Cross-Cultural Issues

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Abstract

Migrants and ethnic minorities are at higher risk to develop mental disorders compared to native population. Culture has an important impact on the symptom presentation, diagnostic process and treatment strategies in all populations. Cultural competence represents good clinical practice and can be defined as a two-way learning encounter where clinician acknowledges the patient's culture as well as his own cultural values and prejudices. Cultural competent response to the mental health care requires knowledge, skills and attitudes. Both individual and organizational cultural competences are needed to improve the effectiveness of psychiatric treatment. In this chapter, we revised the WPA Guidance on Mental Health and Mental Health Care for Migrants and the EPA Guidance on Mental Health Care for Migrants and list a series of recommendations for policy-makers, service providers and clinicians. Cultural competent experiences in the treatment of somatization and other psychiatric disorders across several countries in Europe are also presented.

7.1 Introduction

Health-care professionals regularly have contact with patients from different cultural backgrounds, whose mental health is seriously affected by the social conditions in the receiving countries in which they live [1, 2]. Moreover, if they are immigrants, their mental health could be affected by the conditions under which

they travel or by the reasons of migration. The social determinants of their health, including mental health, are often different from those of the settled community and may require a different, cultural adapted approach from health-care professionals [3–6]. Cultural factors play an important role in the symptoms' presentation of distress and illness, on the diagnostic process and on treatment strategies in all populations [2, 7–11].

One of the leading reasons for under-recognition and under-treatment of mental disorders among people of different ethnic or cultural backgrounds both at the primary and secondary level of care is somatization [12]. Several studies conducted in primary care show that common mental disorders (CMDs) are less recognized and treated in ethnic minorities than in native-born populations, even in cases where rates of consultation are higher [6, 13–16]. The reasons of poor levels of detection and treatment of CMDs among migrants in primary care have been related to difficulty in recognizing somatically presented CMDs [17, 18]. Patients with CMDs are less referred to mental health services (MHS) [16, 17] by general practitioners (GPs); moreover, members of certain ethnic minority groups show lower rates of initiation of appropriate drug therapy [18–21], especially when mental disorders are presented somatically. This primarily somatic presentation of mental disorders in turn appears to be related to underutilization of MHS by immigrants and to higher use of emergency services [2, 22, 23]. Thus, there are important reasons to try to develop culturally competent skills and interventions aimed at overcoming barriers to effective mental health treatment for migrants and ethnic minorities.

In this chapter, we propose to outline some of the key issues related to cultural competence and how to deal with these issues [24]. Cultural competency refers to good clinical practice so that all patients, including those from minority groups and/or with migration history, feel acknowledged and supported even when their cultural backgrounds differ from that of the health professionals [24]. Cultural competence is a way of capturing the capacity to provide appropriate care for diverse patients, overcoming sociocultural differences and other systemic challenges to reduce disparities [5, 24–29]. Cultural competency is not about learning the language of the patient or necessarily knowing details about the specific cultural values of a migrant, but about respecting differences and making sure that these are bridgeable [26, 29–34]. For the purposes of this chapter, cultural competence is best understood as a process and a therapeutic interaction or even a sort of meta-theory rather than a specific attainable skill set. We adopted the recommendations from the EPA and WPA guidance [3, 24, 35] and added new recommendations from the literature.

7.2 Cultural Competence: Framework

Cultural competence is defined as the ability to understand and be aware of cultural factors in the therapeutic interaction between the clinician and the patient [8, 25, 35–39]. Often it is erroneously assumed that only patients belong to ethnic minorities "have cultures" [24], while a cultural competent clinician acknowledges the

patient's culture as well as his own cultural values and prejudices [24]. Clinicians are experts in biomedicine as well as patients in their own experience of distress. Thus, clinical encounters ought to be viewed as two-way learning encounters.

Clinically competent mental health professionals are both interested in the patient's cultural biases and their world view which is strongly coloured by cultural values. They should be also aware of their own personal cultural strengths/weaknesses and prejudices which may affect their responses to specific patients [27, 29, 38–43]. Moreover, cultural competence should be considered at both the individual/clinical level and at the institutional level [1, 9, 27, 29, 44–46].

