Transcultural Psychiatry: Refugee, Asylum Seeker and Immigrant Patients over the Globe

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Abstract

The number of refugee, asylum seeker and immigrant patients over the globe is growing dramatically, and industrialized countries are likely to receive increasing numbers of people belonging to ethnic minorities in the form of refugees and asylum seekers due to a global increase in social and political instability as well as socioeconomic conflicts. The proportion of people with a serious mental disorder such as PTSD among this population is high. Thus health-care services should prepare themselves to better serve this group of ethnic minorities. They are insufficiently prepared for this specific population of mentally ill immigrants or ethnic

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minority groups. Particularly, mental health care for refugee, asylum seeker and immigrant patients is lacking, e.g. in cultural competence, intercultural psychotherapy and ethnopharmacology as well as legislation related to access to and utilization of health services, and varies from country to country. Transcultural psychiatry is a discipline within psychiatry, which deals with refugee, asylum seeker and immigrant patients over the globe. This chapter will give an overview on transcultural psychiatry and psychotherapy and future perspectives.

37.1 Introduction

The older approaches in transcultural psychiatry were part of colonial ways of thinking, in which professionals' work was based on a universal system of knowledge grounded in science that was viewed as acultural [1]. However, the postcolonial turn in scholarship showed clearly that all knowledge systems, including science, bear traces of their social, cultural and historical origins [1].

In its homepage, the WPA-TPS describes that the discipline of transcultural psychiatry (TP) continues to pursue the comparative approach outlined by Kraepelin [2] and subsequently developed by Wittkower [3] in the achievement of its five main objectives. These are:

- Exploration of the similarities and differences in the manifestations of mental illness in different cultures
- Identification of cultural factors that predispose to mental illness and mental health
- Assessment of the effect of identified cultural factors on the frequency and nature of mental illness
- Study of the form of treatment practised or preferred in different cultural settings
- Comparison of different attitudes towards the mentally ill in different cultures

WPA-TP Section represents a global network of researchers, clinical workers and teachers in the field of cross-cultural and ethno-psychiatry. Section membership is open to psychiatrists, psychologists, anthropologists and social scientists who are committed to this field (http://www.wpa-tps.org/about-wpa-tps/transcultural-psychiatry/).

This chapter will give an overview on transcultural psychiatry and psychotherapy and future perspectives.

37.2 Statistical Data About Displaced Persons

According to the UN [18], the number of international migrants, persons living in a country other than where they were born, reached 244 million in 2015 for the world as a whole. This is an increase of 41 per cent compared to 2000. According to

UNHCR [19], there are more than 65.5 million forcefully displaced people worldwide. This figure includes almost 22 million refugees. The majority of these refugees live in neighbouring countries. Only 6 per cent of them are living in Europe. UNHCR [20] reports that the terms asylum seeker and refugee are often confused. According to their definition, an asylum seeker is someone who says he or she is a refugee, but his or her application for asylum has not yet been definitively accepted [20]. Asylum seekers are individuals who have sought international protection ([20], p. 28). "Refugees include individuals recognised under the 1951 Convention relating to the Status of Refugees; its 1967 Protocol; the 1969 OAU Convention Governing the Specific Aspects of Refugee Problems in Africa; those recognised in accordance with the UNHCR Statutes; individuals granted complementary forms of protection; or those enjoying temporary protection. The refugee population also includes people in a "refugee-like situation" ([21], p. 56). They have well-founded grounds for fear of persecution because of their race, religion, nationality or political opinions or membership in a particular social group. These groups are unable to obtain sanctuary from their home country or, because of perceived threat, are unwilling to avail themselves of the protection of that country or, in the case of those not having proof of nationality and who have left their former countries of residence, are unable or, because of perceived threat, are unwilling to return to their former countries of residence [21].

The migrant population includes persons who are forcibly displaced (notably refugees, asylum seekers, internally displaced persons (IDPs)) and those who have found a durable solution (returnees) as well as stateless persons. For reasons of persecution, armed conflict, strife, generalized violence or human rights violations, most of them have had to leave their homes. During 2014 an average of 42,500 persons per day left their homes *to* seek protection elsewhere, either within the borders of their countries or of other countries because of armed conflict and persecution [20]. Many of these displaced persons have frequently been subjected to physical, sexual and/or psychological violence and traumatic bereavement [20]. It is well known that there are significant geographical differences as the developing regions are host countries for 86 per cent of the world's refugees and the least developed countries provide asylum to 25 per cent of the global total [20].

