Cultural Competence and Training in Mental Health Practice in Europe: Strategies to Implement Competence and Empower Practitioners

International Organization for Migration (IOM)

Background Paper

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IOM is committed to the principle that humane and orderly migration benefits migrants and society. As an intergovernmental body, IOM acts with its partners in the international community to: assist in meeting the operational challenges of migration; advance understanding of migration issues; encourage social and economic development through migration; and uphold the human dignity and well-being of migrants.

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Executive Summary

"The ethics of brotherhood is to help someone with 'who we are' and 'what we have'. The ethics of solidarity require going a step further, by also learning cultural codes and representations.Brotherhood is a surge without reserve, which transcends cultures, whereas solidarity in an intercultural context is a surge to be completed by training, to achieve humanist objectives." Rachid Bennegadi

Mental health and wellbeing have become important issues in Europe. Seeking to establish an EU all-embracing strategy on mental health and mental illness, which now affects over one in four adults in the European Union, the European Commission proposed to launch a wide debate on the importance of mental health for the EU, the need for a strategy and the definition of priorities at EU level. This resulted in the adoption of a Green Paper on Mental Health by the European Commission: 'Improving the Mental Health of the Population: Towards a Strategy on Mental health for the European Union' and the launching of a public consultation on how to better tackle mental illness and promote mental well-being in the EU. There is also greater realization in Europe today that mental health levels can have a significant influence on the economic and social welfare of society. The EU strategy pursues the goal of improving the mental health of all the population, addressing inequities that currently exist in the provision of mental health services and to make them more responsive to the individual needs of a diverse society and special groups such as migrants.

In today's EU multicultural societies, mental healthcare approaches are often ineffective, resulting in major disparities especially affecting the migrant populations. Culture plays a major role in the expression and experience of mental health and ill-health; but culture also affects the way people approach mental health services, how they use them, what they expect from them, how and where they look for them and ultimately how they interact with mental health ser-

vice providers. Mental health is therefore a paradigmatic case for the need to build culturally sensitive health services. On the other hand, migrants have been found to disproportionately face mental health problems; migration is not in itself a health risk factor, however the circumstances surrounding the migration process can pose risks to mental health ("Migration: a social determinant of the health of migrants", IOM, paper for the AMAC project, December 2009). A key issue is for migrant populations therefore to have access to appropriate cross-cultural health services.

The need to build and support responsive and cultural competent healthcare service and service providers is currently widely accepted as well as the need to counter-act the impact of inter-cultural, often unequal, interactions between migrants and the healthcare professions. Reports indicate that the quality of care provided to immigrant and ethnic minority patients is not at the same level as that provided to majority group patients. Cultural competence represents a comprehensive response to the mental healthcare needs of immigrant and ethnic minority patients. Cultural competence training involves the development of knowledge, skills and attitudes that can improve the effectiveness of psychiatric and other types of treatment. Assessments of impact of training have revealed an increase in migrants' utilization of health services and a decrease in migrants dropping out from services.

This paper aims to highlight the common denominator of cultural training demands and responses of mental health professionals, regardless of the healthcare system, the European country or the migrant community concerned, as well as the basic elements to efficiently implement cultural competency within the mental healthcare setting.

(I) Cultural training practices for mental health professionals in the EU

The current state of cross-cultural training for mental health professionals in the EU is difficult to assess as a complete list of programmes cannot be gathered. As a first step, it is evident that an Internet search offers an abundance of local initiatives that are springing up in this area. However, the lack of coherent national, let alone European, approach and training models is apparent. No account of practices is offered in this paper since any account would be necessarily incomplete, non-systematic and therefore not conducive to any conclusive remarks. In very broad terms, northern and traditionally migration receiving countries such as the UK have "older" and much developed approaches to training; southern/Mediterranean countries have more recently embraced the need for training and present newer approaches; on the other hand, there is an apparent lack of attention to training in policy and practice in Eastern Europe.

