Univerzita Karlova v Praze

Filozofická fakulta

Katedra psychologie

Diplomová práce

Bc. Martin Tušl

Dostupnost a kvalita péče o duševní zdraví pro cizince v Praze

Accessibility and Quality of Mental Health Care for Foreigners in Prague

Praha, 2017

Vedoucí práce: PhDr. Markéta Niederlová, PhD.

Poděkování

Nejdříve bych rád poděkoval vedoucí práce PhDr. Markétě Niederlové, PhD. za milý přístup a podpůrná slova. Dále děkuji Lori Wyant a Dean Selby za společné diskuze, kterými mě motivovali a inspirovali při práci na tomto tématu, a také za pomoc s formulací položek v anglické verzi dotazníků. V této souvislosti bych chtěl také velmi poděkovat Janě Januševičové, která mi pomohla s ruským překladem dotazníků. Poděkování patří také Kristýně Maulenové, která mi poskytovala důležitou zpětnou vazbu. V neposlední řadě děkuji své rodině za stálou podporu při studiu, konkrétně svému tátovi, mámě a bratrovi. Nakonec bych rád poděkoval Pedro Romero Marquesovi za dlouholeté přátelství a vzájemnou podporu při dosahování studijních i životních cílů. Saudade.

Prohlašuji, že jsem diplomovou práci vypracoval samostatně, že jsem řádně citoval všechny použité prameny a literaturu a že práce nebyla využita v rámci jiného vysokoškolského studia či k získání jiného nebo stejného titulu.

V Praze dne 11.6.2017 ……

Bc. Martin Tušl

Abstrakt:

Práce se zabývá tématem dostupnosti a kvality péče o duševní zdraví pro cizince, kteří žijí v Praze. Teoreticko-přehledová část rozebírá témata z oblasti interkulturní psychologie, která se vztahují k duševnímu zdraví. Zároveň jsou popsány některé typické fenomény, které souvisejí s duševním zdravím cizinců a s problematikou přistěhovalectví. Shrnuje také některé poznatky o dobré praxi psychologické a psychoterapeutické práce s kulturně a jazykově odlišnými klienty. V závěru je nastíněna současná situace péče o duševní zdraví v České republice a její souvislosti a důsledky pro péči pro cizince. Výzkumná část má formu kvalitativního výzkumu, jehož cílem bylo zmapovat, jaké jsou zkušenosti cizinců s péči o duševní zdraví v Praze, a s jakými překážkami se nejčastěji setkávají při jejich využívání. Výzkum byl zaměřen na anglicky a rusky hovořící populaci. Výzkumný vzorek sestával ze dvou skupin – klinické (clinical group; n=27) a neklinické (non-clinical group; n=74). Sběr dat probíhal především prostřednictvím dotazníků a polostrukturovaných rozhovorů. Výsledky z obou skupin identifikovaly osm základních bariér, které souvisejí s dostupností a kvalitou péče o duševní zdraví pro cizince. Zároveň byl sestaven seznam míst, kde cizinci mohou hledat dostupnou odbornou péči. Nejpodstatnější výstupy výzkumu jsou v závěru diskutovány, a jsou navrženy možné cesty, které by mohly přispět ke zlepšení současné situace.

Klíčová slova:

duševní zdraví, cizinci v Praze, interkulturní psychologie, kulturní kompetence, kvalitativní výzkum

Abstract:

The topic of the present thesis is the accessibility and the quality of mental health care for foreigners in Prague. The theoretical part presents some of the principle topics from intercultural psychology that are related to mental health. Further, the phenomena associated with living abroad and with mental health of foreigners are discussed. Then follows a summary of the principle findings about a good practice in psychological and psychotherapeutic work with culturally and linguistically different clients. The theoretical part concludes with an overview of the present situation of the mental health care in the Czech Republic along with information about the regulations and options of mental health care for the foreign population. The empirical part presents a qualitative research which explores what experience have English and Russian-speaking foreigners with mental health services in Prague, and what are the main barriers that hinder their access to a good quality care. The sample was composed of two groups – clinical group (n=27) and non-clinical group (n=74). The data collection was mostly done via questionnaires and semi-structured interviews. The main findings from both groups identified eight principal barriers that adversely impact the accessibility and the quality of mental health care for foreigners. Also, a short list of institutions and practitioners in Prague where foreigners may seek mental health care is provided. The principle outcomes of the research are discussed and some possible ways of improving the current situation are suggested.

Keywords:

mental health, foreigners in Prague, intercultural psychology, cultural competency, qualitative research

Content

List of Abbreviations

APA	*American Psychological Association*
CFI	*Cultural Formulation Framework and Interview*
DMIS	*The Developmental Model of Intercultural Sensitivity*
DSM	*Diagnostic and Statistical Manual*
EU	*European Union*
MIPEX	*Migration Policy Index*
OZP	*Oborová zdravotní pojišťovna (Czech public health insurance company)*
RIAPS	*Regionální institute ambulantních psychosociálních služeb (Crisis intervention center)*
USDHHS	*U.S. Department of Health and Human Services*
VFN	*Všeobecná fakultní nemocnice (General University Hospital)*
VZP	*Všeobecná zdravotní pojošťovna (Czech public health insurance company)*
WHO	*World Health Organization*

List of Tables

List of Figures

Introduction

The number of foreigners living in the Czech Republic has constantly been increasing every year since the fall of communism regime in 1989. Back in 1993, there were 31 thousand foreigners registered with permanent residence. In 2016 the number has reached 272 thousand, and including foreigners with a long-term residence over 90 days, there are more than 493 thousand foreigners living in the Czech Republic nowadays which is about 4,5% of the total population. Prague, the capital city, concentrates more foreigners than any other region of the country. It is one of the most popular European tourist destinations, and the city is sometimes better known in the world than the country itself. As a result, many foreigners decide to settle down in Prague. In 2016, approximately 184 thousand registered foreigners lived in the capital city which represents about 14,5% of the total population (Český statistický úřad, 2016).

The diversification of the society creates challenges. For instance, health care system must be able to provide a good quality service not only to Czechs but also to foreign patients. Mental health care is one of the areas that is more problematic compared to the general medical care. Psychological assessment, which is the first step of the treatment, is based on a collection of thorough information about the life of a client and possible symptoms that are mostly accessible only through verbal communication (Bauer & Alegría, 2010). Similarly, psychotherapy and counseling services are conducted through verbal and non-verbal communication between the therapist and a client. Hence, if a mental health practitioner is not familiar with the culture of the client, and if they have no *lingua franca*, then it is impossible to help.

Naturally, it is not just the case of the Czech Republic, the mixing of populations is a phenomenon of the modern world, and a cultural pluralism has become common in many Western societies (Berry, 1997). Thanks to the modern technologies and the politics of open borders in Western countries, it has become affordable and easy to travel even long distances and to move across countries without any limits. At the same time, people often want to preserve their traditions instead of assimilating to the new host culture (Mantovani, 2000). Therefore, mental health practitioners must be aware of the cultural background of their clients, and they should dispose of knowledge and abilities that make them competent in working with culturally diverse populations (Betancourt, 2004).

The difficulty of the Czech Republic and other post-communist countries is that the diversification of population is rather a new phenomenon. During the era of the Cold War, the countries of Eastern Europe were cut off from the West by an imaginary Iron Curtain, and it was impossible to cross it until the late 80's. A visible example of such barrier was the Berlin wall that was dividing Western and Eastern Germany until its fall in 1989. During that period the population and the politics of these countries had a rigid monocultural character. When the Soviet Union started to fall apart, the borders of the Czech Republic and other communist countries could finally open to the new populations and cultures after almost 50 years of isolation.

The present thesis focuses on intercultural mental health care in the capital of the Czech Republic. Prague has a large Russian-speaking community, and a large Anglophone community that is composed not only of native English speakers but also, English is used as a *lingua franca* within non-native speakers. The wide use of English among non-native speakers supports the fact that about two-thirds of all English users were non-native speakers at the beginning of this millennia (Crystal, 2003). Language is just a small visible part of the culture but, as was mentioned above, it is an essential tool that allows mental health practitioners to communicate with their clients.

Theoretical part opens with a summary of the main topics around culture and intercultural psychology. Then follows a chapter about the process of acculturation and the challenges associated with life abroad. Further, the specifics of treating culturally and linguistically diverse population are discussed. Finally, a brief overview of the situation of mental health care in the Czech Republic, and the specifics for foreigners are outlined. The theoretical part concludes with an overview of the previous works about intercultural communication and intercultural psychology.

The research is designed as exploratory qualitative analysis. The aim of the study is to evaluate the quality and accessibility of mental health care for foreigners in Prague, and to identify the barriers that foreigners face. The research focuses on Russian and English-speaking populations as they represent most of the foreign population of Prague. A practical outcome of the study is a list of places in Prague where foreigners may seek mental health care. To my knowledge, this study represents a pioneer work on the topic of intercultural mental health care in the Czech Republic.

Theoretical part

1 Culture and its psychological aspects

From a cooperation between a psychologist and an anthropologist yielded a short but very accurate sentence: *"Every man is in certain aspects: (a) like every other men; (b) like some other men; (c) like no other man"* (Murray & Kluckhohn, 1953, p. 35).

I believe that this sentence summarizes in a smart way the essence of humans as individual cultural beings. First, we are like *'every other men'* in a sense that we all have a body, emotions, physiological processes and needs, ability to think, need for love and acceptance, existential problems, etc. It is our *human nature,* and it encompasses everything that people around the world have in common (Hofstede, Hofstede & Minkov, 2010).

Second, being like *'some other men'* can be understood in many ways, however, in relation to the topic of the thesis, the cultural aspect is particularly relevant. With *'some other men'* we share the same ethnocultural group, nationality, language, social life, interests, hobbies, work, etc. People with whom we share some of these features are in a way similar to us.

Finally, being like *'no other man'* illustrates that we are all unique beings, we all have our unique body features and personality. They characterize who we are as individuals and make us different from the rest of the people. The present thesis focuses on the cultural aspect of our life, and it stresses the importance of *"like some other men"* in mental health care.

Mixing of cultures as a result of globalization and consequent interactions between people of different racial and ethnocultural groups is a phenomenon of the modern world. People move across countries, travel long distances, and the world seems somewhat smaller than it used to. Situations where people from different cultural, social, economical and political backgrounds get in contact happen frequently. Globalization has always been present to some extent, for example during the era of European colonization or later during the World Wars. What is new in our time is the rise of telecommunication and transportation that occurred towards the end of 20th century as it allowed people an immediate contact with people from all around the world (Marsella, 2012).

Marsella (2012) indicates that the outcomes of globalization can be seen both in a positive and negative way. Positive aspects of cultural diversification such as the creation of alternative beliefs, broadening of values and lifestyles, exposure to new ideas and customs, increased population diversity, can be seen negatively as cultural disintegration, a breakdown in traditional values and

customs, and a loss of national sovereignty. The way how we perceive these aspects is shaped by our beliefs, attitudes, and values towards cultural diversity and it can differ among societies, and in between individuals within the societies (Berry, 1997).

1.1 Understanding culture

In the beginning, it is necessary to define culture and explain why it is such an important aspect when it comes to mental health care. Already back in 1934 an American anthropologist Irving Hallowell (1934, p. 1) wrote: *"If culture is reducible, in any realistic sense, to extremely complicated, but quite specific, chains of socially transmitted patterns which dominate the feelings, thought and behavior of individuals in all human communities, then this factor must be analyzed and evaluated if the etiology and form of mental disorders in different cultures are to be thoroughly understood."*

The problem of culture and cultural differences has been raised already at the beginning of the 20th century, yet it is only in the recent years that it has become particularly relevant with the rise of multicultural societies (Arasaratnam & Doerfel, 2005). Hallowell emphasized that if one wants to understand and evaluate psychological distress in a different culture, one needs to understand the cultural aspect, and be aware of how it can shape behavior, cognition, and emotions.

Understanding culture and its various aspects is not simple. For instance, Mantovani (2000, p. 1) states that: *"Culture is something that Western societies have not clearly understood, so that the challenges they have to face in an increasingly multicultural world are particularly difficult to manage. Understanding culture is certainly not only a Western problem, but a universal problem as well… We have trouble in seeing the cultural dimension for the same reason as fish does not see the water in which it swims. We do not focus on it; we take it for granted because we are constantly immersed in it."*

His metaphor illustrates the difficulty of perceiving something that is so natural and common for us that we do not think about it, we just live in it.

Culture as a term is vast, and it can be understood in many different ways. In fact, the complexity and broadness of it demonstrate Baldwin, Faulkner, and Heft (2006) who reviewed about 300 different definitions of culture. I will provide a few examples of definitions from psychological literature that are, in my opinion, accurate and valid for the purpose of the thesis.

"Culture is a pattern of learned beliefs, values, and behavior that are shared within a group; it includes language, styles of communication, practices, customs, and views on roles and relationships. We all belong

to more than one culture, which may, for example, be social, professional, or religious; the concept goes beyond race, ethnic background, and country of origin. Culture shapes the way we approach our world and affects interactions between patients and clinicians" (Betancourt, 2004, p. 953).

"Culture is set of behavioral norms, meanings, and values or reference points utilized by members of a particular society to construct their unique view of the world, and ascertain their identity. It includes a number of variables such as language, traditions, values, religious beliefs, moral thoughts and practices, gender and sexual orientation, and socio-economic status" (Alarcón, 2009, p. 133).

"Shared learned behavior which is transmitted from one generation to another for purposes of individual and societal growth, adjustment, and adaptation: culture is represented externally as artifacts, roles, and institutions, and it is represented internally as values, beliefs, attitudes, epistemology, consciousness, and biological functioning" (Marsella, 1988, p. 8).

All the definitions share some common aspects, and all have some particularities. Culture is shared and dynamic; we all belong to a particular group of people, and through our culture, we can identify with the people around us. For instance, by hearing our language when we are abroad, we can automatically suppose that the people belong to our cultural group, and along with the language we probably share many other cultural factors. Culture is not a fixed characteristic; it is constantly changing and evolving. These changes result from the situational factors, as well as from the interaction within a cultural group, and the interaction between different cultural groups (APA, 2013b; Kirmayer, 2012).

Representations of culture consist of different aspects that are both visible (language, patterns of behavior, clothing) and invisible (values, beliefs, traditions). They all significantly shape people's behavior, cognition, and emotions and as a consequence, their way of life. Thus, it is important to pay attention not only to the external representations, but also to the internal cultural representations to comprehend people's behavior within a particular cultural group.

Marsella's (1988, p. 8) definition states that culture is learned and that it serves for *"individual and societal growth, adjustment and adaptation."* We are taught culture by the society in which we are born, and we consciously and unconsciously learn and absorb all different cultural aspects during our growth. Understanding culture as a mean of adaptation implies that if we move to a different society, we can adapt to the new environment by learning its culture. Hence, if a psychologist wants to work with a client from a different cultural background successfully, it is necessary that he or she

learns about the culture of the client, becomes aware of cultural differences and how they can impact client's behavior and the problem he comes with.

Betancourt's (2004) definition of culture suggests that an individual can share many different cultures with different people that may be linked to various areas of his life (professional life, hobbies, religion, etc.). They are sometimes called *microcultures* (Neuliep, 2014, p. 112), and I will shortly discuss them in the following chapter.

Hofstede et al. (2010, p. 5) call culture *"software of the mind",* they point out to the fact that culture is similar to a computer software. Culture provides our mind with mental programs that influence our way of thinking, feeling and behaving. Hofstede et al. (2010, p. 8) suggest that culture manifests through four primary paths: *symbols, heroes, rituals and values.*

- *Symbols* include language, non-verbal communication, important objects, etc. They represent the most visible characteristics of culture.
- *Heroes* are represented by persons who carry particular characteristics that are valued in a given culture; they can be real or unreal, alive or dead. For instance, Václav Havel is valued in the Czech society for he represents characteristics that are important to the culture like freedom, humbleness, wisdom, and politeness. Imaginary superheroes such as Superman, Spiderman or Batman are characteristic for American culture and they represent values like individual power, strength, independence, and bravery.
- *Rituals* represent social activities that are performed in specific ways and bear in themselves secret meanings. Examples of rituals are the ways of greeting, eating, use of language, specific words or phrases, celebrations, formal and informal interactions, hygiene habits, etc.
- *Values* are the most invisible part of the culture. They originate in childhood and are molded throughout our life. They represent the basis for our preferences, our opinions about what is good and bad, dangerous and safe, moral and immoral, etc. Contrary to the other three manifestations, values cannot be seen; they can only be deduced from peoples' behavior.

1.2 Macroculture and microcultures

Peoples' identity stems from their gender, sexual orientation, socioeconomic status, race, language, education, religion, etc., and they tend to group together by these cultural aspects into all sorts of

microcultural groups (APA, 2003). Hofstede et al. (2010) talk about different layers of culture, however, I believe that the terms macroculture and microcultures are more suitable to describe this characteristic of culture.

Microculture refers to *"an identifiable group of people who share a set of values, beliefs, and behaviors and who possess a common history and a verbal and nonverbal symbol system that is similar to but systematically varies from the larger, often dominant cultural milieu"* (Neuliep, 2014, p. 112).

People are not shaped just by one culture. Usually, we belong to one dominant macroculture, and within our macroculture we make part of multiple microcultures. The macroculture of a given society represents the dominant culture. To illustrate, an American born citizen who lives in the USA belongs to American macroculture, whereas an American citizen who lives in Prague belongs to American microcultural group in Prague as the dominant culture in Prague is Czech.

In fact, any larger groups of people that share some common features such as age, sexual preference, race, beliefs, interests, opinions, world views, etc. can be considered as microcultures. It can be sport clubs, social clubs, religious or language groups, etc. Microcultures contribute to peoples' diversity within a macroculture, and it is important to consider them to fully understand the cultural identity of an individual (Neuliep, 2014).

Our microcultrues and macroculture also represent what is called in-group and out-group. In-group refers to what we intuitively feel to be "us", while out-group refers to what we feel to be "them". In particular, our microcultural groups often elicit strong in-group feelings in us. For instance, members of a football team often manifest strong in-group feelings, and they despise other teams, even though they might all share the same macroculture (Hofstede et al., 2010).

1.3 Cultural differences

A half century ago Edward T. Hall (1959, p. 53) wrote: "*Culture hides much more than it reveals, and strangely enough what it hides, it hides most effectively from its own participants."* In the same way as Mantovani[1], Hall refers to our blindness to cultural dimension. Hall underscores that such blindness is most striking when it comes to one's own culture. Being unaware of own culture prevents people from seeing the differences between cultures. It often occurs during traveling when one leaves his or her culture, that one is able to realize and see the cultural differences.

[1] See page 13

For instance, the Czech Republic is the leading country in beer consumption per capita, and the Czechs are famous for their beer culture worldwide (Kirin beer University report, 2015). Nonetheless, most Czechs would not say that they drink a lot of beer because they compare themselves to the people around who probably drink in very much the same way as they do. We are immersed in the culture and we do not see that maybe in other cultures people do it differently. When we leave our culture and experience how it works elsewhere, we can better realize some aspects of our culture and how they differ from other cultures. Our reaction to cultural differences is usually negative at first. It is a normal reaction that is part of a culture shock that usually occurs when one gets in contact with cultural differences. The whole process of cultural adaptation and the culture shock have their own course which will be described in the following chapters.

Geert Hofstede has become a well-known person in the sphere of intercultural psychology with his large-scale research on cultural differences among IBM employees from around the world. Based on his research, he designated five bipolar dimensions that characterize cultural variations in national values. His research aimed at values that relate to work and organizational psychology, however, his findings and the dimensions are also relevant when it comes to mental health care (Draguns & Tanaka-Matsumi, 2003).

The cultural dimensions are as follows (Hofstede et al., 2010):

- *Individualism vs. collectivism* – describes the level of interdependency between members of a given society. In individualist societies, people tend to focus on themselves and their close relatives, whereas in collectivist societies people tend to create groups and support each other. Collective goals are more important than individual interests in collectivist societies. Individualist countries are the United States (91)[2] and Australia (90); collectivist societies are China (20) or Colombia (13). The Czech Republic[3] (58) inclines to individualism.
- *Power distance* – is characterized by the level of acceptance and tolerance of inequality in the distribution of power among members of society. Countries with large power distance are hierarchical, and their status defines the position of their members. In such countries, it is common that the use of language adapts to specific situations that vary depending on the status of the persons involved in the conversation. In small power distance countries, conversations are often informal, more direct and people have equal rights to contribute,

[2] Score range 0-100.
[3] For detailed information about the Czech Republic see https://geert-hofstede.com/czech-republic.html

regardless their status. Large power distance countries are China (80), Saudi Arabia (95) or India (77); small power distance are Iceland (30), Sweden (31) or Austria (11). The Czech Republic has a score of 57 and thus inclines to a hierarchical society. Interestingly, Hofstede et al. (2010) claim that in societies with large power distance consultations with health care practitioners are shorter and there is less space for patients to provide information.

- *Masculinity vs. femininity* – represents the variety of gender roles in a society and the importance of values among its members that are typically masculine or feminine (dominance, success, competitiveness vs. interpersonal relationships, empathy, agreeableness, etc.). Masculine societies are Japan (95), Slovakia (100) or Austria (79); Feminine societies are Netherlands (14), Sweden (5) or Iceland (10). The Czech Republic has a score of 57 and as such Czech society inclines to masculinity.
- *Uncertainty avoidance* – refers to the degree of fear of the unknown and avoidance of unclear situations that might potentially cause discomfort or distress. Countries with high uncertainty avoidance value norms, rules and rigid rituals that are appropriate in specific situations and can show intolerance and hostility towards unfamiliar behaviors, beliefs or opinions. Countries with high uncertainty avoidance are France (86), Portugal (99) or Belgium (94); countries with low uncertainty avoidance are China (30), Denmark (23) or Sweden (29). The Czech Republic shows high uncertainty avoidance with a score of 74.
- *Long-term vs. short-term orientation* – describes the way how societies keep their connection with the past while dealing with the problems that wait in the future. Long-term oriented societies are pragmatic, dynamic and focus on future outcomes that help societal growth. Short-term oriented countries tend to be traditional, normative thinking, they draw upon the past and are more focused on achieving immediate results. Long-term orientation countries are China (87), Belgium (82) or Germany (83); short-term orientation countries are Australia (21), Colombia (13) or Mexico (24). The Czech Republic shows long-term orientation with a score of 70. Thus, pragmatic thinking, perseverance, and focus on the future are valued.

1.4 Ethnocultural identity

Ethnocultural identity does not have a commonly agreed definition either. The term refers to ethnicity which represents *"a culturally constructed group identity used to define peoples and communities"* (APA, 2013b, p. 749). Ethnicity implies some shared characteristics within a cultural group. As such, ethnocultural identity can refer to *"the acceptance of the group mores and practices of*

one's culture of origin and the concomitant sense of belonging" (APA, 2003, p. 380). Similarly, Marsella and Yamada (2013, p. 5) define ethnocultural identity as *"the extent to which an individual endorses and manifests the cultural traditions and practices of a particular group."*

The definitions underscore that when determining one's identity, it is not important what is a person's race or ethnicity, but rather the extent of identification with a particular ethnocultural group. Nowadays, people of different ethnics and races live together, and we are often exposed to multiple cultures within a society or even within a family. As a result, the ethnocultural identity of an individual often stems from constant interactions between multiple cultures (Kirmayer, 2012). Ethnocultural identity composed of multiple cultures can be a source of personal and social strength and resilience, but it can also create some interpersonal and intrapersonal conflicts in the development of one's identity (APA, 2013b).

If a practitioner sees a client who belongs to a different ethnocultural group, the practitioner must evaluate the client's ethnocultural identity; i.e. to what extent the client identifies with the particular ethnocultural group. For instance, there are many Vietnamese who were born in Prague. Their parents or grandparents had moved to Prague some decades ago and their children have spent their whole life in Prague. They are usually bilingual and are familiar with both cultures. In such cases, it is vital to understand which ethnocultural group the individual identifies with and which values and rituals assumes.

1.5 Ethnocentrism vs. ethnorelativism

Ethnocentrism refers to *"the natural tendency or inclination among all people to view reality from their own cultural experience and perspective. In the course of doing so, the traditions, behaviors, and practices of people from other cultures are often considered inferior, strange, abnormal, and/or deviant"* (Marsella & Yamada, 2013, p. 7).

Hofstede et al. (2010, p. 387) comprehensibly explain the idea of ethnocentrism comparing it to egocentrism: *"Ethnocentrism is to people what egocentrism is to an individual: considering one's own little world to be the center of the universe."* Ethnocentric view experiences the world through the glasses of one's own culture, seeing it as the best and the only way of doing things and denying any other possible views. The ethnocentric view is often present in monocultural societies which are only familiar with their own cultural view, and do not often get in contact with different cultures. As a result, they are unaware of possible differences in how people from other cultural groups can

perceive the world (Hammer, Bennett & Wiseman, 2003; Neuliep, 2014; Oberg, 1960).

Ethnorelative view, on the other hand, experiences the world in the context of other cultures. Ethnorelativis societies acknowledge that cultural differences exist and that people form other cultures can see the world in a different way. As such, discussion and voluntary contact with different cultural groups is considered the best way to understand the differences. Ethnorelative orientation is typically present in multicultural societies (Bennett, 2004; Hofstede, et al., 2010).

The boundary between ethnocentrism and enthnorelativism is not clear. Neuliep (2014) understands ethnocentrism as a continuum. We are all ethnocentric to some extent; most of the people feel some sort of pride and patriotism for their own group, and it is natural to differentiate between the in-group and the out-group. However, extreme levels of ethnocentrism are pathological as they can lead to discrimination and, as the history shows, even to ethnic cleansing.

Bennett (2004) created a model to measure intercultural sensitivity based on how people experience cultural difference (DMIS). He assumes that peoples' cultural worldview shapes the way how people perceive and think about other cultures. He differentiates six stages out of which three have ethnocentric character, and three have ethnorelative character (see Figure 1).

Figure 1

The Developmental Model of Intercultural Sensitivity (DMIS) (Bennett, 2004).

Denial of cultural differences takes place when a person considers his or her own culture as the best and the only one. Individuals who have such views are not interested in other cultures, and they are not even aware of the existence of some cultural differences. As a result, people from other cultures are ignored and they are considered simply as 'some other people' without any further

knowledge or interest in them. In fact, people in denial avoid noticing cultural differences even in the situations where they are explicitly expressed (Bennett, 2004).

People at *Defense* stage experience cultural differences more than do people at *Denial*, however, their view is mostly negative. They consider their own culture as superior to other cultures and as the only good way of living. As a consequence, they are hostile towards other cultures. People at this stage have a tendency to generalize individual characteristics as national characteristics. For instance, if a French behaves in a way that would be seen as individual deviation in his country, in a foreign country people at the defense stage will perceive his oddness as a national trait and will generalize it to the whole population; i.e. "all French behave in this strange way" (Oberg, 1960). The defensive position might also be expressed in all sorts of complaints such as "their religion is violent", "their eating habits are disgusting", etc. (Bennett, 2004).

Minimization is the last of the ethnocentric stages. People feel less threatened by cultural differences, they focus more on the common aspects of cultures rather than differences between them. People at this stage tend to minimize the racial and ethnocultural differences, and they look for similarities between cultures. Minimization can be expressed in phrases such as "everybody likes Czech beer" or "we all come from the same ancestors" (Bennett, 2004; Hammer et al., 2003)

In *Acceptance* stage, people experience their own culture as one of many other equally complex cultures. They are aware of cultural differences between people, and they are able to see and respect other people in their diversity. In the acceptance stage people are able to identify cultural differences among people and are aware that these can influence interactions between culturally distinct people (Bennett, 2004).