Cultural competence is not a static phenomenon but a developmental process moving along a continuum [47, 48]. This spectrum includes stages of cultural destructiveness, cultural incapacity, cultural blindness, cultural pre-competence, cultural competence and eventually cultural proficiency [24]. It must be remembered that cultural competency should be tempered with what has been termed "cultural humility" [49, 50]: attaining a level of cultural proficiency indicates a level of cultural competence, but this is not absolute and will need ongoing development [24].

Indeed institutional cultural competence requires not only a recognition of barriers to quality care at a systemic, organizational and institutional level but also a project aimed at overcoming these barriers [1, 24, 25]. Some of these barriers are relatively straightforward, such as not having enough professionals who speak the same language of the patient, lack of physical access to services by public transportation, restricted opening hours of the mental health centre and so forth [24]. Thus organizational cultural competence will need to make appropriate changes accordingly [1, 9, 27, 45, 51, 52]. In fact it is extremely important to undertake the effort to make the mental health centre more accessible and comfortable for patients of minority groups through not only linguistically and culturally diverse staff but also the physical environment.

In order to increase cultural competence, (mental) health-care systems need to value diversity, to assess an individual's own cultural values, to be aware of cultural interactions, to incorporate cultural knowledge and to adjust service delivery accordingly [24]. Health-care systems should mark themselves on the cultural competency continuum [47, 48, 52]. Cultural competence also includes access to suitable well-trained interpreters and clinician's ability to work with them [24]. Bilingual professionals can add that extra bit, even if this may not always be possible due to limited resources. Moreover, in some countries, cultural mediators can be utilized: they can offer linguistic interpretation but also mediate between health professionals and service users [53]. In fact, having to communicate distress with language barriers can be a significant reason for nonengagement and increased levels of dissatisfaction.

In conclusion, cultural competence represents a comprehensive response to the mental health needs of care of immigrant patients and requires knowledge, skills and attitudes which can improve the effectiveness of psychiatric treatment [24, 25, 27, 40, 52, 54, 55].

We describe in the paragraphs below basic components of cultural competence at the level of clinician, service provider and policy-maker.

7.3 Cultural Competence Basic Components at the Clinician Level

7.3.1 Cultural Knowledge

Cognitive cultural competence, otherwise known as "knowledge", involves awareness of the various ways in which culture, immigration status and geographical origin impact on psychosocial development, psychopathology and therapeutic interactions. It is not always possible to be fully cognizant of all the cultures, but nowadays it will be possible to get the correct information from multiple sources. However, risks of stereotyping and as such losing sight of the patient as an individual [27, 41, 55–58] must be remembered.

7.3.2 Cultural Skills

Technical competence or skills are essential in applying the knowledge in the clinical context [24]. These key skills include a proficiency in 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 [3, 27, 35, 48, 55]. These skills require the awareness of cultural differences and their role in the expression and explanation of mental distress but also of similarities among cultures. The nature of human cognition and perception helps us to recognize the impact of cultural filters on both sides, on oneself and on others [24]. This, subsequently, forms the basis for a flexible response that is adaptable to the cultural context of the patient [2, 27, 59].

7.3.3 Cultural Attitudes

Attitudes and beliefs, including personal prejudices, will be affected by knowledge and will also affect behaviours [2, 4, 27]. Intercultural work requires the clinicians 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 [24].

7.4 Cultural Competence Basic Components at the Service Provider Level

7.4.1 Providing Therapies for Minority Groups

It was reported that outcomes of therapies in various settings are poor for minority groups [24]. It was found that the proportion of immigrants in admission psychiatric wards of hospitals were roughly similar to that of immigrants in the general

population in Germany [60] and in Italy [61]. However, few immigrant patients were found in psychotherapeutic settings [61]. Two recent meta-analyses [4, 62] enlightened evidences for the effectiveness of the implementation of cultural adaptations in mental health interventions. In details, four common methods of cultural adaptation [62] were showed. First, the cultural values of the immigrant patient should be incorporated into therapy; second, immigrant patients can be matched with therapists of the same cultural or ethnic group; third, mental health interventions should be easily accessible and targeted to immigrant patients' circumstances; and fourth, support resources available within immigrant patients' community, extended family members and tradition should be incorporated into therapy interventions. The results of the meta-analytic review [62] indicate a moderate to strong benefit of culturally adapted interventions. It was found 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. Interventions conducted in patients' native or primary language were twice as effective as interventions conducted in English. Further, the results of additional analysis indicated that the format of intervention (individual therapy, group interventions) did not moderate the overall results [62].

