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Migrations, trauma and mental health: a literature update on psychological assessment

Migrations, trauma et santé mentale : une revue de la littérature sur l'évaluation psychologique

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Abstract

Introduction: Migrants and refugees often face potentially traumatic events and post-migratory stressors. Upon arrival in the host country, they can be referred to mental health services to assess the impact of their previous experiences. These cross-cultural clinical encounters may raise questions, particularly regarding the assessment of mental health using models based on Western conceptions of psychopathology. **Objectives and Method:** The objective of the present non-systematic review of the literature is to discuss the psychological evaluation of post-traumatic reactions in migrants and refugees. More specifically, we present current research on psychopathology, resilience and post-traumatic development (PTG) among the migrant and refugee population. We also examine the cross-cultural validity of concepts such as Post-Traumatic Stress Disorder, resilience and PTG. Finally, we describe the most frequently used tools in cross-cultural psychological assessment and briefly reflect on the question of cultural sensitivity of mental health professionals. A bibliographic search was carried out using the databases: PILOTS, Pubmed, APA PsycNET, and Google Scholar using the following keywords: "migrants", "refugees", "posttraumatic stress disorder", "mental health", "Psychopathology", "risk factors", "protection factors", "posttraumatic growth" and "resilience". We have also reviewed the reference lists of articles encountered from database searches. **Results:** Responses to a potentially traumatic situation are multiple. Regarding the migrant and refugee population, the reviewed articles studied different post-traumatic reactions such as resilience, post-traumatic development, and psychopathologies. The most studied psychopathological responses were depression, anxiety and Post-traumatic Stress Disorder. After reviewing these studies, we asked the following question: considering the complexity of the migration process, what are the factors associated with the development of these different post-traumatic responses? Indeed, several individual and social factors before, during and after migration influence the mental health of individuals in a migration situation. Among the most cited risk factors identified were: to be a victim of or witness to violence in the country of origin and, after migration, to face post-migration difficulties such as asylum denial, to be in a precarious situation with regard to housing and work, as well as the difficulties linked to adaptation to the new culture. We have also described protective factors for the mental health of this population, such as: social support, psychological support, and a good quality of life in the host country. The reviewed articles also describe an important influence of cultural aspects on mental health, such as the perception of an event as traumatic. Although the authors of the reviewed articles accept this influence of culture on post-traumatic responses, most of the tools used to assess the mental health of migrants and refugees were created in a Western context. Studies show a growing concern with these cultural aspects, and certain tools that allow a more culturally sensitive evaluation, such as the "Cultural Formulation Interview", are being developed. **Discussion and Conclusion:** Even if the concern with the sensitivity of the tools used in cross-cultural assessment seems to be more present in the international literature, researchers seem to encounter difficulties in better understanding the effects of culture on the mental health of individuals. With increasingly diverse societies, new research should not be based on participants' geographic or ethnic origins, but rather try to "unpack" culture with, for example, the exploration of the relationships between certain values or orientations and the different expressions of psychological distress. Finally, given the still lacking development in the field of cross-cultural research, certain practices, such as the participation of interpreters, the supervision of cultural mediators or the use of culturally sensitive tools, can help the clinician to maintain good practices with patients from different cultures in the diagnostic and psychotherapeutical processes.

