

## Research paper

# Attitudes towards treatment of migrant children and adolescents and their families among child and adolescent psychiatrists: current clinical practice and developmental perspectives

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### What is known on this subject

- Several studies in children have shown that immigrant families display specific emotional and behavioural problems.
- Diagnostic and therapeutic treatment procedures are influenced by language and culture.
- The quality of the patient–doctor relationship has an impact on the effectiveness of and compliance with healthcare among migrant patients.

### What this paper adds

- It is the first systematic national survey of child and adolescent psychiatrists working in private practice in Germany, focusing on the needs and treatment of migrant children and adolescents.
- It examines the influence of the mental health professional, which is dependent on their own migration background, gender and age, on the ‘cultural receptivity’ of the clinical practice.
- There is no single form of treatment for all migrant children and their families, but rather often idiosyncratic styles of mental healthcare that depend on the characteristics of the health professional and their openness to cultural concepts.

## ABSTRACT

Like many other countries, Germany has an increasing number of children who originate from migrant families. Medical facilities are required to care for people from a diverse range of social and cultural backgrounds. A study-specific questionnaire was used to ask 100 child and adolescent psychiatrists about their impressions of how well the mental health needs of the children of migrants are identified and managed by child and adolescent psychiatric practices in Germany. There was a generally positive attitude towards migrant families and their needs, with most of the respondents indicating

that they enjoyed working with migrant children and adolescents and their families. However, there was a tendency to focus more on language than on other aspects of culture. Most of the respondents felt satisfied with their training in this area. Individual difference variables, such as *age*, *gender* and *familiarity with migration*, affected their awareness of and sensitivity to migrant family health issues.

**Keywords:** child and adolescent psychiatry, families, Germany, mental health, migration, social policy makers

## Introduction

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About half a century ago, non-Germans constituted 1% of the German population, and by the end of 2003 this figure was almost 9%. By 2011, around 16 million (approximately 19.5%) of the 81.75 million members of the population in Germany had a personal or family migration background (Bundeszentrale für politische Bildung, 2013). At present, one in five of the 'foreigners' residing in Germany is German born and represents second- or third-generation immigrants. With regard to geographical origin, migrants in Germany are mainly from Eastern and South-Eastern Europe, particularly Russian and Polish migrants; almost one in five migrants originates from Turkey. There are relatively few migrants from other parts of the world. The number of asylum seekers has increased, and there has been a significant increase in the number of Roma migrants from Eastern Europe. In mental health services, an attempt has been made to employ more Turkish, Russian and Polish native-speaking doctors and psychologists.

## Culture, migration and mental health

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Culture is perceived as a central factor in understanding the migrant patient (Caroppa *et al*, 2009; Kanitsaki, 2003). Bhugra (2004) emphasises the importance of cultural sensitivity and understanding for all mental health professionals, and this is particularly relevant when healthcare providers and migrants often have different ways of expressing distress (Lindert, 2011). However, Helman drew clinicians' attention to the need for sensitivity to cultural differences when formulating diagnoses, but cautioned against overemphasis on culture at the expense of other important factors. Some researchers reject what was referred to as the 'migration-morbidity hypothesis.' For example, Minas (2009) stated that 'The prevalence of mental disorders among different immigrant groups is highly variable. Immigrant status, in itself, is not associated with either increased or decreased risk for mental disorder. ... It is the specific circumstances of pre-migration experience, migration and settlement that are important in influencing risk for mental disorder' (Helman, 2007, p. 343). Language barriers are a frequent source of misunderstanding. Interpretation by a member of the immediate family may lead to a confounding effect on the subsequent diagnosis and therapy, as well as having an impact on confidentiality and the information shared. Machleidt (2013) emphasised that 'speech mediation' serves a much broader function than the construct of 'translator' suggests. The linguistic mediator

must be familiar with the idiosyncratic nuances of the original culture if they are to address issues of cultural difference and potential misunderstandings. The development of a culturally sensitive psychiatric care system in Germany has benefited from guidelines elaborated by clinically experienced migration researchers (Machleidt *et al*, 2012).