Adaptation is the stage in which the experience with other cultures helps to adopt behavior appropriate to these cultures. The cultural worldview of people at this stage is enriched by some skills and knowledge gained from experience with other cultures, and people are able to use their alternative cultural skills in different situations. They are able to orient in different situations and adopt culturally appropriate behavior (Bennett, 2004).

Integration is another step further but it does not necessarily mean an improvement in intercultural competence, it describes an identity change. People at this stage assume different cultural worldviews as part of their identity, and they understand it in a range of two or more cultures (Bennett, 2004). If the integration of different cultures is successful, the person can freely move

between cultures and use different behavioral patterns depending on the situation without losing the sense of their identity (Hammer et al., 2003).

In general, people in ethnorelative stages can better experience cultural differences and adapt to them than do people in ethnocentric stages. Therefore, they are more likely to be successful in intercultural communication (Bennett, 2004). Nevertheless, I believe that it is not possible to put the two orientations as opposed. A certain level of ethnocentrism is necessary for the survival of a group as it strengthens the ties between members and their sense of belonging. At the same time, being ethnorelative facilitates our functioning in the multicultural world. Hence, in my opinion, in a well functioning multicultural society, both orientations should be present to a certain level.

2 Living in a different culture

Life in a different country can be very challenging and immigrants struggle with many issues such as language barrier, misunderstandings, discrimination, loneliness, self-doubts, disillusion, family issues, career-related issues, etc. All these factors make immigrants vulnerable to developing mental health problems such as depression, anxieties, psychosomatic disorders, etc. (APA, 2013a). The presence of a mental disorder can further complicate their already difficult status. Often they lack social support, have limited coping strategies, and the process of adaptation can become very hard. If they are unable to work, financial problems may also occur which can further complicate their situation (Rosso & Bäärnhielm, 2012).

2.1 Acculturation

The process of acculturation starts as soon as an individual gets in contact with a different culture. A classical definition by Redfield, Linton, and Herskovits (1936, p. 149) states that: *"Acculturation comprehends those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original cultural patterns of either or both groups."* Berry (1997, p. 8) uses the terms *dominant* and *non-dominant* group in relation to different cultural groups that are involved in the process of acculturation. I will follow his example as I find it simple and comprehensible.

Acculturation is a reciprocal process, yet it usually requires more effort from the non-dominant group than from the dominant group. The non-dominant group has to become familiar with certain rules, traditions, values, and behavioral patterns of the dominant group and to a certain level, adopt some of these new cultural features. At the same, they bring with them their own

cultural heritage which they often want to preserve. If the process of acculturation is well accomplished in both groups, it can be beneficial for the whole society.

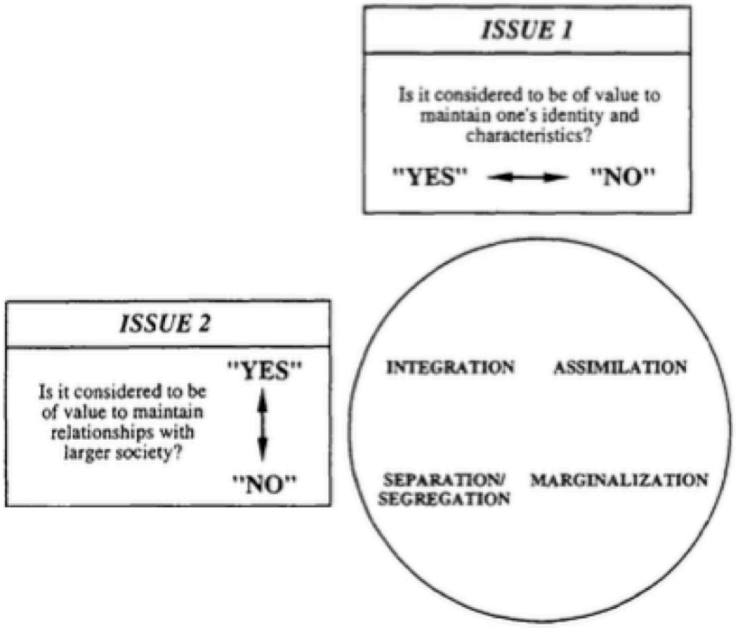
2.1.1 Strategies of acculturation

Adaptation to a new culture results from the strategy of acculturation that one adopts. Berry's model (see Figure 2) differentiates between four acculturation strategies which stem from two decisions that one has to make when moving to a different culture:

- to what extent one wants to preserve the original culture and its characteristics
- to what extent one wants to adhere to the new culture.

As a result, four different acculturation strategies characterize a general attitude of an individual towards the new culture: *assimilation, separation, integration,* and *marginalization* (Berry, 1997, p. 10).

Figure 2
Acculturation strategies (Berry, 1997, p. 10).



An individual who does not want to maintain the culture of origin and seeks contact with the new culture adopts *assimilation* strategy. In contrast, *separation* strategy takes place when one wants to preserve the culture of origin and does not want to be involved with the new culture. A compromise between the two is *integration*, maintaining the culture of origin while simultaneously becoming familiar with the new culture. *Marginalization* is a strategy that is adopted when one renounces the

culture of origin and has no interest in the new culture. Such strategy is rarely adopted voluntarily; it is usually the case of groups that are excluded from their own culture and marginalized or feared in the new culture. For instance, it may occur in the case of refugees (Berry, 1997).

As was stated above, acculturation is a reciprocal process. Therefore, the attitude towards immigrants and the acculturation strategy of the host society is equally important in the whole process. Ethnocentrically oriented societies that adopt assimilation strategy believe that the best approach towards immigrants is to mix them with the dominant culture and create one big culture. This view is sometimes illustrated with a metaphor *'the melting pot'*. It describes that one is forced to renounce the culture of origin, accept the worldview of the dominant culture and melt into the dominant society. For example, American integration strategy is often described as the melting pot (Bennett, 2004). Possibly the most dangerous strategy that a society can adopt is separation or segregation. These strategies aim to separate and isolate different cultural groups from the dominant society and to avoid contact with them. By doing so, they induce fear and prejudice in the dominant society against the separated groups (Bennett, 2004).

The opposite of *'the melting pot'* strategy is *'the salad bowl'*. It represents the adoption of integration strategy that advocates ethnorelative view and multicultural society. The salad bowl aims to preserve cultural differences and create a society where all cultures are equal and respected. The metaphor of the salad bowl represents different cultures as pieces of vegetable that fit together and make one big tasty salad. Canadian immigration strategy is often described as a good example of the salad bowl strategy (Bennett, 2004).

2.1.2 Towards integration

Integration strategy has the most positive outcomes if adopted by both non-dominant and the dominant group (Hofstede et al., 2010). The non-dominant groups may preserve their culture, while they simultaneously create a shared identity with those from the dominant group. If successful, integration can enrich both the dominant and non-dominant group (APA, 2013a; Berry, 1997).

However, certain conditions must be met so that the integration process can be accomplished and it requires that both, dominant and non-dominant groups, make an effort. Berry (1997, p. 11) suggests that integration usually occurs in societies that *"value cultural diversity, have relatively low levels of prejudice, ethnocentrism, racism and discrimination; positive mutual attitudes among cultural*

groups; and a sense of attachment to, or identification with, the larger society by all groups."

The non-dominant group must be willing to learn and respect some fundamental cultural values of the dominant society while the dominant group must make certain steps that facilitate the integration process of the non-dominant group. For instance, promote some policies that support cultural diversity and provide culturally adapted services in institutions such as education, health, work, etc., in order to fulfill the basic needs of the non-dominant group. It is vital that both groups involved in the process participate and interact together so that they can promote cooperation, understanding, and tolerance (Berry, 1997, 2016).

Problems may occur when the strategy of integration is not well adopted. For instance, some countries of the European Union such as Germany or the United Kingdom believed that their efforts for integration and creation of multicultural societies had failed. Berry (2016, p. 8) argues that *"multiculturalism has not failed because it was never fully attempted in these societies. If multiculturalism is viewed as only tolerating the presence of different cultures in a society without the simultaneous promotion of inclusion through programs to reduce barriers to equitable participation, then such policies and ideologies are more accurately described as being a form of segregation."*

Berry (2016) suggests that in this case, the dominant society didn't make enough effort to facilitate the integration process of the non-dominant groups. As Berry infers, the idea of integration is not only about tolerating different cultures, but the dominant society must try to reduce cultural barriers that complicate the everyday life of non-dominant groups. For instance, language barrier should be addressed by providing affordable language courses for immigrants, information about public services should be accessible in foreign languages, etc.

In contrast, Canada is cited as an example of a country where multicultural policies have successfully been adopted and practiced. In fact, Canada was the first country to issue an act about multiculturalism which dates back to 1971. Their approach to the cultural diversity of the country illustrates the general attitude that promotes integration.

"Canadian multiculturalism is fundamental to our belief that all citizens are equal. Multiculturalism ensures that all citizens can keep their identities, can take pride in their ancestry and have a sense of belonging. Acceptance gives Canadians a feeling of security and self-confidence, making them more open to, and accepting of, diverse cultures. The Canadian experience has shown that multiculturalism encourages racial and ethnic harmony and cross-cultural understanding" (Government of Canada,

2012, p. 1).

Multiculturalism believes that all cultural groups should be allowed to maintain their fundamental cultural norms, values, traditions, and language. It is also believed that through acceptance of cultural differences, prejudice and fear can be reduced, and self-esteem of all cultural groups fostered. As a result, the country can benefit from the presence of diverse groups that bring new skills and knowledge to the whole society (APA, 2013a).

The Czech society used to be very diverse and multicultural during Austro-Hungarian Empire in 19th century. Yet, the character of the population got through some significant changes in 20th century. The Nazi annexation of Czechoslovakia during World War II and the subsequent Soviet annexation in 1948 led to segregation of some cultural groups. During the Soviet era, Czechoslovakia was forced to adopt Soviet politics that were hostile to cultural diversity. As a consequence, the 43 years of Soviet dominance created a monocultural society in Czechoslovakia.

Nonetheless, the situation has been changing during the past 25 years. Czech modern society consists of various cultural groups, and their number increases every year. Yet, the overall approach of the dominant group towards immigrants and culturally different populations tends to separate them from the society. Contrarily to countries like Australia or Canada, many European countries have a long history of dominant groups that were independent on immigration. Thus, it is harder for non-dominant groups to integrate into such countries than is the case of societies that were established on immigration (Verkuyten, 2007).

Migration policy index[4] is a project funded by European Fund for the Integration of Third-Country Nationals and it is a multidimensional measure that evaluates policies to integrate migrants of European and other Western countries (Canada, Australia). It evaluates and compares the effort that governments make in order to promote the integration of migrants in their society. In total, there are 38 countries analyzed, and they are assessed in 8 different areas: labor market mobility, education of children, political participation, family reunion, access to nationality, health, permanent residence and anti-discrimination. The ranking is based on 0-100 score that differentiates six values:

[4] For more information see www.mipex.eu

- 0 – Critically unfavorable
- 1-20 – Unfavorable
- 21-40 – Slightly unfavorable
- 41-59 – Halfway favorable
- 60-79 – Slightly favorable
- 80-100 – Favorable

The top placed countries are Sweden (78), Portugal (75) and New Zealand (70). The Czech Republic is in 23rd position with an overall score of 45 - 'Halfway favorable'. The lowest scores obtained were in Political participation (21), Education (38) and Health (44), the highest score was in Family reunion (57). The overall result suggests that *"Czech public opinion is less positive towards immigrants than on average in Europe, for example only ¼ believe immigrants enrich the Czech Republic economically and culturally… Czech integration policies still have far to go in order to guarantee equal rights and opportunities"* (MIPEX, 2015, p. 63, 64).

2.2 Culture shock

The process of acculturation consists of several phases that in the end result in adaptation to the new environment. Culture shock occurs frequently as part of the process and it can be a troublesome but necessary part of the acculturation process.

Berry (1997, p.13) suggests that cultural adaptation consists of three main processes that are *culture learning*, *culture shedding,* and *culture conflict*. In fact, acculturation is not only about *learning* some new behavioral patterns, but it may also require *shedding* some behaviors that are not suitable for the new environment. When adaptation is successful an individual experiences low acculturative stress, and the whole process has positive outcomes. When the demands of the environment are high, a person can experience high acculturative stress which requires that people actively use their coping strategies to overcome the situation. If the level of acculturative stress becomes overwhelming and an individual cannot manage it, then a risk of psychopathology development arises (Berry, 1997). Thus, when treating immigrants, it is vital to pay attention to the process of acculturation and adaptation in the new environment, and how it could have influenced the present health condition.

The term *acculturative stress* is equivalent to *culture shock* which is a more popular term that is widely used both in the general population and in the scientific milieu. Berry prefers to use

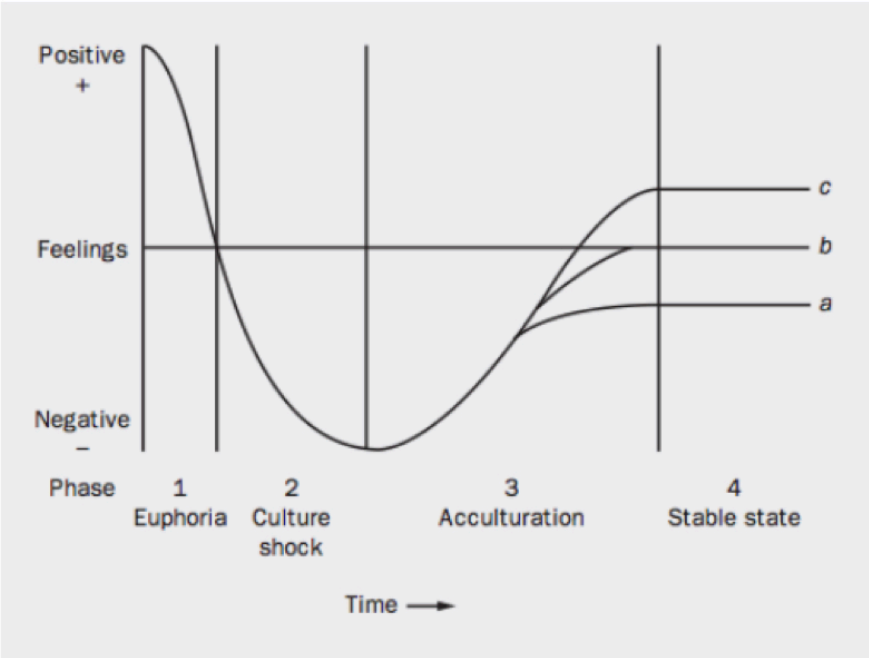
acculturative stress as it more accurately describes the nature and the origin of such experience. By his definition, it is *"a stress reaction in response to life events that are rooted in the experience of acculturation"* (1997, p. 19). I agree with Berry that *acculturative stress* is probably more appropriate, however, I will use the term *culture shock* as it is a better known and accepted term.

The term was first introduced by Oberg (1960) to describe cultural experiences of missionaries who were obliged to spend long periods abroad.

"Culture shock is precipitated by the anxiety that results from losing all our familiar signs and symbols of social intercourse. These signs or cues include the thousand and one ways in which we orient ourselves to the situations of daily life: when to shake hands and what to say when people meet when to talk seriously and when not,… These cues which may be words, gestures, facial expressions, customs, or norms are acquired by all of us in the course of growing up and are as much a part of our culture as the language we speak or the beliefs we accept" (Oberg, 1960, p. 142).

Individual variations exist, however, it is mostly agreed that the process of acculturation develops as is shown in Figure 3.

Figure 3
Acculturation curve (Hofstede, Hofstede & Minkov, 2010, p. 385).



Right after the arrival to a new country, people are usually excited about everything and the new culture seems fascinating. This phase is described *Honeymoon* or *Euphoria,* and it is a relatively short period of excitement (Hofstede et al., 2010). Oberg (1960) suggests that it can last up to six

months, depending on the circumstances and the individual variations. For instance, many tourists return to their home country at this stage, and they are full of excitement and idealization of the country they'd been to, yet their experience with the country is only superficial.

Over time, the honeymoon phase slowly fades out as one has to face various challenges of the real life in the new country and the period of *culture shock* takes place. Again, the length and the intensity in which culture shock affects people varies depending on the individual characteristics and the differences between the original culture, and the culture of the new environment (Hofstede et al., 2010). People who suffer from culture shock can experience symptoms such as strong feelings of frustration, anxiety, helplessness, and hostility; they might constantly worry about being robbed or injured, and have strong feelings of homesickness. As a defense, people usually seek contact with other members of their own nationality, and they are not willing to learn the language of the host country. In general, people project their discomfort onto the host culture, and its people and they feel hostile towards them (Hofstede et al., 2010; Oberg, 1960).

As people gradually become oriented in the new environment, learn some basic language phrases, find routines, and gain some positive experiences with the local people, their self-confidence increases and they enter into a phase that is called *Recovery, Acculturation,* or *Adaptation* period. The attitude towards the new environment and its people slowly shifts to positive, and they start integrating into the new society. Eventually, people reach a relatively stable phase that is called *Adjustment* (Oberg, 1960). As the curve illustrates, this state can result in being negative in comparison with home (a), similar (b), or people may feel better than they felt home (c) (Hofstede et al., 2010).

The length of the acculturation process can vary; it depends on the individual, situational and environmental aspects of one's experience. Oberg (1960) gives two basic suggestions that should help to overcome culture shock and promote adaptation. First, get to know the people of the host country as soon as possible, and second, learn the language of the host country. Both can help to gain confidence and a sense of orientation and familiarity in the new environment. I endorse Oberg's suggestions, from my experience, knowing the language and having some local acquaintances opens up a wide range of possibilities to discover the new culture through authentic experiences which then help to foster confidence and a sense of belonging in the new environment.

Interestingly, people who complete their acculturation process and later have to return home often experience the same process over again in their home country. For instance, it is a quite common

experience among Erasmus students who return to their home after a relatively long period abroad, and they find themselves in a very similar situation as when they had arrived in the new country. This experience is called *reverse culture shock,* and it describes the readjusting process to the old cultural environment which has the same pattern as *culture shock* (Hofstede et al., 2010).

2.3 Challenges of living abroad

Most people who decide to move to another country have to face many challenges that are associated with the new environment. These challenges are often a source of frustration and distress, and they can substantially worsen the negative aspects of the acculturation process if one is not prepared for them.

Language is one of the main challenges that foreigners must face in the new country. Basic everyday communication can become a source of anxiety and frustration. Foreigners often struggle with the language in the Czech Republic. Czech is a Slavic language, and it is very different from Germanic and Romance languages. As a result, foreigners often experience difficulties with communication in Czech even after a long period spent in the country.

In general, most young Czechs can speak English on at least communicational level, especially in Prague. However, dealing with institutions, offices, and officers, everyday situations such as shopping, transportation assistance, police, etc., can be very stressful if one does not speak Czech. Such situations which are usually easy and straightforward become exhausting and frustrating. Also, the language barrier can prevent foreigners from getting to know local people and making friends which is one of the protective factors that can facilitate the acculturation process (Oberg, 1960). Thus, language barrier needs to be considered as a significant handicap which can generate a lot of distress, and can significantly influence one's psychological well-being.

People from different cultural groups are necessarily at risk of being stereotyped. Creating stereotypes about other groups of people around us is a natural process that helps us orient efficiently in unknown situations (Neuliep, 2014). Stereotypes are attitudes that have either positive, neutral, or negative valence; they are usually associated with characteristics such as race, sex, nationality, or profession which are believed to bear certain typical traits and behavior patterns (e.g. women are sensitive; French do not speak English; Czechs are unfriendly, etc.). They create some expectations about other people, and these expectations influence the way how we interact with the stereotyped person. We unconsciously search for the behavior and traits that confirm our

stereotypes about the person, and we thus tend to see what we expect (Hofstede et al., 2010).

Negative stereotypes can lead to prejudice which can result in discrimination and racism (Neuliep, 2014). Physical features of individuals (e.g. race, ethnic) that are uncommon in the country of the settlement are often subject to strong stereotypes (APA, 2013a; Berry, 1997). The population of the Czech Republic is racially homogenous, and most of the population is White. Therefore, people of different races are likely to experience the adverse impact of racial stereotypes. Discrimination and racism need to be taken seriously when it comes to mental health as they are associated with high risk of stress, depression, anxiety, substance abuse, and other disturbances associated with psychological distress (Aklin & Turner, 2006; APA, 2013a; Betancourt et al., 2003; USDHHS, 2001). Moreover, discrimination and stigmatization also complicate the access to appropriate health care (WHO, 2013).

Stereotypes are overgeneralizing and as such, they are dangerous. Stereotyping fosters one's confidence, it allows a certain feeling of understanding and control over the situation. However, such feeling is only imaginary because stereotypes put people into boxes that are only superficial and often very inaccurate (Oberg, 1960). When we encounter an individual from a different cultural group, we need to be aware of our stereotypes towards the particular group and how they influence our perception of the person. Mental health practitioners are as much as anyone else in danger of stereotypical views and prejudice towards diverse cultural groups. Stereotypes and negative attitudes can be challenged and overcome most effectively through a personal experience with the stereotyped individual (Aklin & Turner, 2006; APA, 2003).

Migration often implies that immigrants lose their social ties in their home country. The language barrier, lack of social support, and experiences of discrimination can result in feelings of frustration, distress, and favor an attitude of hostility towards the people from the new environment. Such attitude can further complicate the establishment of new social ties in the new environment. As a result, the individual feels isolated from the society and the repertoire of possible coping strategies can be scarce in the new environment. It is a vicious circle that is fed by the negative feelings and experiences of an individual and the consequent negative reactions from the environment. As a consequence, an immigrant can lack proper relationships and feel alienated and isolated from the society. Such situations are favorable to the development of mental health problems which might have already been present before in a latent form (Hubinková et al., 2011; Kirmayer et al., 2011).

3 Treating culturally and linguistically diverse population

Mental illness stems from a combination of biological, psychological, social, and cultural factors. Any of these factors can play a stronger or a weaker role depending on the specific disorder (USDHHS, 2001). This part will explore the cultural factors and their role in the development and treatment of mental health problems.

As was stated in the beginning, culture shapes one's values, beliefs, and behavior. Hence, in the context of mental health, it shapes client's beliefs, values and behaviors about mental health, mental illness, and possible treatments (Aklin & Turner, 2006). Culture influences how clients perceive the cause of an illness, how they recognize and express the symptoms, what coping strategies they use, what sort of treatment they seek, and what expectations they have about the treatment (Betancourt et al., 2003; Betancourt, 2004; Jacob, 2014; Kirmayer, 2012; Marsella & Yamada, 2013; USDHHS, 2001). In simple words, culture influences what is perceived as a problem, how the problem is understood, and which solutions to the problem are acceptable.

Mental health practitioners, as all human beings, are equally shaped by culture. Their cultural background shapes their understanding of mental health and psychological distress, and the use and knowledge of specific ways of treatment (APA, 2013a; Betancourt, 2004). Moreover, the system of mental health care which provides help, and trains practitioners is equally construed and shaped by culture. Hence, an intercultural encounter in the context of mental health care should be viewed as an interaction between individuals of different cultural backgrounds that are in a culturally specific environment. Practitioners should be aware of how cultural differences may influence the whole interaction and a possible treatment process (Kirmayer, 2012; Hernandez, Nesman, Mowery, Acevedo-Polakovich & Callejas, 2009; USDHHS, 2001).

Some decades ago, Hallowell (1934, p. 3), a cultural anthropologist, highlighted the importance of cultural awareness and knowledge when evaluating normality: *"In order to distinguish clearly the cultural factors at work the investigator must have an intimate knowledge of the culture as a whole, he must also be aware of the normal range of individual behavior within the cultural pattern and likewise understand what the people themselves consider to be extreme deviations from this norm. In short, he must develop a standard of normality with reference to the culture itself, as a means of controlling an uncritical application of the criteria he brings with him from our civilization."*

Later on, American psychoanalyst Karen Horney stressed the importance of recognizing the influence of culture on the concept of normality: *"Applying the same principle to the problem of normal and neurotic structures in a given culture means that we cannot understand these structures without a detailed knowledge of the influences the particular culture exerts over the individual"* (Horney, 1937, p. 20).

In today's multicultural world, these words are ever more present then back in Hallowell's and Horney's time. Culture determines the view of normality and pathology. It is clients' culture that determines what they see as normal and pathological behavior and similarly, practitioners' culture determines what they perceive as normal behavior, and what they treat as mental illness. Thus, mental health practitioners must be aware of their own cultural background when talking about pathology, and they must consider clients' culture to evaluate whether are the symptoms within the normal range of the clients' culture (APA, 2013b; Jacob, 2014; Marsella & Yamada, 2013).

3.1 Culturally competent practice

Betancourt et al. (2003, p. 297) describe a culturally competent practice as *"understanding the importance of social and cultural influences on patients' health beliefs and behaviors; considering how these factors interact at multiple levels of the health care delivery system (e.g., at the level of structural processes of care or clinical decision-making); and, finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations."*

Cultural competence can be evaluated on two levels. First, the individual level, that is the cultural competence of a given practitioner and his or her ability to work with foreign clients. Individual cultural competence includes education, language abilities, knowledge of different cultures, attitudes towards culturally different populations, and the use of culturally appropriate psychological tools and treatments (APA, 2003). Second, cultural competence on the structural level of the system of mental health. A culturally competent system of mental health care tries to make mental health services accessible, acceptable, and effective equally for all people regardless of their ethnocultural group (Kirmayer, 2012).

3.1.1 Individual level

Arasaratnam and Doerfel made a study among a healthy population on how people from different countries understand intercultural communication and what they think makes someone culturally competent. Overall, the description of a competent intercultural communicator was as follows:

"person-centered (me), sensitive and kind, have experience with different cultures, want to learn about cultural matters, and are good at these processes… They are open to others, better in communicating, show interest in differences and are aware of these, and have a level of exposure (exposed) to these differences that make them able to pick up on these" (2005, p. 157).

Individual cultural competence consists of three areas that one can develop – *knowledge, attitude,* and *skills*. American Psychological Association has issued guidelines with some basic principles of a culturally competent practice (APA, 2003, 2013a). The guidelines are criticized for being mostly theoretical and not offering any practical examples (Alárcon & Gone, 2014). Yet, I believe there are some pertinent points that well illustrate what individual cultural competence involves.

1) *"Psychologists are encouraged to recognize the importance of multicultural sensitivity/responsiveness to, knowledge of, and understanding about ethnically and racially different individuals"* (APA, 2013a, p. 8).

First, psychologists should be *knowledgeable* about the client's culture. As was mentioned previously, the more one seeks contact with other cultural groups, the more competent one becomes in intercultural communication, and the less one is at risk of stereotyping and misinterpreting. When dealing with different cultural groups, psychologists should be familiar with their culture.

Mental health problems are more often misdiagnosed among immigrants (i.e. clients of different cultural background) than among local clients (Kirmayer et al., 2011). In fact, lack of knowledge and ignorance of cultural differences can prevent the psychologist from obtaining relevant information which can consequently lead to a wrong evaluation of the problem. In contrast, being attentive to the culture of the client can facilitate the rapport between a psychologist and the client. It can also enhance client's engagement and adherence to the treatment process (Jacob, 2014).

2) *"Psychologists are encouraged to recognize that, as cultural beings, they may hold attitudes and beliefs that can determinately influence their perception of and interactions with individuals who are ethnically and racially different from themselves"* (APA, 2013a, p. 8).