Keywords: migrations, mental health, psychological assessment, trauma

Résumé

Introduction : Les individus en situation de migration sont souvent confrontés à des événements potentiellement traumatiques et à des stressors post-migratoires. À leur arrivée dans le pays d'accueil, ils peuvent être dirigés vers des services de santé mentale afin d'évaluer l'impact de leurs expériences antérieures. Cependant, ces rencontres cliniques transculturelles peuvent poser des questions, notamment en ce qui concerne l'évaluation de la santé mentale à l'aide de modèles basés sur les conceptions occidentales de la psychopathologie. **Objectives et Méthode :** La présente revue non-systématique de la littérature vise à discuter l'évaluation psychologique des réactions post-traumatiques chez les migrants et réfugiés. Plus précisément, nous présentons les recherches actuelles sur la psychopathologie, la résilience et le développement post-traumatique (PTG) parmi la population migrante et réfugiée. Nous discutons également la validité transculturelle des concepts comme le Trouble de Stress Post-traumatique, la résilience et le PTG. Enfin, nous décrivons les outils les plus fréquemment utilisés en évaluation psychologique transculturelle et réfléchissons brièvement à la question de la sensibilité culturelle des professionnels de santé mentale. Une recherche bibliographique a été réalisée à partir des bases de données : PILOTS, Pubmed, APA PsycNET, Google Scholar, en utilisant les mots-clés suivants : « migrants », « refugees », « posttraumatic stress disorder », « mental health », « psychopathology », « risk factors », « protection factors », « posttraumatic growth » et « resilience ». Nous avons également révisé les listes de références des articles rencontrés à partir des recherches sur les bases de données. **Résultats :** Les réponses d'un individu à une situation potentiellement traumatique sont vastes. Concernant la population de migrants et réfugiés, les articles révisés ont étudié différentes réactions post-traumatiques, telles que : la résilience, le développement post-traumatique, et les psychopathologies. Les réponses psychopathologiques les plus étudiées ont été la dépression, l'anxiété et le Trouble de Stress Post-traumatique. Après la révision de ces études, nous nous sommes demandé : considérant la complexité du processus migratoire, quels sont les facteurs associés au développement de ces différentes réponses post-traumatiques ? En effet, plusieurs facteurs individuels et sociaux avant, pendant et après la migration influencent la santé mentale des individus en situation de migration. Parmi les facteurs de risque le plus cités dans les articles révisés, nous avons trouvé : avoir été victime ou témoin de violences dans le pays d'origine et, après la migration, rencontrer des difficultés post-migratoires comme être débouté du droit d'asile, être en situation de précarité en ce qui concerne l'habitation et le travail, ainsi que les difficultés liées à l'adaptation à la nouvelle culture. Nous avons également décrit des facteurs de protection pour la santé mentale de cette population, tels que : un bon réseau de soutien, accompagnement psychologique, et une bonne qualité de vie dans le pays d'accueil. Les articles révisés décrivent aussi une influence importante des aspects culturels sur la santé mentale, commencent par la perception d'un événement en tant que traumatique. Même si les auteurs des articles révisés acceptent cette influence de la culture sur les réponses post-traumatiques, la plupart des outils utilisés pour évaluer la santé mentale des migrants et réfugiés ont été créés dans un contexte occidental. Les études montrent une préoccupation croissante avec ces aspects culturels, et certains outils permettant une évaluation plus culturellement sensible commencent à être développées, comme la « Cultural Formulation Interview ». **Discussion et Conclusion :** Même si la préoccupation avec la sensibilité des outils utilisés dans l'évaluation transculturelle semble être plus présente dans la littérature internationale, les chercheurs semblent rencontrer des difficultés pour mieux comprendre les effets de la culture sur la santé mentale des individus. Avec des sociétés de plus en plus diverses, les nouvelles recherches ne doivent pas être basées sur les origines géographiques ou ethniques des participants, mais plutôt essayer de « déballer » la culture, avec, par exemple, des recherches qui explorent les relations entre certaines valeurs ou orientations et les différentes expressions de détresse psychique. Compte tenu des évolutions qui font encore défaut dans le domaine de la recherche transculturelle, comment un clinicien

doit-il agir pour maintenir de bonnes pratiques auprès de patients de cultures différentes ? Certaines pratiques, telles que la participation d'interprètes, la supervision de médiateurs culturels ou l'utilisation d'outils culturellement sensibles, peuvent aider le clinicien dans le processus de diagnostic et la psychothérapie.