The following patterns can also be observed:

1. Professionals have very different cultural competence skill levels;

2. Theoretical orientations in training are extremely variable;

3. There are no transverse training themes across Europe.

(II) Cultural competence for mental healthcare

A. Definitions of cultural competence

Cultural competence can be defined as a set of behaviors, knowledge and attitudes that enable the health professional to effectively work in cross-cultural situations. Cultural competency is the acceptance and respect of difference and a continuous self-assessment regarding culture.(10) "Culture" refers to integrated patterns of human behavior including language, thoughts, actions, customs, beliefs and institutions of racial, ethnic, social or religious groups.(16) Cultural competence involves awareness of the various ways in which culture, immigration status and ethnicity impact on the psychosocial development, psychopathology and therapeutic transactions.

Cross-cultural health strategies often focus on narrow notions such as a compromise between one dominant culture and a minor one. However, a better approach should preserve the cultural identities of both parties, patients and mental health professionals, without any stigmatization.

B. Designing cultural competence training for mental health practice

Healthcare systems in Europe give very diverse responses to migrant mental health needs and professional training demands. However, there should be common general parameters in cultural training development. A priori, consideration of the following elements contributes to effective design of training for any healthcare structure or service:

1. The specificity of the targeted migrant population;

2. The accessibility to mental healthcare services for migrants and refugees;

3. The availability of mental healthcare prevention tools for migrants and refugees;

4. The availability of formal education training in cultural competency for mental healthcare professionals and related professions (psychiatrists, psychologists, social workers, nurses); (5)

5. Local healthcare systems, their funding and the availability of services specifically catering to migrants (e.g. in France, "specialized" healthcare services contribute to ensuring healthcare access for all).

There exist different approaches or levels of training which can be desirable depending on the specific situation and whether it is an individual solicitation by a professional or case or an organized training strategy:

1. General introduction to cultural competence (no training per se, but rather an awareness raising exercise);

2. Introduction to cultural competence for a specific population and/or on specific mental pathologies (e.g. cultural "packages" for a group; it is important to be aware of and address risks of simplification or further stigmatization of the population in question);

3. Anthropological and psychological training based on the relations between culture and mental health; Healthcare and social service professionals are thus confronted on their explanatory models of health and disease, rather than being offered readily available packages; As a result, these professionals are given the opportunity to discover and make their own tools for cultural competence, which should then help them improve intercultural interactions; This kind of training must combine both psycho-anthropological and psychopathological aspects (e.g. avoiding to hold a migratory background responsible for a psychopathological case and viceversa). (6)

The evaluation of cultural training courses and feedback received by trained mental health professionals point at three classic profiles of trainee:

1. The trainee who knows everything before starting (it is therefore very difficult to have him/her question his/her asserted knowledge);

2. The trainee who is very anxious to reassess and transform his/her relationship with others; (7)

3. The trainee unable to think beyond stereotypes.

In every case, training in cultural competence induces cognitive and emotional changes, as certainties about academic knowledge and relations to "cultural others" are constantly being shifted and reassessed.

Cultural competence training must be validated by on-site professional supervision so that new skills are implemented and assessed in real-life situations. This last element of cultural training is crucial to trainees' professional improvement and their respective healthcare structures' overall practice. (8)

C. Basic knowledge, skills and attitudes in cultural competence in mental health practice

Knowledge:

- Patient's culture (traditions, values, family systems, communication styles);
- Acculturation process and its different forms depending on the levels of adhesion to the cultures of origin and of the host country: acculturation, integration, separation, marginalization; (1)

Abilities:

- Proficiency in intercultural communication: ability to communicate effectively, verbally and non-verbally, to patients of different cultures and to interpretate different cultural codes ("what one person intends is what the other hears"); (2)
- Capacity to develop a therapeutic relationship with a culturally different patient;
- Ability to utilize the concepts of empowerment for patients of different cultures;
- Capacity to distinguish between the symptoms of intra-psychic stress and stress arising from the social structure (coping, resilience, acculturation);
- Ability to adapt diagnosis and treatment in response to cultural difference;

Attitudes:

- Respect for the patient;
- Recognition that own's values and belief systems may conflict with the needs of clients from different cultures (confrontation of explanatory models) and awareness of the limits of any single cultural perspective; (4)
- Awareness of the presence of prejudices: ability to recognize and combat racism, stereotypes and myths on individuals and institutions;
- Recognition that culture influences the perceptions, values, attitudes, communication, behavior and lifestyle of patients and health care personnel alike;
- Creation of a comfortable space according to the patient's needs, engaging personal qualities that reflect genuineness, empathy, non-possessiveness. (3)

(III) Language interpreting and intercultural mediation

It is important that an individual be assessed in his/her primary language. This is especially important in the area of mental health, where emotions play such a heavy role in the individual's level of functioning. Therefore, using the services of professional interpreting services and/or mediators and obtaining assessment materials in an individual's primary language is necessary for technical accuracy as well as ethical appropriateness. The role of intercultural mediators is to "broker" between cultures and to facilitate communication and the therapeutic relationship by increasing the confidence of the participants.

Using instruments that have been translated into another language may help, but should not be assumed to be "enough". Many times, migrants may use local, idiomatic terms that do not correspond with the version of language used in an instrument (e.g. European Spanish vs. Latin American). Non-verbal language can also vary from culture to culture as well as conversational styles (e.g. silence, position, volume, touching). (10)

(IV) Innovative strategies and best practices

It is vital to understand the clinical importance of cultural and social factors in illness, health and the delivery of healthcare. This is the scope of medical anthropology with the concept of culture as the central theme, and as a result the difficulty to separate any society's healthcare system from other aspects of that society. The practical needs arising in the field and the subsequent vast expansion of this subject area have naturally led to setting up innovative strategies such as training for medical students and healthcare professionals. Based on an ethical approach, the training emphasizes the need to understand issues of health and sickness cross-culturally. (11)

Such training should allow trainees to recognize and deal with the complex relations between the biological, social, cultural, psychological, economic and techno-environmental determinants and concomitants of sickness and health on both theoretical and practical levels, and analyze and evaluate how health resources are organized and delivered and whether they are appropriate for any given clinical situation. Mental caregiving situations often call upon the expertise and services of various professionals such as anthropologists, sociologists, psychologists, psychoanalysts and social workers, and each professional must be able to operate and collaborate in such complex specialist environment. (12)

Training can take many forms which are not mutually exclusive but which on the contrary can be compatible. Indispensable nowadays is to support the training with multimedia tools (etraining, with possibility for self-training) and electronic exchange platforms. The main aim of self-training is to offer extensive training at a lower cost and at the convenience of the trainee in terms of location and timing. Self-training should be accompanied by a supervisor trainer and validation exercises.

A. The Centre Françoise Minkowska (Paris) as a Case Study

The Minkowska Centre has gained broad knowledge over the years in cultural mediation and cultural competence training from its field clinical experience. There has been over the past years an increasing need for tools expressed by the Centre's healthcare professionals facing difficulties in the relationship between the therapist and the patient in an intercultural setting. The Minkowska Centre has thus developed a unique approach combining clinical practice, mediation and training for mental health professionals, and supported by innovative multimedia tools.

The Françoise Minkowska Centre treats migrants and refugees from Paris and its suburbs. It follows the French national guidelines of access to healthcare for all. The Minkowska Centre uses clinical medical anthropology, whereby it takes into consideration the linguistic characteristics and cultural representations of mental health. Its clinical team is constituted by: interdisciplinary, multilingual, medico-psycho-social staff catering to patients (children and adults) from all continents in the context of international migration; a mediation reception and orientation cell (MEDIACOR) to regulate the number of patients; a medical committee; a medical information department, and an art therapist.

Cultural competence training is a matter of empowering social workers and healthcare professionals with multi-cultural and other skills to effectively be able to consult with and treat migrant patients. Demands for training are constantly increasing since existing intercultural models were exclusively focused on culture and language, stigmatizing both patients and caregivers. Such models proved to be incomplete as they did not take into account all the care setting elements such as the clinical importance of cultural and social factors in illness, health and the delivery of healthcare. Below are some highlights of the training provided by the Minkowska Centre:

> The training comprises the following aspects or modules: Socio-cultural Module, Psycho-Sociological Module, Psycho-Anthropological Module, Psychopathological Module and Ethical Module.