37.3 Migration and Mental Health

Globalization and refugee migration are significant issues in transcultural mental health care. Migration is part of human life. It is well known that migration can take on different forms, although it may be difficult to differentiate between forced and voluntary migration because both elements are often involved [4, 5]. Factors such as poverty, persecution or violence may play a main role in the process of migration, in which moving from one cultural and social setting to another for an extended period of times is involved and the loss of the familiar language (especially colloquial and dialect), attitudes, values, social structures and support networks may be also involved [4, 6]. Concerning this matter, Eisenbruch [7] termed it as a loss

"cultural bereavement". Particularly, in minority groups, the loss may be serious if the available social support is not appropriate. Sometimes, the cultural bereavement may be diagnosed as a psychiatric disorder; it is misdiagnosed because of linguistic and cultural misunderstandings and because of the use of Western diagnostic criteria in non-Western people [4, 6, 8–10]. Additionally, stress-related risk factors in migrant groups may be related to three arbitrary stages: premigration, migration and post-migration. Furthermore, social factors including cultural bereavement, culture shock, social defeat, as well as a discrepancy between expectations and achievement, and acceptance by the new nation can all affect adjustment [4, 6, 10, 11]. Further risk factors in new communities can include social exclusion, stigma and discrimination. Cantor-Graae and Selten [12] put forward the hypotheses of chronic experience of social defeat related to poor mental health and risk of psychosis in immigrants. It is well known that stigma and social exclusion commonly affect a person's recovery process as well as opportunities for societal participation [13–15]. Social exclusion may especially count for migrants without a resident permit. Laban et al. [16] found, e.g. that a long asylum procedure (with very limited rights to work and education) doubled the risk for a psychiatric disorder, independently from the experienced traumas in the country of origin. Stigmatization and discrimination which is often faced by the migrant in the host country are also emphasized as strong influencing factors of the mental health consequences of migration [14].

Beyond that, Butler et al. [17] highlighted that individual psychological resources, social support, a successful acculturation process, cultural variations and time since relocation are identified as statistically significant protective factors against the development of common mental disorders among migrants. The authors found new enlightening points including the significant impact of varying patterns of psychological distress, which is the most adverse for common mental disorder [17].

37.4 Mental Health in Refugees, Asylum Seekers and Immigrant Patients

It is well known that migration is one of the risk factors for developing mental disorders and that traumatized migrants in particular may face psychological distress and even serious psychiatric illness as they have been exposed to adverse conditions before, during and after migration [4, 6, 11, 17]. Prior to migration, migrants may have been exposed to deprivation, persecution, violence, imprisonment and human rights violation, including sexual harassment and even torture [6, 11]. Particularly, it is recognized that the transition phase which often includes a temporary residence can also be perceived as very stressful as well as the post-migratory phase in the new host country. Data from studies on risk for psychosis show that stress factors in the post-migratory stage over all have more impact on mental health than those in the pre-migratory stage [22]. Several authors reported [23–26] that the loss of loved ones/caregivers and/or livelihood, the destruction of property, deprivation, persecution, insecure living conditions, war, torture, imprisonment, terrorist attacks, abuse and sexualized violence are traumatic experiences of refugees and asylum seekers.

According to Heeren et al. [27], experiences e. g., defencelessness and disorientation, conditions of cold or heat, hunger and thirst, lack of medical care, robbery, assault and discrimination during the process of flight are often. Furthermore, many women may be subjected to different kinds of sexual assaults and violations [28, 29].

Lindert et al. [5] reported that the rate of mental disorders was twice as high among refugees than among economic migrants in Europe. The authors found also that refugees and asylum seekers suffered 44 per cent from depression, 40 per cent from anxiety disorders and 36 per cent from PTSD. Accordingly, Gerritsen et al. [30] reported that among refugees and asylum seekers, 56 per cent suffered from depression, 56 per cent from anxiety disorders and 21 per cent from PTSD. Several studies have the focus on the psychiatric morbidity among different types of migrants in different countries. But findings are not all the same which is reflected in Priebe's finding published in a report for WHO that, in general, the rates of psychotic, mood and substance use disorders in groups of refugees and asylum seekers appear similar to those found in host countries. The authors found also that post-traumatic stress disorder (PTSD) is more common in refugees and asylum seekers [31].