7.4.2 Using Interpreters

Communication between professionals and patients from different cultural origins and without knowledge of each other's language is not possible without the help of interpreters. Psychotherapy in native languages cannot be realized everywhere because the number of qualified psychotherapists who speak a native language is limited. Moreover, each culture has different idioms of distress which are employed to communicate with clinicians. For example, many languages do not have equivalent words to describe depression, but the words "sadness" or "unhappiness" can be easily used and verified. Finally, there is a profound danger in applying diagnostic tools developed in a specific country blindly without taking conceptual equivalence into account. Not only does this affect diagnostic patterns but also does it introduce concepts of what Kleinman calls category fallacy [41, 63].

Non-professional translators (family members, members of hospital staff, etc.) can have a negative impact upon medical treatment via false translation, most commonly by the failure to add "creative elements" from their own interpretation to what has been said. Sometimes the "creative elements" have the aim to protect the patient by avoiding to translate what has been said. Minors are at special psychological risk when asked to help interpreting while a migrant parent with a mental disorder is seeking for mental health care. This issue is of crucial importance in traumatized refugee families. As a consequence, it is generally preferred using professional interpreters. It has been shown that professional translation improves the quality of treatment and patients' satisfaction with treatment [64].

Therefore, the work with psychologically trained interpreters is of great importance. Culture brokers or cultural mediators may provide an insight into different

cultures and enable clinicians to provide better and more acceptable services [24]. In a European expert Delphi study, it was shown that the adequate use of interpreters constitutes the most important factor of influence for the provision of high-quality mental health care [65].

Psychiatrists and other mental health professionals should develop conceptual models, skills and experience for conducting cross-language interviews by the use of interpreters [66]. Tribe [67] describes four modes of interpreting as psychotherapeutic or constructionist, linguistic, advocate or adversarial/community and cultural broker/bicultural. It is helpful to know which model is being used and that sometimes interpreters may hold back information if they feel that sharing something may bring disrepute to the culture [24].

Three challenging issues were pointed out with regard to intercultural clinical settings with interpreters: (1) the vital role of interpreters for the diagnostic process, (2) difficulties to establish confidence and (3) a higher risk for marginalization [68].

7.5 Cultural Competence Basic Components at the Policy-Maker Level

7.5.1 Working on Intercultural Barriers

A key barrier for immigrants could often be inadequate legal entitlements [69]. Sometimes these barriers are mistakenly attributed to cultural differences and misunderstandings, and the term culture may be used as a putative politically correct expression reifying social differences and neglecting discrimination [70]. It is also helpful to recall that institutions have their own cultures which can produce barriers of various kinds, and minority groups may well face strongest barriers to health-care access [38, 39, 61]. Inequitable variation in the use and accessibility of health-care services for immigrants, indigenous populations and other minorities in EU countries remains a matter of concern for both health-care providers and policy-makers as variations in health-care usage between majority and minority populations have been noted [65]. Responsiveness to diversity is being recommended in European countries to improve access and quality of care for minority populations [71–75]. A study conducted in Italy showed that migrants' pathways to psychiatric services vary across cities. Particularly, social services were important sources of migrants' referrals for services providing cultural competent consultation-liaison activities [13]. With regard to massive disparities in the provision of adequate mental health care to refugees and asylum seekers with emotional distress or mental disorders in Europe, the European Psychiatric Association (EPA) established a task force working on this issue. Health-care providers have an obligation and responsibility to ensure that all service users irrespective of their background get highest quality services according to their needs [24].

Focusing on cultural competency, we believe that the recommendations listed in Table 7.1 will help.