Mots-clés : migrations, santé mentale, évaluation psychologique, trauma

Introduction

Human mobility is one of the most crucial issues of the 21st century. In a world of approximately 7 billion inhabitants, it is estimated that 1 billion are on the move nationally and internationally [1] and are variously called migrants, refugees, and asylum seekers. Each concept has a different meaning depending on the context of its use: political, media, security, health or law. Based on the definitions that are provided by international organizations, a refugee is a person who feels threatened because of his or her race, religion, nationality, membership of a particular social group or political opinions and does not feel protected by his or her own country. On the other hand, the term “migrant”, carries a more comprehensive definition: “any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence”. In the “migrant” category, we can include international students, labor/economic migrants, and others [2,3]. The most important distinction between refugees and other migrant categories is the concept of “forced migration”. Economic migrants, environmental migrants, and those migrating for family reunions are considered “voluntary migrants” [1,2].

Refugees and migrants often have a history of exposure to war, violence, environmental disasters, and political violence, among other potentially traumatic events [4,5]. According to Drozdek and Wilson [6], refugees present a complex spectrum of posttraumatic and post migratory psychological states, surpassing the Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of PTSD and including damaged core beliefs, dissociative states, and changes in identity, among others. Despite these negative experiences and their

consequences, refugees and migrants have also shown a great capacity for resilience and growth [7,8].

In order to plan and deliver the most appropriate intervention when these individuals seek mental health treatment in the host country, clinicians must be able to identify, in a transcultural evaluation, the difficulties and strengths presented by the patients. For this, the knowledge developed by disciplines such as ethnopsychiatry and cross-cultural psychiatry is highly relevant. When culture is understood as a dynamic set of beliefs, values and behaviors, it is also assumed to significantly influence individuals' ideas about how to understand and deal with mental health. In a culturally hegemonic society, health practices come naturally, as if culture was "invisible." However, in multicultural societies, where these different practices meet, culture becomes visible, requiring health professionals to develop a specific sensitivity so that they can succeed in the diagnosis and treatment of individuals who do not necessarily share the same culture. Among the consequences of a lack of cultural competence are diagnostic errors and drop-out from treatment [9–11].

For example, in a study developed by Adeponle et al. [9], participants were referred to a cultural consultation service, and the researchers compared the intake diagnoses with the diagnoses after the cultural formulation. The assessment was made with an expanded version of DSM-IV-TR cultural formulation and a multidisciplinary case conference in which a cultural broker was present. The results show an important overdiagnoses of psychosis. Almost 50% of the patients diagnosed with a psychotic disorder were re-diagnosed with a non-psychotic disorder after cultural formulation. The most frequent new diagnoses were major depression, PTSD, adjustment disorder, and bipolar affective disorder.

The present study

To date, several empirical studies in the field of refugee and migrant mental health have already been published. However, in recent years, especially in the area of trauma and cross-cultural assessment, some changes have occurred in the transition from DSM-IV to DSM-V. For example, the diagnosis of PTSD underwent considerable changes, and the Cultural Formulation Interview (CFI) was included. Considering these factors, a descriptive review of the literature is necessary so that clinicians can have at their disposal a summary of the work done with this population and can then think about their own practices.

In order to contribute to best practices in transcultural evaluation, the present study aims to provide a literature review of the psychological evaluation of adult victims of potentially traumatic events in a transcultural context. More specifically, we describe which mental disorders, risk, and protection factors should be evaluated and how to evaluate them.

Results are presented in three sections: the first and second sections are focused on which aspects should be evaluated in this population, including aspects of psychopathology, resilience, posttraumatic growth, as well as risk and protection factors for this population. The third section is dedicated to the transcultural validity of the concepts of PTSD, resilience and PTG. We also describe the most frequently used instruments (e.g. interviews, scales) in transcultural psychological evaluations for trauma victims. The discussion section will present a conclusion of the main findings in the literature review and a brief reflection on the cultural sensitivity of the clinician.