In the case of child and adolescent migrants, Siefen *et al* (1996) have suggested that parents appear to exert a strong influence on their offspring's acculturation experiences and behaviours. Moreover, parental attitudes and behaviours have consequences for their children's socio-cultural and psychological adaptation (Kirkcaldy *et al*, 2009). Vollebergh *et al* (2005) reported that children from immigrant families did not exhibit more emotional problems than their non-immigrant peers. Parents from immigrant families described more problems with their daughters than non-immigrant parents did. However, teachers perceived lower levels of internalising and social and cognitive problems in boys, and higher levels of externalising problems in both male and female immigrant children. In a review of international studies published since 1990, Stevens and Vollebergh (2008) also found that migrant children did not appear to have an increased risk of developing mental health disorders, but this was in part due to multiple variations in migration experiences. However, they also noted poorly defined terminology and a paucity of research in this field. Although migrant children and adolescents may not necessarily display more mental health problems *per se* than the host population, there is evidence that they exhibit specific emotional and behavioural problems (Dogra *et al*, 2011; Hölling *et al*, 2007). Therefore it is essential that child and adolescent psychiatrists are especially aware of the perceptions of and needs for healthcare among migrant families.

## Survey design

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The Federal Association of Medical Directors in Child and Adolescent Psychiatry (BAG) and the Professional Association of Child and Adolescent Psychiatry and Psychotherapy (BKJPP) decided at their members' meetings in 2011 to establish a Working Group for Intercultural Child and Adolescent Psychiatry and Migration. The working group was then commissioned to conduct surveys of the needs and treatment of inpatient, outpatient and ambulatory care among migrants. Members of the group are Board Members from both organisations alongside a third organisation, the Child and Adolescent Psychiatric Society in Germany (DGKJPP). It was agreed that the results would be published in national and international journals to promote further research demands and

international cooperation in this area. In line with practice in Germany at the time, an ethical review was not required.

The aim of the survey was to examine the experiences of mental health professionals who had considerable in-depth experience of the problems confronting migrants to Germany. Health statistics for Germany suggested that, in 2010, there were 1600 child and adolescent psychiatrists, around half of whom ( $n = 688$ ) were working in their own private practices, and an almost equal number of whom ( $n = 673$ ) were working in clinics; a further 80 child and adolescent psychiatrists were employed in a range of other settings, such as health ministries and specialised units (Warnke and Lehmkuhl, 2011). In 2007, the statistics for gender ratio had shifted to 49:51 (male:female). The authors reported that 11% of the child and adolescent psychiatrists were aged 60 years or older.

The primary aims of the present study were to establish:

- 1 the sociodemographic characteristics of child and adolescent psychiatrists working in private practice in Germany
- 2 whether these practices offer a migrant-specific programme of healthcare, and the range of problems and interventions among migrants
- 3 whether there was any indication that the care offered reflected awareness of the cultural factors that warranted consideration
- 4 whether age, gender or experiences of migration of the psychiatrists are related to perceptions of the care provided to migrant groups.

## Materials

The questionnaire was an adaptation of that for medical directors of child and adolescent psychiatric hospitals and clinics. It was structured along the lines of previously used tools in adult psychiatric hospitals (Koch *et al*, 2008; Schouler-Ocak *et al*, 2008). Here the items have been revised and formulated specifically for a sample of child and adolescent psychiatrists. The basic aim was to cover all of the essential domains of pertinent healthcare, namely outpatient, inpatient and day clinics. Furthermore, constituent items were extended to include aspects of 'utilisation' and 'communication barriers.' The focus was on establishing whether administrative, organisational or other conditions prevent migrant families from finding appropriate help in the treatment of psychiatric and/or psychosomatic disorders (see Box 1).

## Procedure

The questionnaires were completed anonymously and returned in a stamped addressed envelope to one of the principal investigators at the university clinic in Bochum within a 3-month period during the final quarter of 2012. The statistical analysis encompassed both descriptive and uni- and multivariate analyses. For the descriptive analyses the ratings of 'frequent and often' were used to explore which responses were most often perceived among psychiatrists. In order to make group comparisons (e.g. male vs. female psychiatrists, those with a migration background vs. those with no migrant family background), we used univariate

### Box 1 The questionnaire for child and adolescent psychiatric practices

The questionnaire had 52 items and was divided into the following areas:

- Practice location and conditions of practice (e.g. practice form, average number of cases, estimated proportion of patients with an immigrant background, estimated frequency of treatment of specific ethnocultural groups).
- Questions relating to conceptual and therapeutic opportunities for migrants.
- Four distinct domains with questions on:
  - problems in understanding and empathy
  - the extent of treatment of patients with an immigrant background being affected by treatment climate
  - the relevance of migration background to current and future treatment plans.
  - openings for future training programmes for cultural sensitivity.
- Conditions for the treatment of patients with a migrant background in recent years, including specific information for potential patients and open-mindedness on the part of migrants.
- The future importance of migrant-specific treatment approaches (e.g. specialised stations, translation services, migrant-based competences, implementation of training and education in this area).
- Inclusion of sociodemographic data in order to understand the influence of sociodemographic factors on the cultural opening of the practices (e.g. occupational status, gender, immigration experience, family immigration background).

The majority of the items require a response on a Likert scale of 1 to 5 (where 5 = very often, 4 = often, 3 = occasionally, 2 = hardly ever, 1 = seldom).

*F*-tests for comparison of means, and multivariate analyses to identify profile differences.

## Results

### General characteristics of respondents

A total of 100 child and adolescent psychiatrists (57 women and 42 men; data missing for 1 individual) responded from 750 practices nationwide. They ranged in age from 36 to 65 years (43.3% were under 50 years of age, and 56.7% were over 50 years). The majority (93.9%) owned their own clinical practice. In total, 8% were immigrants themselves, and 24.2% had a family immigrant background. The majority (90.8%) resided in the Old Federal States.

The age groups of the psychiatrists in this sample are fairly consistent with findings from the national organisations for psychiatrists. The most common age group is 46–50 years (28.9%), followed by 51–55 years (25.8%) and 56–60 years (21.6%). Less than 10% of the psychiatrists were 60 years or older. Only about 1 in 50 (*c.* 2%) were in the youngest age group (36–40 years). In our sample, none of the child and adolescent psychiatrists in outpatient practice were under the age of 35 years.

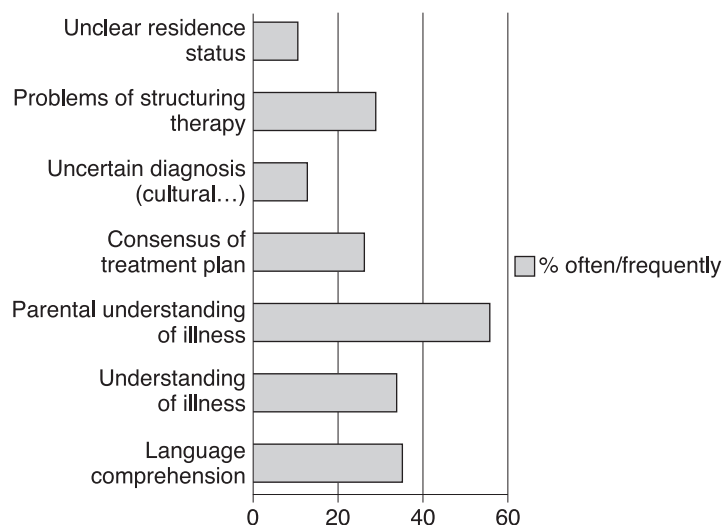
### Child psychiatric healthcare practices

Univariate comparison of means revealed significant differences in the number of patients seen over a quarterly period, depending on which type of psychiatric practice was considered ( $F(4,91) = 7.23, P < 0.001$ ). Psychiatry practices with a social psychiatry agree-

ment (i.e. private practices that have a special contract with the health insurance companies allowing them to employ allied health professionals such as remedial therapists and psychologists) see almost three times the number of cases (mean = 520.9) compared with classical psychiatric practices (mean = 172.6). Psychiatrists focusing on psychotherapy saw far fewer patients per quarter (mean = 129.0), and the same was true of those working in multiple care centres ('MVZ'), which correspond to practices that have the role of outpatient polyclinics (mean = 187.5). On average, psychiatrists see around 460 cases per quarter (for our miscellaneous group, a psychiatric practice that could not be clearly defined as polyclinic or outpatient; mean = 463.3), although the frequency shows large variation, from 20 to 1500 cases (this is in contrast with psychological psychotherapists, who see an average of 50 cases per quarter).

