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Editorial

Migration and transcultural psychiatry in Europe

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European societies are characterised by an increasing number of migrants, and in several countries about one third of all adolescents now have a migratory background [15]. However, migration is nothing new in the history of Europe. From the migration of Indo-European speaking groups to the spread of Celtic tribes as far as Turkey, famously depicted in the Pergamon temple now exhibited in Berlin, from the Roman Empire, which sent its soldiers from different parts of the Mediterranean all over the European continent, to the migration of Anglo-Saxons, Franks and Gothic tribes, and from the spread of Jewish, Protestant and Catholic refugees throughout the 16th, 17th and 18th century to enforced displacement and genocide in the 20th century: Europeans have been much closer connected than it has often been reflected in nationalist ideologies. This contact – as much as it has been associated with individual suffering – has stimulated the exchange of ideas and techniques and created a vibrant network of cultures.

Dealing with psychosocial problems within these settings therefore is nothing new. Psychiatrists who travelled the world have for more than 100 years pointed to cultural differences in the manifestation of certain psychiatric disorders. One example are Kraepelin's travels to Java, from which he returned with vivid descriptions of differences in specific hallucinations and delusions [9]. However, transcultural psychiatry has also been influenced by predominant Eurocentric ideas, which prevailed in the first half of the 20th century. Inspired by an evolutionary understanding of not only human biological history, but also the phylogenetic development of the brain and individual ontogenesis, many psychiatrists assumed that psychiatric disorders can be conceptionalised as an evolutionary dissolution or regression to a more primitive level [4]. Of course, theories about phylogenetically "primitive" mental states remained speculative and authors often instead referred to contemporary colonialised populations, thus denying an adequate appreciation of the cultural development of these people. Modern transcultural psychiatry has to avoid these biases and needs to promote an understanding about basic mental functions and disease categories, while paying specific attention to culturally influenced constellations of stress factors, psychosocial variables that influence treatment outcome and the individual understanding and interpretation of disease symptoms. It was the psychiatrist and anthropologist Arthur Kleinman who coined the term "explanatory models" to emphasize that every patient perceives and explains his or her illness within the network of a culturally influenced model of health and diseases [8]. Differences in explanatory models between patients and professionals, particularly from separate social or cultural backgrounds, can lead to misunderstanding. For example in Jamaica, diabetes, translated as "too much sugar in the blood" and requiring a "diet", does not motivate a traditionally minded patient to reduce the intake of carbohydrates but instead to consume bitter teas, because bitter teas in the traditional explanatory model of disorders are assumed to balance too much sweetness in the blood [5]. Transcultural psychiatry thus requires careful and constant communication and a reflection of the cultural and social background of the individual patient.

Transcultural psychiatry also has to reflect differences in sensitivity for certain side-effects of pharmaceutical drugs in different populations. However, it does not seem to be helpful to understand such population differences within the traditional concept of "race". The race term has been coined on the idea that in different parts of the world, pre-human primates developed into different human "races" [2]. Current research instead indicates that the human race originated in Africa and that the currently existing populations developed by migration from this original population. As a consequence, there is no categorical genetic difference

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between existing populations. Rather, gene frequencies vary to some degree and often a high variability in genetic markers is found in Africa, while due to selective effects of migration, only a smaller genetic variance is represented in populations derived from the original group of human beings [16]. Therefore, human genetic variation is characterized by inclining or declining frequencies of certain genes, and not by absolute genetic differences, and the term "race" is biologically inadequate [11].

Also, cultural differences do not tend to be dichotomous. Instead, even traditional explanatory models are often influenced by modern disease concepts and particularly in migrants, each individual forms his or her explanatory model of a disorder with respect to different information sources, including the media, the neighbourhood, the relevant medical professionals etc. Moreover, disease concepts may already vary considerably between e.g. a person from a small village and a highly professionalised city dweller, who may have spent several years on a different continent [5, 8]. Therefore, transcultural psychiatry is just one example of how careful professionals and patients have to be when trying to understand each other's intentions and concerns.

The current issue tries to tackle current questions of transcultural psychiatry. Two articles describe migrants'psychosocial health, quality of life and acculturation stress:

Iren Akbiyik *et al.* [6] compare quality of life of migrant groups with depressive disorders with patients in the country of origin. Their findings indicate that quality of life of Turkish patients in Berlin appears lower than that of similar patients in Ankara.

Haasen *et al.* [3] examine the association between acculturation stress and mental distress in two different migrant groups in Germany, migrants of Russian and of Iranian origin. In both migrant groups a significant correlation between acculturation stress and mental distress was found, yet no significant association between acculturation stress and length of residency in Germany.

Three articles describe migrants'access to outpatient and inpatient treatment centres for mental health-related problems:

Lindert *et al.* [10] review the literature concerning mental health disorders of migrants and their access to health care and psychosocial services in Europe. The authors describe a fundamental lack of representative data on the mental health of different groups of migrants, refugees, travellers and asylum seekers.

Schouler-Ocak *et al.* [14] present data from a representative nationwide survey of the use of inpatient psychiatric and psychotherapeutic services in Germany by patients of immigrant origin. They report that communication problems remain while the percentage of migrants in inpatient services is now equal to their presence in the general population [10].

Wittig *et al.* [17] examine migrants from Poland and Vietnam in Leipzig, a German city located in the Eastern part of Germany. These migrants display higher scores of physical ill-health, anxiety and depression yet use medical and psychosocial treatment centers less often than native Germans. This article illustrates that even if migrants in general now seem to use inpatient treatment facilities as often as their native German counterparts, different groups of migrants can still suffer from reduced access of treatment facilities.

Two articles focus on approaches that match the need for culturally sensitive diagnosis of mental health problems of migrants and ethnic minorities:

Penka *et al.* [12] describe differences in the explanatory model of addiction and psychiatric disorders in adolescent Turkish and ethnic German migrants from the former Soviet Union and compare them with disease concepts of German adolescents. The authors suggest that differences in disease concepts can contribute to communication problems and reduce access to mental healthy care institutions [3].

Borra [1] suggest that asking culture-related questions leads to a culturally sensitive therapy, to more empathy and better understanding of a client with a different cultural background and illustrates this hypothesis with a case report [16].

Finally, two articles focus on therapeutic approaches that match the need for culturally sensitive treatment of migrants and ethnic minorities:

Qureshi *et al.* [13] explain that cultural competence represents a comprehensive response to the mental health needs of migrants and ethnic minority patients. The authors underline that awareness of the many ways in which culture can interact with expression and understanding of suffering and mental distress and the relevant diagnostic and treatment adaptations are key aspects of cultural competence.

Kastrup [7] outlines a suggestion for competent treatment of patients with multicultural backgrounds, which requires that mental health professionals are aware of the existence of traditional approaches and exhibit a willingness and an ability to bridge between the more traditional and the Western approaches to treatment.

Altogether, the studies presented in this supplement illustrate the increasing importance of research on the mental health of migrants and ethic minorities. They show that some progress has been made and that at least for inpatient treatment, access barriers may have been reduced. However, they also show that problems of communication and outpatient care remain and that the fight against discrimination remains an important topic for current mental health workers and policy makers in Europe.

Conflicts of interest: None.

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