Along this line, a Swiss study reported that illegal migrants, asylum seekers and refugees had higher psychiatric morbidity compared with native groups and that about half of the asylum seekers and refugees fulfilled PTSD criteria [27]. However, Steel et al. [32] reported in a systematic review and meta-analysis an average for PSD in refugees and asylum seekers between 13 and 25 per cent. Hassan et al. [33] underlined that some forcibly displaced people are at particularly higher risk for mental disorders: women in female-headed households, adolescents, the elderly, those lacking documentation, persons with disabilities or pre-existing health or mental health issues, survivors of various forms of violence and those in extreme poverty [33].

37.5 Resilience-Oriented Treatment of Refugees and Asylum Seekers

As shown above the prevalence rates of psychopathology among asylum seekers and refugees are high and next to the traumatic experiences in their country of origin, they face many challenges, disappointments and adversities in the host country. These day to day stressors interfere heavily with the treatment. The debate of what kind of treatment should be given to asylum seekers and refugees is still going on. Nickerson et al. [34] observe two approaches, namely, trauma-focused therapy and multimodal intervention. The trauma-focused approach is grounded in the contemporary cognitive behavioural framework, while the multimodal intervention tries to address not only the psychological reactions that may occur after traumas as well as subsequent psychological stressors, physical health problems and resettlement and acculturation challenges.

A new approach in this seemingly contrasting treatment interventions is based on the concept of resilience. A resilience-oriented approach encompasses both

trauma-focused therapies and multimodal interventions: trauma-focused therapies (e.g. narrative exposure therapy or EMDR) can be added to a resilience-focused treatment programme, when needed, acceptable and possible. The resources of resilience can be classified according to the biopsychosocial model: *biological* (physical exercise, understanding the body, relaxation, treatment of medical illnesses), *psychological* (positive emotions and humour, acceptance, cognitive flexibility, empowering self-esteem, active coping) and *social* (social relatedness, reconnecting the family, creating and enhancing social support). For the asylum seekers and refugee population, two kinds of resources should be added: *cultural* (cultural identity, acculturation, language skills) and *religious/spiritual* resources. (The Cultural Formulation Interview (see later) is a perfect tool to investigate these last two resources.) Southwick and Charney [35] interviewed a variety of groups of trauma survivors and found ten what they call "resilience factors": realistic optimism, facing fear, moral compass, religion and spirituality, social support, resilient role models, physical fitness, brain fitness, cognitive and emotional flexibility and meaning and purpose. This new knowledge is important in the prevention of psychopathology, but it is also helping to shape treatment programmes [36, 37].

37.6 Religion, Spirituality and Migration

Forced migration results in crises of meaning, and refugees commonly resort to religious/spiritual beliefs and practices to help them cope. For forced migrants, there are multiple transitions, from their original homeland, community and family to a place of different faith, culture, language and climate. Being forcefully displaced is traumatic and is associated with multiple stresses including torture, loss, bereavement and suffering. Religion is important to asylum seekers and refugees, and it is notable that many migrants classify themselves by religion or nationality, as opposed to ethnicity [38]. One study of a UK reception centre indicated only 9% declared no faith and 75% declared themselves to be Christian or Muslim [39]. Additionally many organizations who assist asylum seekers are faith based and utilize religious frameworks [40]. But as Summerfield [41] notes, trauma work in humanitarian operations occurs in such a way that medicine and psychology have largely displaced religion in Western culture.

While much of the research on the experiences of dislocation and integration of asylum seekers and refugees focuses on external factors including housing, welfare and education, there is limited work conducted on the subjective experiences, attributions, beliefs, intentions and emotions elicited by a forced migration including spirituality. However, migrants are forced to produce meaning in some way. One study on Kosovar Albanian refugees in the United States found that migrants viewed their suffering as a spiritual experience deploying emotional and cognitive support deriving from their spiritual and religious frameworks [42]. Tweed [43], highlighting the dynamics of religion across time and space, developed a diasporic theory of religions among Cuban catholic exiles in Miami. He argued that forced migrants could deal with suffering by utilizing human and superhuman forces to make homes and cross boundaries. He examines the Nuestra Señora de la Caridad del Cobre

shrine as a site for contested religious meanings, a hallowed centre where Cubans are able to construct their national identity in exile. Raghallaigh [44] found religious coping to be especially important for unaccompanied young asylum seekers in Ireland. Overall the literature suggests that religion is central to the coping strategies of forced migrants, and we argue that significantly more attention should be devoted to this area.

