricting herself to the attender/identifier and formulator/vocaliser roles. This is shown in Fig. 22.1, a transaction-map of a conversation, in which the doctor speaks first.

The dyadic event looks like a very complex route around the ideas being expressed. However, the two interlocutors (doctor and patient) may be simply exchanging pleasantries, or asking for advice or following a carefully crafted script. The interpreter has only been inserted into the dyad by the doctor and the patient for the purpose of resolving the conversation and plays no part in its construction or direction. So now we have a triad, in which the interpreter may not intervene as a true interlocutor. He or she must follow the rules and stay at the level of reformulator/vocaliser, leaving the doctor and patient to converse at the higher level.

A "normal" conversation without an interpreter would simply mean that the doctor principal wishes to ask a technical diagnostic question, which is formulated according to some scientifically established system (e.g. the "hospital anxiety" or "Euro-Quol" index) and vocalised. The patient as attender hears the question, interprets it for themselves and reflects on the question. After a period of thought, they then take the role of principal, formulate a response and vocalise it back. However, with the addition of the interpreter, an additional stage of hearing (A), interpreting (I) and reflection—or in this case, re-formulation into the second language—takes place, before it is then expressed back into voice towards the listening patient; and in reverse, that patient's response has to be processed into the language of the first speaker. What if there are no words for a particular concept, or the interpreter maps one word onto another which they believe has the equivalent meaning but is not the one used by scientists to describe a specific type of pain, anxiety or concern? So many words used in common speech embody poetic imagery or metaphor derived from culture—"feeling blue", "down in the mouth", "heart-ache".

Learning and applying theories

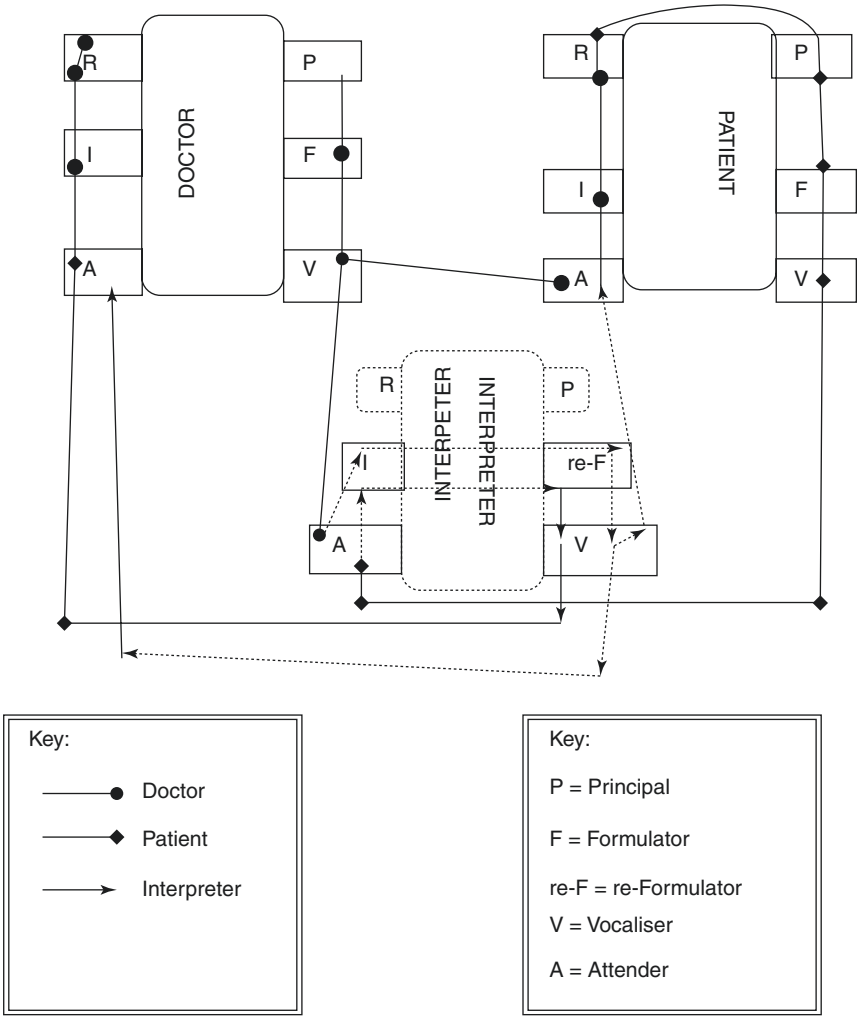

Fig. 22.1 Schema of triadic communicative event through an interpreter showing a single exchange. The doctor speaks first. Note - (A—"attender"—i.e. hearing/listening). Also, note that the patient may have some small knowledge of the language used by the doctor, so the speech line goes both from the doctor as vocaliser, to the listening interpreter AND the patient

The Role of the Interpreter in Refugee and Migration Situations

We were unable to locate a single study focused specifically on the use of interpreters in healthcare with refugee clients. And yet there are many issues which are particular to this setting. The first factor is the prevalence among refugees of exposure to extreme violence and deprivation and the subsequent development of severe

and persistent psychological trauma [25, 26]. The second factor is the experience of multiple losses—of social networks, personal possessions, valued social roles and environmental mastery—endemic among people forcibly displaced from their home community [27]. Thirdly, although we are perhaps unable to address this issue here, is the trauma or potential stress for the interpreter in relaying the stories of those who have been through those processes and seek asylum and support. Researchers, in the absence of a scientific consensus, have to investigate issues in the anecdotal reports of individual clinicians [28, 29].

It is likely that interpreters working with refugee clients will be involved with therapeutic processes that are emotionally very intense and that involve the challenging task of interpreting stories of trauma, separation and loss that are likely to echo similar experiences in their own lives. Given the high risk of secondary traumatisation, retraumatisation or indeed even primary traumatisation working in often violent settings, the need for professional support and supervision is obvious, regardless of whether interpreter, advocate or impartial model interpreter.

Doctors must have instruments that offer a systematic method of diagnosis on the basis of the language used to describe one's distress. There is widespread use of the Hospital Anxiety and Depression Scale (HADS) in Western Psychiatry, and there have been important advances in the diagnosis of depression over the last decade or so, but the universal validity of the HADS is not an uncontested matter. This instrument was developed in 1983 by Zigmond and Snaith [30] to assist in identifying cases of anxiety and depression among patients in non-psychiatric hospital clinics. In 1996 Hermann's systematic review concluded that the HADS was "*a reliable and valid instrument for assessing anxiety and depression*" (Hermann 1996, cited in [31], p. 70), but did not include the general population, though a number of subsequent studies have. Jadhav writes that the diagnosis of depression raises significant issues of cultural validity. The problems include differences between definitions of self across language and culture, as well as cultural variations in language use giving rise to difficulties in the practice of close interpretation [32]. In contrast, in a systematic review of the literature on the use of the Hospital Anxiety and Depression Scale (HADS) published in 2002 Bjelland and his team reviewed over 747 papers on the subject. They concluded that the HADS was found to be effective in assessing "*the symptom severity and caseness of anxiety disorders and depression in both somatic, psychiatric and primary care patients and in the general population*". This is useful and important but seems not to take into account the application of the scale across language and culture. Jadhav argues that psychiatry is not culture-free and it is not necessarily the case that patients of Indian origin can be well diagnosed using the HADS as it stands. He provides a scholarly description of the linguistic origins of ideas about mental illness from Latin and Sanskrit through Saxon, Middle English and other sources to the language of psychiatry and depression as it is used in the West today. He concludes that

> If depression can be taken as local experiences (of the population) that are clarified and validated on their own terms, then depression can be construed as a culturally valid concept for western settings [32].

But, most importantly, that

> […] depression to the culture-free psychiatrist in India is merely a consensus taxonomy amongst health professionals who share a common (Western medical) epistemology, and this is not the same as being culturally 'valid' among the general population. […] it is likely that some patterns of distress may not fit with western descriptions of psychopathology and disorders ([32], p. 281).

There is support for Jadhav's ideas with relation to health outcome measures, as Collins and Johnson reported in 2009.

> Little attention has been addressed to non-Western cultures or immigrants from non-Western or developing nations (and their descendants) that have resettled in Western societies, such as the United Kingdom. Concern has, however, been raised in the literature concerning the appropriateness and validity of self-report health outcome measures in non-Western cultures [33].

It is, they conclude, clear from the findings of their review that health outcome measures including the HADS will remain in use in Britain's ever-more culturally diverse population, although "*There is still no convincing evidence either way to support or discourage the use of such 'standardised' health outcome measures in Britain's BME population*" [33].

Language interpreting is the transfer of concepts, constructs, affect and need across the language and cultural divide in a bilingual medical setting. It is bounded not only by the need for interpreting but, as Jadhav suggests especially in psychiatry, by important differences in models of mental distress, which are not limited to any specific national or language group but where culture is fundamental to the definition of "normality" [34].

Conclusion

This chapter has described the model used in most interpreting work and its implications for good practice. It is set into the peculiar context of some work with refugees, and contrasted with the reality of work in some conflict and resettlement situations. It seems to us that we need consistency in training and an agreement across professions and indeed, environments, about the terminology used, and the understood role of interpreters—as well as training for those professionals who use them, so that they understand the "tools" or "machine" which they are employing in their work! The clinicians interviewed and observed during the doctoral thesis work on which some of the article is based, as well as those encountered in practice by JC, all laid emphasis either explicitly or by example on their need to access the intricacy and particularity of word choice and metaphor in their patients' speech. This aspect of interpreters' work is challenging and needs greater development and training programmes. The old axiom that "you can't know what you don't know until you need to know it" means that the under-trained can believe they know all there is to know. This suggests a need not only for basic training, but for continuing

professional development (CPD) diploma-level courses too. Both clinical (and legal) professionals need this as well as interpreters, but equally, linguists cannot complain that they are not at the negotiating table when interpreting in mental health is planned, unless they form interdisciplinary alliances to develop joint working. There is still some way to go in order to form the interdisciplinary alliances necessary to develop joint work in this field and support research into the practicalities and particularities of working in specific challenging situations such as that of a refugee "crisis".

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Psychotherapy in Japan

23

Kiyoshi Nishimura

Japan: The Historical Roots of a Multicultural Society

Japan has, in many ways, been a multicultural society from the outset. During the early modern period of Japanese history (hereafter referred to as the Edo period), the *han* or domain was a form of nation, of which there were more than 300. It is said that when one travelled two domains away, it was difficult to communicate and the customs were as different as if it were a foreign country. Even today, a Japanese person, especially an elderly one, is likely to ask a fellow Japanese, "What country are you from?" to inquire about their hometown. Thus, up to the Edo period, the domain was a person's nation; the concept of "Japan" or the "Japanese people" did not exist until around 160 years ago.

During the Edo period, a national isolation policy was started by the Samurai in power in the early seventeenth century, almost entirely isolating Japan from the rest of the world in order to prevent cultural erosion mainly by the Christian states. This continued for more than 200 years until Japan was forced to open several ports in 1854 under military threat from the USA. It was not until 1866 that the ban on overseas travel was lifted in Japan, and foreigners were granted residency only after 1899. This period saw a strict "status system" which laid down a social order still detectable in modern society. Approximately 5% of the people were Samurai, who ruled the society, and were permitted by law to kill any commoners who committed acts of insult against them. The tension created by this status system is unimaginable to the people of today's world. Japanese people of non-samurai ranks, who accounted for more than 90% of the entire Japanese population, were not allowed to have a surname for over 1800 years; only in 1875 were they finally allowed to do so, and only so that Japan could appear as a modern state to the international community.

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From the Meiji period, which marked the beginning of the late modern period, Japan went through modernisation, industrialisation, and a number of wars, leading to the democratisation that took place after World War II and the formation of modern-day Japan. The social chasm seen in Japanese society during the Edo period remains today, as the descendants of upper-class samurai from the Edo period continue to have important positions in Japanese politics; in some cases, a grandfather, father, and son have all served as prime minister. When Japan became a democratic state after World War II, there were many (non-elected?) second-generation members in the National Diet (Japanese parliament). This considerable gap in social fairness can be considered one of the reasons for the suppression which is strongly felt in every area of Japanese society compared to the other largest and most developed countries (Germany, Italy, France, the UK, the USA, and Canada). The social background of Japanese society also has a profound influence on the development of the practice of medicine, including psychiatry, as will be explored in the following section.

What Is Japan? Who Are the Japanese People?