Table 7.1 Recommendations for cultural competence implementation

Service providers
• The service providers must initiate a culture change within the institutions to make services culturally accessible and sensitive • Training all staff in cultural competency, cultural empathy and cultural sensitivity is an absolute must • Regular additional training must be part of continuous professional development for all staff members • Providers may consider the likelihood of employing culture brokers or cultural mediators which will benefit both the clinical team and the local communities • Regular cross-cultural supervision must be made available directly or using tele-psychiatry • Culturally sensitive services such as food and physical spaces be made available if relevant • Health education as well as prevention and mental health promotion must be a part of the overall services targeting minority groups • Information for immigrants by means of pamphlets in their preferred languages must be easily accessible and available • The institutions should consider having a nominated lead clinician responsible for cultural competency training and delivery • Qualified interpreters should be available for patients not mastering the language of the host country
Clinicians
• Training and ongoing education for all mental health professionals in understanding diagnosis, illness behaviours and culturally sensitive interventions must be mandatory when needed • Ensuring quality standards for expert court opinions for minority groups in the context of criminal, civil and social law is available and employed in relevant settings • Depending upon the needs of the local community, appropriate knowledge about culture-based medicine, culture-specific, illness-specific and migration-specific aspects should be offered to mental health professionals • Information for minority groups in their preferred languages about their rights, psychiatric disorders and treatment options must be made available • Cultural psychiatry should be an integral part of all curricula from undergraduate levels to continuing professional development • Specific research dealing with the needs of minority groups must be encouraged and appropriately funded
Policy-makers
• Policy-makers must take a lead on ensuring that clear messages on equality and diversity are enshrined in law with non-discriminatory health policies • Mandatory policies should cover all minority groups • More quantitative and qualitative research on aetiological factors, interventions and outcomes must be part of setting up services • Integrated services should be the preferred norm with culturally specific resources allocated according to patients' needs

Adapted from EPA guidance on cultural competence training [24]

7.6 Several Experiences on Somatizations Among Immigrants in Europe

Since 2007, a group of clinicians and researchers within the scientific network of the European Association of Psychosomatic Medicine (EAPM, former EACLPP) started sharing their common interest and curiosity about the mental health of migrants [24]. Common ideas and experiences as well as specificities and differences deriving from different sociocultural contexts and organizations of health-care provision were discussed, also by means of scientific symposia offered during the EAPM meetings. The group progressively acquired a more stable and formal structure culminating in the formal institution of the Cultural CLP Special Interest Group (SIG), in 2010, that aims at promoting multinational exchange of experience and inspiring clinical and research projects at the interface of cultural and CL psychiatry and psychosomatics. The members of the SIG are involved in research projects addressing different subitems and presentations of mental health of migrants [76–84]. These previous experiences were relevant as they suggested what the best further objectives for the SIG should be. The SIG has proved to be a useful forum where to discuss transcultural issues, exchange experiences in establishing mental health services for migrant patients in different European countries, be able to advice others on training, share and disseminate research findings and promote high standard of practice. We briefly present here some example of researches and clinical experiences in Europe.

7.6.1 Somatization Among Migrants at the Bologna Transcultural Psychiatry Team, Bologna, Italy

The Bologna Transcultural Psychosomatic Team (BoTPT) [85] of the Bologna University works together with the local community mental health service [85]. The BoTPT is a multidisciplinary study and research centre of the Department of Medical and Surgical Sciences—Bologna University. The team provides consultations in partnership with the Department of Mental Health of Bologna designed to identify the mental and psychosocial needs of migrants and to direct them to appropriate services. The consultation includes psychiatrists, researchers, psychologists, medical doctors, students, psychiatry registrars and medical anthropologists, and if needed, a cultural mediator joins the team [85]. In addition, the BoTPT delivers training and support activities to informal carers, general practitioners, psychiatrists and mental health operators, social workers, medical students and psychiatric trainees. Training is specially directed to social and voluntary workers working with asylum seekers and traumatized immigrants [86].

A clinical survey and a 6-month follow-up were carried out on immigrants who consecutively attended the Bologna West Community Mental Health Centre between 1 July 1999 and 31 December 2007. An ad hoc schedule collecting socio-demographic, clinical and health service utilization data was specifically designed and adopted. Moreover, at the end of the first visit, the psychiatrists filled out sections 4 and 5 of the *Manual for the Assessment and Documentation of Psychopathology* (AMDP-SYSTEM) [87, 88]. Psychiatric diagnosis was provided according to ICD-10 criteria and confirmed by the Schedule for Clinical Assessment of Neuropsychiatry (SCAN) [89]. According to their birth area, patients were grouped under Maghreb, Sub-Saharan Africa, Asia, Eastern Europe and Central or South America. Following the AMDP structure, psychopathological items were grouped under three psychopathological syndromes: depressive, paranoid-hallucinatory and apathy syndromes [90, 91]; somatic items (nausea, breathing difficulties, dizziness, palpitations, cardiac pain, increased sweating, headache, hot flashes) were grouped together into the psychopathological definition of non-delusional hypochondria and autonomic syndrome [91]. The AMDP already showed good reliability and validity in samples of migrants [92].