37.7 Cultural Competence

Every psychiatrist should see his/her patients in the context of his/her culture as well as their own cultural values and prejudices [4, 6, 8, 11, 45–47]. In such cases the psychiatrists are experts in biomedicine, while patients are experts in their own experience of distress. Therefore, cultural competence should be a main issue in the daily work of the psychiatrists [10, 48, 49]. Cultural competence is one of several concepts used with the ambition of grasping the need of knowledge, skills and efforts to work with culture and context in clinical care. Alternative concepts are cultural sensitivity, humility and responsiveness. Even though the concepts have different historical backgrounds, they all try to capture the need of clinicians to remain open and be willing to seek clarification when presented with unusual or unfamiliar complaints. Psychiatrists should also be aware of their own cultural biases and knowledge on the use of interpreters or culture brokers, culturally different family structures, the effects of discrimination, exclusion, unemployment, intergenerational differences in acculturation, different explanations of illness, symptom presentations and treatment expectations and idioms of distress [50]. They should also be knowledgeable of the training in the use of cultural mediation, culture brokers or other models, including interpreters, working with family members or relatives. Additionally, they should be trained in intercultural psychotherapy, including issues of transference and countertransference and somatization [50]. There must be knowledge on how the professional's own cultural background and limitations could influence working relationships with and the effectiveness of treatment they provide for people from other cultural backgrounds. The context of cultural competence should be a part implemented both at the individual/clinical level and at the institutional level [10, 49, 51].

Cultural competence requires knowledge, skills and attitudes which can improve the effectiveness of psychiatric treatment [52–54]. It represents a comprehensive response to the mental health-care needs of refugee, asylum seeker and immigrant patients. Cultural knowledge means cognitive cultural competence, which is known as "knowledge" about the various ways in which culture, immigration status and race influence psychosocial development, psychopathology and therapeutic transactions. Therefore, it is important to be mindful of the risks of stereotyping [10]. Cultural skills and technical competence are essential in applying the knowledge in the clinical context. There are three main skills: intercultural communication, the capacity to develop a therapeutic relationship with a culturally different patient and the ability to adapt diagnosis and treatment in response to cultural differences between the psychiatrist and the patient [10, 46–49]. These skills explore the awareness of differences and similarities between cultures and their role in the expression

and explanation of mental distress. Cultural attitudes and beliefs which include personal prejudices will be affected by knowledge and will also impact behaviours [55, 56]. Intercultural work requires psychiatrists to challenge their own perceptions of "reality"; to explore their own cultural identity, prejudices and biases; and to be willing to adapt to distinct cultural practices [10]. It should be stressed that cultural competence is not an end product, a kind of technical expertise that confers on the individual a resolved accreditation which will enable them to work with patients from all cultures [49, 57, 58]. Cultural competence is an ongoing process of learning by training. The WPA guidance on mental health and mental health care in migrants [4], the EPA guidance on mental health care of migrants [6] and the EPA guidance on cultural competence [10] offer recommendations to policymakers, service providers and clinicians.

37.8 Cultural Formulation Interview

An important novel approach for awareness of culture and context in clinical psychiatric assessment is the inclusion of a Cultural Formulation Interview (CFI) in DSM-5. With 16 open questions, clinicians can explore cultural aspects of the current illness episode. Patients are encouraged to give narrative responses. Distress is acknowledged in relation to four main domains, cultural definition of the problem, perceptions of cause, context and support and cultural factors affecting self-coping and past help seeking and cultural factors affecting current help seeking [59]. In addition to the core CFI, there are 12 supplementary modules and an an informant version that can be used when additional information is needed [60]. One of the supplementary modules is specifically targeted towards the experiences of immigrants and refugees [61]. The core CFI and the additional interviews are helpful support for including an awareness for cultural verity in illness expressions, explanatory models, hardships and resilience factors in an individualized and non-stereotyping way.