Second, psychologists should be aware of their *attitudes* and beliefs regarding culturally different clients, and how they may influence the interaction with them. This part refers to the previous chapter about stereotypes and prejudice. Our worldview derives from our cultural background and it shapes how we perceive other people. When interacting with a person, we gather information about the content of the interaction, and about the person as a whole, i.e. their physical appearance, age, sex, race, etc. The way how we organize the sum of information and reason about them depends

on our attitudes, values and other aspects of our cultural worldview. To facilitate the process, we put various traits, characteristics, and qualities into categories and we associate them with particular groups of people. We create stereotypes about others by ignoring their individual differences. As a result, our perception of their behavior is biased, and it can have negative consequences on the treatment process (Betancourt et al. 2003; Martinez, 2013).

As was mentioned above, stereotypes are mostly inaccurate, and the more one is unfamiliar with a particular group, the more one is at risk of stereotyping (APA, 2003). In the clinical practice, stereotypes can create biased opinions about a person's feelings and behavior and prevent psychologists from recognizing the person's individuality. Such attitude complicates the rapport between a psychologist and the client (Alcántra & Gone, 2014; Draguns & Tanaka-Matsumi, 2003).

Overcoming stereotypes through personal experience with culturally different populations is of high importance in case of groups that are stigmatized in the society, such as the Gypsy population in the Czech Republic. Stigmatized groups often experience discrimination and such experience is a serious risk factor when it comes to mental health. Understanding the cultural worldview of a stigmatized group allows adjusting one's own potentially biased views of the group. It also helps to understand the way how they might present symptoms of illness, where they might seek help, and how it can affect the process of treatment (APA, 2003). The research on stigma and its effect on mental health service use is scarce. However, it is believed that stigma discourages the stigmatized group from seeking appropriate help when necessary (Alcántra & Gone, 2014; USDHHS, 2001).

In the context of intercultural psychological treatment, differences in the worldview of a client and the psychologist may cause some misunderstandings. Naturally, it's impossible that psychologists have the same worldviews as all their clients, however, it is important that they are aware of their own cultural worldview so that they can understand how it may affect their interaction with culturally diverse clients (APA, 2003).

3) *"Psychologists are encouraged to apply culturally appropriate skills in clinical and other applied psychological practices"* (APA, 2003, p. 391).

Finally, an intercultural setting requires culturally adapted interventions and practices that psychologists use (APA, 2003). Mental health practitioners should *use* culturally sensitive tools and interventions that are tailored to the culture of a particular client. In some instances, it may be necessary to modify the style of interaction with a client, to use a foreign language to communicate,

or to become familiar with some types of interventions that come from the cultural traditions of the client (Kirmayer, 2012).

In sum, a culturally competent psychologist has some knowledge of the client's culture, has established a positive attitude towards culturally different clients, and uses psychological interventions that are sensitive and appropriate with regard to the client's culture (APA, 2013a; APA, 2003; Arasaratnam & Doerfel, 2005; Betancourt, 2004; Betancourt et al., 2003).

3.1.2 Structural level

Addressing cultural competence is equally important on the structural level within a society. Mental health institutions and models of mental health services derive from the culture of a given society. Variations occur in how societies address and view services for culturally different groups that live in the society, and it affects the way how non-dominant groups can access these services (Kirmayer, 2012).

Cultural characteristics of the dominant society shape the way how, why, when, and where its members seek mental health care. Also, the institutions and the psychologists of the dominant society decide what kinds of mental health problems are recognized, and how they are addressed. Non-dominant groups might have a different view of mental health which may not be in accordance with the view of the dominant group (APA, 2013a).

Mental health institutions should dispose of practitioners that are representative of the population in the society. They should ensure that clients of different cultural backgrounds can access the services they need. On a basic level, this can be achieved through linguistic support, interpreter service, translations of documents, and information about the services. Further, the system of mental health can promote culturally appropriate care through the development of specific tools and measures and creation of referral system, and promotion of culturally competent practice among practitioners (Betancourt et al. 2003; Hernandez et al., 2009).

Moreover, institutions that provide mental health services should promote intercultural training among practitioners. As such, the overall culturally sensitive orientation of the services can be incorporated in the system of mental health education and practice (Aklin & Turner, 2006). Betancourt et al. (2003) identify common barriers that complicate the access to mental health care for clients from the non-dominant groups:

- Problems with communication that stem from language barriers, lack of interpreter service and appropriately translated documents, information about the institution, services provided and the treatment.
- Long waiting times for appointments, difficulties and delays in the intake process.
- Lack of qualified psychologists trained in intercultural practice.

These barriers can be overcome by the overall orientation of the system which would seek to promote the culturally competent practice. Foreigners who do not trust local mental health system or have experienced some problems in accessing it, often seek help in their home countries. It can be helpful if the problem is not too complex as they can usually access the care they need. However, in the long-term, it can become difficult to overcome the distance, especially in urgent situations when quick action is necessary. Also, such strategy can further increase the distance and mistrust between the client and the local health system (Rosso & Bäärnhielm, 2012).

3.2 Psychological assessment

The methods and skills that are effective in assessing and treating common mental health problems in the general population are usually also effective with the clients from different cultural backgrounds. Nonetheless, intercultural assessment presents some specific challenges that make the work more difficult. Such problems are related to the barriers that have been indicated in the previous chapter. They mostly consist of barriers in communication, the cultural shaping of symptoms expression, the role of social and family background, and the process of acculturation in the new environment (Kirmayer et al., 2011).

American Psychiatric Association (2013) underscores that for an adequate psychological assessment it is vital to understand the cultural context of the client's distress. Different cultural groups can present symptoms and illnesses that are unique to the group, may have some particular ways of expressing distress, and some specific beliefs about the etiology of a disease. A sensitive psychological assessment should evaluate these cultural aspects to understand the role they play in the problem.

Intercultural psychological assessment usually involves two people with some expectations that derive from their personality, experience, and from their cultural background. Such expectations can be associated with the client-practitioner rapport, the way of communication, or the possible treatment methods. They can differ substantially if the people involved in the process come from a different cultural background. All kinds of cultural differences such as language, beliefs, and values

can provoke fear of the unknown, anxiety, and negatively influence the whole process (Leseth, 2015).

3.2.1 Clinical interview

"The interview is one of the most used methods within psychology, and one of the psychological methods least examined scientifically" (Kvale, 1983, p.171).

Interviewing is substantially shaped by the personalities of all participants involved. That is probably one of the reasons why the clinical interview is hard to examine scientifically. Every interview is in a way unique just as the personalities of the psychologist and the client are unique. Practitioners should be aware of their own influence on the interviewing process and should be flexible in tailoring the interview to the specific needs of each client (Martinez, 2013).

The clinical interview is used to gather information about the client's feelings, attitudes, behaviors, and symptoms. The purpose of the clinical interview is to obtain valid information about a client's problem, and to examine all possible variables that are involved. Apart from the verbal communication, interview also allows getting information from the non-verbal communication of the client. In some cases, the clinical interview can be the only way of getting information. For instance, when a client is extremely distressed, anxious, psychotic or illiterate, or when appropriate adaptations and translations of psychological tests are not available (Aklin & Turner, 2006).

The form of the clinical interview can range form unstructured, semi-structured to fully structured. The appropriate use of different forms depends on a given situation. However, in the context of clinical assessment semi-structured interviews are usually the best option (Alcántra & Gone, 2014). They allow a certain level of flexibility to adapt the interview to the client while reducing the information variance and ensuring that all relevant questions are covered. Also, the use of semi-structured interviews can help in reducing the likelihood of communicational errors and misunderstandings (Aklin & Turner, 2006; Alcántra & Gone, 2014).

Particularly in the intercultural setting, psychologists are discouraged from using fully structured interviews that explore symptoms using a checklist in a decontextualized way as they are likely to yield some inaccurate information. It is important to let the clients talk and pay close attention to their narratives, particularly in regard to the migration process and the process of acculturation. These areas are often a source of important data that help to understand clients' personal history and the development of their problems. Moreover, clients' narratives can reveal information about

their strengths, resources for coping strategies, and their past experiences that might potentially be associated with their present condition (Rosso & Bäärnhielm, 2012).

Martinez (2013, p. 191) suggests three core competences that characterize a good interviewer:

- attaining a constant attitude of care;
- having empathy, nonjudgmental attitude and non-directiveness;
- having compassion for those whom we provide mental health care.

These skills seem elementary and obvious, however, they are not simple to adopt. They help to put the client at ease and create a rapport that induces confidence in the psychologist. Particularly in the intercultural setting adopting these basic skills can be challenging. The more different client's cultural background is, the more difficult it can be for the psychologist to have an unbiased view and express empathy and nonjudgmental attitude. Moreover, with a lack of knowledge about the cultural background of the client, stereotypes tend to dominate in how the client is seen (Draguns & Tanaka-Matsumi, 2003). Psychologists must try to develop a positive attitude towards their clients that includes respect for other ways of life, other religious beliefs, values, or physical features. With a negative attitude, filled with stereotypes a psychologist is very unlikely to express empathy, caring attitude, and compassion in the interviewing process (Martinez, 2013).

At the beginning of the interview, the very first step that a psychologist must do is to determine the language of communication. If not well accomplished, this first step can be a source of awkwardness, discomfort, and frustration both for the psychologist and the client, and it can substantially disturb the whole interviewing process. Ideally, it is the client who decides the language of communication and the psychologist should try to meet this preference (Bauer & Alegría, 2010). If the client speaks more than one language, the psychologist may try to deduce what is the best language or may just ask the client about it if unsure[5] (Martinez, 2013).

Complications may occur when the psychologist does not speak the client's preferred language or has only limited proficiency. In such cases there are three options:

- First, refer the client to a colleague who has sufficient language abilities.
- Second, using an interpreter if there is no qualified practitioner to work in the language of

[5] Language proficiency is often linked to the level of acculturation (Paniagua, 2013). Psychologists may use a brief acculturation scale to learn about the client's preferred language of communication (see Appendix A).

the client. Professional interpreter service can enhance communication and the treatment process. Nonetheless, it also presents some dangers. The use of interpreters can limit the establishment of psychologist-client rapport (Kirmayer et al., 2011); interpreters may intentionally or unintentionally edit what the clients and psychologists say; they might use different words in order to facilitate the translation rather than provide direct translation which can affect the psychologist's decision making (Alcántra & Gone, 2014). Hence, interpretation services should be provided only by interpreters who are educated in mental health care, are informed about the confidentiality of the assessment, and are not family members or friends of the client[6] (APA, 2003; Kirmayer et al., 2011).

- Third, with a limited knowledge of client's language psychologists can still try to conduct the interview on their own as it can be potentially fruitful and rewarding. Even if some misunderstandings may occur, and the communication might not be ideal, it can foster the rapport, and the client might appreciate the fact that the psychologist tries to comply with his or her preference. It goes without saying that repetition, clarification, active listening and other basic techniques are vital in such situations (Martinez, 2013).

Research suggests that psychologists are more efficient if they perform in client's native language and use culturally adapted interventions that are translated into client's native language (APA, 2013a). Being able to communicate in foreign languages is an important skill in clinical practice as it can significantly contribute to the positive outcomes of the process. Hence, it can be extremely beneficial if psychologists who work with foreign clients learn their language (Aklin & Turner, 2006). Still, bicultural and bilingual psychologists are usually best able to work with different cultural groups as they can understand specific idioms, metaphors, expressions and communication styles used by patients (Alcántra & Gone, 2014; APA, 2013a).

Sapir-Whorf hypothesis illustrates the importance of language as a mean to understanding the world around us. Sapir infers that *"the 'real world' is to a large extent unconsciously built up on the language habits of the group"* (Sapir, 1929, p. 160). The hypothesis presumes that the structure of our language shapes our cognition and our world view. Nowadays, the theory is not understood in such a deterministic view, but it is agreed that language significantly shapes our cognition. Hence, being able to speak a foreign language not only allows us to communicate with foreigners, but it also helps to better understand their perception of the world (Sapir,1929; Kay & Kempton, 1984).

[6] See Appendix B for a detailed guide to working with interpreters.

A language barrier during a clinical process makes the establishment of client-practitioner rapport difficult, client's disclosure is lower, and it may prevent the psychologist from identification of some information that is important to the client's distress (APA, 2013a). As a result, the language barrier can lead to misunderstanding (Aklin & Turner, 2006), lower compliance and adherence to the treatment (Bauer & Alegría, 2010; Betancourt, 2004), and it may discourage clients from using mental health services and receiving the care they need (USDHHS, 2001).

Language factor plays a major role in the context of the Czech environment. Czech is not an international language, it is hard to learn and foreigners are rarely able to speak it even if they live in the country for a long time. With an increasing number of foreign nationals in Prague, English has become a widely used language for communication, and it has become a *lingua franca* of many foreigners. Thus, it is a vital skill for Czech mental health practitioners to know English in order to work with foreign clients successfully.

American Psychiatric Association (2013b) acknowledges the importance of evaluating cultural aspects in psychological assessment. Some pioneer information about the assessment of culture appeared in the DSM-IV. Nonetheless, the assessment of culture during the clinical interview was further developed in the DSM-5. The manual provides *Cultural Formulation Framework and Interview* (CFI) which is a semi-structured interview that contains a set of questions that assess cultural issues. The aim of the CFI is to systematically evaluate the cultural identity of the clients, their cultural explanations of distress, cultural factors related to their coping strategies and vulnerability, and the cultural differences concerning the practitioner-client relationship (APA, 2013b; Jacob, 2014; Marsella & Yamada, 2013).

The CFI consists of 16 questions that explore:

- Cultural definition of the problem (e.g. *"People often understand their problems in their own way, which may be similar to or different from how doctors describe the problem. How would you describe your problem?"*)
- Cultural perception of the cause, context, and support (e.g. *"Why do you think this is happening to you? What do you think are the causes of your problem?"; "Are there any aspects of your background or identity that make a difference to your problem?"*)
- Cultural factors affecting self-coping and past help seeking (e.g. *"Sometimes people have various ways of dealing with problem like yours. What have you done on your own to cope with your problem?"*)

- Cultural factors affecting current help seeking (e.g. *"What kinds of help do you think would be most useful to you at this time for your problem?"*) (APA, 2013b, p. 752-754).

The use of the CFI requires a certain level of cultural sensitivity from psychologists. They need to understand their own cultural background and how it contributes to their values, perceptions and personality. Leseth (2011) talks about a sort of amazement that occurs when one faces cultural differences. Psychologists should explore how they react to this experience and ask themselves questions such as *"How am I responding to the situations where I become amazed?"* or *"Do I develop an understanding for a client's culture rather than aversion?"*. Leseth underscores that it is a professional skill to perceive all people as cultural beings and it needs time and effort to develop sensitivity and positive attitudes towards cultural differences.

The CFI focuses on the cultural exploration of the actual problem. However, there are many other factors associated with the migration process that can play a role in the development of a mental health issue. To assess all risk factors and to understand how they may coincide with immigrants' mental health, American Psychological Association (2013a, p. 9) summarizes the key areas that should be evaluated in a culturally sensitive interview:

- Pre-migration factors
- Migration experience
- Reception in the new environment and trauma
- Language/communication
- Changes in gender roles and intergenerational issues
- Economic stress and marginalization
- Resilience
- The multiplicity of identity.

At the end of the clinical interview, it is recommended to provide to the client explanations of psychologist's diagnostic hypothesis, recommendation for treatment, and other ideas that the psychologist thinks are important. Sometimes the terms and expressions that a client uses to describe symptoms may be uncommon. Once the psychologist understands the meaning of client's problem in professional terminology, it is recommended to address them in the client's words and use terms that are understandable to the client (Martinez, 2013). The psychologist should reflect client's perspectives, inform about possible interventions and negotiate a plan of treatment that is

reasonable and acceptable for the client (Jacob, 2014).

Kleinman (1980) has emphasized that when assessing a clients' problem, psychologists should focus on their *explanatory model* of the illness. He underscores that the focus should not be on the symptoms but rather on the clients' view of the problem and the context in which the problem evolved such as the cultural background (norms, values, beliefs), the social background (family, friends), and the institutional background (work) of the client (Rosso & Bäärnhielm, 2012).

Such information can be gathered through the CFI and can help to clarify what the client believes is the problem, and how the client explains what is happening. Once an explanation is given, it is equally important to ask what type of treatment the client thinks might be helpful. In fact, the client should be considered as a teacher who can give explanations about the problem to the psychologist (Betancourt et al., 2003; Kleinman, 1980; Martinez, 2013).

To conclude, the goal of the intercultural clinical interview shouldn't be just to obtain some professional explanations of symptoms, but rather to explore the relationship between the client's current situation in the context of his or her cultural worldviews, values, and personality. To this end, it is best to let the clients talk and pay attention to their *explanatory models* (Kleinman, 1980), their strengths, coping strategies, and life projects (Kirmayer, 2012).

3.2.2 Psychological testing

Testing has an important role in psychological assessment, particularly during the intake phase when a psychologist needs to understand the client's problem thoroughly. Many psychological tests used in the Czech Republic are of foreign origin and have been adapted and standardized for the Czech population (MMPI-2, BDI, WAIS, etc.). Hence, psychologists are mostly familiar with these methods that are used in the United States and other Anglophone countries.

Nonetheless, the most common barrier that a psychologist would face is the language adaptation of these tests as Czech clinics usually do not dispose of psychological instruments in other languages than Czech. Moreover, just the fact that psychologists use a familiar tool but administer it in a different language might be challenging as the whole procedure becomes new and different. Also, using psychological tests with a foreign population is tricky as the normative standards are usually available only for the Czech population.

Further, in the psychological assessment of non-western clients, it is vital to use culturally sensitive psychological instruments that would recognize cultural variations in the expression of illness. Commonly used clinical tools such as MMPI are not culturally sensitive, and they may give biased results when used with culturally different clients. Universal application of certain methods without taking a client's culture into consideration can lead to misdiagnosis. Hence, it is important that psychologists use multiple sources of evidence when assessing culturally different clients (APA, 2013b). Clinical interview stays the most important and helpful tool in the intercultural psychological assessment as culturally sensitive assessment requires formulating a picture of the client that reflects the individual uniqueness in the context of his or her cultural background (Tracy, Pruitt-Stephens & Beard, 2008).

4 Situation of mental health care in the Czech Republic

The Czech Republic has been, as most post-Soviet countries, in transition from communist centrally planned economy to democratic market economy. The communist governing of the past regime has damaged both the functioning and the image of mental health care in the society, and the consequences of it can still be seen in the present situation. As Höschl, Winkler and Pěč (2012, p. 284) suggest "*understanding the history of Czech psychiatry is essential to understanding its current difficulties, hopes, and prospects.*"

There are many problems that Czech mental health care struggles with such as underinvestment, institutionalized mental health care, lack of social care and community-based services (short-term stay clinics), lack of adequate crisis intervention, persisting stigma towards mental health care in the society, and the absence of national mental health legislation (Höschl, Winkler & Pěč, 2012; Muijen, 2014; Raboch & Wenigová, 2012). The system of mental health care in the Czech Republic is most similar to other post-Soviet countries, and it still bears many defects that most Western countries have already overcome. The main problems of the system stem from an extremely low mental health expenditure, and the institutionalized mental health care concentrated in the large psychiatric hospitals (Winkler, Csémy, Janoušková & Krejníková, 2013).

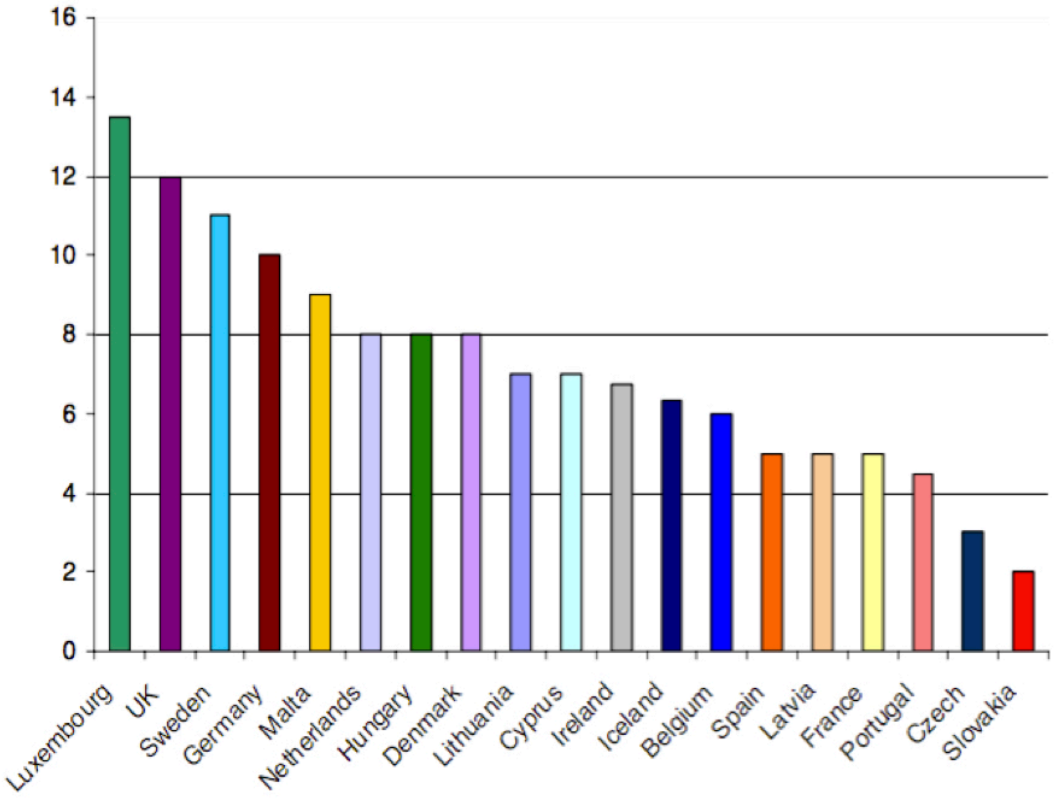
After the Velvet Revolution in 1989, the main direction in the health care system was decentralization and privatization of health care. As a result, newborn insurance companies took over funding of health care (David, Kebza, Paclt, Raboch & Volf, 2006). Since then, the Czech health care system is based on compulsory health insurance. All Czech citizens are obliged to contribute to the public health insurance which is managed by public health insurance companies

(e.g. VZP, OZP, etc.). The insurance companies finance health care institutions and reimburse most of the health care services to their clients depending on the contract that they have with the particular insurance company. Such system ensures access to affordable health care to all citizens (Alexa, Recka, Votápková, van Ginneken, Spranger, & Wittenbecher, 2015).

Nonetheless, mental health care has not been a priority in the Czech health system. The fact is illustrated by a low mental health care expenditure which reaches approximately 3,5% out of the whole amount of funds reserved for the health care (see Figure 4). In this regard, the Czech Republic positions on the penultimate place out of all EU countries where the mental health care expenditure ranges between 5-10% (Raboch & Wenigová, 2012). Mental health treatments such as psychotherapy and medication are covered by public health insurance if advised by a psychiatrist or a general practitioner. It is still fairly uncommon in the general population, though, to seek psychotherapy as the stigma over mental health care still persists (David, Kebza, Paclt et al., 2006).

Figure 4

Mental Health Expenditure in European Economic Area Countries (% of total health expenditure) (European Commission, 2005, p. 21).



Institutionalized mental health care concentrated in large psychiatric hospitals is another negative remnant of the past regime. The largest psychiatric hospitals dispose of up to 1000 beds, and they represent the backbone of the Czech psychiatry. Institutions of such dimensions barely exist in western European countries. The living conditions and the level of individualized care are poor in these facilities and they contribute to the stigmatization of mental health care in the society (European Commission, 2005). Moreover, their maintenance is extremely costly, and it complicates the development of smaller clinics and the envisaged deinstitualization of mental health care which has been promoted in most EU countries. At present, around 87% of inpatient care is concentrated in large psychiatric departments. The community-based care is not well developed and is mostly dependent on the work of non-profit organizations (Muijen, 2014; Raboch & Wenigová, 2012).

As a consequence, most patients are treated in large hospitals separated from the outside world and long-term psychiatric hospitalizations are still a common way of treatement. The system of funding by health insurance companies favors long-term hospitalizations over community-based services as hospitals get money according to the number of beds occupied per day regardless of the treatment outcomes. Hence, hospitalized patients are financially more advantageous than outpatient services which are paid by each single visit (Muijen, 2014). To illustrate, the total mental health care expenditure of the largest insurance company (VZP ČR) in 1995 was 2,52%, out of which 82% went to inpatient care, and only 18% to outpatient care (Škoda, 1998 in Raboch & Wenigová, 2012). The data are not up to date but the numbers in the recent years would still be fairly similar.

Further, there is a lack of appropriate social support and reintegration initiatives connected to the mental health care so the process of returning back to normal life is difficult and for some clients impossible (Muijen, 2014). The current trend in Europe promotes psychiatric hospital care in balance with community-based services such as day clinics, crisis intervention centers, short-stay hospitals, psychosocial help centers, etc. Nonetheless, such initiatives are difficult to integrate into the present system as most of the care takes place in large institutions that are expensive to transform, and the community-based care has not been well established yet. The overall disorganization of mental health care is further deepened by the lack of national mental health policy that would ensure a more systematic functioning of mental health care services (Höschl, Winkler & Pěč, 2012; David, Kebza, Paclt et al., 2006).

Nowadays, there are two ways to access mental health care in the Czech Republic – public and private. Public providers are entirely or partly run by the government, whereas private facilities are owned by individuals (Alexa, Recka, Votápková et al., 2015). The main disadvantages associated with private services are that they are usually expensive because insurance rarely covers the care. Further, with the lack of mental health care policy, almost anybody can open a private practice as a 'counselor' regardless his or her professional background so the quality of such service cannot be guaranteed. On the other hand, private practitioners are usually quickly accessible as there are shorter waiting times, and the clients are free to choose from different practitioners according to their preferences.

Public services are usually harder to access as there are longer waiting times. Also, one needs to be insured with one of the public health insurance companies that are accepted by the facility. Otherwise, the client is obliged to pay for all expenses which can become pricy. Moreover, it is harder to choose a practitioner as the choice is more restricted than in the case of private practitioners. Nonetheless, public services are generally advantageous in a way that they provide complex services where psychologists, psychiatrists, and other specialists cooperate and the care is more affordable as health insurance mostly covers it (David, Kebza, Paclt et al., 2006). The cooperation between private and public clinics is also problematic. Outpatient services are provided mainly by private clinics that have contracts with insurance companies. However, they rarely cooperate with public hospitals. As a result, transferring patients from inpatient public care to outpatient care is not organized, and efficient communication is lacking (Muijen, 2014).

To sum up, the situation of Czech mental health care is far from being favorable. The system struggles with financial problems, institutionalized care concentrated in large hospitals still hinders modernization of the services, and poor communication between mental health care providers complicates the establishment of multidisciplinary balanced care. Nevertheless, the government has recently acknowledged the need to improve the situation and the Ministry of Health (2013, p. 9) adopted *The Strategic Document for the Reform of Psychiatric Care*. The reform addresses most of the problems that have been mentioned with the following objectives.

- *Improve the quality by adopting a more organized and structured system of mental health care services.*
- *Promote initiatives that lead to destigmatization of people with mental illness and of mental health care in general.*

- *Improve patients' satisfaction with mental health care services.*
- *Improve the efficiency of mental health care by focusing on early diagnosis and identification of mental health problems.*
- *Promote reintegration initiatives of psychiatric patients into the society and improve their possibilities of education, employment, housing, etc.*
- *Promote cooperation between different areas of mental health care such as social services, community-based services, activities of non-profit organizations, etc.*
- *Humanize mental health care*.