Of the 180 migrant patients referred to BoTPT, 159 needed psychiatric care. Most of those patients came from North Africa (29%) and Sub-Saharan Africa (26%). At baseline, higher somatic scores were shown by Asian migrants (1.9 ± 3.6 vs. 1 ± 1.8, $p = 0.1$), workers (1.6 ± 2.9 vs. 1 ± 1.9, $p = 0.005$) and patients referred by GPs (2.1 ± 2.8 vs. 1.1 ± 2.3, $p = 0.06$). Somatization appeared to cut across the discrete categories of ICD-10: 40% of patients with anxiety or adjustment and 30% of patients with mood or psychotic disorders showed at least one somatic complain. At 6-month follow-up, a significant improvement of somatization without differences among ethnic or socio-demographic groups was found. Differences in levels of somatization severity persisted among ethnic groups (higher score for Asian migrants).

Functional somatic symptoms showed high prevalence in all diagnostic groups. Somatization severity at the baseline appeared to be related to pathways to care and socio-demographic features, as well as cultural/ethnic background. The BoTPT multidisciplinary approach showed transcultural effectiveness on reducing somatization severity.

7.6.2 Somatization and Self-Harm Behaviours in Migrants: The Experience in Modena, Italy

As the wave of immigration progressively increased in the last 20 years across Italy, health-care services had to adapt and react accordingly. Among the various expressions of this adaptation, there was, in the province of Modena, the institution of a transdisciplinary clinical group, within the local Department of Mental Health, dedicated to mental health of the immigrants as well as many research activities on this topic promoted by the psychiatry section of the University of Modena and Reggio Emilia.

One of these researches explored the differences between natives and foreigners, in a general population sample, regarding the prevalence and the clinical features of

somatic symptoms, and analysed possible explanatory factors. After recruiting subjects in both public places and by a mail survey sent by GPs, somatic symptoms were assessed by means of the Bradford Somatic Inventory, short version (BSI-21), a self-administered questionnaire, created and validated to be used cross-culturally [93, 94]. BSI-21 mean scores and positive cases (subjects above the cut-off of probable mental disorder) were compared, and confounding and explanatory variables tested with logistic regression model. A sample of 229 Italians and 193 immigrants was recruited. Immigrants had a higher BSI-21 mean score (8.02 vs. 5.64, $p = 0.004$) and more positive cases (19.4% vs. 6.6%, $p < 0.001$). Differences were explained by adjustment for satisfaction about oneself and about relationship with Italians, presence of spouse and for reporting as cause of symptoms, poverty, the condition of foreigner, separation from friends and relatives or job (aOR = 1.11, 95% CI 0.48–2.57). This preliminary project suggested that immigrants from low-income countries, independently by origin, experienced more non-organic somatic symptoms than natives, and this seemed to be primarily due to their precarious social conditions and adaptation problems.

Self-harm behaviours among migrants were also felt as a major topic of investigation. At this regard, a retrospective analysis of migrants committing not lethal self-harm behaviours referred to psychiatric consultation at the local A&E department vs. completed (lethal) suicides recorded in the database of the Modena Forensic Medicine Service was conducted. Migrants with self-harm behaviours were 34% (102/297), whereas completed suicides of migrants were 5% (7/122). More recently, one research project was developed to study self-harm behaviours among migrants in jail and impulsivity and trauma as possible associated factors. A prospective cohort study was designed, which assessed 54 migrants (M = 96.3%, mean age 32.5 ± 8.68 years) recently admitted to the local jail for different crimes. At admission, subjects underwent a diagnostic assessment and were asked to fill in three psychometric instruments: the Jail Screening Assessment Tool [95], the LiMEs (List of Migration Experiences) [96] and the Barratt Impulsiveness Scale (BIT-11) [97]. After a 3-month follow-up, incidence of self-harm behaviours was calculated and analysed according to baseline data. According to the LiMEs, the prevalence of exposure to trauma related to war or conflict, in the premigration phase, was of 32.1%. The prevalence of trauma suffered by relatives and worries about the safety of relatives, in the post-migration phase, was 77.4%. The 72.2% of the initial sample was available for follow-up after 3 months, and nine subjects (16% of the initial sample) had presented self-harm behaviours in the meanwhile. A statistically significant association was found between self-harm behaviours and exposure to trauma related to war/conflict before migration or exposure to worries about trauma for family members.