The CFI in DSM-5 was developed from experiences of the Outline for a Cultural Formulation in DSM-IV. Lewis-Fernández et al. [60] discussed the results of research based on the operationalizing cultural formulation (OCF). For each domain of the OCF, the authors summarized findings from the cross-cultural issue subgroup (DCCIS) that was the base for the revision and operationalization in the CFI [60]. For assessment of psychopathology and treatment needs of refugees in the Netherlands, Rohlof et al. [62] had applied the cultural formulation in DSM-IV. They worked out that it was a useful method in mental health care and produced information that challenges the stereotypes of both clinicians and patients.

In the long run, the chapter on cultural formulation of the DSM-5 incorporates the CFI, which makes it possible to find a way of understanding the cultural context of a patient's experience of illness, which is essential for effective diagnostic assessment and clinical management. Using the Cultural Formulation Interview (CFI) of the DSM-5, psychiatrists may obtain information during the mental health assessment about the impact of culture on key aspects of the patient's clinical presentation

and care. The CFI in DSM-5 is helpful for use also in assessment situations where the diagnostic system of ICD is used.

Learning to work with the CFI in the clinical practice of psychiatrists can substantially increase the competence in working with cultural variety. Therefore, understanding psychopathology and formulating psychiatric diagnosis in refugees, asylum seekers and migrants could be facilitated by a dimensional approach, more then by a categorical approach [63–65]. On an individual level, the Cultural Formulation Interview (CFI) can be usefully employed during a mental health assessment to obtain information about the impact of culture on key aspects of a patient's clinical presentation and care, including their concepts of health and disease, expectations of treatment and the stress factors they are confronted with [64]. Training at undergraduate level, postgraduate level, further education or continuing professional development could benefit greatly from the inclusion of teaching on the factors influencing the clinical assessment, treatment and cultural integration of migrants [66].

37.9 Ethnopharmacology

Until recently variations in treatment response across diverse cultural groups, including effectiveness, dosing strategies and adverse effect profiles, have attracted relatively little attention. It is important to be aware that migrants may respond differently to psychotropic medication compared to the host majority. Different pharmacokinetics and pharmacodynamics may render some groups more vulnerable to side effects [67]. For instance, one study found that Asians experienced more extrapyramidal side effects than whites [68]. African Americans have been found to be at greater risk of lithium toxicity than their white counterparts [69].

Cultural attitudes may influence adherence to medication, the interpretation of side effects, enzyme induction as a result of diet and the use of traditional healing, complimentary and herbal medicines. Furthermore, there may be cultural differences in the placebo response. Placebo effects are dependent upon cultural expectations and beliefs; these are responsible both for the therapeutic effects of treatment and also for adverse effects. Mismatches in beliefs and expectations between clinicians and their patients may result in a breakdown of clinician-patient communication with subsequent treatment discontinuation and nonadherence [70]. Thus, it is important to assess attitudes towards medication, folk remedies and the use of tobacco and alcohol [4].

37.10 Intercultural Psychotherapy

Intercultural psychotherapy describes a setting, in which the psychotherapist and the patient have different cultural backgrounds [6]. The communication of distress in the face of language barriers can be a significant reason for nonengagement, increased levels of dissatisfaction as well as of break-off. Sue and Morishima [71] underlined that the greater the similarity between psychotherapist's and the patient's

ethnic and racial backgrounds, the more effective the therapeutic relationship. Accordingly, a culture match between psychotherapist and the patient is expected to facilitate a common understanding of symptom attribution and treatment, self-disclosure and expressive styles and the importance of the family in states of illness and treatment [72]. According to Atkinson [73] and Atkinson et al. [74], cultural matching can minimize problems in assessment, avoid group stereotypes and enhance rapport. These earlier studies are challenged by later studies pointing to that therapist; multicultural training/experience and use of culturally adapted treatments are significantly more important than ethnic matching [75]. Ethnic mismatch between patients and therapists does not have to be a significant barrier to treatment engagement and session attendance [76]. A meta-analysis of 52 studies indicated almost no benefit to treatment outcomes from racial/ethnic matching of clients with therapists [77].