In the Edo period, the *han* or domain was a form of nation. Even today, a Japanese person, especially an elderly one, is likely to ask a fellow Japanese, "What country are you from?" to inquire about their hometown. In other words, up to the Edo period, the domain in which one lived was his or her country, and the concept of "Japanese people" did not even exist. However, the new country's name "Japan" came into use approximately 160 years ago when the long isolation period had ended, and the people had to live as "Japanese" in the new era. In terms of medicine, this meant that Japan became even more inclined towards Western medicine as a whole rather than being limited to what came into Japan via the Netherlands, thus promoting the gradual departure from the Kampo school/style of medicine that people were accustomed to. From the Meiji period, which marked the beginning of the late modern period, Japan went through modernisation, industrialisation, and a number of wars, leading to the democratisation that took place after World War II and the formation of modern-day Japan. Over its history of 2000 years, both Japan as a nation and the Japanese people as a category *are a new form of self-definition*. Interestingly, during the 265 years of the Edo period before the Meiji period, when Japan was divided into nearly 300 countries, Japan could be seen as nothing less than "multicultural". It is said that when one travelled two domains away, it was difficult to communicate and the customs were as different as if it were a foreign country.

The Social Chasm Created by the Status System

During the Edo period there was a strict "status system". The population was approximately one-fourth of that of current Japan. Approximately 5% of the people

were Samurai, who ruled the society, while more than 80% of the entire population was engaged in farming and comprised the commoners along with those who lived in the cities and were involved in commerce and industry. Those who belonged to ranks below the commoners were treated cruelly by the entire society. Incidentally, after the Ryukyu Kingdom was brought to its demise in 1879, there was a similar status system in areas corresponding to the current Okinawa prefecture, but the lowest rank was of the "commoner". The right granted to samurai to kill commoners who committed acts of insult against samurai (authorisation to cut and leave) was clearly set forth in the code of law of the Edo period, which came into existence after the civil wars (the Sengoku period) that lasted for almost a hundred years before the Edo period. The tension that was created by the status system of the time is unimaginable to the people of today's world. Moreover, the Japanese people of non-samurai ranks, who accounted for more than 90% of the entire Japanese population, were not allowed to have a surname for over 1800 years; only in 1875 were they finally allowed to do so, and only so that Japan could appear as a modern state to the international community. The social chasm in Japanese society remains today, as the descendants of upper-class samurai from the Edo period continue to have important positions in Japanese politics; in some cases, a grandfather, father, and son have all served as prime minister. After World War II, while Japan became a democratic state, there were many second-generation (non-elected?) members in the National Diet (parliament). Such phenomena that are unimaginable in other developed countries take place in Japan, one of the seven largest advanced countries. For example, the reason suppression is strongly felt everywhere in the Japanese society compared to countries such as Germany is probably the considerable gap in social fairness. The social chasm created by the status system of the Edo period and the traces of this chasm remain to envelope all of Japan, making Japan stand out from the rest of the seven largest advanced countries (Germany, Italy, France, the UK, the USA, and Canada).

The Dawn of Psychiatry in Japan

During Japan's period of relative isolation, Japanese medicine was a mixture of Chinese-influenced Kampo medicine, Western medicine that entered Japan through the Netherlands, and magical healing systems rooted in the cultural traditions. In the early days of the Meiji period (1868–1912), when Japan opened its doors to the world, while English medicine (clinical medicine) also had an influence on Japan, German-style medicine (basic medical sciences) prevailed in Japan for political reasons. Fifty years ago, elderly doctors still filled out medical records in German. During this period, folk medicine that had been passed down for generations and magical healing systems that had played a role similar to that of current clinical psychology became localised, and there was a gradual departure from the Kampo school/style of medicine that people were accustomed to.

At this time, psychiatry in Japan also belonged to the German-style lineage. I use the word "belonged", since the two countries, which were allies and were defeated

in World War II, were influenced after the war by the psychiatry of the USA, the victor of the war. The first person to give a lecture on psychiatry at the medical school of a Japanese university was a German named Erwin Baelz. He was a physician and was invited to Japan as a professor to take the place of Agathon Wernichs, who was his predecessor in the Faculty of Medicine at the University of Tokyo as well as an ophthalmologist. He lived in Japan for nearly 30 years and taught almost a thousand medical students, valued not only as a university professor but also as an adviser on medical administration in Japan at the time. Hajime Sakaki was the first Japanese professor of psychiatry, who lectured on psychiatry in Japan in 1886. However, Professor Shuzo Kure, who succeeded Hajime Sakaki, made the most contribution in the early days of Japanese psychiatry. He studied in Vienna and Heidelberg, which served as hubs for psychiatry at the time, and at the University of Tübingen between 1897 and 1901. He spread German-style psychopathology based on the work of Kraepelin in Japan. Those in power in Japan at the time lacked the knowledge of "welfare" and "nursing", and even seemed to view them as disagreeable. Above all things, catching up with the advanced countries in the West was their top priority. This meant industrialisation, military expansion, and the development of social infrastructure at the state level. Against such a stark backdrop, the Law on the Supervision and Protection of the Mentally Ill was implemented in 1900. It mandated that those with mental illnesses were to be completely isolated from society by being placed in cages created within their homes and were to be placed under police supervision, as they were considered to be "disrupting order". This method, called "in-home confinement", was not a completely novel concept in 1900; it followed what had been practised nationwide since the Edo period. In an article published in 1918, Shuzo Kure wrote about the "double suffering" endured by the mentally ill patients of Japan, condemning this in-home confinement as "adding the misfortune of being born in this country to the misfortune suffered by over a hundred thousand people with mental illnesses in our country". The abolishment of this utterly inhumane law took 50 years from the time of its implementation.

Japan's Current Mental Healthcare System

Mental healthcare in Japan today takes place mostly in private psychiatric hospitals, of which there are over 1000. As of 2012 (OECD Health Data 2012), the number of beds in Japanese psychiatric wards is approximately 344,000, accounting for approximately one-fifth of the 1.85 million beds in psychiatric wards all over the world. In Japan, once a person has been placed in a psychiatric ward, he/she is hospitalised for an average of nearly 300 days. Recently, there was a case of a male patient with schizophrenia who was discharged from a large private psychiatric hospital in Osaka after 40 years of hospitalisation. A documentary on the life of this man reported that although he was stable, he had not been allowed to leave the private psychiatric hospital near the nuclear power plant in Fukushima after being forcibly hospitalised. He was able to return to society only after 40 years due to the emergency evacuation that took place because of the nuclear accident. He now lives

in a group home in Gunma Prefecture feeling accepted by the local community and is enjoying his lost "days of youth".

Psychiatry in Japan, especially "biological psychiatry", is among the best in the world. However, numerous issues of welfare and nursing, which are aspects of patient-oriented mental healthcare, remain to be resolved.

The Gap Between "Mental Therapy" Unique to Japan and "Psychotherapy"

Unlike in many other industrialised countries, until now, clinical psychology technicians have been granted the title of "clinical psychologist" by a private organisation rather than the government. However, a national examination for clinical psychologists will be administered starting 2018, and "certified psychologists" will be a qualification certified by the government. Psychiatrists offer "mental therapy", which is similar to psychotherapy in nature, but wan, doctors hold a very respectable social position in Japan clinical psychologists are only slowly becoming socially recognised and remain in a weak position as they are yet to find their social stand. During a lecture in forensic psychiatry at the University of Tübingen in 2016, I heard a female doctor saying "I became a psychiatrist, but to be honest, I did not quite understand emotional problems, so I studied psychology again and became a certified clinical psychologist". I was moved by her candid remark, as it contrasted with the situation in Japan, where clinical psychology is generally considered inferior to medicine and psychologists usually give way to psychiatrists rather than working within an equal relationship.

The Three Forms of Japanese-Style Psychotherapy

There are three forms of psychotherapy in Japan. The first is *Naikan* ("reflection") therapy, started by Ishin Yoshimoto, a Buddhist monk who removed religious elements from the self-reflection method passed down in the temples. In the 1950s, it also started to be used for medical purposes. *Naikan* is a concept that was known in the Zen tradition for over 300 years as a relaxation technique for the mind and body. The *Naikan* style of looking into oneself in silence is likened to the spiritual practice in a Japanese Zen temple that foreigners picture in their minds. It had no connection to contemporary schools of psychology which became popular in the West after the late modern period.

The second is *Seikatsu Rinsho* ("life clinic"), which was a therapeutic method started originally as a form of mental healthcare by the psychiatrist Yoichi Ekuma in the 1960s. It was a therapeutic method mainly focused on patients with schizophrenia. It aimed at leading the patients to recovery while having them continue their lives in the local community instead of isolating them. While Yoichi Ekuma passed away at a young age of 50 years, he started this as an associate professor at a local university hospital in Japan more than 10 years before the Italian psychiatrist Franco

Basaglia, who later became globally famous as a leading advocate of anti-institutionalisation, became active.

The third is the Morita therapy, started by Masatake Morita, a contemporary of Freud, as a therapeutic method for anxiety disorders. “Just the way one is” was the motto of the treatment, and complete recovery was sometimes likened to Buddhistic enlightenment. Masatake Morita, who was from a family of samurai-cum-farmers (country samurai), raised the issue of the “soul of the new Japanese people” being fiercely shaken in rapidly modernised Japan, where the feudal system was destroyed by Western values, and this was accepted mainly by the rich who were able to make sufficient investment for the treatment. Of these three psychotherapy modalities, Morita therapy academically meets the conditions of belonging to medicine and psychology and being unique to Japan.

Coverage by Health Insurance and the Health Insurance Score Psychotherapy in Japan

Psychotherapy is covered by insurance under the following three sets of circumstances. Under other circumstances, a person must pay out of his/her own pocket, and many people are unable to begin psychotherapy for financial reasons or unable to continue even if it has been started. Also, in many cases, experienced nurses perform the role played by clinical psychotherapists in other countries. Note that for the health insurance score, 1 insurance point is equivalent to 10 yen.

1. Cases where the doctor counsels a patient as a therapist of standard psychoanalysis

   While each session must last for 45 min or longer, the insurance score is set at 390 points, which is low compared to a session of cognitive behavioural therapy. Counselling sessions with only a clinical psychology technician are not covered by health insurance; such sessions are covered by insurance only if mental therapy is performed jointly by a psychiatrist and a clinical psychology technician. *This point is unclear—who qualifies for this therapy?*
2. Cases of cognitive behavioural therapy after being diagnosed with mood disorders such as depression by a doctor

   Sessions of cognitive behavioural therapy or psychoanalysis therapy with a doctor for depression, bipolar disorder, dysthymia, etc. are covered by health insurance. The doctors must provide a full explanation of the treatment plan to the patient in advance and the sessions must last for 30 min or longer. For this, the insurance score is 420 points. Conventionally, only counselling sessions for mood disorders were covered by health insurance and those for anxiety disorders such as panic disorder and obsessive–compulsive disorder were not covered. However, because of the revisions made to the payment system for medical services in 2016, sessions for anxiety disorders (including obsessive–compulsive disorder, social anxiety disorder, panic disorder, and post-traumatic stress disorder) are now also covered by insurance.

3. Cases of psychosomatic therapy after being diagnosed with a psychosomatic disorder by a doctor

   Psychosomatic therapy is intended to improve symptoms and promote recovery from injuries and diseases by identifying the relationship of psychological and social factors to physical injuries and diseases based on a certain treatment plan and exerting psychological influence on the patient. Each session lasts for 30 min or longer, and the insurance score is set very low compared to those in the previous sets of circumstances, with 150 points for hospitalised patients and 110 points for initial visits by non-hospitalised patients (and 80 points for follow-up visits). The cases of autogenic training, counselling, behaviour therapy, hypnotherapy, Morita therapy, biofeedback therapy, transactional analysis, Gestalt therapy, bioenergetic therapy, fasting therapy, general psychotherapy, and simple psychoanalytic therapy are included in this set.