Just over two-thirds of those doctors who stated that their practice provided services for migrants claimed that they themselves or their allied personnel were bilingual and were competent to work across different cultures. These psychiatrists reported that their estimates for bilingual skills among allied personnel, namely psychologists and social/remedial therapists, were 41.7% and 41.2%, respectively. A note of caution is needed here, as although one-third of the psychiatrists ( $n = 32$ ) offered special services for migrants, slightly more psychiatrists ( $n = 35$ ) claimed to have bilingual skills.

Figure 1 shows those areas most strongly endorsed by psychiatrists. The most common problem encountered when working with migrant children was associated with lack of parental appreciation and understanding of the nature of the disorder (56% of psychiatrists felt that they often or frequently encountered this problem),



**Figure 1** Degree of endorsement of statements by child and adolescent psychiatrists with regard to 'understanding and empathy.'

followed by language difficulties (36%). In contrast, 'uncertain residential status' and 'uncertain clinical diagnosis' were cited by 11.1% and 13.1%, respectively, of psychiatrists.

Overall, child and adolescent psychiatrists appeared to welcome the opportunity to work with migrants, rather than perceiving it as hindering effective treatment (e.g. 62.5% strongly endorsed the item 'It is enjoyable to work with patients/families with a different cultural background'). In addition, there was a tendency to observe cultural differences in communication style, such as non-verbal behaviour (46.4%), but again communication with patients and their immediate family members was seen as having a positive effect in promoting understanding of different perspectives of the situation (54.0%). Only one in four psychiatrists (26.9%) reported having persistent problems with expressing content and understanding, despite the presence of interpreters. Finally, one in three psychiatrists (33.3%) reported problems associated with different perceptions of time, and a further 37.4% experienced cultural differences.

### Perspectives of 'framework conditions' for treatment of patients with a migrant background

The next series of questions pertained to specific aspects of migrant healthcare. Around half (53.1%) of the respondents reported that migrant treatment was a very important aspect of their clinical practice work. One in five (21.9%) felt that migrants were overrepresented in their practices, and 27.6% strongly endorsed 'more openness required/desired from migrants themselves.' Only 3% of respondents stated that working with migrant families had become much less important over the last 5 years, compared with 36.7% who felt that it had increased significantly during the same period. Finally, 13.3% of respondents reported that they frequently drew migrants' attention to their practice care programmes.

The next section looked at the relevance of further cultural training to meeting the demands for the effective treatment of migrant children and adolescents. Almost three-quarters (72.5%) of the respondents expressed a need for the 'availability of interpreters' in their future work with migrants. Closely following this was the need for 'collaboration and cooperation with migrant organisations and institutions' (64.7%). Just under half (45.3%) strongly endorsed the need to appoint 'native language professionals' in the future, and even fewer (37.4%) felt a need to integrate 'specialised treatment institutes/clinics for patients from specific ethnic cultural minorities.' In total, 45.4% of the respondents felt a need for 'development of migrant-related (treatment) concepts.' The need for 'on-site

professional training programs' was strongly endorsed by 55.7% of the psychiatrists, and 51.6% endorsed a frequent need for 'curricula designed to increase intercultural competence.'

## Individual differences: child and adolescent psychiatrists

### Gender differences

There was no difference in the mean percentage of migrant children and adolescents seen in the practice by gender (male psychiatrists: mean = 22.82, SD = 13.07; female psychiatrists: mean = 25.57, SD = 18.11;  $F(1, 91) = 0.52, P > 0.05$ ).

Female psychiatrists were significantly more likely to highlight the importance of further professional cultural training ( $F(1, 93) = 4.70, P < 0.04$ ) compared with male psychiatrists, but this does not mean that more training is actually available, or utilised if it is available. Similarly, female psychiatrists were much more likely to use native speakers as allied personnel as required ( $F(1, 93) = 3.74, p < 0.06$ ). Finally, male and female psychiatrists differed with regard to the scale 'differences in style of communication (e.g. non-verbal communication)' (female psychiatrists: mean = 3.04, SD = 0.86; male psychiatrists: mean = 3.48, SD = 0.68;  $F(1, 88) = 6.87, p < 0.01$ ).