Kirmayer [78] pointed out that the intercultural work challenges the shared "assumptive world" which might result in problems of translation and positioning, working across and between systems of meaning and structures of power that underline the therapeutic alliance and the process of change. He points out that the encounter of psychotherapist and patient from two different cultures is not simply a matter of confrontation or exchange between static systems of beliefs and values. In his concept of "potential space", Winnicott [79] described a space that is not fantasy and not reality, where imagination, symbolization and creativity are possible. In this space, transitional objects and phenomena, as well as play, can exist, and meaningful communication is enabled treatment [72]. Transferring this concept to the setting of intercultural therapy, the creation of a mutual creative space allows both psychotherapist and patient to play with the idea of being the other. This mutual creative space can also help to address the phase in the lives of refugee, asylum seekers and immigrant patients in society facing transitions in which aspects of their existence must be addressed [72]. According to Kirmayer [80], every system of psychotherapy thus depends on implicit models of the self, which, in turn, are based on cultural concepts of the person. Kirmayer [80] underlined that most forms of psychotherapy are based on Euro-American values of individualism. He highlighted that individualistic and egocentric concepts of the person can be contrasted with more sociocentric, ecocentric or cosmocentric views, so that the person could be understood in relation to the social world, the environment and the cosmos. Furthermore for him intercultural psychotherapy must consider the cultural concept of the person implicit in therapeutic discourse and practice to determine how well it fits or conflicts with the concepts, values and way of life of the patient. There are ongoing efforts to adapt psychotherapeutic methods to cultural variety. One example of this cultural adaption is CBT for mental illness [81]. This compromise is making individual case formulations including the background and perspective of the patient and the community. Additionally, it attempts to pass beyond the therapy dyad and if appropriate involve the family, religious leaders and the community [82].

In the setting of intercultural psychotherapy, language plays an important role. Additionally, idioms of distress in which patients communicate with psychotherapists can vary considerably from culture to culture. It is well known that many

languages do not have equivalent words to describe various mental disorders [6]. For example, the word and notion of "depression" do not exist in all cultures, even though sadness, unhappiness and other symptoms can be described and verified [6]. It is therefore necessary for psychotherapists and psychiatrists to be sensitive to cultural and contextual aspects of communication [83]. Without the help of interpreters or culture brokers, effective communication between professionals and patients from different cultural origins and with differing language capacities is sometimes impossible [84]. In relation to that, psychotherapists and psychiatrists had developed conceptual models, skills and experience in conducting cross-language concepts of psychotherapy using interpreters or culture brokers [85]. Particularly with regard to psychotherapy, language ability plays an essential role. Language ability is a main meter for psychiatry and psychotherapy [6, 10] in immigrants' utilization of health-care services, particularly, of psychotherapy. Language challenges can heighten systemic and sociocultural barriers to accessing health information and resources.

Trust and confidence are central to good quality cross-cultural communication. A trustful relation in which the patient and the clinician want to convey and understand the meaning of the other is the basis for overcoming communication barriers. At the same time, trust and confidence are central to good quality cross-cultural communication [83]. According to Bäärnhielm and Mösko [83], a trusting relationship in which the patient and the clinician want to convey and understand the meaning of the other is the basis for overcoming communication barriers. Non-professional translators (family members, hospital staff members, etc.) can have a negative influence on trust and confidence. Non-professional translators can also have negative impact on medical treatment due to erroneous translation in the form of omissions, additions or indeed changes to the initial message [86]. Therefore, the use of professional interpreters or culture brokers is obligatory. Bauer and Alegría [87] highlighted that professional translation improves the quality of treatment and patients' satisfaction with treatment.

While patients and psychotherapist and psychiatrists preferred simultaneous interpretation, interpreters or culture brokers used more often the consecutive method [88]. During intercultural psychotherapy, it is very important to be aware of the model of interpreting which is used. Beside the psychotherapeutic or constructionist mode, there are three more modes of interpreting described. These are linguistic (word for word), psychotherapeutic or constructionist, health advocate/community interpreter or the bicultural work modes [89].