Transcultural Psychiatry in Japan and Its Surroundings

The Japanese Society of Psychiatry and Neurology was founded in 1902 as a psycho-neurological society similar to the German Association for Psychiatry, Psychotherapy and Psychosomatics in Germany. However, because Japan is surrounded by the sea and historically had an extremely small influx of foreigners compared to other countries, interest in the transcultural issues was limited, unlike in the present. Nevertheless, the Japanese Society of Transcultural Psychiatry was founded in July 1993 to professionally explore, from a variety of aspects, the issue of adaptation faced by expatriate employees as well as their families, the issue of re-adaptation faced by returnee children, the issue of adaptation faced by foreign workers, the issues among brides from overseas, issues of conflicts between different nations and ethnic groups as well as refugee issues associated with them, and religious/ethnic issues. Its 24th annual academic conference was held in Tokyo in November 2017. A summary of the lecture given by its director Mr. Yu Abe (who is a psychiatrist and a professor in psychology at Meiji Gakuin University), which was recorded in the society's collection of abstracts, concisely describes the efforts undertaken by the Japanese Society of Transcultural Psychiatry. This is translated as follows:

> In a globalising society, the issue of how Syrian refugees should be accepted has been raised in Europe. In Japan, where doors are almost completely closed to immigrants and refugees, acceptance of foreigners as international students and technical interns is about to take place. However, there are already more than 2.38 million foreigners living in Japan. As yet//However, there is little discussion, in terms of state policies, on the issue of how we should live in harmony with these people. Today, foreigners in Japan who face difficulties include Latin-Americans of Japanese descent who were granted unrestricted entry into Japan because of the amendments made to the immigration law in 1990 and the spouses of international marriages, and for the last seven years or so, they also include technical interns who come to Japan from Asian countries and international students. In 2004, while the Ministry of Internal Affairs and Communications started to promote a multiculturally convivial society, little has been done in terms of policymaking and much has been delegated

to the local governments and accepting institutions. Under such circumstances, a multicultural clinic with a focus on treating foreigners was opened in Tokyo in 2006, which also includes psychiatric care. During the 10 years between the 1st of March 2006 and the 28th of February 2015, 1351 foreigners visited this clinic as new patients. The foreigners were from a variety of countries in Asia, Europe, South and North Americas, Africa, and Oceania. Here, I would like to focus on the 609 Latin-Americans of Japanese descent that visited the clinic as new patients, and their families. Currently, there are approximately 240,000 Latin-Americans of Japanese descent living and working in different parts of Japan. They have the following unique characteristics: (1) They have little contact with their grandparents and other relatives as they live in factory areas and not where their ancestors lived. (2) Many of them live in the Kanto and Chukyo areas, but they have only formed few communities of their own. (3) There is a gap between the image that they had of Japan and the reality. (4) There are many who have lived in Japan but are only able to speak conversational Japanese. (5) Second-generation and third-generation children who grew up in Japan tend to be unable to sufficiently learn Japanese or the language of their parents, as the first language of those children is different from their parents'. (6) They tend to settle down in Japan, although they have not decided whether they would live in Japan or their *home country* in the future. The Latin-Americans of Japanese descent who visited the clinic as new patients comprise 329 Peruvians and 242 Brazilians, while the number of those from other countries is small. This is because most people with Japanese ancestry living in Japan are Brazilians and Peruvians. Of the 609 patients, approximately 60% (371) of them were female and approximately 40% of them were male. The percentage of women in their 30s, 40s, and 50s was significantly high among these new patients. As for the diagnosis of the new patients, 35.3%, 16.4%, 15.8%, 9.6%, 8.5%, and 8.4% of them were diagnosed with depression, adjustment disorder, anxiety disorder, developmental disorder, bipolar disorder, and schizophrenia, respectively. The number of women patients diagnosed with depression and bipolar disorder was more than twice that of men. The number of female patients diagnosed with anxiety disorder and adjustment disorder was also more than 1.5 times that of men. The causes of onset include family relations, different cultures, workplaces, interpersonal problems, illness, and schools. As for the treatment outcome, 58% discontinued treatment, 19% continued to visit the clinic, and 10% completed treatment. There are many possible causes for the significantly higher incidence of mood disorders and neurosis in women. These include the fact that women tend to be more susceptible to stress, they do not have a sense of resistance toward visiting a psychiatric clinic and they can easily obtain information about healthcare. When we consider what we have seen so far from a transcultural psychiatric viewpoint, it becomes clear that the presence of the mother is key, and how mothers become independent in a multicultural convivial society will be the first problem that will arise. Families exist within the local communities and are connected to workplaces and schools. Mothers living in a multicultural convivial society are expected to be able to live side-by-side with the Japanese people and have at least the minimum communication skills and language that forms the basis of their relationship with the Japanese. In other words, I believe that providing support to families, particularly mothers, is most effective for the independence of foreigners in a multicultural convivial society.

Where Japan Stands in the World

As one of the achievements of genome analysis, it has become clear that the earliest ancestors of humans branched off from chimpanzees approximately 7 million years ago, and this marked the beginning of humanity. A few thousand people that existed approximately 200,000 years ago on the southern edge of the African continent are said to be the direct ancestors of modern humans. These people *are Homo sap*iens. Th*ese Homo sap*iens spread across the globe over more than 100,000 years, and

they eventually gave birth to great civilisations with their distinctive characteristics in different parts of the world a few thousand years ago. Today, Japan is a collection of islands on the farthest edge of the Eurasian Continent. Over the last 2000 years, Japan has not been exposed to serious external threats, and the different power holders during this period have endlessly repeated regime changes up to today under the rule of the same emperor. The first instance in which the Japanese felt a real threat from the rest of the world was when four vessels including two steam ships of the East India Squadron of the United States Navy arrived in Japan and pressed Japan to open its doors in 1853. A *Kyoka* (mad *tanka*) popular at the time that read, "Just four cups of *Jokisen* (a brand of green tea, which rhymes with steam ship) put an end to a peaceful sleep and keep you up all night" aptly expresses the people's sentiments. The population of Japan at that time was about one-fourth of what it is today, while the population of the USA was approximately half of the current one and the population of present-day China, which was then known as Qing, was nearly 30 times of that of the USA. Western European countries were pushing forward with the division of colonies all over the globe, and the timing the threat was posed to Japan coincides with the time during which they were growing in influence in Asia east to India. For the Japanese people, the abnormal circumstances under which Asian countries became colonised and the fact that even the greatest of them (present-day China) that had exercised hegemony in Asia for over 2000 years were half-colonised must have been a "national crisis since its foundation". The Japanese people of the time chose the path of leaving Asia and joining the West. In other words, this meant to become westernised in all areas. The Japanese people voraciously learned and absorbed the scientific knowledge of the West at a time when the country was in a state of panic. Meanwhile, one is given the impression that traditional wisdom was neglected. Today, a universal cosmopolitan medical system exists in the world as the quality is standardised for both psychiatry and psychology. However, in practice, how that standardised body of knowledge is used by different countries depends on the cultural norms of those countries. In terms of the mental healthcare system, the cultural norms that the countries originally possessed is not a medical system based on a Western form of written and systematised "knowledge", but rather something that existed in the Caucasian/Christian states in the ancient past and something that existed until recently in the societies of the remaining 70% of the people on earth, such as the magical healing systems. If we can verify this, it will lead to a deeper understanding of other cultures in the area of transcultural mental healthcare through a further understanding of our own culture. An atmosphere that encourages us to look at and understand each other will be naturally fostered, and we will be able to lay the foundation for harmonious coexistence on a global scale.

Exploring the Roots of the Psychiatric Treatment System in Japan

Here, I would like to introduce an article (Interface between Shamanism and Psychiatry in Miyako Islands, Okinawa, Japan: Viewpoint from Medical and Psychiatric Anthropology) by my mentor, Professor Akitomo Shimoji, to explore

the roots of the psychiatric treatment system in Japan. Professor Shimoji was born in the Miyako Island located at the southern end of what is now Okinawa Prefecture (former Ryukyu Kingdom) and stayed there until the age of 18 years. After World War II, when Okinawa Prefecture was still under the rule of the USA, he studied at the School of Medicine, Kumamoto University in Kumamoto Prefecture in Kyushu, Japan, and became a doctor. He then became a psychiatrist after working as a neurologist. Some of his relatives practised the magical healing system, which exists on the Miyako Island to this day, and so he grew up in close association with it. Later, he became one of the founding members of the Japanese Society of Transcultural Psychiatry.

Introduction

On Miyako Islands, the initiatory illness for seeing a shaman is called *Kandaari* [1] or *Kamburi*. *Kandaari* is a key popular concept of disorder on the islands. Major symptoms are audiovisual hallucinations and psychosomatic disturbances such as lack of appetite and body shaking, somnambulism, inability to perform daily work, etc. Miyako people refer to shamans as *kankakarya*, and *kaminohito* (person of god). Despite the condemnation as illegal since the end of World War II, practices by shamans are still flourishing there, because they are thoroughly embedded in the society of the island.

Therefore, psychiatrists working there need to be aware of the major role that shamans play in the health care delivery system. Since an indigenous belief system can frequently attribute mental illness to disturbances in the spiritual world, epidemiological studies are necessary to assess shamans' treatment of mentally ill persons on the islands. We are conducting a pilot study on this account, which will be reported later. With the analysis of our clinical data, it became evident that the patients who presented themselves at our hospital with the *kandaari* syndrome formed a heterogeneous rather than a single group. A large proportion of such cases is diagnosed as schizophrenia or atypical psychosis. Most Miyako people with mental illness used to consult shamans at some point during the course of their illness. Therefore, there is an urgent need to assess the positive and negative effects of shamanistic practices on Miyako Islands' entire health care system.

New therapeutic possibilities would reside in the midway rather than at either extreme. We suggest that any clinician working on Miyako Islands be a mediator between the two worlds, namely shamanistic and modern psychiatric.

Case Reports

The data presented here are taken from the author's 2-year experience as the director of the only psychiatric facility on Miyako Islands at Miyako Prefectural Hospital. The following case histories illustrate some of the commonly observed patterns of psychiatric disturbances observed in relation to *kandaari* attribution.

Case 1

Mr. M. is a 32-year-old single male who was admitted to the Psychiatric Ward of Miyako Prefectural Hospital with chronic psychosis, having failed to recover through the shamanistic treatment.

Although having been described by the environment as *kandaka* (spiritually high in rank), he had never shown gross behavioural abnormalities as a young person. However, he started to exhibit symptoms of schizophrenia at the age of 20. From the psychiatric viewpoint, these were hallucinations and delusions, but his words have gradually gained social acceptance.

His family considered his symptoms as divine messages and consulted a shaman. The shaman assigned certain meanings to his disorders. For instance, she identified his words as those of an ancestor who wanted him to do a pacifying ritual (*kuyo*) for the ancestor. As a consequence of this interpretation, she identified the sanctuaries (*utaki*) to which he should go. Then a shaman took him to a tour of major sanctuaries and sacred wells on the islands and on the mainland of Okinawa. His family was convinced that a miraculous cure should occur during this pilgrimage. His psychotic condition, however, became overt and were characterised by marked auditory hallucinations, bizarre behaviours, and insomnia.

After this, he was cared for by his family. A violence-proof room was prepared in his family's house and they confined him there. A shaman told them that the patient will be no problem within the next 10 years. After 10 years, however, the patient was not better at all. When he destroyed one of the walls of the room, his mother decided to hospitalise him.

On his admission he was catatonic in a statuesque position, with his legs contorted in an awkward position. Attempts to talk to him were of no avail. His face showed no emotional expression. He was indifferent to his environment, and his physical needs had to be taken care of entirely. His family agreed to his continuing hospitalisation, as they could not afford intense care. They were, however, reluctant to accept the psychiatrist's explanation that his condition was induced by a psychiatric disease. Even after this event, they occasionally asked shamans to "discover" the cause of his illness and to conduct nigadzu (purifying rituals).

Case 2

Mrs. K., a 35-year-old married woman with a clinical diagnosis (in psychiatric terms) of atypical psychosis in Mitsuda's sense, ascribed her condition to her non-observance of rituals. She was a *kandaka* woman who was of inborn spiritual high rank.

In our clinic, she was very reluctant to reveal any information related to her rituals because she was afraid that someone might misuse the information to place her under a curse. She attributed her sickness to a curse put on her by another person. She and her mother went to a shaman and asked her to identify the cause of her illness and to conduct purifying rituals. The shaman attributed her sickness to an

ancestor who was demanding a *kuyo* (pacifying ritual). Her family realised that her misfortune meant a message from their suffering ancestor and that she was responsible for appeasing the ancestral souls. One of the shamans assigned the date for the ritual. On the next day the ritual was conducted by the shaman, and a dramatic improvement was evident; hallucinations stopped and her affect became much more vivid. She stated that her recovery took place thanks to the shaman, and her family also emphasised the shaman's contribution to her recovery.

After a while, she made a revisit to our emergency service with her mother. We listened to her mother's narration concerning Mrs. K's *kandaari*. When a relapse occurred, the shaman called me and said that an improper ritual had aggravated Mrs. K's *kandaari*. The shaman told her family, "I would lose my senses if I did not help Mrs. K".