Method

A non-systematic review was conducted in the following databases: PILOTS, Pubmed, APA PsycNET, and Google Scholar in August 2018. The following key-words were used: "migrants", "refugees", "posttraumatic stress disorder", "mental health", "psychopathology",

"risk factors", " protection factors ", " posttraumatic growth " and " resilience ". We have also reviewed the reference list of selected articles. Three authors of the present study selected 56 empirical and review articles, published between 2004 and 2018. Articles were included if they fulfilled the following criteria: (1) empirical or literature review, (2) published in English, French or Portuguese, (3) assessing mental health on adult migrant and refugee samples. For the data analysis, the articles were first separated into two groups: a) risk factors (i.e. factors associated with psychopathology, n=36) and b) protection factors (i.e. factors associated with growth and resilience, n=20) and then assessed according to the following aspects: (1) population, (2) risk/protection factors before, during and after migration, (3) instruments used for psychological evaluation.

Results

[Migration, Trauma and Mental Health](#)

Traumatic events such as wars, natural disasters, domestic and sexual violence are highly prevalent worldwide [12–14]. The range of possible mental health outcomes in the aftermath of these adverse events is broad. Papadopoulos [7] describes three different levels of negative outcomes after exposure to a frightening event: *ordinary human suffering*, a response to an adverse event that is not located in a pathological context whereby the individual is able to make use of resources such as family and community; *Distressful psychological reaction*, more severe than the previous level but where medical intervention is not always necessary; and *psychiatric disorder*, the most severe consequence of the exposure to a potentially traumatic event. This involves PTSD and other mental health disorders and normally requires clinical support.

Among the most studied psychiatric disorders developed after an adverse event is PTSD. The PTSD diagnosis was included in DSM-III [15], and since this first diagnostic proposal a

range of different models have been tested. At present, the DSM-V and ICD-11 manuals do not present the same criteria for the disorder [16]. However, it is important to emphasize that PTSD is not the only disorder that may develop after a potentially traumatic event. In refugee samples, a metanalytic study found that the most prevalent disorders among this population are PTSD, major depression and anxiety disorders [4].

Nevertheless, negative effects are not the only possible outcome. Papadopoulos [7] also describes the neutral and positive consequences of exposure to adverse events. The author refers to resilience when describing neutral consequences, that is, when there is no alteration in the individual's mental health after the event. This definition follows the description of resilience in physics: the "ability of a body not to alter after being subjected to different severe conditions" (p. 308). However, various definitions of resilience are employed in the literature, varying from more pathogenic assumptions, by which resilience is equated to the absence of PTSD, to salutogenic definitions which consider resilience as a multifaceted construct involving social and individual factors [17].

Regarding the positive effects following a potentially traumatic event, the literature provides different nomenclatures with similar definitions, such as adversity-activated development, posttraumatic growth (PTG), adversarial growth, stress-related growth, perceived benefits, thriving, blessings, positive by-products, positive adjustment, and positive adaptation [7,18,19]. Among these labels, PTG has a precise and operational definition and has been studied in various contexts [20]. It is characterized as the positive changes taking place in an individual after an important life crisis, such as experiencing a potentially traumatic event [21].

According to Tedeschi and Calhoun [21], PTG has a complex relationship with resilience, but they remain distinct concepts. Among the varying concepts of resilience, some authors offer a definition of resilience as *reconfiguration*: the capacity to rebound from

adversity as a more resourceful person. This perspective of resilience is similar to PTG because both imply transformation following a stressor. However, in resilience theory, the changes may also be negative, and PTG is the study of exclusively positive changes [22]. PTG refers to a positive transformation of the individual's schemas (e.g. perceptions of self and world). Calhoun and Tedeschi [22] use an interesting metaphor to describe trauma and PTG: “traumas are as psychological earthquakes that shake the foundations of schemas that will then need to be rebuilt to standards that allow resistance to future earthquakes” (p.11).