37.11 Education and Transcultural Psychiatry and Psychotherapy

The Lancet commissions on culture and health [90] highlight the importance of remodelling medical practices by stressing the importance of culture and its effect on well-being. They argue that medical practice needs to account for how cultural values and related heritage can be better understood and nourished in the interests

of health. In line with growing globalization and an increasing number of people on the move across national and international boundaries, it has become vast important that psychiatry and psychotherapy are aware of the different needs of the patients they are responsible for including cultural [66]. Therefore, during times of global migration and an increasing number of ethnic minority migrants including refugees and asylum seekers, psychiatrists and psychotherapists may have a different cultural background than their patients. Thus, cultural psychiatry and psychotherapy are a matter of primary relevance. The onset of illness may occur soon after migration, or mental health problems may develop over time as results of the impact of social factors and changes related to the host society [6, 66]. According to Laban et al. [91], post-migration factors have a high impact on the development of psychiatric disorders. Furthermore, it is well known that the process of migration can lead to a whole spectrum of mental health disorders including psychoses, post-traumatic stress disorder (PTSD), common mental disorders (CMDs), eating disorders and suicidal behaviour [6, 17, 31]. However, there is still a need for further studies to collect more information on the prevalence rates of mental disorders in migrant groups as compared to the host culture. Therefore, cultural psychiatry and psychotherapy must be included as an integral part of educational curricula, from the undergraduate level through continuing professional development. As mentioned in the action plan for the triennium 2014–2017, the WPA should recommend that WPA member societies create national branches or sections of social/cultural psychiatry and psychotherapy if they do not already exist, thereby pushing forward the awareness and knowledge of immigrants, ethnic minority groups, refugees and asylum seekers [50]. Related to cultural psychiatry and psychotherapy, the WPA outlines some of the key issues on what undergraduates and postgraduates need to know as well as what is required for CME/CPD (continuing professional development). Furthermore, WPA summarized in this action plan what service providers, policymakers and mental health professionals should do [50].

37.12 Future Perspectives

Kirmayer and Ban [92] assert that methodological strategies for unpacking the concept of culture and studying the impact of cultural variables, processes and contexts are needed. Quantitative and observational methods of clinical epidemiology and experimental science as well as qualitative ethnographic methods should be used to capture crucial aspects of culture as systems of meaning and practice. According to them, these methods are important to bridge the gap in cultural psychiatric research on cultural variations in illness experience and expression. Additionally, the authors argued that there is more research needed on the situated nature of cognition and emotion as well as on cultural configurations of self and personhood, on concepts of mental disorder and mental health literacy and on the prospect of ecosocial models of health and culturally based interventions. The authors considered the implications of the emerging perspectives from cultural neuroscience for psychiatric theory and practice [92].

According to Laban and Dijk [93], quantitative epidemiological studies still dominate. Little anthropological research with qualitative methodologies and an "experience near" approach has been conducted [93], in which the main topics related to psychiatry were perceptions of illness and disease, use of nonbiomedical health care, health-seeking behaviour, cultural identity and mental health and patient-therapist interaction, especially the effects of ethnic matching of therapists and patients. The authors asserted that the core transcultural psychiatric concepts of idioms of distress and explanatory models have been also topics of anthropological research [93]. Laban and Dijk [93] summarized that the research findings have not yet had much impact on political decisions. Furthermore, the authors pointed out that in a complex world with a multitude of scientific findings, chaotic and incident-focused behaviour of politicians and media and increasing "fact-free politics", researchers have a hard time getting their message through. They considered that perhaps greater cooperative efforts with relevant nongovernmental organizations could increase the chances of the translation of scientific findings into political decisions [93]. In line with that, the authors established a list of research questions, which should be relevant to policy and practice for future consideration: "1. What factors can keep immigrants, refugees, and asylum seekers healthy and make them resilient, and what interventions could improve their mental health and well-being? 2. What is the effectiveness of standard therapeutic interventions in the mental health care of immigrants, refugees, and asylum seekers? And what other interventions could be equally or more effective? 3. Which combination of characteristics—among others, SES, ethnicity, culture, personal life situation—increases the risk for mental health problems in ethnic minority groups, and contributes to underutilization of mental health services and dropout from treatment? 4. Which combination of elements—such as country of birth and upbringing, ethnicity, race, religion, age, gender—in matching patients and therapists contributes most to effective treatment?" ([93], p. 809).