> The goals are the acquisition of analytical tools to confront cultural representations of mental illness and the improvement of intercultural management in the mental care practice with migrants, overcoming intercultural communication obstacles and developing relational capacities in intercultural situations.

> The training team includes professionals (psychiatrists, psychologists, social workers, anthropologists, sociologists, ethnologists, philosophers) working at the Minkowska Centre, as well as outside experts working on intercultural issues in a clinical medical anthropological perspective.

> The Minkowska Centre has elaborated an innovative pedagogical tool (AMECLIN) for the training of any healthcare professional on the intercultural setting and relationship, based on the clinical medical anthropological approach. This is in the context of institutional communication media

Minkowska Multimedia Tool (AMECLIN)

already exising (CD, training and educational media, www.minkowska.com). AMECLIN is a multimedia tool that supports and strengthens all the cultural training sessions. Below is a snapshot of this tool.

AMECLIN is used in training courses for mental health professionals (psychiatrists, psychologists, psychiatric nurses, social workers, educators). It is an interactive tool; this means that the trainee can make all the elements appear or disappear. The purpose of concretely showing all the stages of intercultural communication is to confront explanatory models. This tool is entirely based on the concepts of clinical medical anthropology ("Illness, Disease, Sickness"). (14) It also allows to debate on specific clinical cases by reflecting on the possible deficits in any given care. Every element of this multimedia tool refers to more detailed explanations; for example, the notion of explanatory models or the linguisitic and cultural interpretation. The evaluation and feedback received on this tool has been very positive. It has been reported to modify the relationship between the trainer and the trainee. It is available in several languages: English, French, Spanish, Italian, Arabic and Russian.

B. Practical steps and examples for clinical practice

Practical steps to consider by the therapist in an inter-cultural practice setting:

Step 1: Ethnic identity. The first step is to ask about ethnic identity and determine whether it matters for the patient - whether it is an important part of the patient's sense of self.

Step 2: What is at stake? The second step is to evaluate what is at stake as patients and their loved ones face an episode of illness.

Step 3: The Illness narrative. This step is to reconstruct the patient's "illness narrative".

Step 4: Psychological stresses. This step aims at considering the ongoing stresses and social support that characterize the patitent's life.

Step 5: Influence of culture on clinical relationships. This step examines culture in terms of its influence on clinical relationships.

Step 6: The problems of a cultural competency approach. This step takes into account the question of efficacy - namely, "Does this intervention actually work in this particular case?"

Below are some points which are validated during cross-cultural mental healthcare sessions:

1. The clinical case raises the need for specific training of Western psychotherapists;

2. A bit of anthropological knowledge and experience are always confusing;

3. The clinical frame and the confrontation of explanatory models is a guarantee for efficient counter-transference;

4. There is a tremendous field to explore, concerning the different patterns of distress from the psychodynamic point of view, as well as with the help of neuroscience. (13)

The following table hightlights three phases ("Engagement, Therapeutic Alliance, Outcome") in the professional/patient therapeutic relationship which should be successfully conducted. It shows a transference and counter-transference process in which a confrontation of explanatory models comes into play. The table actually explains what processes in such relationship can go wrong and how, by showing the perspectives of therapist and patient respectively.