Case 3

Mr. H., a 35-year-old man, was escorted to the hospital in an agitated state. He had been well until 3 months prior to admission. He was a diligent sailor. The illness manifested itself gradually and he became agitated and confused. He stopped working, was restless and talkative, and quarrelled with his parents. He became violent and destructive, fought with his father who tried to interfere with him, shouting and cursing at everyone who approached him. He was eventually restrained by the police.

On admission he was very defensive and suspicious, irritable and restless, heard incessant auditory hallucinations, and showed insomnia. His parents were convinced that his symptoms were indicative of *kandaari*, and they expected him to become a shaman. They thought that he was destined to be a shaman as he was the *umarekawari* (a descendant into whom an ancestral soul transmigrates) of his deceased uncle. However, he tried to escape from this destiny by rejecting the *shirushi* (ancestral notification) and by asking *kami* (deity) to wait until he was 50 years old. So they believed that his desperate attempt to escape from his destiny resulted in aggravation of the *kandaari* phenomenon.

During his hospitalisation, his mother, who was a shaman, never came to see him. This was due to her belief that if shamans come into contact with those in a taboo state, they themselves become sick with mental or bodily disturbances. For them, death and childbirth mean taboo states called busozu. This was why she avoided the hospital.

Within several days, his symptoms subsided by treatment with haloperidol. On the seventh hospital day, he asked to be discharged. His father, however, contested his discharge for fear of an exacerbation of his symptoms. Thereupon, the author deliberately assumed the role of a shaman and reassured him, speaking softly, that Mr. H. might be in a state of *kandaari* and be *kandaka* umari. After this verbal exchange, Mr. H. became much calmer and his family agreed to his discharge. However, they objected against his hope of being discharged on the "religious day"

of jurokunichi, because they were convinced that *kandaari* will take place most likely in conjunction with an important "religious day". The author instructed him to go to the hospital at any time when the *shirushi* (notification) alerted him. Many community residents believe that *kandaari* is preceded by a series of *shirushi*. Here, the author conversed with the patient and his family with "vernacular words" (i.e., the terminology used by the people), that is, *shirushi*, *kandaari*, and so on, without resorting to medical and psychiatric jargon. Subsequently, the family agreed to his discharge on this religious day. He was discharged 3 days after the above negotiations.

Discussion

"Kandaari" Syndrome

In the therapeutic work on Miyako Islands, we have often encountered shamanistic thinking and the *kandaari* phenomenon, and so believe now that new therapeutic possibilities might emerge.

After the prospective shaman becomes a shaman, his or her psychosomatic disorders are given a different label (from disorders to divine powers). Miyako people generally believe that becoming a shaman for a prospective shaman with *kandaari* entails therapeutic effects.

From the psychiatric perspective, the *kandaari* syndrome is not a unitary one but is distributed among different psychiatric disorders. *Kandaari* is not simply a conversion disorder, but can be anything from a medical disease to a cultural-bound syndrome.

The cases presented here indicate the necessity of combining biomedical and anthropological assessments [2]. From the therapeutic perspective, we emphasise the need for an anthropological stance to be applied to psychiatry's own taxonomy and methods as well as the indigenous illness belief system of native residents.

The Newer Medical Anthropological Model

In describing "the newer medical anthropological model", Kleinman [2] noted that biological and cultural factors dialectically interact. He further states that "at times one may become a more powerful determinant of outcome, at other times the others, but most of the time it is the interaction between the two". We agree with him that ideally, clinical care should provide a kind of culturally sensitive mini-ethnography of a patient that encompasses the cultural and personal metaphors. How to achieve this in everyday clinical communications is an important issue. In other words, from the viewpoint of anthropology, "biology, history, and culture are deeply interwoven".

Kleinman [3] writes:

> There is a hierarchy of linked systems running from cultural symbols to social relations and on to self and bodily processes. That hierarchy is the biopsychocultural basis for healing: It underwrites the "upward" assimilation of personal experience into cultural meanings and the "downward" particularisation of those meanings into bodily processes via the cognition and affect of a particular person in a particular situation …. just as illness is projected at different levels of the biopsychocultural hierarchy [4], so too is healing a transformation of these recursive systems (p. 132).

Explanatory Models (Kleinman, A.) and Negotiation (Lazare, A.)

All of our cases can be looked upon from the different perspectives mentioned above. Recent anthropological literature [5–8] indicates the importance of recognising the patient's own view of the illness and its causes in attaining the correct diagnosis and effective intervention. Moreover, from the viewpoint of medical anthropology [8–10], the value of the distinction between the "disease" (the pathological process, which may be universal) and an episode of "illness" (the personal and cultural construction of disease) has been emphasised. According to Ohnuki-Tienary [11], nevertheless, our stance resembles Stein's ideas that "the concept of disease in biomedicine in itself reflects cultural bias" [12].

Kleinman has pointed out the usefulness to distinguish between "the explanatory models (EMs)" held by individual patients and practitioners. For example, a patient's EMs contain understanding of the cause of his illness, its pathophysiology, expected course and prognosis, and the treatment that he believes will be or should be administered. So Kleinman stated that EMs must be elicited by open-ended questions in a layman's term. As he says, "this anthropological sensibility should encourage a routine scanning of one's professional perspective in light of alternative perspectives—the patient's, the family's, other professional's, other cultures'".

Along with him, in our cases described above, patients, their families, shamans, and psychiatrists each held disparate EMs for the patient's illness. In this context, we conversed with our patients without resorting to medical jargon, using the "vernacular" terms that are part of indigenous daily discourse and the patient employs to articulate his or her illness problems. Differences or misleadings will take place in clefts from these different perspectives. Following Katon et al. [10] and Lazare et al. [13], we emphasise the importance of "elicitation" and "negotiation" or, as we prefer to call it, "transaction" of explanatory models.

"Climatic" Stance

The above cases are presented as an integration of the different perspectives of patients, families, shamans, and clinicians, and we describe the therapeutic interactions.

Our clinical experience indicates that new therapeutic possibilities reside in the midway rather than at either extreme, so therapists should mediate or negotiate between shamanistic and psychiatric perspectives. From the psychiatric

anthropological views, the third stance is existing neither "inside" (psychiatry) nor "outside" (shamanism) but rather in the "between". Put another way, therapists are in a position to serve as midwives at the birth of the change in the therapeutic process. From this stance, the patient's shamanistic thinking is to be accepted as it is. Our approach could not easily medicalise people's problems—not "medicalise", but instead "climatise" [14] (or "not pathologise" but "vernacularise" as we call it. This can be called a "climatic stance".

In dealing with their *kandaari* attributions, we carefully avoided confrontation of their belief systems. The shamanistic explanatory system should be utilised strategically or moderately, without entering it and reinforcing it. This stance is not a replacement for psychiatric therapy, but rather, an additional skill available to the psychiatrist for the treatment of appropriate patients and illnesses which needs deft handling.

At the moment of a therapeutic conversation, the inclusion of shamanistic thinking in the psychiatric setting may provide flexibility for us. A timely selective incorporation of shamanistic thinking may facilitate effective therapeutic action. To put this differently, although we may not approve of them, we may even encourage the shamanistic practices.

The basic requirement is that the therapist should have the ability to work with diverse "Weltanschauungen", for example, in Miyako society, at a balance between psychiatry and shamanism. To put it another way, it is important for a physician working in Miyako to be aware of the ethnocentricity of psychiatry. What is required is a pliable, strategic stance, which is able to function in diverse cultural and epistemological models (i.e., shamanism and psychiatry).

The patient may be encouraged to make use of remedial rituals prescribed by a shaman as a parallel to psychiatric therapy, without supplanting it, and some ritualistic activities may be incorporated into therapy at different levels through a multidimensional level [9] or "biopsychosocial hierarchy" [4]. This stance described above may help to develop more innovative and epistemological-culturally compatible psychotherapeutic models applicable to situations such as those involving *kandaari* attribution and the development of working relationships between modern medical and traditional healing systems. This approach conjointly copes with individual and social responses to illness, and offers ways of dealing with indigenous belief systems. The shamanistic frame of reference held within the Miyako community does not see illness as being individual, and the treatment orientation is in terms of a "victim" rather than a "patient". Miyako society employs a variety of rituals for dealing with misfortunes, in an environment where disease and illness are viewed as something fateful. An illness is therefore a public, familial, or multigenerational event rather than a private one, and can be managed through public, cooperative rituals.

Our therapeutic tactics are both paradoxical and ironic. We are deliberately using shamanistic thinking to counter shamanistic thinking. Depending on the circumstances it may be wise for the therapist to allow the patient to seek shamanistic help.

The therapist must be able to bridge the epistemological or cultural gap between himself and indigenous patients and their families. We use the indigenous and

vernacular language, convivially and empathically. For instance, within the therapeutic structure, *shirushi* is used to describe both the psychiatric terms and shamanistic terms, synonymously. At the critical moment, ascribing a painful suffering to *kandaari* avoids the risk of widespread disapprobation or stigmatisation.

What seems to happen in a "climatic" therapeutic work on Miyako Islands is a changeover from individual and psychiatric problems to a shamanistic cultural framework. It offers an effective alternative to biomedicine, since the two systems (the psychiatric system and the shamanistic system) are almost ideally complementary. Our "climatic" strategic approach can serve as a bridge between shamanistic epistemology and psychiatric epistemology.

Our Epistemological Stance

Within the therapeutic structure, these two epistemologies (psychiatry and shamanism) complement each other rather than being antagonists. These epistemologies would appear to be incommensurable. In terms of Russel's Theory of Logical Types in Mathematical Logic [15], these two statements at different levels are being made at the same time. The clinical realities have multiple aspects, for example, physical, chemical, physiological, psychological, anthropological, and environmental. Put it another way, the same clinical reality can be seen from differing aspects, in the words of Nakai [16], "universal syndrome", "personal syndrome", "culture-bound syndrome". In the cases, he pointed out that the connection between the syndromes is regarded as a recursive relationship rather than a hierarchically arranged continuum. To our clinical knowledge, it is crucial to shift the focus flexibly from one system level to another system level or scan the whole hierarchical levels or biocultural levels. Within the clinical framework, we need to recognise that the same things may be seen to have a meaning when viewed from one perspective but may have other meanings when seen from other perspectives. In the shamanistic "Klima", we need to recognise that sometimes "psychiatrisation" or "medicalisation" based on an "etic" perspective may be inappropriate and even detrimental.

For our stance, one must turn to the basic writings of M. Polanyi [17]:

> Mechanisms, whether man-made or morphological, are boundary conditions harnessing the laws of inanimate nature, being themselves irreducible to those laws. The pattern of organic bases in DNA which functions as a genetic code is a boundary condition irreducible to physics and chemistry. Further controlling principles of life may be represented as hierarchy of boundary conditions extending, in the case of man, to consciousness and responsibility (pp. 238–239).

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Psychotherapy for Indonesians

24

Dahlia and Marthoenis

Background

Indonesia is an archipelagic country in Southeast Asia that consists of thousands of islands. In 2018, the country had a population of more than 260 million, globally ranking the fourth largest country after China, India and the USA. Indonesia is also home to more than 300 different ethnic groups. Each ethnic group has a distinctive appearance, culture, beliefs and way of life. Some ethnic groups have more similarities with people from the neighbouring countries than their fellow Indonesians. The Papuan aborigines, for instance, have an appearance that is more similar to the Papua New Guinean aborigines than the Indonesians living in Borneo Island. The Acehnese have closer ancestral connections to the Malaysian Malay than the fellow Javanese Indonesians. Due to this diverse cultural background, providing psychotherapy for Indonesians is not an easy task. The only thing that Indonesians have in common is the fact that they speak Bahasa Indonesia, the national language of Indonesia. Indonesia is therefore a context in which no generalisations can be made, a deeply multicultural country in which cultural differences are highly relevant in many areas of life, including psychotherapy.

Historical notes confirm that Indonesia used to consist of small kingdoms across Nusantara, another term for the Indonesian archipelagos. Europeans arrived in Nusantara in the fifteenth century and colonisation started not long after their arrival. The Dutch colonised some of the kingdoms across Nusantara for approximately

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350 years. Later, Indonesia was occupied by Japan for 3.5 years during World War II. Indonesia declared its independence from foreign occupations in 1945.

Before the Indonesian independence, the Dutch colonial powers administered mental health treatment in psychiatric hospitals. The hospital not only treated people with mental disorders, but also functioned as a place of custody, both those who disturbed the social order, and did not comply to the colonial will [1] and those who were diagnosed as insane by a physician [2] were locked inside the asylum. After independence, Indonesia inherited four large psychiatric hospitals and some psychiatric clinics in the major cities that had been under Dutch Colonial rule. The psychiatric infrastructures built by the Dutch then remained in place and served basic mental healthcare, but the very limited budget allocated by the Indonesian government for mental healthcare meant that the facilities were inadequate [3].