Another author, Wintrob [94], maintains that psychiatry has been fundamentally concerned with pathology and its diagnosis and treatment. Factors of individual perseverance in the face of adversity and illness, of spiritual strength and purpose, of family support and of community belonging that contribute to coping ability, recovery and an overall sense of well-being are less in focus [94]. The author also underlined that cultural psychiatry has recognized the importance of each of these factors in coping with the stress of rapid culture change, migration, acculturative stress, the social burden of discrimination and unequal access [94]. He underlined that, culturally, psychiatry needs to expand research into "cultural resilience" as it applies to individuals, families and communities across generations. Additionally, Wintrob [94] favoured the person-centred care within the conceptual framework of cultural psychiatry, which then would emphasize the personal and cultural identity of each individual, their conceptions of illness and its appropriate treatment, personal resilience and family support, religious and spiritual orientation and capacity for long-term restoration and maintenance of individual and family well-being [94].

An upcoming field is cultural neuroscience, an interdisciplinary field that investigates the relationship between culture (e.g. value and belief systems and practices

shared by groups) and human brain functioning. Main focuses of cultural psychiatry for the future should be the implications of cultural neuroscience findings for understanding human brain function in sociocultural contexts [95–98]. Beyond that cultural psychiatry should address questions to cultural neuroscience research for the future.

Further clarification is needed to gain deeper understanding of the relationship between migration and common mental disorder to address contradictions in the literature and health inequalities among migrants [17].

Conclusion

As pointed out in the introduction, in the early phase of our field of interest, the transcultural psychiatry, the focus was on "the people out there". In a later phase, it was recognized that culture is present in every human experience and that all knowledge system bear traces of social, cultural and historical origins [1]. We have the strong feeling that we are moving into another phase of transcultural psychiatry. The mass migration and even more the staggering amount of forced migrants as asylum seekers, refugees and undocumented migrants in all our societies make it clear that people from different cultural backgrounds are interconnected in everyday life. Moreover, the growing inequality in resources between people within and between countries; the policies to build walls and to increase border controls; and the concentration on "our one people", "our own country" is sharpening human relationships and increases the risks of extreme poverty and marginalization. There is an increasing level of public antagonism towards migrants in recent years—whether they be immigrants, refugees or asylum seekers—and a concomitant increase in public policy of non-acceptance and rejection of migrants in countries of the industrialized world that had been the main humanitarian receiving countries for migrants for generations. That is, there are profound negative implications of current cultural stereotyping and, in particular, the fear of terrorism that adversely affects the mental health of the citizens of those receiving countries, as well as the mental health of all migrants. The consequence is, undoubtedly, that the process of acculturation and integration of migrants and refugees will be disturbed; asylum seekers and undocumented migrant will face hard measurements, like imprisonment and exportation.

More obvious than ever before, transcultural psychiatry is connected to human rights issues, social inequalities, discrimination, social exclusion and (threats of) violence and terror. The many risk factors, discussed in this chapter, affect millions of people and will lead to mental health problems in high proportions. Psychiatry as a whole has put a lot of emphasis (and spend a lot of money) on—research on—biology and genes as causal factors of psychiatric disorder. It has to be noted here that in a short time social factors will be the leading cause of the majority of common mental disorders.

The responsibility of psychiatrists, and maybe especially of transcultural psychiatrists, in this era is huge. The knowledge of the negative implications of the present amount and characteristics of risk factors on mental health cannot be ignored. This also applies to the existing knowledge of the "healing factors":

restoration of human rights, safety, social connections, provision of basic needs, an approach of respect and dignity, transparency and promises that are kept and (access to) cultural sensitive treatment, among others. For the millions of people on the move, it is essential that they have the opportunity to bounce back from all adversities they have experienced.

Psychiatrists, together with other health professionals, therefore, have a special duty to raise awareness among the general populations and among policymakers of the dangers we encounter. Equal opportunities to obtain equal levels of mental health and equal access to mental health facilities should go together with opportunities to maintain and achieve resources of resilience. Access to the housing market, education and the labour market is an essential aspect of these resources. Fired by basic facts, ethical considerations and human empathic advocacy activities are necessary on a large scale.

An era has begun in which transcultural psychiatrist should not only closely ally with psychologists, anthropologists and social scientist. They have to widen their scope and search cooperation and affiliation with human rights specialists, employers' organizations, nongovernmental organization migrant/refugee interest groups, common citizens/volunteers and, not in the last place, politicians and (local and national) governments.

Conflict of Interest None.

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