One of the key elements of the reform is the establishment of mental health centers that would focus on patients with less severe forms of mental illness through community and outpatient care in their local environment. Psychiatric hospitals would be reserved only for patients with severe mental illness who are in need of highly specialized and complex care (Ministry of Health, 2013; Třešňák, 2014). The reform should lead to a mental health care system that is based on shared priorities, mutual support and effective communication of all providers that are involved. Financing of the care should become transparent and in favor of quality over quantity. Also, the priority should be the promotion of cooperation between large inpatient institutions and community-based facilities, and as a result, the establishment of balanced mental health care should (Muijen, 2014).

4.1 Previous works on intercultural topics in the Czech Republic

To my knowledge, the following research is a pioneer work that examines the situation of mental health care for foreigners in Prague. Nonetheless, there have already been published some works about intercultural psychology in the Czech Republic, and in some instances, also some information about intercultural mental health care. This chapter contains a selection of some pertinent works.

A team of private practitioners called The City Practice claim that they have been working on a research that explores the use of mental health care of the expatriate community in Prague. They briefly inform about the research on their website, however, nothing has been published so far.

"The City Practice has conducted research examining the mental health needs of the expatriate community living or having lived temporarily or permanently in the Czech Republic. We were interested in three main questions. Firstly, whether the expatriate community was aware of the counseling and psychological services available to them in the Czech Republic; secondly, whether they were using them;

thirdly, what types of issues made them seek help; and finally, whether they were more likely to seek help if they had received some kind of treatment in their native country" (15th April, 2017, Retrieved from http://www.city-practice.com/en/research/).

The University of Economics in collaboration with counselors from other universities published a short booklet with some general information about intercultural counseling in general, and the counseling services for international students in the Czech universities. The booklet also includes a collection of case studies from various university counselors. It is a valuable contribution that raises awareness about the mental health of international students (Hubinková et al., 2011).

Pavlovský and Vevera (2012) wrote a chapter about transcultural psychiatry in a monograph on psychiatry (Raboch & Pavlovský, 2012). It includes a detailed list of culture-bound syndromes such as *Dhat syndrome* or *Koro*, that are believed to be present only in specific societies and cultures (Marsella & Yamada, 2010). Culture-bound syndromes were first published in DSM-IV-TR and they also appear in ICD-10. In light of the present thesis, a more interesting part of the chapter is a summary of some particularities that characterize the work with culturally and linguistically diverse populations. Pavlovský and Vevera (2012) suggest that the reaction to medication usually does not significantly differ among cultures with exception of Asian populations who are sometimes more sensitive to medication. Further, they suggest that hospitalization and psychotherapeutic treatment are often more complicated with culturally different clients. They underscore the advantage of foreign language proficiency among practitioners which can significantly facilitate the whole intake process and the following treatment.

Morgensternová and Šulová (2007) published a book about intercultural sensitivity and intercultural competence in communication. It provides a theoretical overview of the principle theories of intercultural communication, and it also includes some practical tips for practicing and developing intercultural competence. Further, Morgensternová, Šulová, and Scholl (2011) published another work on bilingualism in children and the particularities of the development of language in children raised in multicultural families. Both works are significant contributions to the Czech intercultural psychology. The former provides a useful insight into intercultural communication which can be applied in everyday communication, and it could also serve as a practical guide for mental health practitioners who work with a culturally diverse population. The latter is more oriented to the development of the speech in bilingual children, and as such, it has its important place in the field of developmental psychology.

Průcha (2010a, 2010b, 2011) published a few works on intercultural psychology and the upbringing of multicultural children in the Czech society. The publications are important as they raise awareness about the problem of multiculturalism in the Czech Republic, and the problem of integrating and educating immigrant population in the society. They contain some theoretical information about psychological aspects of intercultural communication, and one of the books (2010b) also touches the topic of intercultural communication in the health care.

Empirical part

5 Research

5.1 Reflexivity (researcher and the initial preconceptions)

"Qualitative research acknowledges that the researcher influences and shapes the research process, both as a person and as a theorist. Reflexivity is important in qualitative research because it encourages us to foreground, and reflect upon, the ways in which the person of the researcher is implicated in the research and its findings" (Willig, 2008, p. 18).

The choice of this topic evolved from my general interest in clinical and intercultural psychology and from my passion for discovering other cultures and learning foreign languages. I've spent a fair amount of time abroad throughout my studies. One of my early experiences was during my Bachelor's degree when I spent a year at a university in the south of France as an Erasmus student. Then, during my Master's degree, I spent a semester at a university in Australia and later, one semester in Italy. Apart from my studies, I'm also an enthusiastic traveler in my spare time, and I enjoy discovering new countries and new cultures. When I'm in Prague, I'm often in contact with immigrant and expatriate community. I have a positive attitude towards foreigners, and I actively seek contact with them. One of the benefits that I find very enriching is that it allows me to learn and practice foreign languages easily.

Speaking about languages, it is extremely difficult for foreigners to learn the Czech language. In particular, if they come from the Western countries and their mother tongue is from the Romance or Germanic language families. As a consequence, most of the western foreigners who live in Prague communicate in English and only a few motivated individuals manage to master Czech at least on the communicational level. Hence, it is quite normal to hear English in Prague and it is considered to be an unofficial lingua franca for foreigners in Prague. According to the English Proficiency Index (2016), the Czech Republic has high English proficiency and ranks 16th out of 72 countries worldwide. However, because of the communist history of the country, many of the older generation still struggle with English. During the communist era, Russian was taught at schools as the principal foreign language. Only after the Velvet Revolution in 1989 English language has become part of general school education.

As a consequence, the generation who got their education before 1989 could not learn English at school. This generation is nowadays aged 40+, and they are the experienced professionals in the working field. In the past, people were not free to travel, and it was uncommon to be in touch with other countries and cultures. Therefore, the mid-aged generation usually lacks such experience in

their education and in general, they are used to living in a monocultural Czech population. The Velvet Revolution and the end of the communist regime in 1989 have shifted the style of education towards the West, and it opened the country to the world. For me and my generation (I was born in 1989), it is natural to travel, learn languages, and freely decide what to study and in which country to pursue our professional career. Most of my peers have some abroad experience as part of their education, speak at least one foreign language and have some foreign friends.

Nonetheless, the shift in the society takes time, and even after 27 years of democracy, the Czech society is still not used to multiculturalism. The system of public services such as transportation, education, and health are made accessible and user-friendly for the Czech population. The general attitude of Czechs seems to me very assimilationist (Berry, 2003), I believe that the following statement illustrates it well: "If you live in the Czech Republic, you should speak our language and behave as we do." Still, Prague is different from the rest of the country, and the assimilationist attitude is not felt as much as outside the capital city. Being one of the major tourist destinations, Prague is flooded by tourists from all around the world throughout the whole year, and tourism is one of the main benefits for the economy of the county. The statistics inform that 6,5 million tourists came to Prague in 2015 which is almost six times the whole population of Prague (approximately 1,2 million inhabitants; Prague city tourism, 2016).

I think that the Czechs like tourists and the economic benefit they bring to the country, however, the system is less welcoming towards foreigners who wish to settle down. There is an infinite amount of commercial activities that are well described in various languages, and one can easily access information about all kinds of attractions, restaurants or sightseeing tours in Prague. Also, the vast majority of people who work in tourism and get some financial benefits out of it can speak English, Russian or other principle languages. However, when it comes to public services that do not pertain to the commercial sector, it becomes extremely difficult to get by if one does not speak Czech. An example that illustrates well this phenomenon is the Czech immigration office where all foreigners must apply for a permit if they wish to stay more than 90 days in the country. Although immigration office by its nature has to deal with people who most likely do not speak Czech, it is frequent that the officers who work there do not speak any foreign language.

Hence, my expectations about the findings that would bring my research were not very favorable. I expected that there would be many barriers complicating the access of foreigners to a good quality mental health care, particularly in the public institutions.

5.2 Design and the research question

The present study has form of qualitative research. As Elliott, Fischer and Rennie (1999, p. 216) suggest, *"in qualitative research, the researcher attempts to develop understandings of the phenomena under study, based as much as possible on the perspective of those being studied."* The central purpose of qualitative research is *"to contribute to a process of revision and enrichment of understanding, rather than to verify earlier conclusions or theory."* The study was conceived as exploratory research. The aim of the research was to explore the situation of mental health care for foreigners in Prague, and to contribute to the understanding of its strong points and its flaws. As was mentioned in the theoretical part, the concentration of foreigners who live in the Czech Republic is the highest in Prague thus, the research was focused on the capital city. The initial research question of the study was:

RQ: What is the level of accessibility and quality of mental health care for foreigners (non-Czech/Slovak population) in Prague?

5.3 Methods

The research question examines two different aspects of mental health care for foreigners – accessibility and quality. Those aspects represent two basic categories that were considered as measurable and relevant to assessing the state of mental health care. In order to obtain data that would allow for valid and relatively objective conclusions, it was important to gather information from various sources, i.e. to *triangulate* (Willig, 2008, p. 39).

First, data were collected from the population of foreigners who had had experience with mental health services in Prague (clinical group). The main methods that were used for data collection included questionnaires, semi-structured interviews, observation, email correspondence and phone calls. The aim was to obtain detailed information about foreigners' experience that would answer to questions such as:

- What is foreigners' experience with mental health care services in Prague?
- How do foreigners access mental health care services in Prague?
- What do foreigners experience as the main barriers in accessing and using mental health care services in Prague?

Initially, the data were gathered through an online questionnaire (Questionnaire A[7]) that had been prepared specifically for the purpose of the study. The questionnaire was created through the website survio.com, and it was designed in a way that would be easy to fill and, at the same time, it would allow participants to open up and provide detailed information. The pilot version of the questionnaire was prepared in English and a sample of three participants tested it. As was mentioned in introduction, *lingua franca* of most foreigners who live in Prague is English and Russian. Hence the final version of the questionnaire was also translated into Russian. The questionnaire consisted of 28 items in form of multiple choice questions and open questions.

The first part of the questionnaire collected some personal details about the participants such as gender, age, nationality, number of years living in Prague, etc. Second part was mostly composed of open questions that meant to explore participants' experience with mental health services in Prague. It contained questions such as *"What were the main barriers that you have encountered in accessing mental health services?"* or *"What were the main positives and negatives of your experience?"* It was expected that some participants might have seen more practitioners, therefore it was specified that the participants should consider their most positive experience with a mental health practitioner, or the one that had the biggest impact on them.

The topic of the study is rather sensitive, and I was aware that some people might feel suspicious and uncomfortable sharing their personal experience with a stranger. To reduce mistrust, participants could fill out the questionnaire anonymously. Nonetheless, at the end of the questionnaire, they had the possibility to leave their email address if they wished to further participate in the study. In the next step, the participants who had provided their email address were contacted and an interview was arranged. Individual semi-structured interviews were conducted with each participant to further explore their experience. Participants were asked for a permission to record the interview to which all interviewees consented.

Second, over the course of the research several hypotheses were emerging from the data and a short questionnaire (Questionnaire B[8]) was developed to evaluate the plausibility of the hypotheses. Again, the questionnaire was created through the website survio.com. It aimed at all adult foreigners who live in Prague with a goal to evaluate how are foreigners informed about mental health care

[7] 'Quality and Accessibility of Mental Health Care for Foreigners in Prague' see Appendix C for the full version of the questionnaire

[8] 'Accessibility of Mental Health Care for Foreigners in Prague' see Appendix D for the full version of the questionnaire.

services in Prague, and how would they seek help in case of need. The questionnaire was also prepared in English and in Russian. To enhance people's willingness to participate, it was composed as a brief, easy-to-fill questionnaire. It consisted of 14 items; the majority of items were multiple choice, there were two Likert scale items, and four open questions. At the end of the questionnaire, the participants could leave their email address if they wished to be informed about the results of the study.

Third, further data were collected from mental health practitioners who offer services to foreigners. The aim was to explore the options of mental health care for foreigners, and to get an idea of how various practitioners such as psychologists, psychotherapists, psychiatrists, and counselors work with foreigners. The data were gathered mostly via individual semi-structured interviews, Questionnaire C[9], and phone calls.

Finally, more information was gathered through internet, phone calls, and document analysis to cross-check the information that had been obtained from the participants, and to evaluate the availability of information that can foreigners access if they seek mental health services in Prague. The data aimed to answer questions such as "How accessible is information about the options of mental health services for foreigners in Prague?" or "Which sources have the most helpful information about mental health care for foreigners in Prague?"

5.4 Ethics

Ethical questions need to be considered with particular attention in qualitative research. As Brinkmann and Kvale (2008, p. 263) suggest *"The human interaction in qualitative inquiries affects researchers and participants, and the knowledge produced through qualitative research affects our understanding of the human condition. Consequently, qualitative research in psychology is saturated with ethical issues"*

Participation in the present study was voluntary, and from the initial contact all participants were informed about the purpose of the research, its procedures, and its potential outcomes. Detailed information had been provided before the data collection took place so that the participants could consider their participation knowing what would be demanded from them. The design of the present research didn't require any deception of participants.

[9] 'Mental Health Care for Foreigners in Prague' see Appendix E for the full version of the questionnaire.

All participants had the right to withdraw from the study at any time. They could request erasure of all the data they had provided without any consequences. The participants who were interviewed were asked permission to record the interview and were informed that the record would be used solely for the purpose of the study. All personal data about participants are confidential and their use is reserved only for the purpose of the study. Any names or other personal information mentioned in the results section which may lead to identifying the person have been changed in order to ensure anonymity of all participants[10].

The first part of the research consisted of several in-depth interviews that required fairly close and lengthy contacts with participants and the topic of the interviews was personal and sensitive. This aspect needed to be taken into consideration because as Willig (2008, p. 20) infers *"qualitative in-depth interviews can lead to quasi-therapeutic relationships between researcher and participant, potentially giving rise to feelings and expectations on the part of the participant that the researcher may not be equipped to deal with."*

In fact, some of the interviews did have sort of quasi-therapeutic character as the participants were sharing very personal information with the researcher. In most cases it didn't cause any problems as the limits of the relationship were clear to both sides, and there were no other expectations raised neither from the part of participants, nor from the researcher. Nonetheless, in one case there was a tendency to initiate a closer relationship after the interview had ended by inviting the researcher to a more informal meeting. This was politely declined by the researcher for ethical reasons as it might have breach the limits of the formal relationship with the participant.

In qualitative study, the researcher should not only protect participants from any harm or loss, but should also try to be beneficial to participants as the knowledge that comes out of qualitative research may be helpful (Willig, 2008). At the end of the interviews with the clinical group, all participants had a possibility to ask information about the options of mental health services if they needed suggestions. Also, they were ensured that if they would need some information in the future, they could contact the researcher through the email address that had been provided to them.

All participants who had provided their contact details were instructed that they would be informed about the results of the study. Moreover, all practitioners who had participated were informed that the results of the study might be used for creating a database of practitioners who work with various

[10] Except for the third part of the results where information about mental health institutions and practitioners is provided (p. 86).

foreign populations. Such database would be at disposal to all practitioners and it might help for a more structured and organized cooperation among practicing professionals who work with foreign clients.

5.5 Data collection

The data were collected during a period of two months from the beginning of March 2017 until the end of April 2017. Data collection was based on purposive sampling, i.e. the participants were chosen according to the judgment of the researcher (Willig, 2008).

First, the research focused on the group of foreigners who have experience with mental health care in Prague (clinical group). The initial data were collected through Questionnaire A which was promoted in the pre-selected Facebook groups[11] where most foreigners who live in Prague gather, and via individual email communication.

Questionnaire A was promoted in the Facebook groups with a short description[12] in different languages according to the nationality of the group. The advertisement informed about the research, specified the population that was searched for, and briefly explained the purpose and the goals of the study. An email account[13] had been created specifically for the purpose of the study, where potential participants could write if they had any questions or needed further information. Subsequent interviews were conducted in public places such as cafes or libraries which had been pre-selected to ensure that it would be a comfortable space with enough privacy.

Second, further data were collected from the general foreign population of Prague. The data collection was done through Questionnaire B which was distributed in the same Facebook groups as Questionnaire A. It was important to finish the data collection with Questionnaire A first, and start with Questionnaire B afterwards as it might have potentially been confusing to advertise two fairly similar questionnaires at the same time, in the same groups. The questionnaire had a brief and specific description[14] and it was expected, that Questionnaire B would bring a higher number of participants than Questionnaire A as the only requirements for participation were to be of other nationality than Czech or Slovak, and to be adult.

[11] See Appendix F
[12] See Appendix G for all language versions
[13] mental.health.prague@gmail.com
[14] See Appendix G for all language versions

Third, data were collected from practitioners who offer mental health services to foreigners such as psychotherapy, counseling, psychological assessment or psychiatric consultations. They were searched for on the internet and through personal referrals. They were contacted via email and phone calls with a request to arrange a short interview. Here is an example of the request:

Dear Ms. or Mr.,

I'm a psychology student at Charles University and I'm writing my Master's thesis about mental health care for foreigners in Prague. As part of my research I do short interviews with Prague mental health practitioners who work with foreign clients in various languages.

I'd like to ask if you'd be willing to arrange an appointment and have a short interview about your work. The meeting would not take more than one hour and I'm happy to adapt to your schedule. Feel free to ask questions if you'd like to have more information about my research.

Kind regards,

Martin Tusl

The interviews were mostly conducted in practitioners' office and, in a few instances, in a cafe that had been suggested by the practitioner. The majority of participants were interviewed and those who were not able to meet were interrogated via an online questionnaire (Questionnaire C), or over the phone. The initial aim was to interview practitioners from both public and private practice, however, the former group turned out to be difficult to motivate for participation so in the end, the sample is composed mostly of private practitioners.

Finally, throughout the whole data collection, further information was gathered from other sources such as internet websites, paper documents, email and phone communication to cross-check the plausibility of the information obtained from the questionnaires and interviews, and to get more details about the issues that had been identified. These information sources consisted of hospitals' and clinics' website, practitioners' website, information websites for expatriates in Prague, information booklets for Prague expatriates, field visits to Prague hospitals and clinics, etc.

5.6 Data analysis

The data were analyzed following the *immersion/crystallization* strategy which is described as *"intuitive analysis style, where the researcher organizes data by examining the text thoroughly and then crystallizing out the most important aspects"* (Malterud, 2001, p. 486).

The first part of the research focused on the clinical group and the process of data analysis started as soon as the first responses came. All Questionnaires A were analyzed individually, the qualitative data were read several times and the most pertinent points were highlighted. Subsequent interviews with participants were recorded, transcribed, analyzed, and put together with the data from the Questionnaires A. All qualitative data were grouped into final meaningful categories that represented the most pertinent themes that appeared in the questionnaires and in the interviews. An excel document was created with a separate column for each category and the highlighted excerpts from the interviews and questionnaires were copied into cells and grouped within the respective category they belonged to.

The analysis of the Questionnaire B was simpler. The key questions consisted of two Likert scale items that didn't require any further categorization. Further, the questionnaire contained four open questions that provided qualitative data similar to some of the data that had been gathered via Questionnaire A. Therefore, those data were analyzed more thoroughly, grouped into categories, and then compared with the categories from Questionnaire A.

Lastly, the data gathered from mental health practitioners were analyzed. The goal of the interviews was to map the options of mental health services for foreigners in Prague, to get a better understanding of how practitioners work with foreign clients, and to create a list of practitioners who work with foreigners. Such database would provide reliable and transparent information to foreigners who seek help and also, it would help practitioners with referrals.

5.7 Results

Results are organized into three parts. First, the analysis of the data from the clinical group will be presented (i.e. foreigners who have experience with mental health care in Prague). Then will follow the additional data from the non-clinical group (i.e. general adult foreign population of Prague). The final part will consist of a list of various clinics and practitioners both from private and public area where foreigners can seek help.

5.7.1 Clinical group

Sample

Questionnaire A completed 27 participants, 20 filled out the English version, and 7 participants the Russian version of the questionnaire, both groups will be discussed together. Demographic data are shown in Table 1. The sample is composed mostly of female participants, the most frequent

age was 26-35, and the nationality was American and Russian. All but one participants were actively working and were mostly employed. All of the participants have been living in Prague for more than 1 year, and 12 participants more than 10 years which should ensure a fairly high level of acculturation among participants.

Table 1

Demographic data of the Clinical group (n=27)

		Female	Male	Total	Percent
Age (years)					
	18-25	2	-	2	7,4
	26-35	12	2	14	51,9
	36-45	4	1	5	18,5
	46-55	6	-	6	22,2
	Total	24	3	27	100
Nationalities					
	USA	7	1	8	29,6
	Russia	6	-	6	22,2
	UK	3	-	3	11,1
	Ukraine	3	-	3	11,1
	Austria	1	-	1	3,7
	Albania	1	-	1	3,7
	Germany	-	1	1	3,7
	Norway	1	-	1	3,7
	Portugal	-	1	1	3,7
	Romania	1	-	1	3,7
	Turkey	1	-	1	3,7
	Total	24	3	27	100
Occupation					
	Employed	14	1	15	55,6
	Entrepreneur	6	1	7	25,9
	Freelancer	3	1	4	14,8
	Unemployed	1	-	1	3,7
	Total	24	3	27	100
Years living in Prague					
	<1year	-	-	0	0,0
	1-3 years	5	1	6	22,2
	4-7 years	8	1	9	33,3
	8-10 years	-	-	0	0,0
	>10 years	9	1	10	37,0
	>20 years	2	-	2	7,4
	Total	24	3	27	100

A contact email address provided 12 participants and out of those 7 responded to the request for an interview. Face to face interviews were conducted with 5 participants, 1 participant wished to be interviewed over the phone, and 1 via email communication. The interview sample was composed of 5 females and 1 male (3 American, 1 Norwegian, 1 Albanian, 1 Ukrainian, and 1 Portuguese male).

Qualitative data from the questionnaires and from the interviews will be presented together. The results of the key items will be presented in separate tables with accompanying comments and excerpts from the questionnaires and the interviews.

Accessing mental health care

Table 2 lists the problems participants mentioned that made them seek mental health care. The most common process of accessing mental health care is depicted in Figure 5.

Table 2

Issues that lead to seeking mental health care

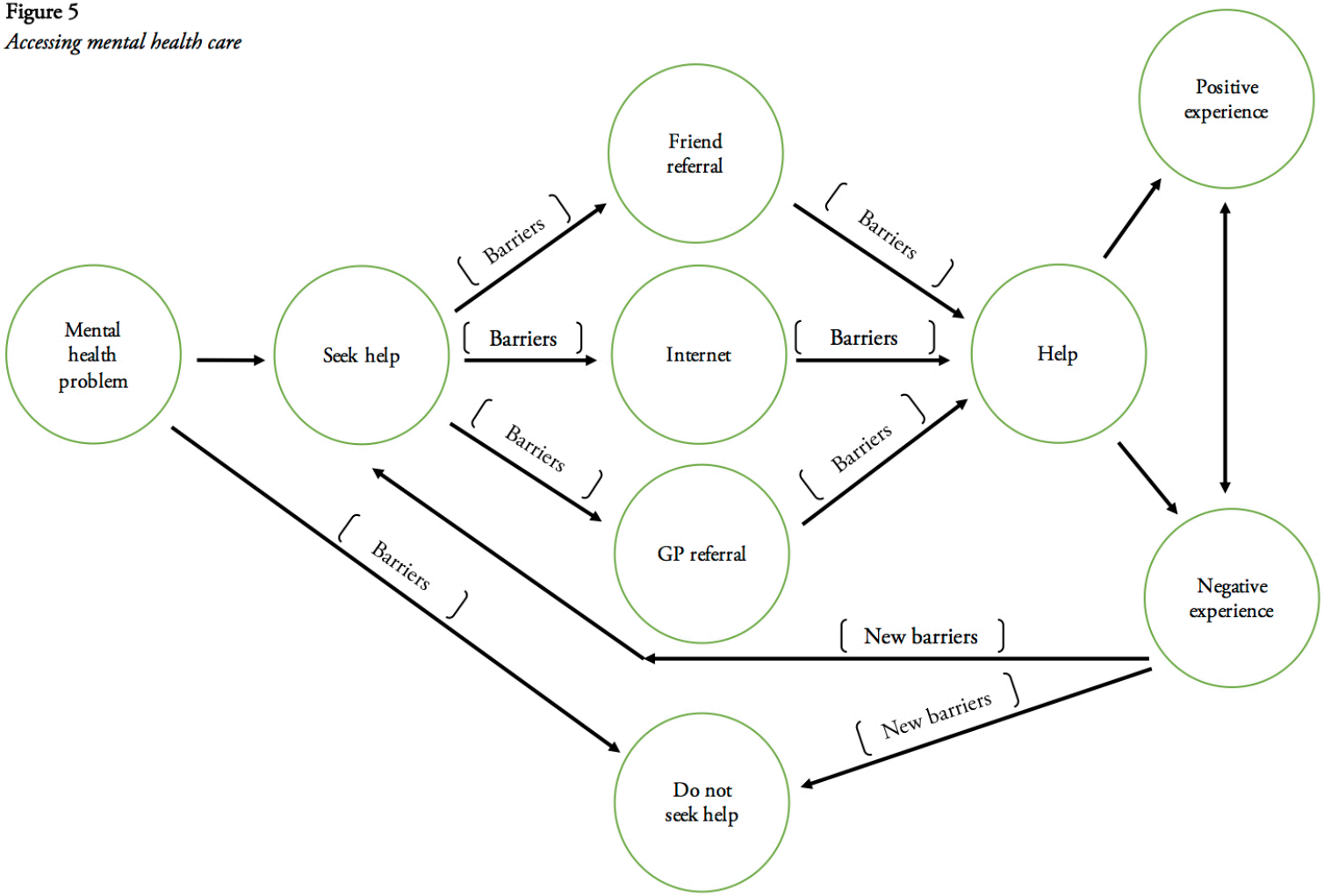
Could you briefly describe the reason for your visit? (optional) (n. 11)				
	Female	Male	Total	Percent
Anxiety and depression	7	-	7	29,2
Family or couples' problems	4	1	5	20,8
Personal growth	1	1	2	8,3
Recovering after breakup	2	-	2	8,3
Sleep problems	1	-	1	4,2
Weight-loss	1	-	1	4,2
Burnout	1	-	1	4,2
Manic and depressive episodes	1	-	1	4,2
Court order	-	1	1	4,2
High stress level	1	-	1	4,2
OCD and Social Phobia	1	-	1	4,2
Low self-esteem	1	-	1	4,2
Total	21	3	24[a]	100

[a] 3 participants decided not to answer this item (n=24).

The most frequent problems were anxiety and depression which mentioned 7 participants. Also, problems related to family and relationships were common. These two categories embrace 50 percent of the sample. It is important to stress that the listed problems are not official diagnosis; they simply represent how participants described the reason that made them search for mental health care.

Figure 5

Accessing mental health care



Most participants tried to seek help as soon as they felt that their situation required professional help.

"There came a moment when I decided I needed a psychiatrist to speak to because I was very weak and I was completely shut down I was not able to speak to anyone I was just going in a spiral of degrading my physical and mental health."

In some cases, there were some initial barriers that prevented them from seeking appropriate help immediately such as a lack of information about where to seek help, language problems, a feeling that 'I can deal with it on my own', or previous bad experience with Czech health system as illustrates the following excerpt.

"I should have sought help earlier and even when I finally did it just didn't help because the experience was really bad.… so I just left and I reckoned that I would manage it myself."

Table 3 shows that the most common way to seek mental health care was via internet and a friend referral.

"I received their phone number (SOS Centrum) from a friend after I had a panic attack."