During the colonial era, the Dutch implemented European methods of mental treatment in the Dutch East Indies, the Dutch name for Indonesia during colonialism. Although the Dutch Government established the first psychiatric hospital in 1882, the hospitalisation of people with mental disorders had happened earlier. Around the seventeenth century, the *Verenidge Oost-Indische Compagnie* (VOC, Dutch East Company) built a hospital outside Batavia (modern-day Jakarta) with treatment allocated only for Europeans. At that time, the prevailing medical theory assumed that being sick or healthy depends on the balance of humour in the body. The humid climate in Southeast Asia was believed to affect humour of the Europeans, and common therapies included cupping, bloodletting and trepanation [4].

Despite the fact that this psychiatric hospital was reserved for Europeans, large numbers of locals were also hospitalised for different reasons. Between 1638 and 1642, locals who were rebels or who did not comply with the Dutch will were punished inside the psychiatric hospital. They were subjected to violent treatment including whipping, being tied up and being forced to perform heavy tasks; these were the same punishments as those given to patients who showed mental and behaviour decline [4]. In 1635, driven by a sense of personal moral regret, the Board of Deacons established an accommodation for the locals, especially the orphans. This institution was the first in Indonesia to serve a non-European population. Later, a small number of people regarded as the "European insane" were also treated in the facility, while the "native insane" were imprisoned and chained [4].

The third institution for medical treatment in Indonesia was the Chinese hospital in Batavia, established in 1640. It was funded by wealthy members of the Chinese community, staffed by Chinese medical specialists, and served the Chinese community, including people with mental disorders. The hospital eventually served those locals who had significant contact with the colonial presence. At the end of the eighteenth century, the Chinese hospital bought a nearby building, which later turned into psychiatric wards. At the end of the nineteenth century, the local people from Batavia and outside the island was locked up in the Chinese hospital in Batavia [4]. The Dutch also built a large psychiatric hospital on the Island of Sabang, which now is part of Aceh province. The hospital mainly served psychiatric patients from Sumatra Island and once had more than 1200 patients. The hospital was later closed

and has since been replaced by a new psychiatric hospital in Band Aceh, the capital of Aceh province [1].

Despite such changing and challenging political situations, the effort to improve mental health services in post-colonial Indonesia began in 1966, when the ministry of health applied three principles as a key to mental healthcare systems: prevention, treatment and rehabilitation. During the 1970s and 1980s, the number of mental hospitals in Indonesia increased. New forms of mental health care were developed and research projects conducted. The period was considered as an achievement for Indonesian psychiatry because it was offered as a model for other Southeast Asian Nations. Unfortunately, during the 1990s, the Indonesian government decreased the budget for mental health services, leading to the deterioration of their quality [2].

The Condition of People with Mental Disorders in Indonesia

The current condition and treatment of people with mental disorders in Indonesia represents a significant neglect of human rights [5]. Large numbers of people with mental disorder are treated improperly, not given access to proper medication, unable to have a job or to earn an income; thousands of them are even locked away or chained up by the family or the community [6]. The local term "*pasung*", which is defined as physical restraint and confinement of people with a mental disorder in the community, is still very common in almost all provinces of Indonesian [7]. The government has raised concerns about the *pasung* problem, but efforts to release the patients from restraint are nevertheless still far off.

Improper treatment of people with a mental disorder has to do with the large treatment gap for mental disorders. The treatment gap for mental disorders in Indonesia is estimated to be more than 90%, meaning that the vast majority of people with a mental disorder do not obtain proper treatment. A large treatment gap is the consequence of a lack of awareness of, literacy about and stigma towards mental illness. The absence of health facilities or the long journey to such facilities to access treatment also contributes to this large treatment gap [1], a situation that requires further attention from the government and healthcare providers.

Large numbers of people with mental disorder cannot obtain proper treatment as primary health institutions give low priority to mental health treatment. The healthcare staffs working in these institutions have very limited expertise in detecting and providing appropriate treatment for patients with mental disorders. Furthermore, the quality of the services in the psychiatric hospitals is generally poor. Many psychiatric inpatients were under normal weight [8], indicating poor nutritional intake during hospitalisation. Custodial treatment is the only approach offered by the psychiatric hospitals. Involuntary treatment is common even though there is no legal basis for involuntary admission. Someone who shows strange behaviour can be taken to the hospital without his or her consent. Comparable to the situation in other developing countries, the standard of psychiatric care in Indonesia is generally poor and fails to protect the human rights of the patients [9].

Cultural Factors and Psychotherapy for Asian

Scientists and clinicians stressed the importance of cultural factors in the practice of psychotherapy in the early 1960s. Consequently, comparative research on the practices of indigenous healing, contemporary and formal psychotherapy were initiated. They investigated the culturally specific psychotherapies, the examination of intercultural psychotherapy and transcultural psychotherapy or counselling across cultures. Transcultural psychotherapy emphasises the importance of overcoming the cultural barriers that exist between the therapist and the patient. Intercultural psychotherapy identifies that the cultural background between the therapist and the client will interact through the therapeutic process, therefore emphasising the "intercultural", "interactional" process. These terms highlight important influences on cultural processes in the practice of psychotherapy [10].

Due to the importance of cultural factors in psychotherapy, the therapists should consider several principles of engagement while interacting with people of Asian ethnicity [11]. The principles include respecting the culture, exploring the experience of the distress, adapting the communication style that is acceptable to the individual preferences. Some Asian living abroad might not speak fluent English, having someone to accompany during the therapy session might also be helpful. Further, the therapist should also assess and address their limitation in understanding the mental health services system of such a country. Providing them with such information is expected to increase their adherence to the therapy. The therapist might invite the family or someone close to the client in discussing the treatment goals. Ensure that the goals are not only fit with the preference of the client, but also his or her family. The therapist should keep in mind that the connectedness between family members is high among Asian community and therefore the family should be involved in most process of psychotherapy. The therapist should therefore assess the literacy of the family member towards mental problem and psychotherapy. When necessary, the therapist should also educate the family [11]. The perceived stigma of having psychotherapy is also prevalent among Asian [12–14], thus assessing their perceived stigma is important. The therapist then has to discuss issues related to stigma and set the goal and methods to reduce the perceived stigma with the client. Lastly, Asia is a large continent with many countries that culture can be significantly different, such generalisation cannot be made when engaging with client of Asian background. As it has been stated above that even in a country such as Indonesia, the culture can be different. Respecting the individual cultural values should be, therefore, one of the focuses of the therapist while engaging with the client.

Psychotherapy in Indonesia

Previously, psychotherapy in Indonesia was considered unnecessary because it was not well understood by health practitioners. The Indonesian medication system was dominated by the materialistic-organic point of view that placed no attention on the

influence of mental treatment movement. Yet, in society, the mental treatment movement took their action that encouraged a very small group of psychiatrists to deal with unresolvable mental disorders. The treatment of neuroses was outside the scope of the medical profession, which encouraged medical schools to be more vigorous in initiating treatment for neurosis disorders. Despite the fact that cases of neurosis had been recorded long before World War II, it was not until later, amid rapid modern movement, the assimilation of new concepts of life and increased education in psychology, that neurosis gained more attention as a subject. As the result, the report on the prevalence of neurosis increased rapidly after Indonesian independence [15].

The Indonesian model of counselling and psychotherapy adopts concepts from the West. The school of psychology at the universities in Indonesia teaches Western methods and uses Western books. Among the common psychotherapy techniques applied by the Indonesian therapists include psychoanalytic and psychodynamic, humanistic, rational-emotive, gestalt, cognitive, behavioural and analytical psychotherapy. These philosophical orientations of therapy for mental disorders were also adapted from the West, such as the Indonesian Manual of Diagnostic and Classification of Mental Disorders (PPDGJ), which is based on the American Diagnostic and Statistical Manual of Mental Disorders (DSM) with some modifications. Nevertheless, Indonesian clinical psychologists or psychiatrists usually adopt the local wisdom in their practices, thus integrating local and Western practices. Nevertheless, this effort has been challenging due to a lack of research conducted in this area. Thus, the scientific evidence on the effectiveness of adopting the Western psychotherapy in Indonesia is therefore also scarce. Nevertheless, such paper stressing the importance of developing culturally relevant counselling to Indonesian is existing [16].

Customised Counselling in Indonesian Culture

Cultural influences on counselling and psychotherapy cannot be underestimated. Psychotherapeutic approaches such as psychoanalytic, behavioural therapy, gestalt therapy, person-centred therapy and transactional analysis are different from theoretical frameworks and paradigms. It is perilous to ignore the lack of a theoretical framework in relation to culture, so it is imperative that therapists look for accurate ways to properly test their diverse approaches and strategies [17]. In addition, the Western style of psychological service is difficult to be fully applied in developing countries due to cultural and other differences and the lack of professional human resources. If Western culture approach is applied in developing countries, it can disrupt important elements in the regions' native cultures. Therefore, psychological or therapeutic assistance must be suited to the culture and the local human resources. Through a cultural approach that sees the definition of disorder based on cultural perspectives and also with existing community assistance, a clear understanding of appropriate psychological interventions can be applied to people in need of psychological help [18].

Indonesian people have different cultural values than Western people. The application of Western psychotherapy, therefore, needs to be adjusted to Indonesian culture [16] or specifically to which community in Indonesia the client comes from. The ecological point of view stresses the importance of the modification and adaptation, as it aims to fit the interventions onto the local cultural perspectives [19]. In order to ensure that psychotherapy is culturally competent, there are three levels of cultural adjustment that must be done, which include technical adjustments, theoretical modifications and philosophical reorientations [20].

Appropriate technical adjustments are required in therapeutic relationships between therapist and patients, the field of communication, the therapeutic focus and the choices of therapeutic models. The goal is to provide clients with appropriate therapy from a wide variety of backgrounds. In the West, meeting a psychotherapist is considered a common way of dealing with problems in life. In contrast to some Asian cultures, which include the Indonesian, meeting a psychotherapist is undesirable because mental illness may be stigmatised [1, 20]. Apart from the low literacy rate on mental health, stigma is considered as the leading factor that hinders the prompt treatment of mental disorders among Indonesians [1]. Furthermore, the way Indonesians understand psychotherapy is also different from the Westerners. Unlike the Westerners who on average have a positive attitude towards psychotherapy and tend to consider it as a viable treatment for mental disorders [21], Indonesian people seem to be reluctant to share their problems with others and prefer to talk to their family, friends or trusted ones. In fact, an intervention study conducted among war-affected population in a province of Aceh, Indonesia, found no intervention effect of talk therapy in reducing the burden of depression and anxiety [22]. This might be due to the fact that the Acehnese feel less confident to share their problem in public as it was in the intervention, or perhaps the fact that Acehnese usually use talking and sharing their problem to their family and friend in private way, thus no different between intervention and control found in the study.

Family might provide additional support during a psychotherapy session, so it is therefore important for the therapist to determine both the client's and his/her family's knowledge about and orientation towards psychotherapy. Some customisations are required including providing knowledge about psychotherapy itself to the client and the family and applying more concise and practical approaches where possible. In the relationship between therapist and patient, Indonesians usually appreciate therapists' self-disclosure to the patients, seeing it as a mark of professionalism. Other cultural adjustments are needed in order to conduct psychotherapy sessions with Indonesian patients. This includes involving the client's interpersonal networks, applying a more direct therapeutic style, focussing on harmonious relationships and incorporating spiritual and religious approaches [16].

Theoretical modifications are commonly applied to the concepts of self, body and mind, interpersonal dependency, defence mechanisms, coping and personality development concepts. The Western theoretical concepts of psychotherapy need to be examined and evaluated upon its application to patients from different cultural backgrounds. For example, the psychoanalytic personality theory, which divides the self-structure into the id, ego and superego, can be blurred or even confused in

another culture [20]. In the context of Indonesian culture, they strongly emphasise social relations, while the interests of individuals receive less emphasis. The family, including the extended family, has an important place for the individual [16]. When someone suffers from health problem, other extended family members feel responsible for the individual, typically providing a wide range of support, from moral to financial. In terms of health seeking, most of the time it's not the patient who seeks help from the professional or traditional healer, but rather the family members who seek helps on his or her behalf. The concept of interpersonal dependency therefore differs strongly to the relative independence of the individual in the Western world.