### Age differences

Respondents were divided into two groups on the basis of being younger (36–50 years of age; 43.3%) or older (51–65 years of age; 56.7%). These dichotomised groups were then analysed in the same way as for gender and migration background differences. The profiles on the first domain, 'understanding/empathy', did not emerge as statistically significant ( $RC = 0.29, \lambda = 0.92, \chi^2(7) = 7.57, P > 0.05$ ), but the individual univariate analyses revealed that older groups did differ in terms of their responses about 'limited diagnosis due to cultural differences between doctor and patient' (older group: mean = 2.46, SD = 0.87; younger group: mean = 2.88, SD = 0.92;  $F(1, 92) = 5.13, P < 0.03$ ).

The profiles of younger and older psychiatrists differed significantly in the domain 'motivation/pleasure and novelty' in the work with migrants ( $RC = 0.45, \lambda = 0.80, \chi^2(6) = 18.52, P < 0.00$ ). The groups differed on two of the six items. Older psychiatrists were more likely to report 'problems relating to migrants having differences in their time structure' (e.g. punctuality, cancellation of sessions) (older group: mean = 3.20, SD = 0.99; younger group: mean = 2.55, SD = 1.27;  $F(1, 86) = 7.25, P < 0.01$ ), and were less likely to observe that in instances where 'interpreters were available difficulties in communicating still existed' (older group: mean = 2.66, SD = 0.98; younger group:

mean = 3.08, SD = 0.97;  $F(1, 86) = 3.98, P < 0.05$ ). The latter finding indicates that younger psychiatrists perceive communicating, even when experienced translators are present, as a frequent source of problems.

Neither of the other two areas, namely 'future plans/migration relevance' ( $RC = 0.25, \lambda = 0.94, \chi^2(6) = 5.59, P > 0.05$ ) and 'training' ( $RC = 0.19, \lambda = 0.96, \chi^2(7) = 3.30, P > 0.05$ ) emerged as statistically significantly different. There was no statistically significant difference in the percentage of migrant children and adolescents seen in the practices of younger and older psychiatrists (younger group: mean = 22.87, SD = 17.94; older group: mean = 25.42, SD = 14.90;  $F(1, 91) = 0.55, P > 0.05$ ).

### *Presence or absence of a personal or family migrant history*

Of those who responded to the questionnaire, 91.9% did not have a personal migrant background, 8.1% had a parent or grandparent who was a migrant, 24.2% had a family migrant background, and three-quarters (75.8%) did not. This is consistent with the proportion of migrants in the adult population (19.5%).

Psychiatrists with migrant backgrounds appeared to see more migrant children, almost 7% more (migrant background: mean = 29.35, SD = 18.06; non-migrant background: mean = 22.56, SD = 15.25;  $F(1, 91) = 3.12, P < 0.10$ ). The responses of those with and without a personal or family migration background differed on four of the 26 items. Again taking the entire sequence of responses and comparing profiles for each of the four domains separately, only the first segment, namely 'understanding/empathy', was statistically sig-

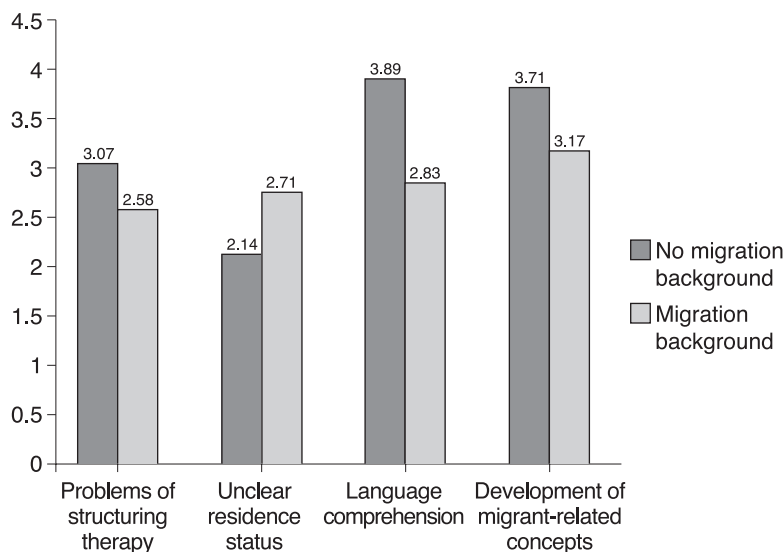
nificant ( $RC = 0.45, \text{eigenvalue} = 0.25, \lambda = 0.80, \chi^2(7) = 20.54, P < 0.005$ ).