Table 3

Accessing mental health care (n=27)

How did you search for the psychologist? (n. 12)		
	Frequency	Percent
Internet	16	40,0
Friend referral	15	37,5
GP referral	6	15,0
Street flyer	1	2,5
Social services	1	2,5
Go to a clinic	1	2,5
Total	40[a]	100
How difficult was it to find a psychologist that would meet your needs? (n. 13)		
	Frequency	Percent
Very easy	1	3,7
Rather easy	11	40,7
Rather difficult	8	29,6
Very difficult	7	25,9
Total	27	100

[a] A total of answers that all participants (n=27) provided (i.e. some participants gave more answers).

Some participants were referred by their general practitioner but this option didn't have favorable outcomes in most cases.

"I went to see my GP, I told him this whole story about the places that I'd been and he told me that I should go and see a psychiatrist who works at the hospital at the end of the green line (Motol). He said that I could just go there that I do not need an appointment and foolishly I believed him and traveled the journey to that hospital only to be told that I needed an appointment like six months in advance and I was sent back to my GP."

In one case, the initial contact was through a street flyer, once through social services, and one participant went directly to the nearest clinic close to where she was living.

"I just went outside from the house of my friend and there was a clinic on the first floor so I was like that's it I'm going there."

Participants usually mentioned that they tried more than one way to seek help. Table 3 also shows that about a half of the sample stated that it was rather easy and in one case even very easy to find help. Yet, sometimes the whole process of finding help was somewhat complicated as the following excerpts illustrates.

"I spoke with another American friend about what was going on and he suggested that I see someone about it. It was interesting because he has multiple sclerosis and he had also struggled with depression and he spoke about it with his own doctors. One of his doctors went through pretty much the same thing as I did, she went through divorce, she got depressed, etc. She passed to him, and he passed to me a contact to a doctor in Bohnice so I contacted Bohnice and that doctor was not doing therapy anymore he was in research, but they put me in touch with PCP. I got in touch with them and I could speak Czech at the time so I called and spoke with a woman on the phone and she was able to arrange an appointment for me pretty quickly."

Table 4
Price & overall experience

How did you feel about the price you were charged? (n. 23)		
	Frequency	Percent
Cheap	4	14,8
Adequate	14	51,9
Expensive	9	33,3
Very expensive	-	0,0
Total	27	100
Overall, how would you rate your experience? (n. 25)		
	Frequency	Percent
Excellent	8	29,6
Good	9	33,3
Neutral	5	18,5
Bad	4	14,8
Terrible	1	3,7
Total	27	100

The majority of participants (23) have been to a private mental health practitioner or to a private clinic; and 7 participants mentioned an experience with a public hospital. Table 4 shows that almost 70 percent of the sample stated that the price that they were charged was adequate or cheap. Nonetheless, as will be discussed in the following part, the cost of mental health services for foreigners was one of the main barriers that participants mentioned. Table 4 also shows that approximately 60 percent of participants rated their overall experience with mental health care as excellent or good. Yet, it is important to remind that participants were instructed to consider their most positive experience.

Barriers

Participants described barriers that complicated the whole process of accessing and using mental health care. As Figure 5 illustrates the barriers were present in almost every part of the process. As a result of the analysis, the barriers were grouped into seven categories that represent the most frequent issues that participants mentioned. Table 5 presents a quantitative analysis of the barriers retrieved from Questionnaires A. Each barrier will be further discussed.

Table 5

What were the main barriers that you have encountered in accessing mental health services? (n. 14)

	Frequency	Percent
Cost/Insurance	12	28,6
Language	8	19,0
Information	6	14,3
Professionalism	6	14,3
Availability	5	11,9
Attentiveness	3	7,1
Cultural differences	2	4,8
Total	42[a]	100

[a] A total of answers that all participants (n=27) provided (i.e. some participants mentioned more than one barrier).

The barriers can be grouped into two main categories depending on whether they are associated with accessibility of mental health services, or with the quality of the services. *Cost/insurance*, *information,* and *availability* represent the barriers that are related to the accessibility, whereas *professionalism*, *attentiveness,* and *cultural differences* are related to the quality of services. *Language* is a barrier that is linked to both categories as it can hinder the access to services but also, it can impair the quality of the treatment. All categories and examples that illustrate each category are

shown in Table 6. The excerpts that are used as examples were retrieved from Questionnaires A and from the interviews.

Table 6

Barriers and their examples

Accessibility	Cost/Insurance		*"After a year of struggling, I finally found a therapist I can stick with, but I pay more than I can afford because the English sessions are not covered by insurance."*
	Information		*"I would like more information, recommendations. Each psychologist has his own site, where he publishes only positive reviews, but there is no objective information."*
	Availability		*"It took over a month to get an appointment despite the situation being very urgent."*
	Language	Accessibility	*"It was very difficult to find one who spoke English"*
		Quality	*"They did not hide their resentment at having to speak English"*
Quality	Professionalism		*"The two that I found and visited were incompetent, did not take me seriously."*
	Attentiveness		*"In my first visit I felt like my first doctor tried her best to understand. But later on she was very forgetful and it gave me an image that she didn't care. Therefore, after a short time I quit seeing her."*
	Cultural differences		*"The gender politics in the Czech Republic feel very traditional to me, and I feel like I need to work doubly hard to be taken seriously because I'm a woman."*

Most barriers were present in a single case study of Ida – a young Norwegian woman (18-26 years old) who was interviewed about her in-depth experience with various mental health practitioners and facilities in Prague[15]. Ida moved to Prague because of a job offer and she had been living here for about two years. She sought help for depression and for episodes of self harming.

Each barrier will be discussed separately and illustrated with examples from Ida's case. Additional excerpts from other participants' experience will be added at the end of each category to provide more evidence and examples for each barrier/category.

[15] See Appendix H for a full version of the interview.

Ida

I was having a really hard time at work, I was working and my depression issues would start to develop. It was getting quite difficult to deal with it and I realized that I really really needed to talk to someone, I needed to start taking action otherwise I was not going to make it through the month. I kept looking for places online but everything was, yeah, I actually wrote emails to any place that I could get my hand on, every place that I found, no one wrote me back. The ones who did, wrote like four or three line sentences in poor English saying like sorry but we cannot help you. Eventually, I started to see a private therapist for a little while but she was super expensive and I had to stop because it was way over my budget so I only went to her three or four times. It was 1000 crowns for a 50-minute session which was way higher than I could afford. It would have been helpful if it continued I'm not good at talking to people, especially not about me so it takes a while for me to get into it with a therapist but it was cut short before anything could come out of it really. I asked her if she could recommend me someone she knew in case of emergency that I could go to because I was very desperate. She volunteers at women clinic at Bohnice so she suggested that I contact the crisis center there and she gave me their number.

I was feeling very hopeful because I'd heard that this is the place where they can help and I was like 'if anywhere they can help me, this must be it'. But I called the number that she gave me and no one spoke English, I was calling from work just when I was feeling really desperate and I needed something like preferably that day. But no one understood me, they handed the phone to someone who said call this number there will be English speakers there, I called that number and they didn't understand me either, eventually they got someone who spoke kind of almost English to tell me to call back after some time that there would be someone who could speak English better. I was crying on the phone obviously not very happy but I called back after the time they said. There was a nurse who said that I could come that evening and there would be a guy who spoke English, she said to come after 7pm. I came at 7pm my girlfriend traveled with me, we waited and then like three hours later I got to see the guy and the conversation lasted for about thirty minutes. I could tell he probably had had a very long day by the time he got to me. He basically listened to what I had to say but seemed to go for whatever was the easiest, he seemed to do just like a quick pseudo diagnosis and said ok, it seems like you have this issue so I can recommend…well, nothing actually. He gave me information for a private clinic where they have psychologists and psychiatrists and told me to contact them, something in Karlin. And he wrote me this paper, because whenever you go to a public crisis center they have to write this summary of what they learned about you. Obviously it was in Czech and obviously they do not tell you what is on this thing so you have to go home and google translate it. Also, I said that I had a hard time sleeping so he gave me this document and one sleeping pill to take that night and the number for this therapist place which I had to contact on my own. I was really disappointed because I was really messed up back then and I know that this crisis clinic they have more things that they can offer to someone who comes and is really really desperate than just a pill and a note. But there was not even a hint offering me any more help. The whole experience felt to me like I was bothering them, which you do not really want to feel like when you need help.

I did call the clinic, there was a lady on the phone who could speak English and a week and a half later I had an appointment with their psychiatrist which I had to pay for. When I finally got to talk to him… well, he was not very friendly to begin with, but that might be just a personalities clash. Anyway, the psychiatrist suggested that I see their therapist who does speak English very well and takes foreign clients. But at the time it was sometime around April and he told me that I could have an appointment in the beginning of June and it would cost something around 1000 crowns. So I politely declined and that was the only thing I got from that clinic. I decided that it was a waste of time so I went to see my GP again… he knows me quite well… you know most of my sick leaves when I'm ill or something. I told him this whole story about the places that I'd been and he told me that I should go and see a psychiatrist who works at the hospital at the end of the green line, that giant hospital you know (Motol). He said that I could just go there that I do not need an appointment. Foolishly I believed him and traveled the journey to that hospital only to be told that I needed an appointment like six months in advance and I was sent back to my GP.

So I went back and told him how well that went. That is when he told me about this another hospital somewhere between IP Pavlova and Karlovo namesti, do not remember exactly where it was (VFN). I went there and talked to someone because essentially what I was looking for was to be admitted somewhere where I could get a full time

help for a little while, which I told them. They read the note and I told them everything I went through and they basically panicked and wanted to admit me on the spot which I told them I could not really do at the moment. I didn't have any things with me you know… So they made me promise that I would go back home pack my stuff and return in the morning, they made me swear that I would be there at 9 am exactly. So I came the next day and I spent a week in the mental wing. That was probably the most pointless thing I've ever done. There was one kind of doctor who spoke some English who came and dropped by once a day to ask me how I was doing. There were two nurses who kind of spoke English which meant that they could translate for me when they were people telling me some things or yelling at me all the time. I got lucky, though, that there was one patient who had a Swedish husband so her English was perfect and she helped me the first few days but essentially no know did anything for me during that week apart from stuffing me with drugs. No one tried to get me involved with other patients because hardly anyone from the staff could speak English. It was usually like, 'Oh here comes the English speaker what are we going to do with her?' I just spent a lot of time on my own reading and listening to music. That was not helpful and unbelievably lonely so after a week I basically said to them, look this is not helping I'm leaving tomorrow which took a lot effort but at least I finally got to talk to the real doctor whom I had seen only once since I got admitted. He spoke English very well which was great but it was again too late and it didn't really help, he actually had to just sign my discharge papers and that was it.

The good thing that came out from my week in that hospital was that they gave me an information about a psychiatrist that I should see regularly for my prescriptions. And finally, I got to see someone whose English was great, who actually listened to me when I talked and seemed to actually want to help me and be happy about offering me the services. That was awesome! I stopped looking for anything else, because I kind of gave up on therapists at this point, I mean there were therapists too but they were also expensive and I thought it was not worth it until two months ago. I came to see him regularly for the prescriptions and just the fact that he was not trying to get rid of me and he seemed to understand when I was complaining about the Czech service I was getting, he just laughed and said 'yeah I get it' because he clearly sees the same thing all the time with other foreigners. So basically, I could see that he knew how difficult it could be to find a good help and he seemed to not want to be part of that system and that was great. I'm still seeing him and some time ago when things were getting really difficult again, we just agreed that it's probably time that I try therapy again. He suggested this guy who is working with him, he got me an appointment for only 800CZK an hour (irony) which was still way more than I could afford but at one point you're just so desperate that you have to do it. I've been seeing this guy for maybe two months and, his English is not perfect but he really really wants to help and that's great. But you know even this therapist if I was Czech the insurance would cover it and that would help. I'm happy with the clinic and I feel comfortable with the therapist, or at least as comfortable as you one can be with any therapist. I also still see the psychiatrist and I think it is a good support system, it actually feels that I have somewhere to contact if I need.

Language

As the case of Ida illustrates, *language barrier* may significantly complicate the access to mental health care throughout the whole process. In the beginning, it can hinder the initial contact and the access to mental health services. Later, it can also complicate the process of treatment and impair the quality of services. In Ida's case the language barrier was most evident in the public mental health institutions.

At first, Ida tried to search on the internet and write emails to the practitioners she'd found which is a common way that most foreigners do when they seek mental health care. Eventually, she got to see a private psychotherapist but the financial burden was too heavy. She then tried to seek help in the public institution that was recommended by the therapist. When Ida tried to reach Bohnice

via phone she was being transferred from one person to another because nobody could communicate with her in English. In the end, she was able to speak with someone in English but the whole process was fairly long, stressful and uncomfortable. Moreover, the visit in the crisis center was not helpful and the language barrier happened to be one of the main aspects that contributed to it.

Her experience in the next hospital (VFN) started much better and she got admitted which was what she had hoped for. However, her stay was not helpful either, the language barrier didn't allow for any complex treatment so the quality of the service was very low. The treatment was based on medication, nobody worked with her therapeutically and the overall communication of the staff was scarce. She described her experience as lonely and sad, and the week in the hospital as *'the most pointless thing I've ever done'.* Ida mentioned that during the whole process of accessing mental health care, she constantly felt that people were bothered when they had to communicate with her.

"The whole experience felt to me like I was bothering them, which you do not really want to feel like when you need help."

"Oh here comes the English speaker what are we going to do with her?"

In the end, she got to see a private practitioner who was an English speaker and was willing to work with her. Although her treatment consisted mostly of psychiatric care at first, the fact that there was not language barrier made the contact with the practitioner much more comfortable and helpful. Later, she started seeing a psychotherapist in the same clinic who was proficient enough in English and that further helped to improve her state. Throughout her experience Ida always found extremely beneficial and relieving when she got in contact with someone who was able to communicate in English.

Language is one of the main barriers that participants mentioned. Even though some participants had some knowledge of Czech language, for most of them it was important to find a mental health practitioner who would be able to speak their native language or the language in which they felt comfortable to communicate, and that was predominantly English.

"I wanted to see an English-speaking therapist to allow me freer and more direct communication."

"Ideally you find a therapist who speaks English because at best you need to be able to express yourself in the language of your childhood which obviously was not Czech. And its true that in Czech sometimes the way of expressing something you need a completely different set of words than in English."

The language barrier was complicating the initial contact as it was hard to access mental health practitioners who could work with foreigners.

"I wanted to find a Russian-speaking psychologist, but there are not enough of them."

Further, the language barrier was also complicating the treatment as the level of English of some practitioners was poor.

"I could see that his English was not as good as he had claimed. I had to speak to him as though he were a small child, slowly and using small words."

The first contact with mental health services is very important as it can influence the probability that the person keeps on searching for help. As was mentioned in the previous part, a first bad experience can discourage any further initiatives to search for help.

Cost/Insurance

In Ida's experience, the price of the services was an important barrier that prevented her from getting appropriate help. Even though she was happy with her private psychotherapist, she was forced to quit because the cost was too high (1000 CZK per session). Later on, she had to decline the services for the same reason in the private clinic where she was sent from Bohnice.

"I started to see a private therapist for a little while but she was super expensive and I had to stop because it was way over my budget so I only went to her three or four times. It was 1000 crowns for a 50-minute session which is way higher than I could afford. It would have been helpful if it continued I'm not good at talking to people, especially not about me so it takes a while for me to get into it with a therapist but it was cut short before anything could come out of it really."

Ida mentioned that psychiatric medication was partially covered by her insurance in the last clinic where she found help so she didn't have to pay that much. However, the psychiatric care was not sufficient and she decided to start psychotherapy sessions as well. Although she was not completely comfortable with the price, she accepted to pay it because she felt that her situation required psychotherapeutic help.

"…some time ago when things were getting really difficult again, I went to see him and we just agreed that it's probably time that I try therapy again so he suggested this guy who was working with him, he got me an appointment for only 800CZK an hour (irony) which was still way more than I could afford but at one point you're just so desperate that you have to do it."

In general, it is difficult to find foreign-friendly services that would be affordable or at least partially covered by insurance. Private psychotherapists have rarely contracts with insurance companies so these sessions must be paid by the clients. Moreover, a therapy in English or in other foreign

languages is often considered an extra service and it costs more than a therapy in Czech. The average price of a therapy in English is around 1000 CZK per session which is generally not accessible for people who would need it the most. Different prices for Czech and foreign therapy is an unresolved issue and even therapists differ in their view about its eligibility. Yet, when I talked about it with some participants their opinion was clear as the following excerpt illustrates.

"You know once I was shocked, there was this therapist who was a child psychologist and he has a website in Czech and a website in English and he charges more for English than for Czech because he considers it to be an extra service. So in Czech, it was actually what I paid 800czk per hour but for an hour in English its 1200 crowns. I found it just whatever... Let's put it this way, the psychotherapist is not speaking that much right? They usually listen a lot and I do understand how that can be tiring but does it really justify asking for a way more money? I think that even ethically it is not correct you know its like if I go to a restaurant and I say 'jedno pivo prosim' paying 42 crowns but if I say 'oh sorry I only speak English, may I have a beer?' and I would pay 80 crowns. That was you know how things were working here back in 90's and that was horrible. Should the taxi driver who takes you to the airport charge you more because he understands the word airport instead of letiště? I think it is an ethical question that should be discussed in organizations here."

The conditions of insurance are not clear and it can be very confusing when it comes to mental health care. Foreigners who have permanent residence in the Czech Republic or are employed in a Czech company can access public health insurance such as VZP or OZP which should cover psychotherapy and psychiatric medication. However, some participants mentioned that psychotherapy was not covered by insurance if it was provided in English.

"It's never covered by insurance (even though service from the same source in Czech would be covered completely), so to get the help you need, you have to pay a lot."

Many foreigners have private insurance (e.g. VZP for foreigners, Slavia) which does not cover any psychiatric or psychotherapeutic care at all so they are obliged to pay for everything on their own.

"Private insurance for foreigners does not cover any psychiatric care and I had to pay for everything out of pocket. It was very expensive even for one visit and I would have to pay for all medications myself."

If one seeks help in public institutions, it is necessary to have a public insurance or, in case of emergency, the EU insurance card (EHIC) should be sufficient. Without public health insurance, all services must be paid by the client and it can get very pricy. For example, hospitalization in the crisis center in Bohnice costs around 3000 CZK per day which is perhaps one of the reasons why foreigners are usually not granted the possibility to be hospitalized as was the case of Ida. Financial barrier was mentioned by most of the participants as one of the principal barriers in accessing mental health care.

"The main obstacle to seeing a therapist is cost. It needs to be more affordable."

"Price was always a concern. Although I stated that the fee was adequate and I do not feel that I was ever overcharged, the fact remains that it is not a service I could readily afford."

"After a year of struggling, I finally found a therapist I can stick with, but I pay more than I can afford because the English sessions are not covered by insurance. And it would never have taken me a year to get real help if I spoke Czech. There are frighteningly few avenues to help English speakers find help for mental issues."

Information

Ida had a hard time accessing information about where she could get appropriate help. At first, she searched online and it was difficult to reach someone who would be willing to help. In the end, she was able to find a private psychotherapist but the price was too high.

"I kept looking for places online but everything was, yeah, I actually wrote emails to any place that I could get my hand on every place that I found, no one wrote me back, the ones who did wrote like four or three line sentences in poor English saying like sorry but we cannot help you."

Ida got referred several times. First, she was referred by a psychotherapist, then in Bohnice they referred her to another clinic, later on, her GP recommended two hospitals, and after her stay in the psychiatric wing of VFN, she got referred to a private clinic where she finally found help.

"She volunteers at women clinic at Bohnice so she suggested that I contact the crisis center there, she gave me a number….. He gave me information for a private clinic where they have psychologists and psychiatrists and told me to contact them, something in Karlin… he told me that I should go and see a psychiatrist who works at the hospital at the end of the green line, that giant hospital you know (Motol)…. he told me about this another hospital somewhere between IP Pavlova and Karlovo namesti, do not remember exactly where it was (VFN)…. The good thing that came out from my week in that hospital was that they gave me an information about a psychiatrist that I should see regularly for my prescriptions."

Ida's case illustrates how difficult it can be to find information about mental health care for foreigners. Even the practitioners themselves weren't able to provide any helpful information. It seemed like they were referring her to places where they thought, or maybe just guessed, that Ida might get help, however, most of the recommendations were blind.

The language barrier and the information barrier are closely related. Lack of accessible information in other languages than Czech often prevents foreigners from finding helpful information. It is fairly easy to find some information on the internet about private psychotherapists and private clinics that offer their services in English, however, similar information about public facilities are much more difficult to find. For instance, Bohnice is one of the largest and most well known mental hospitals in the Czech Republic and the hospital also disposes of a crisis center that provides help

for people who are in a crisis situation. Although Bohnice can offer help to foreigners, the hospital does not have an English version of their website so without the knowledge of Czech language, it is impossible to access information about the services. Also, if one ventures to a public institution such as Bohnice it mostly depends on a person's luck if the practitioner on duty has some knowledge of foreign languages. Moreover, confusion about the insurance system and the cost of mental health care can discourage foreigners from seeking mental health care as they might be scared away by the potential cost of the services.

"There is a lack of information about how it works."

Ida's case reflects the fragmentation of the mental health care system. There is a lack of some organized list or database that would provide some systematic information about mental clinics and practitioners that provide help to foreigners. Such information would be useful for GPs, public clinics, mental health practitioners and, most importantly, also for foreigners.

"I think compiling a database (both for private practices and professionals accepting Czech insurance, with language capabilities) is a wonderful idea and could be very useful for foreigners living abroad."

At present, reliable information about where to seek help is usually available only through personal recommendations.

"Right now the only way to find an English speaker seems to be word of mouth, which is slow and unreliable."

Yet, foreigners often do not know any local people whom they could turn to and ask for a recommendation. The most common way becomes internet but there is not a website that would provide reliable information about foreign friendly mental health services. There are many private practitioners who have their own website and promote their services on the internet, however, the validity of such information cannot be verified as basically anybody can promote counseling services regardless his or her professional background. Moreover, many different terms that are associated with mental health care such as psychologist, psychiatrist, psychotherapist, counselor, or coach further add to the confusion of the general population as it becomes difficult to figure what kind of services a practitioner can provide. Thus, it mostly depends on the luck if one comes across a qualified and competent practitioner.

"I wanted to find a Russian-speaking psychologist, but there are not enough of them. Since the choice is small, not a single suitable one was eventually found. I would like more information, recommendations. Each psychologist has his own site, where he publishes only positive reviews, but there is no objective information."

Availability

As Ida experienced, availability can be an issue particularly in the public institutions. The first time she was trying to reach Bohnice she was in a crisis situation and in such cases quick and efficient communication is important. Nonetheless, it took a while until she was able to talk to someone in English and the whole process was somewhat clumsy. Later, when she came for an appointment she had to wait a fairly long time to get a brief examination that resulted in a pill, a document written in Czech, and a referral to another clinic.

"I called the number that she gave me and no one spoke English, I was calling from work just when I was feeling really desperate and I needed something like preferably that day and just no one understood me, they handed the phone to someone who said call this number there will be English speakers there, I called that number and they didn't understand me either, eventually they got someone who spoke kind of almost English to tell to call back after some time because there would be someone who could speak English better. I was crying on the phone obviously not very happy but I called back after the time they said and there was a nurse who said that I could come that evening and there would be a guy who spoke English, she said to come after 7pm. I came at 7pm my girlfriend traveled with me we waited, I brought all the papers, she said to bring. And then like three hours later I got to see the guy and the conversation lasted about thirty minutes."

The private clinic where she was referred from Bohnice was not helpful either. She was offered psychotherapy but the first appointment available was in about two months' time, and the financial barrier was also present.

"At the time it was sometime around April and he told me that I could have an appointment in the beginning of June and it would also cost something around 1000 crowns."

Later on, her GP sent her to the largest hospital in Prague supposing that she didn't need an appointment. That was not the case and she was sent back with a six months waiting time.

"He said that I could just go there that I do not need an appointment. Foolishly I believed him and traveled the journey to that hospital only to be told that I needed an appointment like six months in advance and I was sent back to my GP."

In fact, the scarce availability of services for foreigners is related to the language barrier and the financial barrier. For instance, there are practitioners in Bohnice and other public clinics and hospitals. Yet, they cannot offer any help to foreigners unless they have knowledge of some foreign languages. Also, many practitioners who do speak English or another foreign language work in a private practice, and their services are available only to those who can afford it.

"The few psychotherapists recommended to me were either full, prohibitively expensive, often both it took over a month to get an appointment despite the situation being very urgent."

Public institutions are tailored to the needs of Czech population so without the knowledge of the Czech language it can be extremely hard to access help. If one has public health insurance and wants to see a practitioner from the public practice the waiting time is usually very long.

"Price was also a concern and in order for treatment to be covered by VZP the waiting list was three months."

Professionalism, Attentiveness, and Cultural differences

The main drawbacks that many participants mentioned in the phase of treatment were a lack of professionalism, attentiveness and cultural differences. The three categories are closely related; they are all associated with the quality of the treatment and they will be discussed together in relation to one another.

Ida's experience was difficult mostly because of the barriers that have already been discussed. In her case, a lack of professionalism, attentiveness and cultural misunderstandings were primarily caused by the language and the information barriers. Naturally, if a practitioner is unable to speak the language of the client, or cannot do more than just a brief consultation, then the practitioner cannot provide professional or attentive care. Ida's disappointment with Bohnice mainly comes from the fact that she was very hopeful to get some help because she had been informed that they were able to provide a good quality care in Bohnice.

"I was feeling very hopeful because I'd heard that this is the place where they can help and I was like 'if anywhere they can help me, this must be it'.

Yet, the language barrier and the lack of available English speaking practitioners didn't allow for any good services in English. After a panoply of phone calls and negotiations, Ida was able to see a psychiatrist who was probably trying to do his best, however, he was unable to offer more than just a brief consultation.

"I could tell he probably had had a very long day by the time he got to me. He basically listened to what I had to say but seemed to just go for whatever was the easiest, he seemed to do just like a quick pseudodiagnosis and said ok, it seems like you have this issue so I can recommend…well, nothing actually. He gave me information for a private clinic where they have psychologists and psychiatrists and told me to contact them, something in Karlin… I was really disappointed because I was really messed up back then and I know that this crisis clinic they have more things that they can offer to someone who comes and is really really desperate than just a pill and a note."

During her experience in VFN it was equally the language barrier that prevented the practitioners from providing a more professional and attentive care. She was offered medication and some brief

consultations but she didn't find these interventions very helpful as no psychotherapeutic work was offered to her.

Finally, her last experience in the private clinic was positive because the practitioner was able to speak English, therefore he could be as professional as with other clients. Ida particularly valued the fact that he was attentive to her problems and that he was willing to help and not just find the easiest way to get rid of her.

"…finally, I got to see someone whose English was great, who actually listened to me when I talked and seemed to actually want to help me and be happy about offering me the services. That was awesome!"

Ida's experience also illustrates that one does not need to have perfect knowledge of the language to be able to provide professional and attentive care. The psychotherapist whom she has been seeing does not speak English perfectly, yet Ida finds helpful his general attitude.

"I've been seeing this guy for maybe two months and, his English is not perfect but he really really wants to help and that's great."

Other participants mentioned that they felt a lack of attentiveness from the practitioner when they talked about their problems which negatively influenced their experience.

"The psychologist was not very high-quality and I had to explain several times the same thing, so that the psychologist understood what I'm talking about. He made premature conclusions."