Despite the growing number of studies investigating PTG in different cultures, only a few examine the phenomena among migrant and refugee samples [23,24]. Four studies describe the prevalence of PTG among migrants and refugees [8,25–27]. Two of them show low to middle levels of PTG. These studies were performed with refugees and displaced persons from the former Yugoslavia now living in Sarajevo [26] and with refugees from various countries living in Norway [8]. Two studies investigated PTG in Latina women living in the United States. In Berger and Weiss' investigation [25], the participants reported high levels of PTG. However, Swanson [27] described low to moderate levels of PTG in their pre-treatment phase and moderate to high levels after treatment.

Thus, experiencing a threatening event does not necessarily imply the development of a mental health disorder. When investigating PTSD in the general population, researchers have found that a minority of individuals develop the disorder, as illustrated in population-based studies in the US and Australia [13,28,29]. Regarding refugees, one metaanalysis study shows that one in ten adult refugees in Western countries has PTSD [4]. These data led us to an important question: what are the factors associated with the development of mental disorders in the population of immigrants and refugees? Or, in other words, what gives rise to resilience and post-traumatic growth? We will address these two questions in the next section which is

dedicated to describing current research on the risk and protective factors for mental health among the migrant and refugee population.

[Risk and protective factors for the mental health of migrants](#)

According to the World Health Organization (WHO) a risk factor is “any attribute, characteristic or exposure of an individual that increases the likelihood of developing a disease or injury”, and a protective factor is defined as factors that “increase the likelihood of positive health behaviors or outcomes” [30]. Migrants and refugees are exposed to several risk factors related to mental health disorders, some of which are specifically related to the migration process, while others are also present in the general population. For example, in a comprehensive review of the literature, Jurado et al., [31] investigated the factors associated with psychological distress and common mental disorder in migrant populations. The authors described some risk factors specifically related to the migration process, such as forced migration, poorly planned migration, irregular migration, lower acculturation levels, and longer periods of residence in the host country, among others. Yet, they also identified risk factors with rates comparable to the general population: being a woman, being widowed, divorced or separated, young, unemployed or with adverse work conditions.

One of the most important risk factors for migrant and refugee mental health problems before and during migration is exposure to potentially traumatic experiences, including war situations, political persecution, torture, prison, and domestic violence among others [32–37]. Although the studies report a significant prevalence of potentially traumatic event exposure among refugees and asylum seekers, they may also be important among economic migrants [5,38]. When arriving in the host country, the migrant may face several difficulties such as delays in the bureaucratic process, language differences, lack of social support, and not being allowed to work, among others [39,40]. This set of situations is known as *post-migration living*

difficulties (PMLD) and has been found to be linked to mental disorders in several studies [8,32,33,35,41–44].

These results show the importance of the context in which the migrant integrates the host country. This question is addressed by Miller and Rasmussen [45,46] in two studies in which they criticize the focus on the direct effects of exposure to war-related violence and loss and mental health on mainstream research with refugees. The authors suggest that daily stressors also play an important role in refugee mental health and propose a social ecological model of refugee distress including various levels, from the individual to the macrosystem [46]. In their model, they include not only exposure to potentially traumatic events but also to daily stressors such as *displacement-related stressors* (similar to PMLD: unemployment, discrimination, uncertainty regarding asylum status, etc.) and family functioning/parental wellbeing.

Miller and Rasmussen [45,46] also describe four main reasons why daily stressors contribute so significantly to refugee mental health: (1) daily stressors are proximal whereas war exposure is often a distal experience; (2) daily stressors are beyond individual control; (3) daily stressors are highly present in refugee and war-affected populations, whereas the level of direct exposure to potentially traumatic events varies; and (4) the term daily stressors also includes potentially traumatic situations, such as child abuse and family violence. In general, daily stressors generate an experience of vulnerability and may lead to significant distress [45,46].