Subsequently, the univariate statistical analysis revealed that those who were themselves familiar with migrant backgrounds were less likely to perceive 'linguistic understanding' as a problem (see Figure 2). This suggests that those with no personal experience of migration would see 'language comprehension' as much more of a problem ( $F(1, 94) = 8.10, P < 0.01$ ). The 'understanding of illness' as problematic in treatment was perceived differently by those with migrant and non-migrant backgrounds. Psychiatrists with a history of migration were less likely to perceive this as a problem ( $F(1, 94) = 4.97, P < 0.05$ ).

Moreover, those psychiatrists with a migrant background were more likely to perceive problems arising through 'uncertain residential permit status' of a patient (see Figure 2), for example, whether political asylum was warranted ( $F(1, 94) = 6.1, P < 0.02$ ), than those without such a background. Finally, those with migrant experience placed a higher value on the development of special competencies than did psychiatrists who were not personally familiar with migration ( $F(1, 93) = 4.71, P < 0.04$ ).

## Discussion

This survey of German child and adolescent psychiatrists, working in various types of outpatient clinical practices, yielded interesting findings that have implications for medical education training and clinical practice.



**Figure 2** The most significant differences in aspects of treatment and diagnosis of migrants between child psychiatrists with and without a migrant background themselves.

## Characteristics of the child and adolescent psychiatrists

A high proportion (57%) of the sample were women working in private practice as child and adolescent psychiatrists, which is consistent with the findings of other studies (German Ministry of Health Report; Bundesministerium für Gesundheit, 2012). Most of the child and adolescent psychiatrists resided in the Old German Federal States, which correspond geographically to Western Germany, where there is a significantly greater migrant population than in Eastern Germany. With regard to workload, defined as the number of patients seen over a 3-month period, the figure is highest for practices with a social psychiatric commitment (i.e. practices that are permitted to employ ancillary therapeutic staff, such as psychologists and educators) and lowest for psychiatrists working as psychotherapists, which suggests that the latter group invests much more time in intensive and longer-duration psychotherapy.

## Cultural responsiveness of practices to migrant children and their families

Child psychiatrists felt that the most prevalent problems among migrant children were likely to be associated with parental understanding of their disorder and insight into the problems displayed by their child. This highlights the importance of incorporating parents and significant family members into the therapeutic alliance (Siefen *et al*, 1996; Dogra *et al*, 2011). It is usually the parent who brings the child to the clinician. Their willingness to do this depends on the level of insight of the parents, their culture's attitude to mental illness, and their confidence in the kind of treatment they are likely to receive. This highlights the importance of a good relationship between the health professional and the parents, who are required to participate in the therapy programme.

Deficits in language and lack of familiarity with the host culture may also generate problems in understanding (Machleidt, 2013; Razum and Spellek, 2009). It is possible that child and adolescent psychiatrists erroneously perceive difficulties in parents' understanding of illness, which may in fact be a reflection of the psychiatrists' own problems in accommodating migrants' groups and difficulties and providing suitable solutions with regard to treatment. Language problems seem to be more important than issues relating to uncertain residential status, partly because, on the basis of national statistics, migrant groups are so diverse and include both those moving for economic reasons and those who are seeking political asylum. It is possible that subjective reports of residential status being the least important factor may reflect an inac-

curate or incomplete assessment of the situation. Involuntary exile and escape from persecution, which is likely to characterise the flight of asylum seekers, cannot be compared to the voluntary choice to enter a country with a view to seeking permission to work (Kirkcaldy *et al*, 2005).

## Extent to which practices offer migrant-specific programmes of healthcare

The child and adolescent psychiatrists expressed a high level of satisfaction with regard to working with migrant groups. Moreover, they indicated that they enjoyed communicating with migrant families and seeking to promote their health, but they were aware of cultural differences and the possible impact of these on the communication styles used by their patients. A significant number of psychiatrists claimed to have a bilingual competency, but were less likely to rate their allied health professionals as having an equivalent level of cultural and linguistic skills. This may reflect a biased belief among the psychiatrists, who felt that their personal linguistic skills were superior to those of their allied health professionals. It may also reflect their tendency to employ others who share with them the linguistic ability to communicate with patients. A minority of psychiatrists reported problems with conveying information to parents. There is perhaps a tendency to comment on the most obvious difficulties, such as language, and the clinicians may not realise that more subtle cultural factors are involved.