I) Engagement	
Therapist	**Patient**
Notices difference: "Oh my god, I've never had a patient from this culture!"	**Notices difference:** "It's the first time I've been referred to a psychotherapist!"
Doesn't acknowledge importance: "I don't think that everything this patient is telling me has any importance for me to make a diagnostic."	**Assumes therapist won't understand:** "Does she understand that what I'm telling her about women is important for me?"
Sees client as stereotype: "Oh I see now, I have been taught that this is a common behavior in people from this culture!"	**Fears of being judged:** "My god, I hope he's not judging me by the culture I come from."
(II) Therapeutic Alliance	
Therapist	**Patient**
Does not understand client: "I don't know what therapeutic help to propose!"	**Feels misunderstood:** "I hope he's not going to propose something that instead of helping me is going to complicate my life!"
Fails to respond to mistrust: "How am I going to be able to convince this patient to trust me?"	**Shows increased mistrust:** "How can I trust someone who belongs to a society that colonized me?"
Sees client as unmotivated or not psychologically minded: "It's not a real demand for help, and I'm wondering if this patient is even ready to engage in a psychotherapy."	**Decreases self-disclosure:** "Finally I don't think that I should go any further with my help seeking demand."
Assumes client is resistant: "I understand that this person isn't prepared enough and I also think that there is tremendous resistance."	**Does not develop rapport:** "I came to ask for help, and I have the impression that I came to the wrong place, and the wrong person."
(III) Outcome	
Therapist	**Patient**
Shows anxiety and frustration: "I'm aware that I'm not handling this situation correctly and it's worrying me."	**Shows frustration and anxiety:** "What a pity that I'm obliged to follow a treatment that I don't believe in."
Exhibits misalliance; may misdiagnose: "I'm not very happy with this first session, it's going to be hard to diagnose this patient correctly."	**Cancels sessions:** "I know and I don't know why I'm cancelling some sessions."
Perceives faulty treatment planning: "And yet I thought that he was suffering from depression . . .!"	**Fails to show for appointments:** "I'll show up for my appointments if and when I can."
Observes failed outcomes: "I really don't think that I made the best therapeutic choices for this patient."	**Terminates treatment prematurely:** "I'm going to stop with this therapist and find myself someone else!"

Table 1. Developed by the author of this paper based on his professional practice and personal communication with patients.

Some specific case studies are presented below:

Case Study N°1: "I can't stop washing my hands."

A young male refugee from Sudan, a practicing Muslim, arrived as an asylum seeker in January 2005. He got his papers from the commission and from that moment he felt very anxious and said that he began washing his hand more than necessary.

Reaction (psychiatrist): "What could the diagnosis be, considering the fact that excessive hand washing is not a symptom for me?"
Reaction (social worker): "How come anxiety manifested when the patient received his papers?"

Case Study N°2: "You have no respect for my sense of decency."

A young woman joined her husband in February 2006, from Morocco. Totally lost in the city, her husband explained to her how to get by, but refused the social worker's help. « I don't want her to learn how to be autonomous, because sooner or later I will be in trouble ». She was very depressed, crying all the time and talking about a spirit that possessed her body and pushed her to behave strangely.

Reaction (social worker): "Are we faced with a social or psychological problem, because the question may concern the cultural representation of a woman's autonomy?"

Reaction (psychiatrist): "But depression is a psychiatric symptom and not an acculturation problem."

Case Study N°3: "I can't even commit suicide. It's forbidden by my religion."

A 52 year-old Algerian woman's husband left her for a new younger wife. She was depressed and was always complaining to her children, in a hysterical way. They all left the house and now she is trying witchcraft because it's the only reliable explanation for her.

Reaction (social worker): "Why, according to her culture, are woman so dependent on a man that she considers suicide as a solution?"

Reaction (psychiatrist): "It's interesting to know that cultural values (religious beliefs) could be a support against suicide."

Case Study N°4: "I don't know what to do with "spirits"!"

A migrant worker, living and working in Paris for the past 30 years, was referred to a psychologist by his GP who knows him very well and has been treating him for a depression with drugs, and who told him that he should talk to a shrink because, when it comes to «spirits » he is not qualified.

Reaction (nurse): "This GP is very prudent. When you don't know the meaning of the cultural representation, it's better not to go further that one's own limits."

Reaction (anthropologist): "Why disqualify oneself when you can learn from the patient?"

Case Study N°5: "Why don't you believe in the cult of saints and praying to cure my distressed mind?"