Regarding protective factors, below we describe studies which investigate those factors related to resilience and posttraumatic growth. Resilience is explored in the literature as a process or as an outcome [22]. Resilience as a process can be considered as a protective factor for mental health disorders, as described in a study conducted by Arnetz [47] who compared two samples, one of refugees and another of non-war-exposed migrants. Both groups had

similar levels of resilience and, for both samples, resilience negatively predicted psychological distress. When considering resilience as an outcome, researchers usually focus on factors that predict or contribute to resilience. For example, in a qualitative study, Alessi [48] found that “staying hopeful and positive”, utilizing community and legal services, receiving support from significant others and friends, “doing whatever it takes”, and “giving back” contributed to resilience among gender minority forced migrants. A systematic review conducted by Siriwardhana et al. [49] showed that social and family support are associated with increased resilience. They also describe other factors that may affect resilience, such as daily stressors and prolonged displacement.

In PTG literature, being younger [26], participation in counseling [25], and quality of life [8] were found to be positively associated with growth, whereas post-migration stressors were negatively associated to it [8]. In a longitudinal study, conducted with Kosovo refugees resettled in the United States, PTG was associated with hope and cognitive *coping* [50]. It is important to highlight that, while the majority of studies found no correlation between PTSD and PTG, most of them found at least some level of PTG occurring in concomitance with PTSD [8,25,26,50].

In summary, the mental health of migrants and refugees, as in the general population, is the outcome of a complex interaction between risk and protective factors. However, mental health is a multidimensional construct, and some individuals present both psychopathology symptoms and signs of resilience and growth [8,47]. These elements (e.g. the patient’s personal history, the host country context and immigration policies) should all be taken into account during a transcultural evaluation in order to provide a more holistic understanding and to prevent diagnostic errors. In the next section we will discuss cultural influences on posttraumatic reactions and describe tools which can be used to achieve a more culturally sensitive evaluation.

Transcultural psychological evaluation following a potentially traumatic event

The initial research into the trauma field was conducted primarily among North American war veterans. It was then expanded to other contexts and populations, provoking considerable discussion as to the disorder's transcultural validity [51]. In a literature review, Kienzler [52] outlines the two most opposite positions concerning the universality of psychopathological response to trauma: (a) PTSD as a universal and cross-culturally valid response, and (b) PTSD as valid only in a Western context. The author considers that the debates between these two points of view gave rise to agreement that PTSD takes little account of certain key questions, such as indigenous expression of disorder and idioms of distress. However, some characteristics of a traumatic reaction may be universal, especially when the trauma becomes more severe.

Studies have shown that culture may influence traumatic responses in different ways. The very concept of "traumatic" is culturally biased, that is, individuals from different cultures may see different events as more or less traumatic [for an overview see Hinton & Lewis-Fernández, 53]. Studies conducted in various countries have shown that the type of trauma may influence the post-traumatic symptom presentation, with single interpersonal trauma being associated with more severe PTSD symptoms and early-onset chronic interpersonal trauma with Complex PTSD symptoms [54–56]. However, cultural specificities must also be considered. For example, in a study conducted by Sachs, et al. [36] with Tibetan refugees, 62.2% of the sample ranked religious persecution (e.g. being forced to leave the monastery or publicly denouncing the Dalai Lama, etc.) among the most upsetting events. In addition, this event was a positive predictor of PTSD, anxiety and somatization, even when controlling for other traumatic events such as torture [36].

The influence of culture on PTG is discussed in the book *Posttraumatic Growth and Culturally Competent Practice* [24] which sets out to present theoretical and empirical research in this field. The comprehensive model for PTG proposed by Calhoun, Cann and Tedeschi [57] stipulates that the process of schema modification occurs through self-analysis, which arises from ruminative thoughts, or other actions such as writing, praying, talking with friends and family, among others. The model includes sociocultural influences during the growth process: from the subject's perception of a potentially traumatic event, to the cognitive strategies employed, such as the search for support.

The findings regarding cultural influence on PTSD and PTG are examples of the diverse influences that culture has on mental health. However, the scales employed by researchers for symptom evaluation are usually translated versions of those used in research with Western populations, such as the Posttraumatic Stress Disorder Scale [58,59], Interviews from DSM-IV and DSM-V (SCID)[60], the Impact of Events scale [61], and Beck's Depression Inventory [62], among others. To evaluate resilience and PTG the most frequently used scales are the Resilience Scale [RS, 63] and Posttraumatic Growth Inventory [PTGI, 21]. Both scales have already been used in studies with samples of migrants and refugees [8,47,50].