7.6.3 From Epidemiology to Intervention in Somatization: A Brief Report from Manchester, UK

People of Pakistani origin form the largest ethnic minority group in Manchester. Evidence from earlier research shows high rates of distress in Pakistani Muslims [80, 81]. Higher rates of depression and anxiety in British Indians and Pakistanis as compared to the larger white population and higher rates of presentations with

physical complaints have been reported in various works of research, although there has been contrasting evidence from other works of research [82] underlining the need for further analysis. A study was therefore conducted in Manchester, looking at rates of depression and access to primary care among people of Pakistani origin vs. white Europeans [83].

Cross-sectional population-based survey, followed by a prospective cohort study of depressed subjects, was conducted in order to determine whether the consultations were for somatic or psychological presentations and a description of GPs' interventions. In the first phase, patients were assessed with the Self-Reporting Questionnaire (SRQ) [98]. The SRQ has been successfully used in the Pakistani Muslim population and has shown good sensitivity and specificity for this group. In the second phase, all high scorers (score of 7 or more on SRQ) and a 1 in 4 sample of low scorers were contacted for an interview using the Schedule for Clinical Assessment in Neuropsychiatry (SCAN) to assess whether subjects met the criteria for either ICD-10 or DSM-IV depressive disorders [99]. A pain picture where the respondents were asked to mark any site where they would have experienced pain that lasted for more than a day in the previous 30 days was also used. Using the general practitioners' case notes, all consultations in primary care for 1 year prior to the 6-month follow-up were identified. All instruments were translated into Urdu, and these were reviewed by a bilingual focus group of mental health specialists and lay people according to a standard procedure [99].

Rates of depression were higher in women of Pakistani origin compared to white European women. There was no difference in somatic scores on the SRQ between the two ethnic groups whether depressed or nondepressed. Nor was there any difference in the psychological scores on the SRQ or on the pain scores or levels of distress. The correlation between total SRQ scores and pain was also exactly the same in the two groups. However, people of Pakistani origin had more frequent visits with their GPs for bodily symptoms. Although the prevalence of depression was significantly higher in the Pakistani population and there was no difference in symptoms of anxiety and depression presentations to the GPs in the two groups, people of Pakistani origin were less likely to be prescribed antidepressants and were less likely to be offered psychotherapy compared to the white European group.

The workgroup in Manchester is also currently working on the development of a culturally appropriate guidance on the delivery of cognitive behavioural therapy (CBT) for use with British South Asian women with medically unexplained symptoms. The guidance will include a manual, training programme and referral mechanism. It will be evidence-based and developed in partnership with service users. This is preliminary to an exploratory controlled trial of a ten-session, CBT-based, culturally adapted psychological intervention, which will focus on understanding the participant's model of illness, discussing physical manifestations of an existing mental state, modification of illness behaviour, cognitive restructuring to address dysfunctional cognitions and improving interpersonal relationships.

7.6.4 Social and Cultural Factors Affecting Physical and Psychosocial Wellbeing in Hospitalized Migrants in Barcelona, Spain ADIL

In Barcelona, in a sample of Latin American immigrants admitted in a general hospital, a study exploring the relationship between acculturation, social integration and social context with psychosocial and physical wellbeing was performed. Specifically, the focus is to explore the degree to which one or another acculturation strategy was more or less related to psychosocial and physical wellbeing and to see if that relationship was mitigated by acculturative stress.

The sample consisted of 290 Latin American immigrants who sought medical attention in a tertiary care hospital in Barcelona. Somatization was registered using the somatic symptoms subscale of the Patient Health Questionnaire (PHQ). Information about the patients' clinical outcomes, socio-demographic details, acculturative stress, social adaptation and legal status, anxiety and depression levels, acculturation and perceived stress was gathered.

