Recommendation for diagnostic interview in an intercultural context

Flight- and migration-specific aspects of medical history

History of origin	social status, education, previous experience with western health care, relation to the culture of origin, religiousness
Family history (von Lersner & Kızılhan, 2017)	relation and structure of the primary family (possible generational conflicts, change of values of the following generations, traditional family image etc.) and extended family (possible obligations in host-country or in the country of origin), form of marriage (traditional, voluntary or forced marriage)
History of migration resp. family reunion	individual, familiar, professional, political, economic, existential, etc. reasons for migration; history of family reunification
Integration history	residential status, access to housing, employment, education, health care and community organizations, adopted/traditional values, feelings of discrimination, acculturation stress (Berry, 1997)
Migration summary	individual evaluation of flight/migration, quality of life and happiness in the host country, social comparisons with other refugees/migrants
Future perspectives	remigration plans and pressure (Sabbioni & Salis Gross, 2006)
Course of the disease	psychological health before flight/migration, circumstances of the first occurrence or aggravation of the complaints, taking into account the individual and collective biography
Personal explanation models	divergent ideas about the understanding of the anatomy and functioning of one's own body and causes of complaints (magic, curse, punishment, etc.) are possible

(according to Sabbioni, 2012)

Intercultural competence

Intercultural competence is…

„[…] the ability to deal and work together with people who have different cultural backgrounds, which should be perceived as successful intercultural communication on both sides." (von Lersner & Kızılhan, 2017)

- personal attitudes and experiences are put aside
- willingness to revise stereotypes and prejudices, openness to new things
- foundation: basic therapeutic competences i.e. appreciation, empathy, authenticity (Rogers, 1981)

Factors influencing misconceptions/diagnoses in the intercultural setting (von Lersner & Kizilhan, 2017)

Patient	Practitioner
• shame, taboos: some topics are avoided due to cultural norms among a certain group of people (e.g., sexual abuse, severe mental disorders) • culturally specific concepts of illness or suffering (e.g., psychological complaints are communicated via somatic impairments) • social desirability: treatment provider is perceived as an authority, which can lead to more conformist, less open communication • linguistic communication difficulties: difficulty in correctly translating specific diagnosis-related information • aggravation, simulation: simulation of symptoms with a specific goal in mind (e.g., compassion, asylum significance)	• Halo effect: context information (e.g., skin color, appearance) negatively influences diagnosis • symptom, time and process criteria of the disorder are not taken into account, conclusion on individual phenomena • expectations (shaped by, e.g., stereotypes about a particular culture) • culturalization of a mental health problem due to lack of culture-specific knowledge → clinically relevant symptoms are misinterpreted as culture-specific phenomena

Use of language and cultural mediators in diagnostic interviews (von Lersner & Kizilhan, 2017)

- possible overload and stress of the language mediator due to the content of the conversation → debriefing of the patient conversations with the language mediator (Kluge, 2011)
- language mediator has additional cultural mediating task, i.e., to transmit cultural meaning of a message
- word-for-word, comment-free, and impartial translation, considering semantic comprehensibility
- no conversations between interpreter and patient or therapist and patient without translation → every comment will be translated
- translation is simultaneous and in the verbatim speech (Morina et al., 2010)

Special feature in the diagnosis of specific diseases

Anxiety disorders	• depending on the culture, it can manifest itself cognitively, affectively, somatically and/or behaviorally, making diagnosis difficult (Agorastos et al., 2012) • sometimes cognitions arise that do not correspond to reality and take on delusional character • evil magic and ghosts are topic in many cultures
Depression	• shows itself non-European rather by physical symptoms and intra-European by depressive mood (Koch & Kraus, 2005) • traditional families: depression reflects problems in the family/marriage/friendships → if these areas are destabilized, also impact on identity • stigmatization can spread to the entire family, so professional help is often not sought • tendency possible to express symptoms very strongly to make it clear that role tasks can no longer be performed • in collectivist-oriented families often excessive care, therefore in the crisis less withdrawal and separation possible than in Western societies
Somatization	• in many cultures body is "platform" for psychological complaints • psychological symptoms are denied, fixation on physical symptoms • differentiation from somatoform disorder, idioms of distress, and anxiety/depression important

Schizophrenia	• higher risk of misdiagnosis: sometimes different results in diagnosis of German and Turkish patients (when examined by Turkish-speaking and German-speaking practitioners) (Haasen et al., 2000)
	  ○ reasons: cultural differences in symptom descriptions, lack of intercultural competence of German physicians and misinterpretation of culture-specific symptom descriptions and possible discrimination tendencies
	• in traditional cultures difficult to distinguish between delusion and reality or delusion and belief, delusional persuasions or beliefs possibly part of culture and not pathological (Schouler-Ocak, 2010)
	• possession and trance rituals are used in some cultures for healing of mentally ill people
	• content of delusion and frequency of several symptoms are systematically different between cultures: reflect particular mission statements and anxieties of the culture in which they occur
	  ○ *recommendation*: use of structural interviews such as SKID and DIPS, as well as Cultural Formulation Interviews (von Lersner & Kızılhan, 2017)
	(see also Machleidt & Graef-Calliess, 2017)

PTSD	• successful coping can mean not talking about the trauma and not be declined by community → exposition not in every culture accepted as intervention method • often in collectivistic societies: social harmony highest priority, no “loss of face”

(von Lersner & Kızılhan, 2017)

Suizidality:

- religion can be protective factor but also risk factor, because it impedes disclosure of suicidal experience and behaviour as well as making use of interventions (Wu et al., 2015))
- risk factors of suicidal experience and behaviour: experiences before and during the flight, separation from or loss of the family, integration difficulties, longer stay in provisional refugee shelter and lacking support (Vijayakumar, 2016; Wasserman, 2017)
- see also Schouler-Ocak et al. (2015)

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