Migrants frequently use culture-specific 'idioms of distress' (Lindert, 2011). Focusing on this concept helps clinicians to avoid misunderstandings. Aichberger *et al* (2012) and Kanitsaki (2003) have demonstrated the value of personal contact in facilitating migrants' ability to comply with treatment, and in reducing the fear of stigmatisation. Helman (2007) highlighted the importance of culturally sensitive measures of assessment and treatment modalities. To support this approach, training in cultural diversity is needed to allow the implementation of culturally sensitive treatment (Karnik and Dogra, 2010; Dogra and Karim, 2010).

## Problems within diagnosis and therapy among migrants

Many psychiatrists perceived the treatment of patients with a migrant background as central to their working goals. The majority strongly endorsed the notion that if anything, over the last few years, there has been a distinct increase in migrant families and children requiring treatment. This may reflect an increased willingness among migrant families to seek professional help and/or an increase in the likelihood of

emotional and psychological problems among children and adolescents over the years. The majority of the psychiatrists did not perceive migrants as over-represented in their clinical practice, which suggests that migrant children and adolescents were not more likely to suffer from psychological distress, thus supporting the findings of Vollebergh *et al* (2005). However, it may also be the case that they were less likely to seek or be offered help. Just over a quarter of the psychiatrists reported a lack of openness to treatment options on the part of migrants. This is not surprising, as many cultures find mental illness in the family shaming and therefore strive to hide it (Siefen *et al*, 1996).

### Impact of treatment of migrant patients on the treatment culture/climate

Overall, the majority of the child and adolescent psychiatrists endorsed the importance of tailored migrant treatment for their practice, that is, they appreciated that migrant origin does influence the treatment programme. Few psychiatrists expressed a decrease in interest in migrant care. In fact, over the last five years, interest in migrant care had increased, which suggests that society had highlighted the importance of more effective and individualised programmes of healthcare for migrant children. Taken together, these findings suggest that although there was not a predominance of migrants attending clinical practices, there was a need to address idiosyncratic problems arising from a migratory background (American Psychological Association, 2013).

### Aspects of healthcare that psychiatrists view as important 'openings' or developments in effective treatment of migrant children and adolescents

Our findings showed that professionals working in the field of child and adolescent psychiatry with migrants and their families require assistance in ensuring that these families have an adequate understanding of the nature of the problems and their subsequent treatment. Access to qualified interpreters is essential for this purpose, although this does not necessarily imply using native speakers as allied professionals in the practice. Many of the psychiatrists felt that, in working with members of diverse cultures, they would profit from cooperation with migrant organisations. However, this may mean that they seek certainty about what to do with migrant families, rather than in engaging with the child and family themselves. The

lack of understanding may be one of the reasons why migrants tend universally to underutilise the mental health services, and may explain the high dropout rate (Kanitsaki, 2003). Understanding is a bidirectional phenomenon. An appreciation of the language and cultural habits of a migrant requires psychiatrists to be willing to familiarise themselves with the traditions of that culture (Caroppa *et al*, 2009).

### Individual differences: gender and age

The gender and age of the psychiatrists appeared to moderate their perceptions of the needs of their young patients. Female child psychiatrists found the involvement of allied personnel who were native speakers more useful than did male psychiatrists. They were also much more likely to emphasise the value of professional courses, thus highlighting the gender preference for improved communication. This may explain, to some extent, the increased number of women now entering not only the field of child psychiatry but also the medical profession in general (Kirkcaldy *et al*, 2010).

Age was also a factor that played a part in determining perception of patients' needs. Older psychiatrists reported more problems related to punctuality and cancellation of sessions than did younger psychiatrists. Conversely, younger psychiatrists experienced more problems in communicating, even in cases where an experienced translator was present. Perhaps younger psychiatrists are more sensitised to communication difficulties, or less experienced in handling problems in this area. Age and gender did not appear to influence either the number of cases seen during a 3-month period or the percentage of migrant children and adolescents who were seen in the clinical practice.