The scales developed specially for the migrant and refugee populations include the Harvard Trauma Questionnaire and the Hopkins Symptom Checklist [HSC, 64,65]. These scales evaluate PTSD, anxiety and depression symptoms respectively and were created especially for the psychiatric care of refugees. Nevertheless, both are based on DSM-IV, and so are outdated, particularly regarding the important changes made to PTSD diagnoses from DSM-IV to DSM-V. The HSC also evaluates the presence of potentially traumatic events and has a section dedicated to torture history which applies in particular to refugees and asylum seekers. To obtain information from traumatic events and post-migration living difficulties, from a population that also includes economic migrants, the List of Migration Experiences

[LIMES, 40] seems more appropriate. Another scale that was developed for the migrant and refugee populations is the Immigrant Acculturation Scale [66]. The scale measures the five acculturative orientations of the immigrant community proposed by the Interactive Acculturation Model [67]: integration, assimilation, separation, anomie and individualism.

In addition to the use of scales, it is important that the clinician also obtains qualitative data in order to better understand the patient's experience. In a bid to offer guidance to clinicians on conducting mental health assessment in multicultural contexts, a Cultural Formulation Interview (CFI) was developed for DSM-V. The CFI is a semi-structured interview and is composed of four assessment domains: (1) Cultural Definition of a Problem, (2) Cultural Perceptions of Cause, Context, and Support, (3) Cultural Factors Affecting Self-Coping and Past Help Seeking, and (4) Cultural Factors Affecting Current Help Seeking [68,69]. The interview also has 12 supplementary modules available (ex. social network, older adults, children, migrants and refugees, etc.) and an informative version to provide the clinician with additional information. Although the CFI does not include specific questions about trauma, it may be useful, along with scales that assess trauma-related disorders, to better understand the influence of the individual's culture on the expression of the symptoms. Recent studies have investigated the use of the CFI on clinical settings and have shown the clinical utility of the tool to improve the cultural competency of the clinician and the patient-clinician relationship and to understand patients' individual needs in their cultural context [69,81,82].

Unlike the LIMES and Harvard Trauma Questionnaires, which are tools specific to the evaluation of first-generation migrants, the CFI is recommended to be used with any patient [83]. They are all useful in understanding a patient's personal, familial and cultural background and improving the accuracy of diagnoses. The CFI guidelines [70] suggest that the clinician should use CFI results with other clinical materials, such as culturally valid scales, to define a

patient's diagnosis and treatment. Table 1 and 2 summarize the important topics and the scales available for transcultural mental health evaluation.

Discussion

International migratory movements are modifying modern societies and making them increasingly multicultural. This phenomenon impacts the way in which researchers in the field of psychopathology perceive the impacts of culture on mental health. Instead of a psychopathology that compares Western with non-Western cultures, and the "civilized" with the "primitive", current research has come to understand psychopathology as a complex interaction between culture, genetics, and context, among others. Moreover, *hyper-diverse* societies no longer enable the country or region of birth to be directly associated with a given culture [84].

Instead of viewing a psychopathological expression as associated with a particular nationality or ethnicity, researchers began to investigate the relations between values or orientations and the expression of distress [84,85]. For example, Burri and Maercker [86] investigated the cultural value orientation as a mediator to the relationship of war and civil trauma exposure and the prevalence of PTSD in 11 European countries. The results pointed to the predictive effect of value orientation on PTSD prevalence. Specifically, "stimulation" value, representing a modern orientation, was positively associated with PTSD and with trauma exposure [86]. Even if the use of values and orientations may provide a good opportunity to "unpack culture" [85], culture cannot be considered as something static and individual but rather as a phenomenon resulting from human relations and constantly evolving, especially when referring to the population of migrants whose subjects are in contact with new cultures and facing the process of acculturation [84,85].