In addition, the psychological development of the individuals differs between Eastern and Western cultures. In Western countries, growing up fast and becoming independent is generally considered important during adolescent. In contrast, children in Asian societies are often treated in such a way by their parents and extended families that they are not forced to move towards the next stage of individual development [20]. To give some examples from Indonesian culture, breastfeeding is extended until the babies reach 2 years old or older, children sleep in their parents' room until they start schooling, and parents feed them until they are capable of doing it without spilling food. However, when children enter school, they are expected to be more mature and disciplined. If the children have younger brothers and sisters, they are expected to take on the role of big brothers or sisters who take part in raising their younger siblings. In some Indonesian society, even after getting married, the new couple is expected to stay with the parent until they have two to three children, able to take care of them and can be financially independent from the parent. The way Indonesian societies accept and experience psychological development need to be considered and adjusted culturally while applying the Western developmental theories [16].

A considered philosophical orientation is also necessary for culturally competent psychotherapy. Lifestyle choice, soul and spirituality, and the meaning of maturity are concepts to be considered as part of philosophical reorientation [20]. The purpose and meaning of psychotherapy differ between cultures. While Western styles of therapy often have more focus on cognition, such as getting insight and awareness about childhood experiences, Eastern culture focuses more on experience and enlightenment through struggle and self-seeking, emphasising personal and subjective experiences as well as their role in and responsibility to the society. Therapy through prayer and fasting taught in Islam, for example, is believed to encourage positive feelings and values of tranquillity, happiness, joy, empathy, faith, connection, mindfulness, wisdom and trust [23]. Furthermore, how clients assess and interpret their lives also differs, one difference being acceptance versus conquering. Western culture generally considers that problem solving has many advantages and can develop a person's potential and help them attain achievement. In contrast, in Eastern cultures, individuals are expected to accept their limitations and live by the rules given by nature [20]. With regard to the cause of mental illness, many Indonesian Muslims believe that mental problems occur when someone has a high expectation towards something and has lower acceptance of the God-given gifts; thus, working with the concept of acceptance might help in reducing a client's mental health problem.

Islamic Based Psychotherapy in Indonesian

In Indonesia, over the last two decades, there has been an awareness of the importance of developing indigenous psychotherapy. Some academics have tried to dig up local values and develop culturally specific models of psychotherapy. One such example is Islamic psychotherapy, which has been developed based on Islamic values that are followed by the majority of Indonesians [16]. They use the term of Islamic psychology to distinguish between the Western model of psychology and the Islam-based psychology. Among the scholars and scientists who are trying to establish Islamic psychology in Indonesia are Djamaluddin Ancok, Fuad Nashori Suroso, Hanna Djumhana Bastaman and Subandi. They have introduced the concept of Islamic psychology in various forums and writings [24, 25]. Nevertheless, research to provide scientific evidence to support this new model is yet to be conducted. This new method therefore requires more research before it can be used on a wide scale in Indonesia.

Psychologist Hanna Djumhana Bastaman is one of the psychologists attempting to enrich Indonesian psychology by introducing the concept of Islamic psychology. He has a distinctive and special place in the world of modern thought, being among the very few scholars who were very serious about the relevance of psychology and Islam. He founded the concept of Islamic psychology, stating that Islamic psychology was born as part of the effort to include the Islamic values in the world of psychology and psychotherapy. His vision, the "Islamisation of psychology", is defined as an attempt to incorporate Islamic insights into the foundation of philosophy and psychology in Islamic world, especially in Indonesia. In other words, Islamic psychology is defined as a psychological style based on the human image according to Islamic teachings. In the concept of Islamic psychology, it studies the uniqueness and patterns of human behaviour as an expression of the experience of interaction between the self, the environment and spiritual nature, with the aim of improving mental health and religious quality. This view builds on the Islamic psychology methodology, embracing the Islamic view of the human, and has a goal of leading to a healthy mind [24].

Other psychologists, such as Djamaluddin Ancok and Fuad Nashori Suroso, have also discussed their concepts and views about Islamic psychology [24, 25]. They stressed that in Islam, there is no separation between science and religion. Religion and science instead should go hand in hand and are inseparable. Therefore, it is very unlikely for a religious Muslim to separate between a psychological approach (religion-free) rather than seeing science and religion as the way of life. The teachings of Islam and psychotherapy can be combined; indeed, there are even several verses in the Qur'an that show that religion itself contains aspects of therapy for mental disorders [26]. Nevertheless, all concepts of Islamic psychology discussed above are under development phase and have not been implemented by all therapists in Indonesia. Only some therapist who have good understanding on Islamic religious aspects, or when the client prefers to have more Islamic components of therapy, then this approach is usually applied. After all, evidence-based

research has been rarely conducted with regard to this issue; thus, the efficacy and effectiveness of the approach is largely questioned.

Nevertheless, for religious and practicing Muslims, religious aspects are important for their daily life [23]. Therefore, therapists should consider these aspects while conducting psychotherapy with Indonesian Muslims. The therapist might invite the client and the family into "religious conversations" such as by asking about daily prayer activity, difficulty with performing prayer or whether they could find a mosque or a place for performing daily or weekly prayer. Some empirical research has found that different forms of religious psychotherapy are effective for Muslim clients who suffer from anxiety, depression and bereavement [27]. After all, asking about religion and religious preference to Indonesian is not taboo as it is to Westerners, where assessing religious or spiritual functioning is largely neglected in clinical practices [28]. The Indonesians are usually very open with their religious preference and always happy to talk this issue with the therapist.

Psychotherapy and Pharmacotherapy: Treatment Preferences

Despite the effort in improving the quality of mental health services by providing both psycho- and pharmacotherapy to clients with mental problems, pharmacotherapy seems to dominate and be preferred by the many of Indonesian client and therapist. In Bahasa Indonesia, the Indonesian language, the word for "having a treatment or having a consultation with a doctor or other healers" is called "*berobat*", which literally means "to take a drug". With this concept of health seeking in the Indonesian consciousness, every meeting with a doctor should be followed by having drug to take home. A medical doctor who does not prescribe or give drugs to the patient might be seen as unprofessional or less intelligent. Many believe that only a chemical substance can help to relieve the problem, even for mental and psychological problems. Psychotherapy is seen as nothing but sharing the problem with someone else. Formal psychotherapy sessions are also not preferable for some Indonesians; instead, informal discussion and communication might help the client to be open about his or her problem. The therapist has to put more effort into explaining the advantages of having psychotherapy and how the client will be benefitted from it in the long term.

Conclusion

Psychotherapy is one of therapeutic efforts that aims to help people with mental and psychological problems. The concept and techniques of psychotherapy are mostly invented, developed and implemented in Western societies. The difference in the cultural concept and values between Western and Eastern might conflict the application of Western psychotherapy to people from the Eastern society such as Indonesian. The therapist should consider various aspects of the client, from their understanding

the concept of psychotherapy, help seeking preference, role of family, inspiration of the society, influence of religious background as well as perceived stigma towards having consultation with a therapist. Lastly, multiculturalism is unavoidable in psychotherapy. Therefore, it is important for therapists to pay more attention to the issues around culture and religion when providing psychotherapy to Indonesian clients.

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Psychosocial Interventions in Rehabilitation: An Intercultural Perspective

25

Reham Aly, Farooq Naeem, and Afzal Javed

Introduction

The first and the foremost aim of the psychosocial rehabilitation is to control active symptoms of psychiatric disorders. Yet, for the patient, symptoms of psychiatric disorders have meanings, and the mere process of recovery is sometimes accompanied by complex losses and powerful realisations [1]. Therefore, the ultimate aim of rehabilitation is restoring hope in people who suffered major setbacks in self-esteem because of their illness. This kind of hope comes with learning to accept the fact of one's illness and one's limitations and proceeding from there [2]. Psychiatric rehabilitation concentrates on the individual's rights as a respected partner and endorses his or her involvement and self-determination concerning all aspects of the treatment and rehabilitation process. These rehabilitation values were also incorporated in the concept of recovery [3]. Psychiatric rehabilitation involves a team approach. Today's mental health landscape includes psychiatric nurses, clinical social workers, marriage counsellors, family therapists, clinical pharmacists, in addition to psychologists and psychiatrists. This has inspired authors to refine psychosocial rehabilitation service as an exercise in network building and teamwork [4]. Psychosocial interventions play a vital role in psychiatric rehabilitation. Several psychological and behavioural interventions are mandated. These interventions

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should be empirically tested for application with several symptoms of psychiatric disorders [5]. In other words, psychotherapy has a central role in every step of the process of recovery and all components of psychosocial rehabilitation. This begins from the very first beginning of establishing a therapeutic alliance till reaching the ultimate aim of mental well-being [6].

Motivational enhancement techniques are employed to design the therapeutic goal and to facilitate engaging the patient in his program of rehabilitation. Involving the patients' family and techniques to improve family communication can also be used to help to engage the patient in the program [7]. Consequently, there is a need to match explanations of symptoms to each patient carefully and to ensure the individual's readiness to accept them. In that essence, the National Institute of Clinical Excellence guidelines for psychosocial rehabilitation prioritises the principle of meeting the patient with hope and optimism which counts very much in the recovery process [8]. The program of psychosocial rehabilitation always begins with psychoeducation. Interventions aiming to educate the patient and his family into the symptoms have proven to reduce the risk of relapse through awareness of early signs and enable both patient and prescriber to learn from the experience [9]. Similarly, psychological interventions aiming to enhance communication skills and social network have been reported to be associated with improved recovery from chronic diseases, higher life satisfaction, and enhanced ability to cope with life stressors [10]. Self-management strategies can also empower individuals to take control of their lives [11]. Interventions aiming at peer support and teamwork were found to be one of the most important factors facilitating recovery [12].

The interface of rehabilitation and psychological intervention is utilised during the acute and stabilising phases of a severe mental disorder. For example, the 'Community Re-Entry Module' is an educational and skill building program for patients with psychiatric disorders. It is useful for establishing continuity of psychosocial care from the inpatient till the outpatient phases. This program teaches patients in hospitals and day treatment programs illness management skills as well as how to re-engage in community life, deal with the stressors of life after discharge, and make connections with long-term, outpatient treatment [13].

Therefore, the interaction between psychotherapeutic techniques and psychosocial rehabilitation interventions begins early in the program. It starts with the very first steps of designing, refining, implementing, and auditing the psychosocial rehabilitation program. Whether motivational interviewing, communication skills training, social skills training, behavioural interventions, relaxation training, and/or the more sophisticated psychotherapeutic interventions of cognitive therapy, exposure therapy, and/or dynamic therapy, these are all crucial and fundamental into enabling a patient to attain the goals of any successful psychosocial rehabilitation program. Psychotherapeutic interventions in a rehabilitation program are inseparable. They are two sides of the same coin.

Psychosocial Rehabilitation and Culture

Culture is a confusing term to define. Essentially, the core of culture is the traditional ideas and their attached values. Culture is often considered a product of

current actions and a conditional element for future actions [14]. More recently, a comprehensive view has set culture as a set of basic assumptions, values, and orientations to life, beliefs, policies, procedures, and behavioural conventions. This character set is shared by a group of people, and further influences (but does not determine) each member's behaviour and his/her interpretations of the 'meaning' of other people's behaviour [15]. Hence, culture can be recognised as the collective programming of the mind which distinguishes the members of one group of people from another [16].

In mental health, culture manifests at different levels. The early experiences and cultural and religious values adopted in childhood shape an individual's belief systems and assumptions. How a person interprets psychological distress is based on his culture, education, social class, and religion. These interpretations stem from beliefs about illness and health, treatment options, and systems of care. Patient's belief systems determine their and their families' perspectives about psychological distress and psychiatric disorders. Patients' culture also guides pathways they take to find help, and directly affect their decisions to engage with the services. Therefore, one patient's cultural background can be a source of support or a cause of distress. Culture is present in the universal human nature and in every individual personality. It is the footprint of an individual group over and beyond another. Culture also influences the family values which has implications for early development, achievement in schools, and how individuals learn to view themselves in the context of the family and broader community. An individual's culture has an influence on early experiences, core beliefs, assumptions, and hence psychopathology.

The study of cultural values allows for an understanding of how peoples define themselves, and for a deeper understanding of the goals that motivate them. Every patient's values guide the selection or evaluation of events and behaviour [17].

Contemporary mental health practitioners recognise the importance of studying these cultural issues in psychotherapy. In-depth knowledge of cultural factors and adequate skills in dealing with them within the psychotherapeutic process are necessary for a successful treatment outcome [18]. Yet, conducting a culturally appropriate and relevant psychotherapy can be quite challenging.

Cultural diversity presents challenges that modern therapists must confront daily in clinical practice in our increasingly multiethnic and culturally metropolitan society. The influence of culture on the theory and practice of psychotherapy has attracted the attention of psychiatrists, medical anthropologists, and mental health workers since the middle of the last century [19].