The study revealed that acculturative stress and social integration (i.e. language, basic needs covered and legal status) play an important role in the psychosocial and physical wellbeing of the patient. Furthermore, none of the acculturative strategies appeared to be related to an improvement in psychosocial or physical wellbeing. Immigrants with higher levels of social support presented fewer symptoms of depression. After controlling for perceived stress, clinical outcomes and anxiety, legal status was the most predictive social integration variable for physical wellbeing (measured as somatization).

In conclusion, although culture may play an important role in somatic expression of distress, barriers to achieving immigration goals, or what could be considered strong stressors, seem to be what increase somatization.

7.6.5 Somatic and Depressive Symptom Variation in First-Generation Vietnamese and Native German Patients in a CL-Psychiatric Outpatient Clinic in Berlin, Germany

Vietnamese migrants are the largest group of immigrants from East Asia in Germany, and in Berlin they constitute the seventh largest immigrant group. In comparison to larger migrant groups, mental health-care utilization by first-generation (FG) Vietnamese migrants in Germany has been very low, and studies on symptom presentation and somatization in depression in Vietnamese immigrants were completely lacking. On the one hand, the Berlin working group aims to improve psychiatric and psychosomatic treatment facilities for Vietnamese migrants in Berlin [84]; on the other hand, these clinical activities are accompanied by research projects to study the complexity of migration processes and mental health [100].

A study that aims at exploring whether first-access FG Vietnamese CLP outpatients had a tendency to present more somatic symptoms and less psychological

symptoms in depression and whether only a subset of symptoms was responsible for differences in the somatic or depressive symptom scores was reported [101].

All patients were simultaneously assessed with a semi-structured clinical interview according to DSM-IV by a team of native Vietnamese psychiatrists and a German psychiatrist. Psychological or affective symptoms of depression were assessed by the depression scale of the Patient Health Questionnaire (PHQ-9), and somatic symptoms were assessed by the somatic symptom scale of the PHQ-15. Both PHQ scales were presented in either German language or as a translated Vietnamese version, as appropriate. PHQ assessments of Vietnamese patients were further validated for understanding with a native Vietnamese psychiatrist. To minimize possible confounders, only patients who met DSM-IV criteria for major depressive episode (MDE) were included in the study. First-access German outpatients at the same outpatient clinic were matched for age, gender and clinical diagnosis of MDE.

A sample of 110 first-generation migrant Vietnamese patients and 109 native German outpatients was included. While no significant differences on the total score of the PHQ-9 between both groups were found, FG Vietnamese outpatients had an overall significant and markedly higher score on the somatic symptom scale PHQ-15. When analysing single somatic items, FG Vietnamese outpatients were significantly more likely to report somatic symptoms of headache, chest pain, dizziness and fainting than the native-born group. There was a trend towards higher scores on the item from the depression scale (PHQ-9): “moving or speaking so slowly that other people could have noticed” in Vietnamese outpatients, which might reflect a tendency to external orientation, as reported in other East Asian samples.

Depressed Vietnamese outpatients reported psychological symptoms at similar levels of severity or at a single item level as matched native German outpatients. That was in contrast to the first hypothesis that stated that native German depressed outpatients were more likely to report psychological symptoms. Confirming the second hypothesis, depressed Vietnamese outpatients had a higher total score for somatic symptoms using the PHQ-15. Emphasis on certain somatic symptoms does not reflect a minimization of depressive symptoms in FG Vietnamese immigrant outpatients. Limited language proficiency was shown to be linked to higher somatic symptom reporting. Cultural differences in somatization should be interpreted in the context of culturally shaped and migration-related experiences of help-seeking behaviour, also related to pathways to care.

7.7 Conclusions and Implication for Psychosomatic Medicine

With increasing globalization, there is an urgent need of adequate diagnoses and treatment strategies for patients with a migration background. Migrants and ethnic minorities show a higher prevalence of mental disorders when compared to natives or fellow countrymen without migratory experiences. Thus, it is very important for clinicians and mental health-care specialists to be aware of the wider determinants

of the mental health of immigrants and to be trained in cultural competence. If a health-care system wants to increase its cultural competence, it needs to value diversity, be able to assess itself culturally, be aware of how cultures interact, incorporate and institutionalize cultural knowledge and adjust service delivery in order to understand and be aware of diversity between and within cultures.

A multidisciplinary and bio-psycho-social-cultural approach to illness is pivotal in the understanding of complexity and may promote cross-cultural effectiveness in detecting and adequately managing symptoms of somatization among migrants.

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