### Impact of personal migration history

Psychiatrists who were personally familiar with migration were more likely to endorse the central 'importance of understanding and appreciation of subjective models of ill-health' (e.g. items such as 'make therapy more difficult', 'one's own certainty in diagnosis', 'therapist mode of therapy', 'illness-related concepts of parents', 'linguistic understanding', 'patient's comprehension of disorder', 'experience differences/incongruity', 'implementation of translator impaired'). Overcoming language barriers in mental healthcare requires native speakers who play a key role in communication in a clinical context.

Finally, there was a tendency for those psychiatrists with a family or personal migrant background to see more patients/clients with a migrant background, which suggests that their own life experience as first-



or second-generation migrant children had influenced their own interest in working with migrant children and adolescents (Kirkcaldy *et al*, 2010). Furthermore, those child and adolescent psychiatrists who have a more sensitive awareness of cultural issues are more likely to be recommended by members of the ethnic communities.

Our findings highlight the importance of guidelines for mental health as listed by Bhugra *et al* (2011). These state that clinicians should have access to resources and information about specific cultural issues. There are various child mental health service-specific resources that could be drawn upon (Dogra *et al*, 2007; Dogra and Karim, 2005, 2010; Karnik and Dogra, 2010). Bhugra *et al* (2011) also recommend that mental health issues among migrants should be an integral part of professional training, to enable clinicians to offer culturally appropriate services that take into account the special needs of children and adolescents and their parents. Cultural competence should be seen as a professional goal. Bhugra *et al* (2011) further argued that service providers should focus on reducing barriers which impede help-seeking, by ensuring engagement between services and programmes that are culturally sensitive and geographically accessible. Services should also ensure the provision of cultural competency training as a core feature of all models of cultural liaison.

## Limitations of the study

This study has a number of limitations. The response rate was small, given the total number of individuals surveyed, but is within the expected range for surveys. It is possible that those psychiatrists who agreed to take part had rather different, probably more positive, attitudes to migrants. It is always advantageous to have a larger, more representative sample, particularly one that includes mental health professionals from diverse migrant backgrounds, including nurses and allied health personnel, primary care practitioners, and perhaps parents themselves.

Furthermore, surveys have well-known limitations. The questionnaires had to be brief if they were to be accepted by the respondents, but they might have been too short to fully examine the issues. We also observed that respondents often ignore open-ended questions, hence the decision to minimise the number of open-ended questions. Finally, the powerful influence of subtle wording in some questions was difficult to control for.

Notwithstanding its exploratory nature, this national survey has some interesting and important implications for those working in a child and adolescent

psychiatric setting. It is also hoped that it will stimulate further research in this field.

## Implications of the study and conclusion

Overall, the results suggest a generally positive attitude towards the migrant families and their needs, as most of these German psychiatrists appeared to enjoy working with migrant children and adolescents and their families, and to experience job satisfaction in doing so. They tended to focus more on language than on other aspects of culture. Moreover, they seemed to express a high degree of intrinsic satisfaction with their training. Individual difference variables, such as age, gender or familiarity with migration, affected their awareness of and sensitivity to migrant family health issues. This favourable attitude should be further developed. The study highlights the need for cultural diversity training to be more readily accessible in Germany.

In future work it will be necessary to distinguish between the different migrant groups and to differentiate between their needs and expectations. Future studies may help to clarify the following: the distinctions between the different stages of transition from country of origin to the host country and duration of settlement; voluntary versus forced migration; the differences and similarities between the cultures of the country of origin and the host country; first-, second- and third-generation migrants; the level of social support in the host country and the history of family support; socio-economic history and status; migration patterns and how these change over time. This is consistent with the arguments of Dogra *et al* (2011, p. 206) that it is desirable to have 'more consensus about the terminology used to enable better comparisons of migration of different groups and in different contexts.'

In addition, it would appear crucial to develop more sensitive instruments for screening. Huemer *et al* (2009) have emphasised the value of culturally sensitive measures and psychometric instruments standardised for multicultural groups and multimodal therapies.

Future studies may expand the requirements of guidelines and regulations for mental health practitioners (Machleidt *et al*, 2012), to include analyses of the subjective perceptions of the physician/therapist (Furnham *et al*, 2013). A liberal attitude towards diverse forms of therapy to help migrant families and their offspring is likely to enhance acceptance and a willingness to participate on the part of mental health professionals.

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CONFLICTS OF INTEREST

None.

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