Many differences occur between eastern and western societies with regard to the effect of cultures on mental health and psychiatric disorders. These differences revolve around the personal and professional relationships towards psychosocial services. Eastern societies are often regarded as collectivist societies. These communities are family and group oriented. Accordingly, they are privileged with their extended families. An extended family may be considered to be a social support network for patients suffering from psychiatric disorders. The social status in collectivist societies is determined by age and position, which usually affects the therapeutic approach in conducting psychotherapy sessions. Other characteristics of a collectivistic culture include an obligatory relationship with kin, marriage sometimes is partially arranged, decision-making usually consists of the whole family

members, and an external locus of control. In addition, the physician is generally in a more superior position, especially in a therapeutic relationship. Religion is a primary factor in collectivistic societies. Patients typically comply with God's will. These communities might take pride in the family care of mentally ill, and in their family ties [20]. All of these factors directly and profoundly affect the main aim and process of psychotherapy.

On the other hand, western cultures are individually oriented. They focus only on the nuclear family. In western cultures, relationships are a personal choice (of kin and marriage). They value autonomy and adopt an internal locus of control orientation. The therapeutic relationship is predominantly collaborative, patients are self-determined, and the care of the mentally ill is provided by the community [20].

The relationship of culture and psychotherapy has been extensively examined. Literature classifies it into two types: culture-embedded therapies and culture-influenced therapies. Culture-embedded therapies are recognised as the religious ceremonies or healing exercises related to supernatural or natural powers—folk psychotherapy. Culture-influenced therapies (e.g. mesmerism, rest therapy, and Morita and Naikan therapies) make use of the cultural fabric of any society, with its associated beliefs and aspirations and ways of seeing the world. Finally, culture-influenced therapies (e.g. Culture-embedded and culuture-influence; the second one include CBT, Family and group therapy) have been developed in specific cultures taking on the unique approaches inherent in them and therefore requiring adaptation if they are to be used in other settings [21].

Taking into consideration, all of the direct and indirect effects of culture on psychotherapy is mandated. Ideally, culturally responsive psychotherapy is en evidence-based psychotherapy that involves and incorporates cultural influences at all levels of the recovery process. These levels include how culture tinges every patient's personal history, the meaning of psychological stress, mobilising functional coping patterns, and other influences that definitely affect current psychopathology.

Culturally responsive psychotherapy also involves comprehending the cultural components of the patient's illness and help-seeking behaviours, in addition to the patient's expectations of the therapist. The process of psychotherapy also acknowledges culturally relevant ways to communicate towards a successful therapeutic relationship. In that essence, understanding personal and ethnic interactions between patient and his therapist is sometimes a challenge. A therapist must be able to determine the most culturally suitable goals, models, and techniques of therapy for a patient. This is only attained parallel to the patient needs [22]. There is no simple recipe for the therapist to follow in making these choices, but the principals involved apply to all patients, whether minority or majority, of whatever ethnic background.

In the doctor–patient relationship, personal assumptions directly affect the therapeutic alliance. If a patient assumes that the doctor is 'in charge', these assumptions are usually translated into values around leadership and decision-making attitudes. Such an approach may conflict with a balanced collaboration and a successful therapeutic relationship [23].

The process of psychotherapy and rehabilitation aims to fulfil the needs of the patient. Culturally adapting psychotherapy to meet the needs of ethnic minorities is

an essential new 'hot topic'. This requires special dedication and precise knowledge. Given that three-fourths of the world is collectivistic and possesses belief systems that are distinctly different than the Western world, improving the effectiveness of mental health services for people of non-European backgrounds is currently prioritised. If psychotherapy is a Western method of treating mental illness, then culturally adapting psychotherapy to meet the needs of ethnic minorities better is an important endeavour [24].

Psychosocial Rehabilitation: The Culturally Responsive Service

Barriers to Providing Culturally Sensitive Services

Several roadblocks hinder the provision of culturally sensitive psychosocial rehabilitation services. Appropriate designing of psychosocial rehabilitation service requires pinpointing the target group of potential clients. In ethnic minorities and immigrants, it is necessary to identify all relevant cultural factors in advance. This includes issues related to culture, religion, capacity, circumstances or characteristics of the health system, and philosophical orientation including knowledge and beliefs related to health, illness and its management [25].

For a therapist to be culturally competent, it is vital to understand their own cultural background. Identifying the pieces of one's own cultural context allows therapists to become more efficient when working with those who are culturally different in therapeutic relationships. Increasing therapists' self-awareness and knowledge of their own culture indirectly enhances their knowledge of their clients' culture and activates cultural empathy [26].

The awareness of patients' and carers' availability of resources is imperative. Resources may be human and/or financial resources. The awareness of the availability of trained therapists may be a first step towards approaching the service. Generally, patients' of ethnic minorities and immigrants may lack knowledge of the health system or of any available treatments and their likely outcomes. Awareness of availability was identified as an essential factor in service utilisation and engagement [25]. Plans for increasing awareness of mental health rehabilitation services among minority groups and cultural diversity are imperative.

Pathways to care and help-seeking behaviours are related to social systems, cultural and religious beliefs, and health systems. Cultural minority clients may face various barriers to accessing mental health care including their attributions of illness, limited language proficiency, remote geographic settings, stigma, fragmented services, cost, co-morbidity of mental illness and chronic diseases, cultural understanding of health-care services, and incarceration [27].

The literature identifies differences in help-seeking behaviours across the cultures. Patients from collectivistic cultures find religion a major source of relief for many, if not all, problems. This is particularly true for mental and psychological problems. A Minister, an Imam, a Rabaee or any other person considered to be a holy man might serve as the first line helper for these groups. Some surveys report

that 21% of respondents with a serious personal problem reported seeking help from a minister, while only 9.4% went to a psychiatrist and 8.7% went to another mental health provider [28].

Misperceptions and biases about psychological and mental health services that could be activated in the environments that clients live. This directly affects rates of service utilisation. Another obstacle to service utilisation can be an economic one. Members of minority cultures may be socio-economically disadvantaged and live in segregated housing and suffer high unemployment, reduced economic development, concentrated poverty, suboptimal education, and diminished access to health and mental health care [27].

Therapists are known to be uncomfortable dealing with religious issues and may avoid exploring them. A culturally competent therapist is encouraged not to dismiss or judge the alternate help-seeking behaviours. Any perception on the part of the client or their family that they are being judged is likely to lead to premature termination of therapy [22].

It is always useful to examine the initial impressions of patients from ethnic minority groups about the mental health service location and place. Steps can then be taken to make it welcoming. Hiring ethnically diverse staff especially in areas that have a large population of ethnic minorities was found helpful [29].

Other individual factors can interface with the therapy. Research from low and middle income countries suggest that young, educated men are more likely to engage in therapy. On the other hand women are dependent on men to be brought to the hospital [30]. It is also vital to consider barriers related to language and communication styles in psychosocial rehabilitation services. Proper translation of psychological concepts is very important to facilitate communication with culturally diverse groups [25].

Psychopathology has always stressed on examining and treating conceptions and beliefs related to the problem and to its treatment. Dysfunctional beliefs and cognitive errors vary from culture to culture [31].

The lack of adequate understanding of symptoms effects proper diagnosis. Inappropriate diagnoses mean reduced access to evidence-based therapies which in turn disengages and disadvantages clients. Mistrust of the health-care system is common in some minorities and is a reason they may not engage with services or terminate prematurely [32]. Interpersonal communication is directly affected by culture. What might be acceptable in one culture is a taboo in another. For instance, strict Arabic cultures would view a male therapist's touching a female patient as an inappropriate sexual overture [33]. African Americans are expected to look away while listening, which may be perceived as disinterest, others maintain a belief in the curative powers of touch ('royal touch') and may consider a therapeutic encounter incomplete without a 'laying on of hands' or physical contact between the patient and healer. Thus, a physical examination is preferable to a verbal diagnostic interview [34]. It is only natural that a mental health service provider is entirely aware of such differences when working with specific populations.

Successful application of rehabilitation services requires excellent comprehensive assessment of needs, and strengths. Efforts are directed to create opportunities

for further social integration and enhancement of patient's mental well-being. This is based on a proper functional assessment for the patient's current situation.

A baseline to measure change is useful to track progress in the program. Rating instruments can help in this process. Nowadays, instruments are validated for the use with many cultural backgrounds [35].

Psychotherapy programs differ in the technique and join in the aim. Some techniques are very structured, while others are less. Cognitive behaviour therapy has been described to be very structured. Yet, there has been a lot of speculation about why clients from non-majority cultures do not access the evidence-based CBT or whether they would respond favourably to them. Others re-attribute this to the fundamental principle of cognitive behaviour therapy, the collaborative empiricism. Collaborative empiricism supports teamwork and balanced contribution from both the therapist and client. This collaborative model is more difficult to accept in some cultures that are paternalistic and expect the clinician or therapist to be a figure of authority. Clients from some Eastern cultures may take a very passive stance that could be misunderstood by culturally uninformed therapists [22]. For patients from collectivistic cultures, a more directive counselling style might be preferable to a collaborative approach. The Asian model of spiritual healing is a saint or a guru who gives sermons, as opposed to teaching through a 'Socratic dialogue' that is preferred in individualistic cultures [36].

On the other hand, the didactic technique aiming at the exploration of opinions about problems might lead to doubts about the clinician's competencies. The therapist, therefore, needs to be creative to actively engage the client in participating in their own recovery and managing the transition from consultative to a collaborative approach. A therapist can continue to maintain a collaborative empirical approach by working with the client from where they are positioned. The transition from the consultative to collaborative empiricism is crucial in adapting cognitive behaviour therapy to culturally diverse groups [22].

A psychosocial rehabilitation program for culturally diverse groups should benefit from functional cultural coping mechanisms. Studies conducted in the UK on minority groups concluded that they tend to use religion as a means of coping with their psychological distress [37]. Asian Americans who initially sought help from church were found to be more likely to seek mental health treatment as well. Spirituality-focused groups have also been found to be a good antidote to the lack of hope and demoralisation that is so often associated with being seriously mentally ill [38].

Targeted efforts based on the understanding of the factors that promote and hinder mental health service use in ethnic minority groups are needed to bridge the gaps between mental health needs and available effective treatments to promote better service acceptance [39].

Opportunities and Solutions

Cultural adaptation of psychosocial interventions is an emerging field and offers numerous opportunities in developing, refining, and testing interventions. In almost

all psychotherapy trials, minority groups or groups outside the developed world are under-represented. Generalisation of findings to other ethnicities and cultural groups may not be valid or appropriate. Unfortunately, the subject of culture and ethnicity in these trials was not always discussed objectively and scientifically, as it can evoke deep feelings resulting in polarisation. Generally, discussions of culture focus on non-dominant groups—'otherness'—emphasising their deficits rather than their adaptive strengths and how they are different from the dominant societal definitions of 'normality' [40].

Under-representation of all minorities in research samples is a significant concern that prompted the National Institutes of Health (NIH) to issue a policy in 1994 mandating that ethnic minorities be included in all NIH-funded research. This policy was updated in 2001 [8]. For example, in the few clinical trials where the focus has been on minority groups, the therapeutic alliance has been shown to be very important for better client outcomes. The therapeutic alliance accounted for 45% of the variance in psychotherapy outcome in one study of Hispanics from Puerto Rico [41].

Cultural adaptation of psychotherapy is one main pillar of a culturally responsive psychosocial rehabilitation program. Several frameworks for the adaptation process were suggested, but none was empirically tested. The recent years have shown a surge in that field. The evidence-based cognitive behaviour therapy was usually the subject for adaptation based on its proven efficacy.

The only evidence-based framework to culturally adapt cognitive behaviour therapy was developed using mixed methods research. This model has been used to adapt CBT in Pakistan, England, China, Middle East, and Morocco [25]. The process of adaptation of therapy started with gathering information from the different stakeholders, using a qualitative methodology. Information thus gathered was then analysed to develop guidelines for culturally adapting CBT. Therapy material was then translated and included in a manual and field tested again to allow further adjustments and refinements. The steps of this process are illustrated in Fig. 25.1.