Progress has been made in psychopathology research and impact on clinical practice, for example through the construction of clinical tools such as the CFI. However, as described earlier, in the trauma field there is no consensus on several issues regarding PTSD diagnoses, such as the number of criteria and factors, subtypes and transcultural validity. Thus, the differences that were already present between DSM-IV and ICD-10 are more significant between ICD-11 and DSM-V [16]. We have also identified a higher focus of research about psychopathology in refugees and asylum seekers and a lack of research regarding salutogenic outcomes, such as posttraumatic growth, and the investigation of the exposure to potentially traumatic events in other migrant populations such as economic migrants.

Considering the developments that are still lacking in the field of research, how should a clinician act in order to maintain good practice with patients from different cultures? Some practices, such as the participation of interpreters, supervisions with cultural mediators or the use of validated instruments, can assist the clinician in the diagnostic process and psychotherapy. However, another key skill that must be developed by clinicians is cultural sensitivity. According to Drozdek and Wilson [6], cultural sensitivity is an essential factor for intercultural trauma psychotherapy. According to the authors, the therapist who is culturally sensitive “combines his/her knowledge of healing with authentic curiosity about his/her own and the patient’s cultural background. The therapist is aware of his/her own identity, and at the same time is sensible and open for explanatory models of illness, disease and healing that the patient brings into treatment” [6].

Conclusion

In this article we describe various tools, such as scales and interviews which are used in transcultural practice and research. We also draw attention to the fact that most psychological tools have been constructed in a Western context and therefore may not encompass the

complexity of the patient's mental health. Yet, we think that the use of scales may well contribute to the diagnosis when the clinician is able to understand the results in the patient's context. To this end, we support the idea of a *Globality as a Clinical Posture*, described by Derivois [87] as "a disposition of mind in which the clinician is concerned about considering the singular individual in the world and simultaneously identifying the global in the slightest expressions (behavior, gestures, words, symptoms etc.) of this singular individual" [87]. In the current context of the "migration crisis", this posture makes it possible to analyze three types of interculturality (interculturality of patients, professionals and tools). In this sense, it goes beyond Western ethnocentrism to consider the mental health of migrants in a global perspective.

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Table 1. Assessing risk and protection factors

Risk/protection factors	Methods of assessment	Characteristics	French Version
Migration status and characteristics (e.g. forced or voluntary; planned or not);	The Cultural Formulation Interview - Migrants and refugees supplement [70]	Semi-structured interview	Modules complémentaires de l'Entretien de formulation culturelle de base – Migrants et réfugiés [71]
Exposure to potentially traumatic events before, during and after migration;	Harvard Trauma Questionnaire [65]	Structured interview/self report	Harvard Trauma Questionnaire [72]
	List of Migration Experiences [73]	Structured interview/self-report – allows specifying if the event occurred before, during or after the migration	List of Migration Experiences [73]
Post-migration living difficulties;	List of Migration Experiences [73]		List of Migration Experiences [73]
Acculturation levels	Immigrant Acculturation Scale [66]	Self-report	Immigrant Acculturation Scale [74]

Table 2. Assessing mental health outcomes

Mental health outcomes	Methods of assessment	Characteristics	French version
PTSD	PTSD Checklist [58] Impact of event's scale [75] Harvard Trauma Questionnaire [65]	Self-report	PTSD Checklist [76] Impact of event's scale [77], Harvard Trauma Questionnaire[7]
Anxiety/Depression	Hopkins Symptom Checklist [64] Beck Depression Inventory [62]	Self-report	Hopkins Symptom Checklist[78] Beck Depression Inventory[79]
General Mental Health	SCID [60], The Cultural Formulation Interview [70]	Semi-structured interview	The Cultural Formulation Interview [71]
Resilience	Resilience scale [63]	Self-report	Resilience Scale [80]
Posttraumatic Growth	Posttraumatic Growth Inventory [21]	Self-report	Posttraumatic Growth Inventory [20]