A young adult, born in France and working in a computer company, was referred to a psychologist by his boss who does not accept his new behavior in the team and who told him to seek some help because he may be suffering from a burnout. According to the patient, the causes of the burnout were experienced as a sudden feeling of being observed and controlled through the computer by "non- believers". The patient asked: "Why don't you believe in the cult of saints and praying, to cure my distressed mind from these external forces? Why do you want to add something to help me?"

Reaction (psychiatrist): Religious beliefs and faith are part of the organization of the personality and when the patients use them as a spiritual strategy against pathologies, it could be complementary in psychotherapy.

Reaction (psychiatrist): Religious beliefs as a tactical defense in psychopathological identity distress or emergency social coping should be handled with care.

Reaction (social worker): I would say that more and more patients are aware of the limits of the influence of religious beliefs as a reliable therapy, even though they need to use traditional concepts to express the pathology.

Conclusions

Training of mental professionals and professionals of other medical specialities is an element of a set of necessary answers to offer better healthcare to diverse and in particular migrant populations. Although most mental health professionals and bodies such as the European Board of Medical Specialists recognize awareness of cultural issues as a core component of the psychiatry specialization, few medical schools provide training in cultural issues. An appropriate training strategy allies the notion of cultural competence and the foundation on formal/academic education together with the use of multimedia tools and the possibility of supervision to validate progress of trainees. (15)

Greater infrastructure and longterm funding is needed to support efforts of medical schools and healthcare institutions. Training and funding in the healthcare sector varies across European countries ac-cording to local economies and systems. However, the better health-care and social service professionals are trained to enact strategies that avoid stigmatization, ethnocentrism and indifference, the less European states will have to spend on ensuring proper healthcare and social service access to immigrants and refugees. Cultural competence training is therefore a cost-effective strategy also from the financial perspective.

The field would also benefit from greater cooperation at European level. Common tools, methods and practices may be developed or reassembled so as to create common European structures of exper-tise and training in cultural competence, eventually giving place to a common European cultural competence diploma.

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EUGATE: Best practice in access, quality and appropriateness of health services for immigrants in Europe. http://mighealth.net/eu/index.php/EUGATE_contact_details_and_associated_partners

EUROMED: European-Mediterranean Network on Migration and Mental Health. Newsletter: http://mighealth.net/eu/images/f/f1/News.pdf

HOME: Health and Social Care for Migrants and Ethnic Minorities in Europe COST Action ISO603 http://www.cost.esf.org/index.php?id=233&action_number=ISO603

IOM: International Organisation for Migration http://www.iom.int/jahia/Jahia/lang/en/pid/1

MIGHEALTHNET Information network on good practices in healthcare for migrants and minorities in Europe. www.mighealth.net

MINKOWSKA CENTRE: Mental Health and Cultures http://www.minkowska.com

WHO: World Health Organisation http://www.who.int/en/index.html

WPA-TPS: World Psychiatric Association, Transcultural Psychiatry Section http://www.wpa-tps.org/

Cross Cultural Training

http://www.kwintessential.co.uk/cross-cultural/cross-cultural-courses.html

http://www.training.medact.org/

http://mentalhealth.samhsa.gov/publications/allpubs/SMA00-3457/ch2.asp

Movie Website and Databases

http://faculty.dwc.edu/nicosia/moviesandmentalillnessbibliography.htm

Movies and Mental Illness Filmography:
http://faculty.dwc.edu/nicosia/moviesandmentalillnessfilmography.htm

Movies on Race and Ethnicity collection at UC Berkeley:
http://www.lib.berkeley.edu/MRC/EthnicImagesVid.html

Hollywood's Portrayal of Psychopathology:
http://home.epix.net/~tcannon1/psychmovies/home.html

106-page document & filmography on Using Film to Teach Psychology:
http://www.lemoyne.edu/OTRP/otrpresources/filmresources.html

Literature, arts & medicine database
http://endeavor.med.nyu.edu/lit-med/lit-med-db/index.html

NATIONAL FILM BOARD OF CANADA - Free! Over 100 films about cultural diversity now online:
http://www.nfb.ca/newsletters/20071003/