"When I described an inability to sleep even when taking tranquilizers, paranoia, delusions, and extreme restlessness, all of which lasted for over a month, he brushed it off as "anxiety". I tried to explain other issues as well - including that I'm autistic, hypersensitive, have a severe sleep disorder, and have a history of being abused both in my family and in other relationships - and he didn't seem at all interested in any of that."

"The two that I found and visited were incompetent, did not take me seriously."

"I didn't feel comfortable. I had a feeling that the psychologist did not care what happened to me."

Some participants described that their appointment with the practitioner had more of a business character as the practitioner was interested in the financial part but not in the client.

"She didn't want to help, only collect the money."

"Despite the fact that the psychologist had a good rating, it seemed to me he did not hear my problem and kept trying to offer me a registration in some kind of HR organization."

In fact, professionalism is more or less overlapping with attentiveness as being attentive should be part of professional skills of mental health practitioners. Yet, a lack of professionalism can also

manifest in other ways. For instance, one of the participants mentioned that her therapist was visibly shocked when she tried to bring up her sexual life.

"…she was not prepared to discuss my sexual life with me. She just seemed so uncomfortable when I came up with it. I think I told you already that later she came back and said that she was ready to talk about it but it was impossible for me at that point… In my experience, you do not want to pick and choose what you say to a therapist for fear that it might make them uncomfortable."

Another participant shared a similar experience.

"I have seen a few different therapists here but one thing that has remained the same would be shock at some of the things I said I had experienced. I know that in my home city those experiences are very well-known so I was not expecting that. Furthermore, even if it had been completely outlandish it is vital that a therapist never show that they are shocked, dismayed, or doubtful."

Such experience might be also linked to cultural differences, i.e. what is considered normal in one culture might be shocking in another culture. Participants from the Western countries mentioned several times that they had experienced a big gap in the gender politics in the Czech Republic and the traditional view of men and women roles in relationship.

"When I think about what that therapist told me, I remember that it was a comfort at the time, and I really put a lot of her advice into practice. But now I'm ashamed that I did because it seems so far removed from my values. We talked a lot about the things I could do in order to communicate better with my boyfriend, but that only meant that I was changing the way I behaved in order to be more agreeable when that boyfriend was being unkind to me. I wish I'd had a therapist who didn't encourage me to be more submissive to my partner."

"Someone from West vs from the eastern bloc sometimes seemed she veered towards more traditional female roles."

"I saw a marriage counselor and it didn't last long because I realized that my husband at the time was not really into it. He went because he had to but he actually just ticked this imaginary box you know, I attended. So we only saw the women twice but she also was kind of encouraging me that there are certain things that are expected of me and that maybe if I fulfil these expectations I could make our marriage better, we discussed that a little bit longer and then I think she understood that the problem was not just that I could not cook svickova (a traditional Czech dish)."

A few other participants also mentioned that cultural differences were problematic but they did not give any specific examples.

"Cultural differences made for some discomfort." (n=3)

"She was Slovak, but had done some of her studies in the US, but I still felt like there was a tiny culture gap, I'd have felt better with a therapist from North America."

"I remember thinking that the cultural barrier between the therapist (a young woman) and I was too great to overcome."

Positive experience

Most of the participants mentioned also some positive experiences with mental health practitioners in Prague. Such experiences were mostly related to the quality of mental health care and, in general, they represent the opposites of what has been discussed as barriers.

Participants found very positive and helpful when they encountered a practitioner who was able to communicate in their native language or the language they felt comfortable with (mostly English).

"It was comfortable that we shared the same native language and similar background (Russian speaking, relocation and motherhood experience)"

"I felt comfortable enough, my therapist had lived in Canada and was quite fluent in English."

"Positive was common language and cultural understanding."

Therapeutic skills such as acceptance, attentiveness, empathy, and openness were often highly appreciated and they prove to be the key skills that contributed to most of the positive experiences that participants had.

"Positives were her empathy and listening skills, particularly given that we weren't working in her language."

"I felt he understood my problem, he listened carefully and asked questions."

"Openness made me feel comfortable." (n=5)

"I received compassion, insight, a fair look at other ways to examine my problem without being made to feel disbelieved; willingness to work with me if finances became difficult."

"She is very personable. Our sessions were recorded for her PHD study and yet she made it feel like it was just me and her having a very open chat about my life and struggles and strengths."

"My psychotherapist makes extra effort to understand every aspect of my problems, and he never tries to "aim" me in the easiest direction so he can be done with me - a lot of Czech health care people have done that in the past."

Even in such instances when there was a slight language barrier it didn't hinder the process, if the practitioner adopted a positive and attentive general attitude.

"The psychologist tried very hard to understand my words and positions… I was lucky to meet a psychologist who tried to understand me despite the incoherent speech and my errors in the Czech language. This psychologist did not pay attention to this. Communication was excellent."

One of the participants mentioned the topic of cultural competency, and positively valued that the practitioner was open to discuss the cultural issues that might have been associated with the client's problem.

"She is able to explain why some things are the way they are, what are people's expectations and I could understand many things much better. Because you know even though I had been here for so long, I didn't grow up here and she did so she was able to provide some explanations to me and it was all very good. I considered her to be an ally, how would I explain, not a friend just a person who could understand and accept my point of view. And I felt I could be honest with her. And her room felt always nicely decorated and comfortable, this sort of a safe environment."

5.7.2 Non-clinical group

During the collection and analysis of the data from the clinical group, several hypotheses emerged that needed further exploration. Questionnaire B was created in order to obtain more evidence about some of the areas. Firstly, many participants mentioned that accessing mental health services was difficult because they didn't have information about it. Information barrier can become a serious problem in situations of mental health crisis that need an urgent treatment. Hence, two Likert scale items were designed to further evaluate how is the foreign population informed about mental health services, and one open question aimed at exploring how they would access it in case of need.

Secondly, price was an important barrier that prevented many participants from accessing appropriate psychotherapeutic help. English or other foreign language speaking therapists in Prague are mostly private and they tend to be expensive (minimal price around 1000CZK). Nonetheless, psychotherapy is usually supposed to be a paid service, so I was interested in how much would foreigners feel adequate to pay for psychotherapy. Therefore, one item was designed to gather information about the adequate price for psychotherapy.

Lastly, one open question was designed to gather more information about the barriers that foreigners feel might complicate their access to mental health services, and one open question for any further comments and suggestions.

Sample

Questionnaire B completed 77 participants, 69 filled out the English version, and 8 participants the Russian version of the questionnaire. The final sample counted 74 participants as 3 participants

were removed (1 participant because of Slovak nationality (n.16), and 2 participants because they provided confusing information that indicated poor attention during the completion of the questionnaire (n. 19 and n. 21). Demographic data of the sample are shown in Table 7.

Table 7

Demographic data of the Non-clinical group (n=74)

Age (years)		Female	Male	Total	Percent
	18-25	28	5	33	44,6
	26-35	20	8	28	37,8
	36-45	5	3	8	10,8
	46-55	3	2	5	6,8
	Total	56	18	74	100
Nationality					
	EU	32	8	40	54,1
	USA	6	5	11	14,9
	Latin America	5	-	5	6,8
	Russia	5	1	6	8,1
	Kazakhstan	2	-	2	2,7
	Canada	2	-	2	2,7
	India	2	-	2	2,7
	Ukraine	1	-	1	1,4
	Philippines	1	-	1	1,4
	Australia	-	1	1	1,4
	Egypt	-	1	1	1,4
	Israel	-	1	1	1,4
	Turkey	-	1	1	1,4
	Total	56	18	74	100
Occupation					
	Student	33	6	39	52,7
	Employed	14	9	23	31,1
	Entrepreneur	5	2	7	9,5
	Freelancer	1	1	2	2,7
	Unemployed	3	-	3	4,1
	Total	56	18	74	100
Years living in Prague					
	<1 year	29	8	37	50,0
	1-3 years	9	3	12	16,2
	4-7 years	11	2	13	17,6
	8-10 years	4	2	6	8,1
	>10 years	2	2	4	5,4
	>20 years	1	1	2	2,7
	Total	56	18	74	100

Around 80 percent of participants were aged 18-35 years. Most participants come from the EU countries and a half of the sample is composed of students. International students represent the

majority of participants who have been living in Prague for less than 1 year (37 participants). Most of participants (61) didn't have any experience with mental health care in Prague. Some participants (13) mentioned some experience. Further, 3 participants stated that they tried to access mental health services but were not successful.

"I saw a university counselor."

"I saw a therapist for three sessions some years ago."

"I wanted to but never ended up finding a suitable psychologist."

"One time I did write to a centrum (Hadovka) on the recommendation of my doctor, but they did not respond and so I gave up."

"I tried to make an appointment but because insurance didn't cover it, it didn't work out."

Accessing mental health care

Most data were analyzed together, only the information about the adequate price for psychotherapy was analyzed separately for the group of students, employed and unemployed, as it was expected that these groups would significantly differ in their income. Table 8 shows the results of the key items that explored how are foreigners informed about mental health services.

Table 8

Likert scale items

If I needed a competent psychologist/psychotherapist in Prague, I know where to look for help. (n. 8)

	Frequency	Percent
Strongly agree	2	2,7
Agree	9	12,2
Neutral	13	17,6
Disagree	23	31,1
Strongly disagree	27	36,5
Total	74	100

If I were having a mental health crisis, I know where to look for the appropriate psychological help in Prague. (n. 9)

	Frequency	Percent
Strongly agree	1	1,4
Agree	10	13,5
Neutral	8	10,8
Disagree	30	40,5
Strongly disagree	25	33,8
Total	74	100

The results show that almost 68 percent of respondents do not know where they would look for a mental health practitioner, and 74 percent do not know where they would seek help if they were having a mental health crisis.

Table 9 shows that the most popular way to access information about mental health services is to search on the internet, many participants also mentioned asking a friend for advice, and some students would also try to reach their university for help.

Table 9

If you were having a mental health crisis and needed psychological help quickly, how and where would you search for it? (n. 10)

	Frequency	Percent
Internet	38	46,3
Friend referral	13	15,9
University referral	8	9,8
Go to a hospital	7	8,5
Do not know	6	7,3
GP referral	4	4,9
Reach help in my home country	3	3,7
Call 112	2	2,4
Call ambulance	1	1,2
Total	82[a]	100

[a] A total of answers that all participants (n=74) provided (i.e. some participants mentioned more than one answer).

The data shown in Table 10 reveal that foreigners think that language and cost would be the main barriers that would complicate their access to mental health services.

Table 10

What do you think would be the main barriers for you in accessing mental health services in Prague? (n. 12)

	Frequency	Percent
Language	52	52,5
Cost/Insurance	17	17,2
Information	10	10,1
Availability	8	8,1
Personal barrier	**5**	**5,1**
Cultural differences	4	4,0
Professionalism	3	3,0
Total	99[a]	100

[a] A total of answers that all participants (n=74) provided (i.e. some participants mentioned more than one barrier).

The barriers are mostly similar to what the clinical group experienced, only personal barrier was not mentioned by the clinical group. Nonetheless, it is an important aspect to consider because for some, it may be difficult to access mental health care as they might feel a personal barrier that prevents them from seeking help. Such barrier is usually culture bound; i.e. in some countries mental health is still stigmatized and people who use mental health care may be seen as lunatics. Hence, foreigners who come from such cultures might not seek help because they might feel suspicious about mental health care[16].

Finally, Table 11 shows some descriptive data about the price that would participants feel adequate to pay for psychotherapy. The results are presented for the whole sample, and for the three different income groups (employed, unemployed, students).

Table 11

Adequate cost of psychotherapy

If you were in search of psychotherapy, how much would you feel adequate to pay for a 50-minute session?[17]			
Sample (n=74)		Price (CZK)	Frequency
	Maximum	2000	2
	Minimum	200	3
	Mode	500	12
	Median	600	
	Mean	748	
Employed (n=32)	Maximum	2000	2
	Minimum	200	2
	Mode	500	7
	Median	800	
	Mean	863	
Unemployed (n=3)	Maximum	700	1
	Minimum	500	1
	Mode	500	1
	Median	600	
	Mean	600	
Students (n=39)	Maximum	1500	1
	Minimum	200	1
	Mode	600	5
	Median	600	
	Mean	674	

[16] See Appendix I for an example of a personal barrier.

[17] See Appendix J for a complete list of all prices that participants provided

Minimum price was 200 CZK and maximum 2000 CZK. A few participants (n=4) stated that psychotherapy should be covered by insurance so the actual minimum was 'free of charge'. Mode of the whole sample was 500 CZK, median 600 CZK, mean 763 CZK. Overall, the reasonable price that most participants would feel adequate to pay ranged between 400-1000 CZK.

5.7.3 Options of mental health care for foreigners in Prague

Table 12 shows all kinds of different places where foreigners might find help. It is not an exhaustive summary of all available services it only represents some examples that have been identified during the research.

Apart from public and private mental health facilities, there are two non-profit organizations that offer psycho-social services to foreigners and they also offer psychological consultations and short-term psychotherapy free of charge. They have a website in English and in other languages, and there are psychotherapists proficient in various foreign languages. Nonetheless, they mostly focus on the integration initiatives for immigrants and psychotherapy is not their primary activity. Also, advertising free of charge services is complicated as the capacity of the service is limited, and it is funded only through voluntary contributions and grants.

International students can sometimes access mental health services at their university. The main public universities such as Charles University or the University of Economics provide free counseling services to the international students, however, in most cases the students are not informed about it. Probably the best system of promotion of the service has the Third Faculty of Medicine at Charles University. There are many international students who study a full time degree at the faculty, and the counseling center has an English speaking psychiatrist/psychotherapist for the international students. The center has its own website both in Czech and English, and students are informed about the center during their orientation week. Moreover, the students have lectures about a healthy life style during their studies provided by the counselors of the center.

Counseling centers of other departments and universities have a less elaborated system of promoting the service. It usually consists only of brief information on the website[18]. Also, the availability of the service is scarce which is probably one of the reasons for the low promotion. For example, the counseling center of Charles University provides help to international students one day a week during 3 hours.

[18] www.cuni.cz/UKEN-189.html

Table 12

Options of mental health care for foreigners in Prague

Public hospitals (for clients with public insurance)

- Bohnice Psychiatric Hospital
  - www.bohnice.cz (do not have website in English)
  - There should always be someone on duty who is able to speak English
- General University Hospital
  - www.vfn.cz/?lang=en
  - Short-term stay (up to 7 days)
  - Usually an English speaking psychiatrist is present
- Na Homolce Hospital
  - www.homolka.cz/en-CZ/home.html
  - Only one psychiatrist who speaks English, waiting time for examination is
- Military Hospital
  - www.uvn.cz/index.php?lang=en
  - Short-term hospitalizations (up to 60 days)

Crisis intervention centers

- CKI Bohnice
  - www.bohnice.cz/krizova-pomoc/ (do not have website in English)
  - Do have English speaking practitioners on staff
  - Short-term hospitalizations (public insurance or EHIC should be covered)
- SOS centrum Diakonie
  - www.soscentrum.cz
  - Do have English speaking practitioners on staff

Non-profit organizations

- InBaze
  - www.inbaze.cz/jazyky/english/
  - Short-term psychotherapy based on voluntary contribution (up to 12
  - Therapists can work in many languages (ENG, RU, DE, FR etc.)
- Association for Integration and Migration
  - www.migrace.com/en/
  - Free counseling services in English and Russian (Frantisek Cihlar)
- The Social Clinic
  - www.socialniklinika.cz/the-social-clinic
  - Offer psychotherapy based on a voluntary contribution (ENG)

University Counseling Centers

- Charles University
  - www.cuni.cz/UKEN-189.html
  - apps.szu.cz/poradna/successfulstudent/?rewrite=poradna/successfulstudent
- University of Economics
  - fph.vse.cz/akademicke-centrum/psychologicka-poradna/for-foreign-
- University of New York in Prague
  - www.unyp.cz/student-alumni-services/unyp-resources/counseling-center

Private hospitals/clinics

- Canadian Medical Care
  www.cmcpraha.cz/en-US
  Psychological assessment and psychotherapy for foreigners, three
  2500 CZK first visit, 1400 CZK following consultations
- ProPsyche
  www.propsyche.cz/index.php/en/
  Psychological counseling, psychotherapy, assessment (EN, ESP, GR)
  Reasonable prices (600 CZK for psychotherapy)
  Do have contracts with VZP public insurance company
- Terapie.info
  www.terapie.info/?lng=en
  Psychiatric care, psychotherapy, counseling
  Do have contracts with VZP and OZP public insurance company
- City Practice
  www.city-practice.com/en/
  Psychological assessment and psychotherapy for foreigners

Private psychotherapists

English speaking

- A list of English speaking therapists
  www.expats.cz/prague/directory/therapists/
- Mariann Ziss
  www.marianziss.com
- Milan Polak
  www.kalea-prague.cz/en/us.htm
- Lucie Schöll (ENG, DE)
  www.psycholog-lucie-scholl.cz/en/

Russian speaking

- A list of Russian speaking therapists
  www.b17.ru
- Anna Medvedeva
  www.b17.ru/medvedeva_anna/
- Viktor Pasnichenko
  www.pasnichenko.org

Private psychiatrists

- MUDr. Patrik Grexa (ENG)
  www.centrumpsychoterapie.cz/konzultanti/mudr-patrik-grexa/
- MUDr. Peter Pöthe (ENG)
  www.dr-pothe.com/cv/
- MUDr. Tomáš Rektor (ENG)
  www.terapie.info/?lng=en

5.8 Discussion

5.8.1 General discussion

Prague welcomes hundreds of thousands of tourists, and a steadily increasing number of foreigners decide to settle down in the capital city of the Czech Republic every year. As a consequence, the population of Prague has been diversifying since the end of Soviet occupation, and this trend is likely to continue in the following years.

Living abroad can be very challenging. People have to cope with various new situations, they may struggle with the language barrier, they often lack a proper social background (Kirmayer et al., 2011), they may have financial problems, they are at risk of being stereotyped and discriminated (APA, 2013a), and they are exposed to a higher stress associated with the whole process of acculturation. As such, people are at a greater risk of developing mental health problems such as depression or anxiety (Aklin & Turner, 2006; Betancourt et al. 2003; Hubinková et al., 2011).

Hence, it is important that appropriate mental health care is accessible to the foreign population of a country. The present qualitative study aimed to explore the situation of mental health care for foreigners in Prague. It was designed as exploratory research with the following research question:

RQ: What is the level of accessibility and quality of mental health care for foreigners (non-Czech/Slovak population) in Prague?

The sample was composed of foreigners who live in Prague, and included two main groups; clinical group (n=27; i.e. foreigners with an experience with mental health care in Prague), and non-clinical group (n=74; i.e. foreigners living in Prague who do not necessarily have an experience with mental health care in Prague).

Analysis of the qualitative data from the clinical group identified several obstacles that regard both the quality and the accessibility of mental health care for foreigners. The main barriers associated with accessibility were: language, cost, lack of information, and low availability of practitioners. Data analysis of non-clinical group further added a personal barrier, which may also hinder the access to appropriate mental health care, and it is related to the culture of an individual. The main barriers associated with quality were: low foreign language proficiency of practitioners (i.e. communication barrier), low attentiveness, low professionalism, and cultural differences.

The barriers are present both in private and public mental health facilities, but their prevalence is different. Mental health services in public institutions are tailored to the needs of Czech clients so, in general, the staff is not trained to work in foreign languages. Most public mental clinics do not have their website in English. Therefore, it is difficult to access information about the services without knowledge of the Czech language. For instance, the largest mental clinic in Prague Bohnice does not have an English version of their website, even though they can provide help to foreign clients.

Information about private practitioners who work with foreign clients is fairly accessible. Private clinics and private practitioners often have their own website with information provided in English. Nonetheless, the quality of their services cannot be guaranteed as there are no regulations for private 'mental health counselors'. Further, private practitioners and private clinics tend to be expensive and thus inaccessible to foreigners with an average/low wage. Findings from the non-clinical group suggest that most participants would feel adequate to pay for psychotherapy between 400-1000 CZK. A common price for psychotherapy in foreign language ranges between 1000-1500 CZK, hence it is difficult to access for most of the foreign population.

Foreigners who have public health insurance (e.g. VZP, OZP) should have psychiatric care and psychotherapy covered. So, mental health care in institutions that accept public health insurance should be financially accessible for them. However, foreigners can rarely benefit from it because they need to find an English-speaking practitioner who has a contract with public insurance companies. Such practitioners are difficult to find, and they are usually extremely occupied. Thus, foreigners who do have public health insurance mostly end up seeking help from private practitioner where they cannot use their insurance and they have to pay for the services. Foreigners with private health insurance do not have any mental health care covered, and they are obliged to pay for all expenses.

Emergency services such as crisis intervention are the most problematic area. There are two main public crisis intervention centers in Prague – Bohnice and RIAPS. The former does assist to foreign clients, however, it essentially aims at Czech clients so the character of the place does not allow for any complex treatment of foreigners. Also, Bohnice does not have any information in English available online so foreigners are usually not aware that they can seek help there. Information about RIAPS crisis center can be found in English on the internet[19], however, the center is tailored to the

[19] www.csspraha.cz/en/24941-crisis-center-riaps

needs of the Czech clients and they do not treat foreigners at all. Based on a personal testimony RIAPS refer foreigners to Na Homolce hospital or to General University Hospital (VFN) which do not seem to be offering any complex help to foreigners, as was illustrated in Ida's case.[20]

The Evangelical church runs a crisis intervention center, and they have English speaking therapists on staff. It is a good option for foreigners who seek help in crisis as their services are free of charge. Yet, the center does not have a psychiatrist on staff and the care consists mostly of short-term ambulant consultations. As a result, there is not any complex crisis intervention for non-Czech speaking population available in Prague.

Further, the findings from non-clinical group suggest that almost 68% of participants do not know where they would seek help if they needed a mental health practitioner, and 74% do not know where they would look for help if they were having a mental health crisis. Such results indicate that foreigners are not well informed about the options of mental health care in Prague.

Culturally competent mental health care presumes that a good quality mental health services is accessible to all populations regardless their ethnic, race, or nationality (APA, 2003). Cultural competence can be assessed on the individual level (i.e. cultural competence of an individual practitioner), and on the structural level (i.e. cultural competence of the system of mental health care; Betancourt et al., 2003; Kirmayer, 2012).

The main findings suggest that deficiencies in the cultural competence of Prague mental health care are most significant on the structural level where most of the barriers are present. Previous studies (Betancourt et al., 2003) suggest that the main structural barriers that complicate the access to mental health services for non-dominant groups include: problems with communication that stem from the language barrier, a lack of interpreter service and appropriately translated documents, a lack of information about the institution, services provided and the treatment, long waiting times for appointments, difficulties and delays in the intake process, and a lack of qualified psychologists trained in intercultural practice (APA, 2013a).

In the present study, language is one of the most frequent barriers that was mentioned by participants; besides, the use of interpreters is basically non-existent in the system of Czech mental health care; there are long waiting times, particularly in the public institutions; and there is a lack of information about mental health services for foreigners. Moreover, the cost of mental health

[20] See page 68

services makes it inaccessible for a big part of the foreign population of Prague.

According to Berry's (1997) dimensions, the findings of the study reflect poor integration orientation of the Czech society towards foreigners which also supports the previous conclusions of MIPEX[21] (2010). The general attitude is most similar to the assimilation strategy as the system of mental health care focuses on the needs of the Czech clients, and there are only some minor initiatives in providing mental health care to culturally different clients in public mental health institutions.

The findings of the present study cannot make any conclusions about the cultural competence of Prague practitioners on the individual level as there is not enough evidence. In fact, the study did not primarily focus on assessing individual cultural competence. Nonetheless, some partially information from the participants can allow for some general comments. Out of the triad knowledge, attitude, skills, which characterize individual cultural competence (APA, 2013a), the most important quality that some participants appreciated was practitioners' positive attitude towards culturally different clients. Further, Martinez (2013) suggests that in intercultural setting a common problem that appears is that practitioners label the secondary effects (anxiety) of a client's problem as primary, instead of identifying the underlying core problems. One of the participants described the exact experience. The practitioner did not pay attention to her explanation of the problems and simply suggested that she suffered from anxiety.[22] Such unawareness of client's explanations and preliminary conclusions suggest a poor cultural competence of the practitioner. It underscores the importance of Kleinman's (1980) explanatory model which emphasizes that when assessing a clients' problem, psychologists should primarily focus on their explanation of the illness.

[21] See page 26
[22] See page 77

5.8.2 Limitations of the study

The contribution of this study should be considered in light of its research limitations. Qualitative research is for the most part based on the interpretation. As such, the background of the researcher necessarily affects the process of data collection, the subsequent analysis, and the interpretation of the findings. Researcher's personality, opinions, previous experience and cultural background shape the way in which the data are collected, analyzed, and interpreted. Such aspects need to be considered as they may question the validity and reliability of the findings (Rosso & Bäärnhielm, 2012).

Reflexivity of the researcher meant to promote the validity of the study as the reader can understand the results in light of the researcher's opinions, background, and expectations (Willig, 2008). Also, during the interviews, I tried to ensure that participants were free to challenge and, if necessary, correct my assumptions about the meanings of what they said.

Collecting data through online questionnaires presents a danger to the validity of the present study. It was important to accurately construct all items as questionnaires gather only a restricted amount of data. Questionnaires A and B were developed gradually, they were tested first, and the relevance of all items was discussed with participants during the pilot study which should ensure that the questionnaires have face validity. The topic of the research required that the participants have a possibility to provide information anonymously, however, participants from the clinical group were motivated to provide their contact details, so that the information can be developed during the interview. In the end, only 6 participants out of 27 were interviewed, hence much of the information that participants provided in the questionnaires was not possible to further develop. As a consequence, some of the information taken from the questionnaires might have been misunderstood or misinterpreted by the researcher. Yet, the high number of participants should rule out the danger of potentially biased interpretations of the main findings.

In order to generalize the findings, it was important to gather a sample that would be representative of the foreign population. Prague has a large community of Russian-speaking foreigners from the Post-soviet countries, and English speaking foreigners from the EU and other western countries. Hence, in order to gather a sample that would reflect the characteristic of the foreign population, the research questionnaires were available in English and Russian language versions. The nationality variance of the sample was well achieved, however, the gender inequality is probably one of the main drawbacks of the study. Particularly the sample of the clinical group was from a big part

composed of female participants, there were 23 female participants and only 3 male participants. Nonetheless, I believe that it may reflect the difference between the male and female population in willingness to seek mental health care, and also, the willingness to share such personal information with a stranger. Further research would be needed to verify these assumptions.

On the other hand, the use of questionnaires allowed to gather a relatively large sample which is not common in qualitative research. In general, qualitative research tends to work with small samples due to the time-consuming nature of qualitative data collection and analysis (Willig, 2008) Also, the cross-checking of the data collected from the clinical group with non-clinical group should contribute to the validity of the findings. Another strong point is that the research was conducted in real life setting, and it reflects the situation in the real world so it should have a high ecological validity.

In general, qualitative research is less concerned with reliability as it usually explores a unique phenomenon (Willig, 2008). Yet, I believe that in the present study, the data would yield similar findings if they were collected by a different researcher applying the same methods. The data were gathered from various sources and the main findings were cross-check which should ensure that the data are objective and reliable. Nonetheless, the personality and the background of the researcher necessarily influence the whole process and thus puts in danger the reliability of the results. Reflexivity is meant to ensure that the reader understands the researcher's position and that any potential misinterpretation by the researcher is transparent.

5.8.3 Practice implications

The main findings of the study suggest that a lot of steps can be taken in order to improve the accessibility and the quality of mental health care for foreigners in Prague.