Stage of cultural adaptation was initiated by reviewing of previous literature and discussions with field experts. This was aiming at gathering information, through

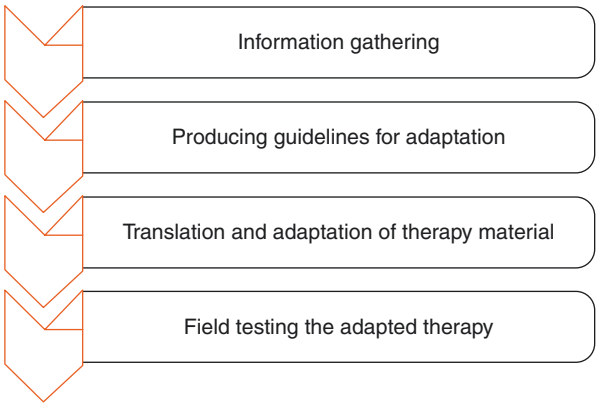

Fig. 25.1 Evidence-based Framework to Cultural Adaption of CBT [25]

the use of qualitative methods, from patients and caretakers/laypersons, therapists/mental health practitioners, and service managers. Practitioners' experiences and views about a particular problem were all reviewed and analysed. The second stage included guidance and specific norms to adapt the therapy manual. This was followed by translating and adapting the therapy material into a manual. The last and most crucial stage was field testing the adapted manual and further refinement of the guidelines [25].

In the process of modifying a given therapy to adapt it to a different culture, it is not only the adaptation per se that is essential. Other factors must be reviewed to ensure that the therapy is fully adapted; these factors include access to therapy, its delivery and, most importantly, its availability.

Evidence indicates that cultural adaptation of CBT should focus on the following levels: philosophical orientation, practical considerations of societal and health system-related factors, technical adjustments of methods and skills, and theoretical or conceptual changes (Fig. 25.2).

Useful adaption of therapy in a given culture should ensure the cultural competence of the manual. The study proposes the 'Triple-A Principle' (Ref) as a mean to summarise areas of cultural competence targeted in the process of adaptation. These areas are awareness, assessment, and adjusting. The first field of awareness indicates identification of relevant cultural issues and preparation for therapy. Awareness of relevant cultural issues, in turn, involves (a) Issues related to culture and religion, (b) Consideration of the capacity and additional circumstances or characteristics of the health system, and (c) Philosophical orientation including knowledge and beliefs related to health, illness and its management. This is followed by an area for assessment and engagement of patients in the therapy process. Finally, adjustments to therapy techniques in concordence to the culture may be indicated. However, any

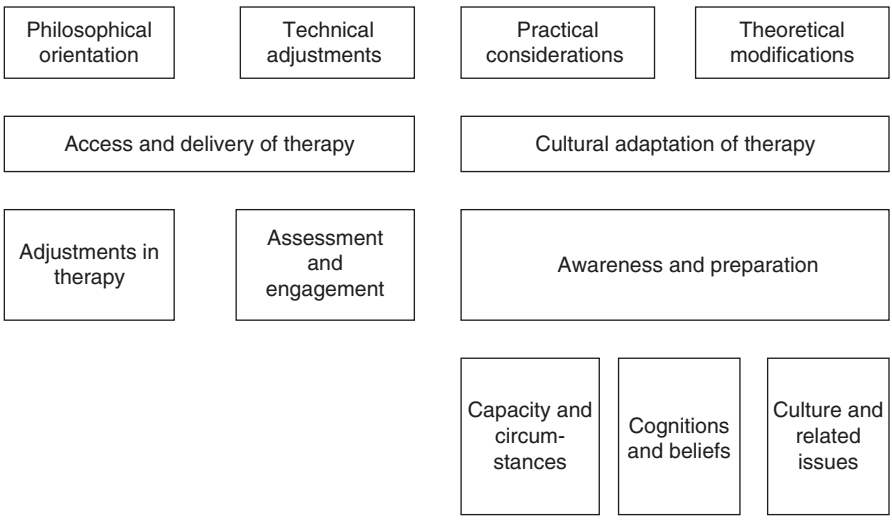

Fig. 25.2 Levels of Cultural Adaptation of CBT [25]

other wider political issues might also be considered if relevant to the process of cultural adaption [25].

Education and Training in Psychosocial Rehabilitation

The framework mentioned above provides an evidence-based methodology to adapt manuals and techniques of psychotherapy culturally. Still, practitioners in the field of psychosocial rehabilitation are in dire need of training and education through the whole process. A more comprehensive methodology of education and training is urgently required to empower the mental health practitioners with the knowledge and skills needed for efficient service delivery. The increasing awareness of cultural diversity and its relevance to mental health psychopathology and psychotherapy is a must.

This cultural knowledge need should cover primary areas and then explicitly be developed to fit each individual patient [18]. Some even might suggest that to be an ethical practitioner or educator one must be culturally competent and that these constructs cannot be separated [42].

In that same sense, accredited education and training programs for rehabilitation counsellors are indicated to address issues of social and cultural diversity. Moreover, rehabilitation counsellor educators are directed to help trainees 'develop and maintain beliefs, attitudes, knowledge, and skills necessary for competent practice with people across cultures' [30]. It is now well noted that the ethical responsibility of educators in the field of psychosocial rehabilitation points them to address cultural considerations. Educational courses and professional development workshops and training and supervision practices, all include relevant knowledge of cultural diversity and competence. The code of professional ethics for rehabilitation counsellors mandates that basic level education about ethics respect how issues of culture affect the development and implementation of rehabilitation and treatment [30].

A psychiatrist in the psychosocial rehabilitation field is expected to be skilled at applying this knowledge to clinical assessment and the choice of psychotherapeutic technique. Yet, a culturally competent therapist requires additional skills. The therapist must be able to put the patient's situation in their own cultural context. Any and every psychotherapeutic intervention must be chosen by these identified cultural considerations, not just on a narrow view of the patient's psychopathology [18].

Other areas necessary to enhance the cultural competence of the therapist can be acquired, through awareness and exposure to different cultures. Though identifying therapist's own personal variables that are salient and noting any personal experiences with discrimination, incredible changes in cultural competence can be achieved [31].

The psychosocial rehabilitation daily work of continual confrontation of illness, sadness, suffering, fear, and pain makes staff insensitive towards patients. Occasionally, practitioners may find it particularly challenging to handle these difficulties with sensitivity. This can adversely affect the rehabilitation process and contribute to poor outcome. Studies have pointed out that this might lead to

treatment dropouts, lack of meaningful therapeutic relationships and acting-out behaviour as well as rapid turnover of staff. Often, new practitioners have to be trained again [32]. Eventually, psychosocial rehabilitation staff is woefully overburdened. Nevertheless, in most countries, the ratio of staff to patients is rarely in accordance with law and requirement [43]. These facts only highlight the importance of a standardised education and training program to be readily available to empower new practitioners with required skills.

Role of Family in Psychosocial Rehabilitation

In designing and implementing cultural responsive psychosocial rehabilitation service, the knowledge of the family system is often particularly valuable. Although the importance of family is universal, there are wide cultural variations. Different cultures demonstrate obvious differences, for example, roles of men versus women, freedom to develop relationships outside the family, child-rearing practices, and so forth [44].

Research examining the causes of underutilisation of mental health service among patients of ethnic minority groups found that Asian Americans have a very low rate of utilisation of mental health services. Studies have also identified some factors that account for this reduced utilisation [33]. For instance, Asian American's family cultural conflict, but not family cohesion, was associated with service use [34]. Nonetheless, many cultural minority patients trust and rely only on family members, elders in the community, or priests' more than traditional services and health-care professionals. Therefore, the help-seeking pathways they take reflect the relative lack of trust in health-care systems [35]. Thus, patients are more likely to seek help from faith or spiritual healers (for example, the imam, a person who performs religious duties in a mosque, or pirs, practitioners of Sufism), traditional or non-traditional healing systems [45].

The extended family plays a variety of roles such as mediators in problems, providing temporary shelter in times of hardship and emotional support. In some cultures, ministers have also been key players in providing mental health care [46]. Pakistani patients, for instance, often live within an extended or joint family. In such cases, involving family can be helpful. Family can improve patients' engagement into therapy, ensure the completion of psychotherapy assignments, and can even improve follow-up. It is also important to note that female patients might have to gain permission from the man in the house to seek help. When working with female patients, it would therefore help to involve the accompanying man during the rehabilitation process. Thereafter, a therapist can provide psychoeducation to the accompanying person and emphasis on how the mental health of the woman can have a positive effect on the health of the family, especially any children involved [25].

Since 1960s, the locus of care of severely mentally ill has moved to community settings through the establishment of community mental health centres. With the current emphasis on recovery and community integration, care is moving into integrated systems such as medical homes or to the natural setting of clients' homes

[47]. The body of evidence has also directed the mental health care locus from the clinic to a community model of treating. It was proven that treating individuals in their natural settings is more productive. Thus, psychosocial rehabilitation services might actually benefit from involving both individuals and their family members in the process of recovery. Occasionally, a therapist may choose to conduct sessions in client's homes in order to facilitate engagement and reduce barriers to accessing care [22].

Indeed, the family can be a cause of conflict and stress but also can be a valuable resource to help and support patients. Tactfully involving the family, with consideration of boundaries, can enhance engagement. The family can especially assist in information gathering, therapy (by being a 'co-therapist'), support the patients, and bring the patients back for a follow-up. All of which can only emphasise the importance of the family role in the rehabilitation process in all cultures [10].

Support groups were also found useful in some cases. Participation in a support group meeting positively affects adaptation to mental illness. A patient and/or the responsible family member may participate in these groups. Family members who attended support group meetings regularly for a minimum period of 6 months can get more information about the illness and thus develop skills to cope with problems at home and to deal with the patient [48].

Psychosocial Rehabilitation for Immigrant and Refugees

By the end of 2009 there were some 42.3 million people displaced globally as a result of conflict, violence, and human rights violations. Of these, 27.1 million were internally displaced persons, while 15.2 million were refugees outside their country of nationality or country of habitual residence. Unfortunately, refugees were often displaced in protracted situations in the host country. It is generally recognised that there are humanitarian, political, security, and development challenges during times of displacement. These challenges might continue in the period after durable solutions have been identified, either in the home country, a neighbouring state, or elsewhere [49]. The refugee presence in hosting countries has potential social impacts on the ethnic balance of hosting areas, social conflict, and delivery of social services. The sociocultural impact of refugees on the host community may occur simply because of their presence.

The provision of psychosocial rehabilitation services may differ between locals and immigrants. The study of the probability of receiving rehabilitation, residential or inpatient care, the intensity of outpatient treatments, and the duration of hospitalisations and residential care for immigrant patients found out that the number of interventions and the length of admissions are significantly lower for immigrants. It is thus advised to integrate these data from mental health information system with qualitative data on unmet needs from the immigrants' perspective to inform mental health care decision-makers to apply necessary measures to balance these population needs with service provision [50].

Research has also found a direct relationship between perceived discrimination and psychological distress [51, 52]. Discrimination also influences service utilisation. When participants encountered discrimination from medical practitioners, it added to their stress and discouraged them from utilising support in the future [53].

Conclusion

In line with clinical realities, psychosocial rehabilitation must begin concurrently with pharmacological efforts to treat symptoms and deviant behaviours that interfere with learning skills and generally living in the community settings. Yet psychopharmacological interventions do not teach patients the necessary skills. Without a comprehensive program to enable patients with these skills, psychosocial rehabilitation programs cannot reach its objective. There should be no distinction made between treatment, psychotherapy, and psychological rehabilitation. Separating these elements is both fatuous and harmful.

Each psychosocial rehabilitation program is individualised to meet each patient's needs. A person's cultural origins and personal meanings are the reference points of such a design. Therefore, no single 'version' of psychosocial rehabilitation program can fit all. On the contrary each program must be tailored to fit each patient. Psychotherapy is a main item in psychosocial programs. Yet it is the most sensitive element to cultural effects. Moreover, the efficacy of the whole psychosocial program implies integrating all relevant cultural factors. Efforts to include these factors are currently mounting. Guidance was developed and updated to promote cultural adaptation of psychotherapy and the preservation of the core useful elements of the psychotherapy. On the other side, Western therapists have frequently described the need for better knowledge and models to work with different cultural populations. Cognitive behaviour therapy is evidence-based psychotherapy characterised by being structured and well-demonstrated efficacy over several psychological disorders. Therefore, it was frequently included into trials of cultural adaptation of psychotherapy. The development of a framework for CBT cultural adaptation is a landmark on the road to deliver adequate service to this population.

In today's world, principles of cultural responsive service have become more broadly accepted and endorsed. Several attempts are carried out to meet needs of culturally diverse patients suffering from psychiatric disorders and in need for psychosocial rehabilitation services. But in practice, every patient is always unique; a different personality, a specific family constellation, and peculiar sociocultural circumstance all of which guide the patient's thinking, feeling, and behaving. It is only natural, that is, each individual is a unique culture by himself.

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