First, information barrier should be addressed. The findings suggest that most foreigners access information about mental health care via the internet. Hence, mental health institutions that are able to help foreigners, must have their website in English. Further, there is a relatively large community of practitioners in Prague such as psychologists, psychotherapists, or psychiatrists who work with foreign clients. However, they mostly work in a private practice and are not connected with each other. Cooperation between private and public practice in referring foreign clients is rare and most public institutions do not know where to refer foreigners if they are unable to work with them. It would be useful to create an online database with practitioners who work with foreign clients both from private and public practice. Such database would help to connect practitioners, help with referrals, and most importantly, it would be helpful for foreigners who seek mental health care. The majority of those who seek mental health care turn to their GP first (Höschl, Winkler & Pěč, 2012). Hence, an online database could also help GPs in referring clients to appropriate practitioners.

Second, the language barrier is one of the most important barriers that hinder both, the accessibility and the quality of mental health services, most evidently in the public institutions. During my interviews with practitioners, I noticed that many underestimated their ability to work in a foreign language. I would like to challenge this view reminding Martinez (2013) who suggests that with a limited knowledge of client's language practitioners can still try to work with the client. Even if some misunderstandings may occur, and the communication might not be ideal, it can foster the rapport and the client might appreciate just the fact that the psychologist tries to help. Such statement underscore testimonies of some participants who mentioned that a slight language barrier was not important if they felt that the practitioner was trying to help[23].

On the other hand, I am aware that it is impossible that all mental health staff would speak foreign languages. I believe that the use of specially trained interpreters could be a way to go. Large public hospitals such as Motol can usually arrange for interpreter service if necessary, yet there is a scarce use of interpreters in public mental health facilities. I believe that the use of interpreters, at least

[23] See pages 69 & 79

during the first contact with the client, would be extremely beneficial and helpful for the clients and for the practitioners.

Third, the cost of mental health services prevents many foreigners from accessing appropriate help. The barrier is mostly associated with private practitioners and psychotherapeutic services. It is considered as everyone's own business, and there are no regulations for the financial part of the services. Hence, practitioners can set the price and the rules of pricing as they wish. As a result, there is a fairly large variability in prices starting from around 1000 CZK and reaching up to amounts as high as 2500 CZK per session. Such amounts are accessible only to the richest population, but for the most of the population, and particularly for those who would need it the most, it is usually inaccessible. Also, many private psychotherapists have double rates or an extra fee for foreign language which means that they charge a different price for a therapy in foreign language than for a therapy in Czech. In my opinion, double rates are discriminatory, and they raise an ethical issue.

As the World Health Organization (2013, p. 9) states *"funding arrangements should ensure that appropriate care is available for the whole population, without barriers for the most vulnerable."*

Finally, I believe that crisis intervention is the crucial area of mental health care for foreigners that should be addressed. There are frighteningly few options for foreigners in mental crisis. Nowadays, the two best options are probably the crisis intervention center in Bohnice and the SOS centrum Diakonie. However, neither of those centers provides any complex care, it mostly consists of a brief consultation and, in the case of Bohnice, of medication. Perhaps, in the present state of mental health care, it would be impossible to establish a crisis center that would be focused on the foreign population. Yet, I believe that the first step to address this problem might be creating a phone line such as Linka důvěry or Bílý kruh bezpečí, which would be reserved for English-speaking foreigners.

To sum up, I believe that the situation of mental health care for foreigners in Prague could improve significantly with some first basic steps. The system of mental health care should promote fairness and should try to make the public institutions more accessible to the foreign population. The main problems stem from the fact that Prague has become a multicultural city during the past two decades, yet the system of mental health care has not reacted to the shift in the population. As a result, the services persist in being focused solely on the Czech population and foreigners have to deal with many obstacles in order to access appropriate help.

The World Health Organization (2013, p. 3) suggests that "*everyone should be enabled to reach the highest possible level of mental well-being and should be offered support proportional to their needs. Any form of discrimination, prejudice or neglect that hinders the attainment of the full rights of people with mental health problems and equitable access to care should be tackled*."

The present work provides an important insight into foreigners' use of mental health services in Prague and the barriers they deal with. Nonetheless, further research is needed to support the findings of the study. The main flaw of the present study is the evident lack of male participants in the sample. It would be valuable to gather more information about the use of mental health care from the male foreign population of Prague. Also, the present study focused on the capital city of the Czech Republic, however, there are many foreigners in other parts of the country. Hence, it would be useful to evaluate the situation in other regions. Finally, comparing the situation in between countries of the European Union would be extremely valuable. Assessing how countries differ in dealing with mental health care for foreign citizens could help to further integrate the system of mental health care in the EU countries.

Conclusion

The goal of the present thesis was to explore the accessibility and the quality of mental health care for foreigners in Prague, and thus to contribute with some practical outcomes to the intercultural mental health care in the Czech Republic. The thesis is composed of the theoretical part and the empirical part.

The first chapter of the theoretical part defined culture and its importance for mental health care. It outlined some of the psychological aspects of culture such as macroculture and microcultures, theories of cultural differences, ethnocultural identity, and ethnocentrism.

In the following chapter, some characteristic issues associated with the life in a different culture were addressed. The main areas that were discussed included the process of acculturation and its different strategies, the concept of culture shock, and some of the main challenges that are associated with life abroad.

Further, the thesis focused on the specifics of the intercultural mental health care and in particular, it addressed the cultural competency and its practical implications for mental health care. Cultural competency was defined on two levels – individual level and structural level. The specific characteristic of both levels and their place in a culturally competent practice were discussed. This chapter also addressed the problem of intercultural psychological assessment and the issues that practitioners may encounter in their practice.

The final chapter provided an overview of the current state of mental health care in the Czech Republic discussing the main problems that the system struggles with. The chapter closed with a summary of the previous works on the intercultural mental health care, and on intercultural psychology in general that were published in the Czech Republic.

The research part of the study evaluated the quality and accessibility of mental health care for foreigners in Prague. In particular, the study focused on the English and Russian-speaking population. It was designed as a qualitative exploratory study and as such, the data were mainly gathered via questionnaires and semi-structured interviews. The main barriers that hinder both the access of foreign population of Prague to appropriate mental health care were identified.

The present study contributes to the understanding of how the foreign population of Prague accesses and uses mental health services, and describes the principal obstacles that complicate the quality and the accessibility of mental health care for foreigners. Also, the results include a list of mental health care practitioners and institutions in Prague where foreigners may seek help. Finally, in light of the findings, some recommendations on the steps that might be taken to improve the situation were suggested.

References

Aklin, W. M., & Turner, S. M. (2006). Toward understanding ethnic and cultural factors in the interviewing process. *Psychotherapy: Theory, Research, Practice, Training. 43,* 50-64.

Alarcón, R. D. (2009). Culture, cultural factors and psychiatric diagnosis: review and projections. *World psychiatry*, *8*(3), 131-139.

Alcántara, C., & Gone, J. P. (2014). Multicultural issues in the clinical interview and diagnostic process. In F. L. Leong, L. Comas-Díaz, G. C. Nagayama Hall, V. C. McLoyd, J. E. Trimble (Eds.), *APA handbook of multicultural psychology, Vol. 2: Applications and training* (pp. 153-163). Washington, DC US: American Psychological Association.

Alexa, J., Recka, L., Votápková, J., van Ginneken, E., Spranger, A., & Wittenbecher, F. (2015). Czech Republic: health system review. *Health systems in transition*, *17*(1), 1-165.

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist, 58*, 377-402.

American Psychological Association. (2013a). Working with immigrant origin clients: an update for mental health professionals. *Based on crossroads: the psychology of immigration in the new century.* Washington, DC: American Psychological Association.

American Psychiatric Association. (2013b). *Diagnostic and Statistical Manual of Mental Disorders DSM-5 (5th ed.).* Washington: American psychiatric publishing.

Arasaratnam, L. A., & Doerfel, M. L. (2005). Intercultural communication competence: Identifying key components from multicultural perspectives. *International Journal of Intercultural Relations*, *29*(2), 137-163.

Baldwin, J. R., Faulkner, S. L., & Hecht, M. L. (2006). A moving target: The illusive definition of culture. In J. R. Baldwin, S. L. Faulkner, M. L. Hecht, & S. L. Lindsley (Eds.), *Redefining culture: Perspectives across the disciplines* (pp. 326). Mahwah, NJ: Lawrence Erlbaum Associates.

Bauer, A. M., & Alegría, M. (2010). Impact of patient language proficiency and interpreter service use on the quality of psychiatric care: A systematic review. *Psychiatric Services, 61*(8), 765-773.

Bennett, M. J. (2004). Becoming interculturally competent. *Toward multiculturalism: A reader in multicultural education*, *2*, 62-77.

Betancourt, J. R. (2004). Cultural Competence – Marginal or Mainstream Movement?. *The New England Journal Of Medicine, 351*(10), 953-955.

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong, O. (2003). Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. *Public health reports*, *118*(4), 293-302.

Berry, J. W. (1997). Immigration, acculturation and adaptation. *Applied Psychology: An International Review, 46*, 5-68.

Berry, J. (2016). Comparative analysis of Canadian multiculturalism policy and the multiculturalism policies of other countries. *Psychology In Russia. State Of The Art, 9*(2), 4-23.

Brinkmann, S. & Kvale, S. (2008). Ethics in qualitative psychological research. In: Willig, C. & Stainton-Rogers, W. (eds.). *The SAGE Handbook of Qualitative Research in Psychology*. New Delhi: Sage, pp. 263-279.

Crystal, D. (2003). Why English? The Cultural Legacy. In *English as a global language* (pp. 86-120). Cambridge University Press.

Český statistický úřad. (2016). Cizinci: Počet cizinců. Retrieved from https://www.czso.cz/csu/cizinci/cizinci-pocet-cizincu

David, I., Kebza, V., Paclt, I., Raboch, J., & Volf, J. (2006). Mental health in the Czech Republic: current problems, trends and future developments. *Journal of Public Mental Health*, *5*(2), 43-47.

Draguns, J. G., & Tanaka-Matsumi, J. (2003). Assessment of psychopathology across and within cultures: Issues and findings. *Behaviour Research And Therapy, 41*(7), 755-776.

EF English Proficiency Index. (2016). Comparing English skills between countries. Retrieved from www.ef-czech.cz/epi/regions/europe/czech-republic/

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British journal of clinical psychology*, *38*(3), 215-229.

European Commission. (2005). Green Paper – Improving the Mental Health of the Population: Towards a Strategy on Mental Health for the European Union. Brussels: European Commission.

Government of Canada. (2012). Canadian Multiculturalism: An Inclusive Citizenship. Retrieved from http://www.cic.gc.ca/english/multiculturalism/citizenship.asp

Hall, E. T. (1959). *The silent language* (Vol. 3, p. 1959). New York: Doubleday.

Hallowell, A. I. (1934). Culture and mental disorder. *The Journal of Abnormal and Social Psychology, 29*(1), 1.

Hammer, M. R., Bennett, M. J., & Wiseman, R. (2003). Measuring intercultural sensitivity: The intercultural development inventory. *International journal of intercultural relations*, *27*(4), 421-443.

Hernandez, M., Nesman, T., Mowery, D., Acevedo-Polakovich, I. D., & Callejas, L. M. (2009). Cultural competence: A literature review and conceptual model for mental health services. *Psychiatric Services, 60*(8), 1046-1050.

Hofstede, G., Hofstede, G. J., & Minkov, M. (2010). *Cultures and organizations: software of the mind: intercultural cooperation and its importance for survival (3rd ed.).* New York: McGraw-Hill.

Horney, K. (1937). *The neurotic personality of our time*. New York: W.W. Norton & Company, Inc.

Höschl, C., Winkler, P., & Pěč, O. (2012). The state of psychiatry in the Czech Republic. *International Review of Psychiatry*, *24*(4), 278-285.

Hubinková, Z., et al. (Eds.). (2011). *Multikulturní poradenství ma vysokých školách v České republice: Sbírka případových studií*. Prague: University of Economics Press, Oeconomica.

Jacob, K. S. (2014). DSM-5 and culture: The need to move towards a shared model of care within a more equal patient–physician partnership. *Asian journal of psychiatry*, *7*, 89-91.

Kay, P., & Kempton, W. (1984). What is the Sapir-Whorf hypothesis?. *American anthropologist*, *86*(1), 65-79.

Kirin Beer University Report: Global Beer Consumption by Country in 2014. (2015, December 24). Retrieved from http://www.kirinholdings.co.jp/english/news/2015/1224_01.html#table3

Kirmayer, L. (2012). Rethinking cultural competence. *Transcultural Psychiatry*,*49*(2), 149.

Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., & ... Pottie, K. (2011). Common mental health problems in immigrants and refugees: General approach in primary care. *Canadian Medical Association Journal, 183*(12), e959-e967.

Kleinman, A. (1980). *Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine, and psychiatry* (Vol. 3). University of California Press.

Kvale, S. (1983). The qualitative research interview: A phenomenological and a hermeneutical mode of understanding. *Journal of Phenomenological Psychology, 14,* 171–196.

Leseth, A. B. (2015). What is culturally informed psychiatry? Cultural understanding and withdrawal in the clinical encounter. *BJPsych Bull*, *39*(4), 187-190.

Malterud, K. (2001). Series: Qualitative research: standards, challenges, and guidelines. *The Lancet, 358,* 483-488.

Mantovani, G. (2000). *Exploring borders: Understanding culture and psychology*. Psychology Press.

Marsella, J. A. (1988). Cross-cultural research on severe mental disorders. Issues and findings. *Acta Psychiatrica Scandinavica Suppl*, *344*, 7–22.

Marsella, A. (2012). Psychology and globalization: Understanding a complex relationship. *Journal of Social Issues*, *68*(3), 454-472.

Marsella, A., & Yamada, A. (2010). Culture and Psychopathology: Foundations, Issues, Directions. *Journal of Pacific Rim Psychology*, *4*(2), 103-115.

Marsella, A. J., & Yamada, A. (2013). The study of culture and psychopathology: Fundamental concepts and historic forces. In F. A. Paniagua, A. Yamada, F. A. Paniagua, A. Yamada (Eds.), *Handbook of multicultural mental health: Assessment and treatment of diverse populations, 2nd ed* (pp. 3-23). San Diego, CA, US: Elsevier Academic Press.

Martinez, C. (2013). Conducting the cross-cultural clinical interview. In F. A. Paniagua, A. Yamada, F. A. Paniagua, A. Yamada (Eds.), *Handbook of multicultural mental health: Assessment and treatment of diverse populations, 2nd ed* (pp. 191-204). San Diego, CA, US: Elsevier Academic Press.

Ministerstvo zdravotnictví České republiky. (2013). Strategie reformy psychiatrické péče. Retrieved from www.strukturalni-fondy.cz/getmedia/3cba95de-e355-4225-8838-625ee0cf153c/Strategie-reformy-psych-pece.pdf?ext=.pdf

MIPEX. (2010). Key findings. Immigrant integration policy. Retrieved from http://www.mipex.eu/countries

Morgensternová, M., Šulová, L. & Scholl, L. (2011). *Bilingvismus a interkulturní komunikace.* Praha: Wolters Kluwer ČR.

Morgensternová, M., & Šulová, L. (2007). *Interkulturní psychologie: rozvoj interkulturní sensitivity.* Praha: Univerzita Karlova v Praze, nakladatelství Karolinum.

Muijen, M., (2014). Péče o duševní zdraví v České republice. Regionální úřad WHO pro Evropu. Retrieved from http://www.cmhcd.cz/CMHCD/media/Media/Ke%20stazeni/CZE-report-MNH_CZ.pdf

Murray, H. A., & Kluckhohn, C. (1953). *Personality in nature, society, and culture.* New York, NY: Knopf.

Neuliep, J. W. (2014). The Microcultural Context. In *Intercultural communication: A contextual approach* (pp. 83-116). Sage Publications.

Neuliep, J. W. (2014). The Perceptual Context. In *Intercultural communication: A contextual approach* (pp. 151-182). Sage Publications.

Oberg, K. (1960). Culture shock: Adjustment to new cultural environments. *Practical Anthropology, 7*, 177-182.

Paniagua, F. A. (2013). Assessment and Diagnosis in a Cultural Context. In M. M. Leach & J. D. Aten (Eds.), *Culture and Therapeutic Process: A Guide for Mental Health Professionals*, (s. 65-99) New York: Taylor & Francis.

Pavlovský, P., & Vevera, J., (2012). Transkulturální psychiatrie. In Raboch, J., & Pavlovský, P. *Psychiatrie*. (pp. 430-436). Praha: Karolinum.

Prague city tourism. (2017). Praha loni pokořila rekord v počtu turistů i v jejich přenocování. Retrieved from www.praguecitytourism.cz/cs/media/tisk/praha-loni-pokorila-rekord-v-poctu-turistu-i-v-jejich-prenocovani-12230

Průcha, J. (2010a). *Interkulturní komunikace*. Praha: Grada.

Průcha, J. (2010b). *Interkulturní psychologie: [sociopsychologické zkoumání kultur, etnik, ras a národů]*. (3. vyd., 220 s.) Praha: Portál.

Průcha, J. (2011). *Multikulturní výchova; příruška (nejen) pro učitele*. Praha: Triton.

Raboch, J., & Pavlovský, P. (2012). *Psychiatrie*. Praha: Karolinum.

Raboch, J., & Wenigová, B. (2012). Mapování stavu psychiatrické péče a jejího směřování v souladu se strategickými dokumenty České republiky (a zahraničí). Odborná zpráva z projektu. *Odborná zpráva z projektu. Praha: Česká psychiatrická společnost os*, (s 17), 25.

Redfield, R., Linton, R., & Herskovits, M. J. (1936). Memorandum for the study of acculturation. *American anthropologist*, *38*(1), 149-152.

Rosso, M. S., & Bäärnhielm, S. (2012). Use of the Cultural Formulation in Stockholm: A qualitative study of mental illness experience among migrants. *Transcultural Psychiatry*, *49*(2), 283-301.

Sapir, E. (1929). The status of linguistics as a science. *Language*, 207-214.

Tracy, C. R. R. M. L., Pruitt-Stephens, L., & Beard, M. K. W. J. (2008). Multicultural Assessment Validity. In Suzuki, L. A., & Ponterotto, J. G. (Eds.). (2007). *Handbook of multicultural assessment: Clinical, psychological, and educational applications* (pp. 22-33). John Wiley & Sons.

Třešňák, P. (2014). Taking mental health into the community. *Bulletin of the World Health Organization*; 92, 702-703.

U.S. Department of Health and Human Services (USDHHS). (2001). *Mental health: Culture, race and ethnicity – A supplement to Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Office, Office of the Surgeon General.

Verkuyten, M. (2007). Social psychology and multiculturalism. *Social and Personality Psychology Compass, 1*, 280–297.

Willig, C. (2008). *Introducing qualitative research in psychology: adventures in theory and method (2nd ed.).* Maidenhead: Open University Press.

Winkler, P., Csémy, L., Janoušková, M., & Krejníková, L. (2013). Reforma systému psychiatrické péče: mezinárodní politika, zkušenost a doporučení. *Prague: Psychiatrické centrum Praha*, 29.

World Health Organization. (2013). The European mental health action plan. Retrieved from http://www.euro.who.int/__data/assets/pdf_file/0004/194107/63wd11e_MentalHealth-3.pdf

Appendices

Appendix A: Brief acculturation scale[24] (Paniagua, 2013, p. 72)

BOX 4.1: BRIEF ACCULTURATION SCALE

Instruction: Please check only one item from the group of Generation items, Language Preferred items, and Social Activity items.

My generation is:

First	Second	Third	Fourth	Fifth
(1)	(2)	(3)	(4)	(5)

The language I prefer to use is:

Mine only	Mostly mine	Both mine and English	Mostly English	Only English
(1)	(2)	(3)	(4)	(5)

I prefer to engage in social activity with:

Only within racial group	Mostly within racial group	Within/ between racial groups	Mostly with a different racial group	Only with a different racial group
(1)	(2)	(3)	(4)	(5)

Total Score: _____

Number of Items Checked: _____

Acculturation Score (Total Score/Number of Items Checked): _____

The Level of Acculturation for this client is (circle one):

Low Medium High

Source: Adapted from Paniagua (1994, 1998, 2005).

[24] The Level of Acculturation (Mean):1,75 = low acculturation, 1,76 to 3.25 = medium acculturation, and 3,26 to 5 = high acculturation.

Appendix B: A guide to working with interpreters

Box 1: Clinical approach to working with interpreters and culture brokers

Before the interview

- Meet with the interpreter to explain the goals of the interview.
- Discuss whether the interpreter's social position in country of origin and local community could influence the relationship with the patient.
- Explain the need for especially close translation in the mental status examination (e.g., to ascertain thought disorder, emotional range and appropriateness, suicide risk).
- Ask the interpreter to indicate when a question or response is difficult to translate.
- Discuss any relevant etiquette and cultural expectations.
- Arrange seating in a triangle so that the clinician is facing the patient and the interpreter is to one side.

During the interview

- Introduce yourself and the interpreter and explain your roles.
- Discuss confidentiality and ask for the patient's consent to have the interpreter present.
- Look at and speak directly to the patient; use direct speech (e.g., "you" instead of "she" or "he").
- Avoid jargon or complex sentence constructions; use clear statements in everyday language.
- Slow down your pace; speak in short units to allow the interpreter time to translate.
- Do not interrupt the interpreter; keep looking at the patient while the interpreter is speaking.
- Clarify ambiguous responses (verbal or nonverbal) and ask the patient for feedback to make certain that crucial information has been communicated clearly.
- Give the patient a chance to ask questions or express concerns that have not been addressed.

After the interview

- Discuss the interview and ask the interpreter to assess the patient's degree of openness or disclosure.
- Consider translation difficulties and misunderstandings and clarify any important communication that was not translated or was unclear, including nonverbal communication.
- Ask the interpreter if he or she had any emotional reactions or concerns of his or her own during the interview.
- Plan future interviews; whenever possible, work with the same interpreter or culture broker for the same patient.

More detailed information and resources for locating interpreters and culture brokers can be found at www.mmhrc.ca.

Appendix C: Questionnaire A 'Quality and Accessibility of Mental Health Care for Foreigners in Prague'

'ENGLISH version'

Quality and Accessibility of Mental Health Care for Foreigners in Prague

Dear participant,

I'm a psychology student at Charles University currently enrolled in the final year of my Master's program. My interest is focused on intercultural psychology, and I'm writing my Master's thesis about the quality and accessibility of psychological care for foreigners who live in Prague (psychotherapy, psychodiagnostics, crisis intervention, counselling, etc.). In order to gain insight into foreigners' experiences with psychologists/psychotherapists in Prague, I have prepared a short list of questions about your own personal experience.

The completion of the questionnaire is anonymous and it will take you 10 minutes. The data from the questionnaires will be summarized in a final report that will reflect the overall quality and accessibility of psychological care for foreigners in Prague. Also, positive references for psychologists will be used to create an online database of recommended psychologists who work with foreign clients in Prague.

If you have any questions or if you'd like to contact me feel free to do so via e-mail: mental.health.prague@gmail.com

Thank you for your participation!

Martin

1. I identify my gender as

- ◯ Female
- ◯ Male
- ◯ Prefer not to disclose

2. Age

- ◯ 18-25
- ◯ 26-35
- ◯ 36-45
- ◯ 46-55
- ◯ 56-65
- ◯ 66-99

3. Nationality

4. Languages spoken (at least conversational level - B1)

- ☐ Czech
- ☐ English
- ☐ Polish
- ☐ German
- ☐ French
- ☐ Spanish
- ☐ Italian
- ☐ Polish
- ☐ Ukrainian
- ☐ Vietnamese
- ☐ Other (please, specify) _____

5. Visa status

- ○ Short-term visa for a stay up to 90 days (Visa "C")
- ○ Long-term visa over 90 days (Visa "D")
- ○ Permanent residence
- ○ EU
- ○ Other (please, specify) _____

6. How long have you been living in Prague?

- ○ 1-3 months
- ○ 4-7 months
- ○ 8-12 months
- ○ 1-3 years
- ○ 4-7 years
- ○ 8-10 years
- ○ More (please, specify) _____

7. Occupation

- ◯ Student
- ◯ Entrepreneur
- ◯ Employed
- ◯ Unemployed
- ◯ Other (please, specify) _____

8. Have you ever had personal experience with a psychologist/psychotherapist in Prague?

- ◯ Yes
- ◯ No (please, go to question 26)

For the following questions, if you've seen more psychologists in Prague, please consider the most positive experience or the one that had the biggest impact on you.

9. What kind of psychologist did you see?

- ☐ Private
- ☐ Private hospital/clinic
- ☐ Public hospital/clinic
- ☐ Other (please, specify) _____

10. Could you briefly describe the reason for your visit? (optional)

_____

11. How did you search for the psychologist?

- ☐ Internet
- ☐ GP referral
- ☐ Friend referral
- ☐ Other (please, specify) _____

12. How difficult was it to find a psychologist that would meet your needs?

- ◯ Very easy
- ◯ Rather easy
- ◯ Rather difficult
- ◯ Very difficult

13. What were the main barriers that you have encountered in accessing mental health services? (e.g. language, price, availability, lack of information, lack of competent psychologists, long waiting times, cultural differences, etc.)

14. From the moment you started searching for a psychologist, how long did it take to get your first appointment?

- ◯ Less than a week
- ◯ 1-2 weeks
- ◯ Less than a month
- ◯ 1-2 months
- ◯ 3-4 months
- ◯ More (please, specify)

15. How many appointments did you have with the psychologist?

- ◯ 1
- ◯ 2-5
- ◯ 6-10
- ◯ 11-20
- ◯ 21-30
- ◯ 31-50
- ◯ More (please, specify)

16. In which language did you communicate? Did the psychologist respect your language preference for communication?

17. Did the psychologist use an interpreter to facilitate communication with you?

- ◯ Yes
- ◯ No
- ◯ Partly (please, specify)

18. Did you feel comfortable communicating with the psychologist? What made you feel comfortable/uncomfortable?

19. Did you feel that there were some misunderstandings or uncomfortable situations that might have been due to cultural differences between you and the psychologist?

20. Did you feel that the psychologist understood well all aspects of your problem? What made you feel this way?

21. Did the psychologist help you with the problem you came with?

- ◯ Yes
- ◯ No
- ◯ Somewhat (please, specify)

22. How did you feel about the price you were charged?

- ◯ Cheap
- ◯ Adequate
- ◯ Expensive
- ◯ Very expensive

23. Were the expenses covered by your insurance?

- ◯ Yes
- ◯ No
- ◯ Partly (please, specify)

24. Overall, how would you rate your experience?

- ◯ Excellent
- ◯ Good
- ◯ Neutral
- ◯ Bad
- ◯ Terrible

25. What were the main positives and negatives of your experience?

26. Would you be able to recommend any competent psychologists/psychotherapists who work with foreign clients in Prague? (your positive reference may be used to contact the psychologist in order to do a short interview)

27. Anything you would like to add (comments, ideas, recommendations, etc.)? Would you have any suggestions on how to improve the accessibility and quality of mental health services for foreigners in Prague?

28. Thank you for your time! If you'd be willing to further participate in the research (a short interview about your experience), and get information about the results of the study, please leave your e-mail address below or contact me at mental.health.prague@gmail.com

Questionnaire A 'RUSSIAN version'

качество и доступность психологической помощи для иностранцев в Праге

Уважаемый участник опроса!

Я студент Карлова Университета по специальности психология и в этом году заканчиваю последний курс академической учёбы. Специализируюсь на интеркультурную психологию и в своей дипломной работе исследую качество и доступность психотерапевтической помощи для иностранцев, живущих в Праге (психотерапия, психодиагностика, консультация). Чтобы узнать об опыте иностранцев с психологами и психотерапевтами в Праге, я составил короткий список вопросов о Вашем собственном опыте. Заполнение анкеты не займёт более 15 минут. Данные из анкеты будут резюмированы в конечной статье, которая будет отражать качество и доступность психологической помощи для иностранцев в Праге. Из всех позитивных рекомендаций будет сделана онлайн база данных, содержащая перечень всех рекомендованных психологов, работающих с иностранцами в Праге.

Существуют-ли у Вас какие-нибудь вопросы, можете меня свободно контактировать на мой электронный адрес: mental.health.prague@gmail.com

Спасибо за принятие участия!

1. Пол

- ◯ Мужской
- ◯ Женский
- ◯ предпочитаю не указывать

2. Возрост

- ◯ 18-25
- ◯ 26-35
- ◯ 36-45
- ◯ 46-55
- ◯ 56-65
- ◯ 66-99

3. Национальность

4. Владею языками (как минимум уровень - B1)

- ☐ русский
- ☐ чешский
- ☐ англии☒ски☒
- ☐ украинский
- ☐ другой (пожалуйста уточните) _____

5. Статус визы

- ◯ краткосрочная виза для пребывания до 90 дней ("C" виза)
- ◯ долгосрочная виза для пребывания на более 90 дней ("D" виза)
- ◯ вид на жительство
- ◯ ЕС
- ◯ остальные (пожалуйста уточните) _____

6. Как долго Вы живёте в Праге?

- ◯ 0-3 месяца
- ◯ 4-6 месяцев
- ◯ 7-12 месяцев
- ◯ 1-3 года
- ◯ 3-6 лет
- ◯ более (пожалуйста уточните) _____

7. Профессия

- ◯ студент
- ◯ работающий
- ◯ предприниматель
- ◯ безработный
- ◯ другой (пожалуйста уточните) _____

8. У Вас есть собственный опыт с психологом/психотерапевтом в Праге?

- ◯ ДА
- ◯ НЕТ (пожалуйста перейдите к вопросу 26)

Если Вы были в Праге у более чем одного психолога, в следующих вопросах пожалуйста выберите самый полезный опыт, или такой, который на Вас более всего повлиял.

9. У которого вида психолога Вы были?

- ◯ Частная практика
- ◯ агентство
- ◯ больница
- ◯ остальное (пожалуйста уточните) [ ]

10. Можете коротко сообщить о причине Вашего визита? (необязательно)

[ ]

11. Как Вы психолога искали?

- ☐ Интернет
- ☐ больница
- ☐ назначение врача
- ☐ рекомендация друга
- ☐ остальное (пожалуйста уточните) [ ]

12. Как сложно было наити психолога, который соответствовал Вашим требованиям?

- ◯ Очень легко
- ◯ скорее легко
- ◯ скорее сложно
- ◯ очень сложно

13. Вы почувствовали какие-то барьеры в процессе получении психологической помощи? (например язык, цена, расстояние, доступность, долгое время ожидания, недостаток информаций, культурные различия, недостаток качественных психологов и т.д.)

14. Какое прошло время между тем, как Вы начали искать психолога и Вашей первой встречей с ним/ней?

- ◯ Менее чем неделя
- ◯ 1-2 недели
- ◯ менее чем месяц
- ◯ 1-2 месяца
- ◯ 3-4 месяцы
- ◯ более (пожалуйста уточните)

15. Сколько встреч Вы с психологом имели?

- ◯ 1
- ◯ 2-5
- ◯ 6-10
- ◯ 11-20
- ◯ 21-30
- ◯ 31-50
- ◯ более (пожалуйста уточните)

16. На каком языке Вы разговаривали? Соблюдал-ли психолог в коммуникации Ваше языковые предпочтения?

17. Использовал-ли психолог помощь устного переводчика, что бы облегчить коммуникацию?

- ◯ ДА
- ◯ НЕТ
- ◯ ЧАСТИЧНО (пожалуйста уточните)

18. Вы себя чувствовали в коммуникации с психологом комфортно? Почему Вы чувствовали себя комфортно/неудобно?

19. Вы почувствовали какие-то недоразумения или неудобные ситуации из-за культурных различий между Вами и психологом?

20. Понял психолог хорошо все аспекты Вашей проблемы? Почему так думаете?

21. Помог Вам психолог с Вашей проблемой?

- ◯ ДА
- ◯ НЕТ
- ◯ ЧАСТИЧНО (пожалуйста уточните) [ ]

22. Как Вы относитесь к оплаченной цене?

- ◯ Дешевая
- ◯ соответствующая
- ◯ дорогая
- ◯ очень дорогая

23. Покрыло страхование все расходы?

- ◯ ДА
- ◯ НЕТ
- ◯ ЧАСТИЧНО (пожалуйста уточните)

24. В общем, как бы Вы оценили данный опыт?

- ◯ Отлично
- ◯ хорошо
- ◯ нейтрально
- ◯ плохо
- ◯ ужасно

25. Какие были основные положительные и отрицательные аспекты Вашего опыта?

[ ]

26. Можете назвать какого-нибудь психолога/психотерапевта работающего в Праге с иностранными клиентами? (Ваша позитивная рекомендация может быть использована как основа для связи с психологом, с целью короткого интервью о его/её работе)

27. У Вас есть что-нибудь, что хотите дополнить (комментарии, идеи, рекомендации)? Имеете какие-то идеи, как улучшить доступность и качество психологической помощи для иностранцев в Праге?

28. Спасибо за Ваше время! Если хотите принять более активное участие в исследовании (короткое интервью о Вашем опыте) и получить информацию о результатах исследования, пожалуйста, напишите мне на mental.health.prague@gmail.com

Appendix D: Questionnaire B 'Accessibility of Mental Health Care for Foreigners in Prague'

'ENGLISH version'

Accessibility of Mental Health Care for Foreigners in Prague

Dear participant,

I'm a psychology student at Charles University currently enrolled in the final year of my Master's program. My interest is focused on intercultural psychology, and I'm writing my Master's thesis about the quality and accessibility of psychological care for foreigners who live in Prague (psychotherapy, psychological assessment, crisis intervention, counselling, etc.).

I have prepared this short survey in order to explore how foreigners (non-Czech/Slovak population) who live in Prague are informed about the options of mental health care in Prague and how they access it.

The completion of the questionnaire is anonymous and it will take you less than 5 minutes.

If you have any questions or if you'd like to contact me, feel free to do so via e-mail: mental.health.prague@gmail.com

Thank you for your participation!

Martin

1. I identify my gender as

- ◯ Male
- ◯ Female
- ◯ Prefer not to disclose

2. Age

- ◯ 18-25
- ◯ 26-35
- ◯ 36-45
- ◯ 46-55
- ◯ 56-65
- ◯ 66-99

3. Nationality

4. Visa status

- ◯ Short-term visa for a stay up to 90 days (Visa "C")
- ◯ Long-term visa over 90 days (Visa "D")
- ◯ Permanent residence
- ◯ EU
- ◯ Other (please, specify) _____

5. How long have you been living in Prague?

- ◯ 1-3 months
- ◯ 4-7 months
- ◯ 8-12 months
- ◯ 1-3 years
- ◯ 4-7 years
- ◯ 8-10 years
- ◯ More (please, specify) _____

6. Occupation

- ◯ Student
- ◯ Erasmus student
- ◯ Employed
- ◯ Unemployed
- ◯ Entrepreneur
- ◯ Other (please, specify) _____

7. Have you ever had personal experience with a psychologist/psychotherapist in Prague?

- ◯ Yes
- ◯ No
- ◯ Somewhat (please, specify) _____

8. If I needed a competent psychologist/psychotherapist in Prague I know where to look for help.

- ◯ Strongly agree
- ◯ Agree
- ◯ Neutral
- ◯ Disagree
- ◯ Strongly disagree

9. If I were having a mental health crisis, I know where to look for the appropriate psychological help (crisis intervention) in Prague.

- ◯ Strongly agree
- ◯ Agree
- ◯ Neutral
- ◯ Disagree
- ◯ Strongly disagree

10. If you were having a mental health crisis and needed psychological help quickly, how and where would you search for it?

11. If you were in search of psychotherapy, how much would you feel adequate to pay for a 50 minute session?

12. What do you think would be the main barriers for you in accessing mental health services in Prague?

13. Anything you would like to add (comments, ideas, recommendations, etc.)?

14. Thank you for your time! If you wish to get information about the results of the study, please leave your e-mail address below or contact me at mental.health.prague@gmail.com

Questionnaire B 'RUSSIAN version'

Доступность психического здоровья для иностранцев в Праге

Уважаемый участник,

Я студент психологии в Карловом университете, в настоящее время заканчиваю магистерскую программу. Мой интерес сосредоточен на межкультурной психологии, и в моей дипломной работе я исследую качество и доступность психологической помощи для иностранцев, живущих в Праге (психотерапия, кризисное вмешательство, консультирование и т. д.).

Я подготовил эту краткую анкету, чтобы узнать, как иностранцы (не чешское / словацкое население), живущие в Праге, информированы о вариантах психологической помощи в Праге и как они её могут получить.

Заполнение анкеты анонимно и не займёт более 5 минут.

Если у Вас есть какие-нибудь вопросы или Вы хотите связаться со мной, не стесняйтесь обратиться на меня на электронном адресе: mental.health.prague@gmail.com

Спасибо за Ваше участие!

Мартин

1. Пол

- ◯ Мужской
- ◯ Женский
- ◯ предпочитаю не указывать

2. Возраст

- ◯ 18-25
- ◯ 26-35
- ◯ 36-45
- ◯ 46-55
- ◯ 56-65
- ◯ 66-99

3. Национальность

4. Статус визы

- ◯ краткосрочная виза для пребывания до 90 дней ("C" виза)
- ◯ долгосрочная виза для пребывания на более 90 дней ("D" виза)
- ◯ вид на жительство
- ◯ ЕС
- ◯ остальные (пожалуйста уточните)

5. Как долго Вы живёте в Праге?

- ◯ 1-3 месяца
- ◯ 4-7 месяцев
- ◯ 8-12 месяцев
- ◯ 1-3 года
- ◯ 4-7 лет
- ◯ 8-10 лет
- ◯ более (пожалуйста уточните)

6. Профессия

- ◯ студент
- ◯ работающий
- ◯ предприниматель
- ◯ безработный
- ◯ другой (пожалуйста уточните)

7. У Вас есть собственный опыт с психологом/психотерапевтом в Праге?

- ◯ ДА
- ◯ НЕТ

8. Если мне нужен компетентный психолог / психотерапевт в Праге, я знаю, где искать помощь.

- ◯ Полностью согласен
- ◯ Согласен
- ◯ Нейтральный
- ◯ Не согласен
- ◯ Абсолютно не согласен

9. Если бы у меня был психический кризис, знаю, где искать подходящую психологическую помощь (кризисное вмешательство) в Праге.

- ◯ Полностью согласен
- ◯ Согласен
- ◯ Нейтральный
- ◯ Не согласен
- ◯ Абсолютно не согласен

10. Если бы у Вас был психический кризис и Вам была бы нужна быстрая психологическая помощь, как и где Вы бы её искали?

11. Какую цену Вы бы считали подходящей для 50-минутную психотерапевтическую сессию?

12. Какие по Вашему мнению могут появиться препятствия в процессе искания психологической помощи в Праге?

13. Вы бы хотели что-то добавить(комментарии, идеи, рекомендации и т. Д.)?

14. Спасибо за Ваше время! Если хотите получить информацию о результатах исследования, пожалуйста, напишите мне на mental.health.prague@gmail.com

Appendix E: Questionnaire C 'Mental Health Care for Foreigners in Prague'

Mental Health Care for Foreigners in Prague

Dear Sir / Madam,

I'm a psychology student at Charles University currently enrolled in the final year of Master's program. My interest is focused on intercultural psychology, and I'm writing my Master's thesis about the psychological care for foreigners who live in Prague (psychotherapy, psychodiagnostics, crisis intervention, counselling, etc.).

This short questionnaire makes part of my research. You will find several items that ask about your personal experience with psychological treatment of foreign (culturally different) clients in Prague. By filling out this 5-10 minute survey, you will help me to better understand how mental health specialists who have experience in the field of intercultural psychology perceive the actual situation in Prague.

The questionnaire is in English but feel free to fill out the open questions in the language you feel most comfortable with.

For any questions, please contact me at: mental.health.prague@gmail.com

Thank you!

Martin

1. I am a

- ☐ Psychologist
- ☐ Clinical Psychologist
- ☐ Psychotherapist
- ☐ Psychiatrist
- ☐ Counsellor
- ☐ Other (please, specify) _____

2. I work

- ☐ As a private practician
- ☐ In a private hospital/clinic
- ☐ In a public hospital/clinic
- ☐ Other (please, specify) _____

3. I focus on

- [ ] Psychological testing and assessment
- [ ] Psychotherapy
- [ ] Crisis Intervention
- [ ] Couples and Family counselling/therapy
- [ ] Other (please, specify)

4. Years of professional practice

- ◯ 1-2 years
- ◯ 3-5 years
- ◯ 6-8 years
- ◯ 9-11 years
- ◯ 12-15 years
- ◯ More (please, specify)

5. Do you take insurance?

- ◯ Yes
- ◯ No
- ◯ Other (please, specify)

6. Nationality

7. I work with

- [ ] Individuals
- [ ] Couples
- [ ] Groups
- [ ] Children
- [ ] Families
- [ ] Other (please, specify)

8. I work with foreign (non-Czech/Slovak) clients in Prague

- ◯ Yes
- ◯ No
- ◯ Other (please, specify) _____

9. How many clients do you see per week? (approximately)

- ◯ 1-3
- ◯ 4-6
- ◯ 7-10
- ◯ 11-15
- ◯ 16-20
- ◯ More (please, specify) _____

10. How many of the clients you work with are foreigners? (average percentage)

Assign: 100 points

Foreign clients	
Czech/Slovak clients	

11. What are the nationalities you usually work with?

- ☐ Czech/Slovak
- ☐ English (UK)
- ☐ American
- ☐ Canadian
- ☐ Russian
- ☐ Ukrainian
- ☐ Polish
- ☐ Vietnamese
- ☐ Other (please, specify) _____

12. In which languages can you work?

- [ ] Czech
- [ ] English
- [ ] Russian
- [ ] German
- [ ] French
- [ ] Spanish
- [ ] Italian
- [ ] Other (please, specify) _____

13. Have you ever used an interpreter to communicate with a client?

- ◯ Yes
- ◯ No
- ◯ Partly (please, specify) _____

14. Do you charge extra fee for consultations in your non-native language?

- ◯ Yes
- ◯ No
- ◯ Other (please, specify) _____

15. Do you also provide crisis intervention for foreign clients?

- ◯ Yes
- ◯ No
- ◯ Other (please, specify) _____

16. If you do not provide crisis intervention for foreign clients, to where would you refer them in case of emergency?

17. What do you think are the main barriers for foreigners in accessing psychological care in Prague?

18. What is most challenging for you in working with foreign clients? Are there any specific populations or settings that you find particularly difficult to work with?

19. From your experience, are there any characteristic problems/difficulties that foreign clients frequently present? (e.g. loneliness, difficulties with adaptation, cultural issues, etc.)

20. Do you use any specific methods, interviews or tests when working with foreign clients (e.g. translations of tests, structured or semi-structured interviews)?

21. Would you have any suggestions on how to improve the accessibility and quality of mental health services for foreigners in Prague?

22. Do you think it would be useful to have a list of practitioners (psychologists/psychotherapists/psychiatrists) both from private and public practice who work with foreign clients? If so, would you like to be on the list?

- ◯ Yes and I would like to be on the list
- ◯ Yes but I wouldn't like to be on the list
- ◯ No

23. Thank you for your time! Please leave your email address below if you wish to be informed about the results of the study or you can also contact me at mental.health.prague@gmail.com

Appendix F: Facebook groups where Questionnaire A & B were promoted

Name of the group	Members (April 2017)	Link
Foreign population in Prague		
Crowdsauce	9004	n/a
Prague Expats	14081	www.facebook.com/groups/134269863329043/
Expats in Prague - Unite	12009	www.facebook.com/groups/praguexpat/
Italiani a Praga	7349	www.facebook.com/groups/466215766683/
Peuple francais a Prague	1142	www.facebook.com/groups/1529392053939775/
Portugueses.cz	1744	www.facebook.com/groups/portugueses.cz/
LATINOS en Praga	2550	www.facebook.com/groups/latinosczech/
PRAGER RUNDE	1354	www.facebook.com/groups/prager.runde/
Чехоходы - сообщество русскоязычных…	7041	www.facebook.com/groups/2863544494715/
Чехия. Жизнь в Чехии…	8618	www.facebook.com/groups/blogczru/
International students in Prague		
IC CUNI 2016/2017	1396	www.facebook.com/groups/624161877756189/
Exchange/Erasmus at University of Economics, Prag	930	www.facebook.com/groups/1953191008820111/
ISC CTU Spring 2017	639	www.facebook.com/groups/iscctuspring2017/
CZU Erasmus Prague 2016 – 2017	265	www.facebook.com/groups/1010487565627945/
Erasmus Prague 2016/2017 by Student Zone	1869	www.facebook.com/groups/erasmusprague2016/

Appendix G: Advertisement for Questionnaires A & B in all language versions.

Questionnaire A

ENGLISH

Hello,

I'm a psychology student at Charles University and I'm writing my Master's thesis about the quality and accessibility of mental health care for foreigners in Prague.

In the first part of my research, I'm looking for foreigners who have experience with a psychologist/psychotherapist in Prague and who would be willing to share their experience with me via a short questionnaire:

https://www.survio.com/survey/d/C4B1W3H9Q1B2N7F4N

The goal is to get an overview about the problems that foreigners encounter when accessing and using psychological services. Also, in the final part of the questionnaire, I'm collecting positive references for psychologists in Prague, in order to create an online database of recommended psychologists who are competent at working with foreign clients.

In the long term, this information might help to improve the quality and accessibility of psychological services for foreigners in Prague.

Please, feel free to share the link with your friends or people that you think might find it interesting. For more information, contact me at mental.health.prague@gmail.com

Thank you!

RUSSIAN

Здравствуйте!
Я студент психологии на Карловом университете, в моей дипломной работе исследую качество и доступность психологической помощи для иностранцев в Праге.

В первой части моего исследования я ищу иностранцев, которые имеют опыт с психологом в Праге, и которые хотели бы поделиться своим опытом со мной через короткий вопросник:

https://www.survio.com/survey/d/H4A5T6E8S2E8F4B0H

Цель состоит в том, чтобы получить обзор проблем, с которыми сталкиваются иностранцы при доступе и использовании психологических услуг. Кроме того, в заключительной части анкеты я собираю у своих клиентов позитивные рекомендации для психологов в Праге, чтобы создать онлайн-базу рекомендованных психологов, компетентных в работе с иностранными клиентами.

В долгосрочной перспективе эта информация может помочь улучшить качество и доступность психологических услуг для иностранных клиентов в Праге.

Пожалуйста, не стесняйтесь поделиться ссылкой с друзьями или людьми, которым это будет по Вашему мнению интересно. Для получения дополнительной информации напишите в чате ниже или свяжитесь со мной по адресу mental.health.prague@gmail.com

FRENCH

Bonjour,

Je suis étudiant de psychologie à l'université Charles. Je fais une recherche sur le soutien psychologique pour les étrangers à Prague. Je cherche des personnes étrangères qui ont déjà eu une expérience avec les psychologues/psychothérapeutes à Prague.

J'ai préparé un bref questionnaire à travers lequel je recueilli les informations sur les cotés positifs et les cotés négatifs de votre expérience. Il faut à peu près 5-10 minutes pour remplir le questionnaire. Je vous remercie de votre participation. N'hésitez pas à le partager avec vos amis ou les personnes qui pourraient être intéressées.

Voilà le lien: https://www.survio.com/survey/d/C4B1W3H9Q1B2N7F4N

Pour tout renseignement vous pouvez me contacter sur mental.health.prague@gmail.com

Merci!

ITALIAN

Buongiorno,

Sono uno studente di psicologia all'università Carolina. Per la mia tesi di specialistica, faccio una ricerca sulla qualità e disponibilità del sostegno psicologico per i stranieri a Praga. Nella prima parte della ricerca vorrei raccogliere delle esperienze dei stranieri con i servizi psicologici a Praga. Ho preparato un breve questionario con qualche domanda sulla vostra esperienza. Il questionario è in inglese, pero potete compilarlo in italiano.

Ecco il link: https://www.survio.com/survey/d/C4B1W3H9Q1B2N7F4N

Per qualsiasi domanda, potete scrivermi su mental.health.prague@gmail.com

Grazie mille!

SPANISH

Hola!

Soy un estudiante de psicología y estoy haciendo una investigación sobre el ayudo psicológico para los extranjeros en Praga. Me interesa como son los extranjeros informados sobre las posibilidades del ayudo psicológico en Praga y como lo buscarían en caso de necesidad.

Preparé un breve cuestionario que podéis encontrar aquí:

https://www.survio.com/survey/d/C5L9H7F6U9T2N0F2S

El cuestionario está en ingles pero las preguntas abiertas (hay tres) podéis cumplir en español. Necesita menos de 5 minutos para cumplir.

Podéis también compartirlo con otras personas extranjeras que conocéis que viven en Praga.

Muchas gracias!

Questionnaire B

ENGLISH

Hello,

I'm a psychology student and I'm doing a research on the accessibility of mental health care for foreigners in Prague. I would like to find out more about how foreigners are informed about mental health care services in Prague and how would they access it in case of need. The Erasmus population is very large in Prague and your view is very valuable for my research. The completion of the questionnaire takes less than 5 minutes.

https://www.survio.com/survey/d/C5L9H7F6U9T2N0F2S

If you'd have any questions, feel free to PM me or write me an email on mental.health.prague@gmail.com

Thank you!

RUSSIAN

Здравствуйте!

Я занимаюсь исследованием в области психологической помощи для иностранцев в Праге. В одной части исследования я хочу узнать, как иностранное население информировано о возможностях психологической помощи подходящей для иностранцев в Праге и как они бы её искали в случае необходимости. Пожалуйста, найдите минутку, чтобы заполнить эту короткую анкету, её заполнение займёт менее 5 минут.

https://www.survio.com/survey/d/N1L1C3F7F6H4P4S4K

Appendix H: Questionnaire A and interview with Ida

Questionnaire A (open question items only)

Have you ever had to access emergency mental health services (crisis intervention) in Prague? If so, could you briefly describe your experience?

Yes, I was desperate to find good help and went to the crisis centre (I think at Bohnice), where I had to call several people to finally get an appointment with an English speaker. I spoke with him for maybe twenty minutes and he wrote me a reference for me to take to some therapist who I told him was way too expensive for me (but he didn't know of anyone else). It was not a helpful experience at all.

Could you briefly describe the reason for your visit? (optional)

Extreme depression and self-harm

What were the main barriers that you have encountered in accessing mental health services? (e.g. language, price, availability, lack of information, lack of competent psychologists, long waiting times, cultural differences, etc.)

All of the mentioned examples. The people who speak English are nearly impossible to find, and when you do find them, it's never covered by insurance (even though service from the same source in Czech would be covered completely), so to get the help you need, you have to pay a lot. Also, it's normally just the doctor who speaks some English, and nurses or receptionists still make it tough and uncomfortable by not wanting to talk to you.

From the moment you started searching for a psychologist, how long did it take to get your first appointment?

I tried to find help for over six months without finding a good option.

In which language did you communicate? Did the psychologist respect your language preference for communication?

English, but he is not very good, though it means a lot that he tries hard.

Did you feel comfortable communicating with the psychologist? What made you feel comfortable/uncomfortable?

This one, yes. Mental health professionals I've dealt with in the past made me very uncomfortable. They did not hide their resentment at having to speak English, and many suggested I should even go back to Norway for help. It was very upsetting.

Did you feel that there were some misunderstandings or uncomfortable situations that might have been due to cultural differences between you and the psychologist?

Yes. The fact that I do not speak Czech makes some treat me like an intruder, while that would be unacceptable in my home culture. Plus, a lot of things get lost in translation.

Did you feel that the psychologist understood well all aspects of your problem? What made you feel this way?

My current one, yes. He makes extra effort to understand every aspect of my problems, and he never tries to "aim" me in the easiest direction so he can be done with me - a lot of Czech health care people have done that in the past.

What were the main positives and negatives of your experience?

After a year of struggling, I finally found a therapist I can stick with, but I pay more than I can afford because the English sessions are not covered by insurance. And it would never have taken me a year to get real help if I spoke Czech. There are frighteningly few avenues to help English speakers find help for mental issues.

Anything you would like to add (comments, ideas, recommendations, etc.)? Would you have any suggestions on how to improve the accessibility and quality of mental health services for foreigners in Prague?

I think the least that should be done is to have English therapy sessions covered by insurance in the same way Czech sessions are. It's the exact same service, only in English! And I believe it should be a legal requirement for anyone in any way connected to the health system to speak good conversational English. That alone would have made my experiences much less traumatic.

Interview

Your case is valuable for my survey because you have an experience with both public and private practitioners. I would like to ask you more about your public experience. In the questionnaire you've mentioned that it took you like 6 months to find someone who could help you so I would like to know more about it. I can imagine that it was quite acute at the time so how did all these things start?

Well, I was having a really hard time at work, I was working and my depression issues would start to develop. So it was getting quite difficult to deal with it and I realized that I really really needed to talk to someone, I needed to start taking action otherwise I was not gonna make it through the month. And I kept looking for places online but everything was yeah I actually wrote emails to any place that I could get my hand on every place that I found, no one wrote me back, the ones who did wrote like four or three line sentences in poor English saying like sorry but we cannot help you, essentially. So finally when I first came here for my first job in Prague, I started to see a private therapist for a little while but she was super expensive and I had to stop because it was way over my budget so I only went to her three or four times.

Could you mention how much it was?

It was 1000 crowns for a 50 minute session which is way higher that I could afford. But I dug up her address and I wrote to her if she could recommend me someone she knew in case of emergency that I could go to because I was very desperate and she said that I should contact Bohnice.

So in the beginning you were trying to find someone on the internet.

I did and it was not very helpful.

Did you have any social support? I mean some friends you could ask for help?

I have a good Czech friend who sees a therapist but she also sees only Czech people so she could not really do anything and you know any recommendation I got from the ones I contacted online they got back to me way to late and there was just not a lot of resources, not a lot of places to get support.

So basically, you found someone on internet, you had three sessions and then it was way to expensive and you could not afford it. Was it still helpful this short intervention?

It would have been helpful if it continued I'm not good at talking to people, especially not about me so it

takes a while for me to get into it with a therapist so it was cut short before anything could come out of it really. Also, with my work at the time I didn't have set hours Monday to Friday so I had to contact her when I actually could and I could not always set a new session for the next week like I didn't have a structured schedule so it was difficult to get time and later I realized that when it cost so much it was not really worth it, I thought. you know I cannot get broke every week when I see a therapist.

So you asked for an advice for some public place where you could go?

Yeah I emailed her for a reference and she volunteers at women's clinic at Bohnice so she suggested that I contact the crisis center there, she gave me a number. I was feeling very hopeful because I'd heard that this is the place where they can help and I was like if anywhere they can help me, this must be it. But I called the number that she gave me and no one spoke English, I was calling from work just when I was feeling really desperate and I needed something like preferably that day and just no one understood me, they handed the phone to someone who said call this number there will be English speakers there, I called that number and they didn't understand me either, eventually they got someone who spoke kind of almost English to tell to call back after some time because there would be someone who could speak English better. I was crying on the phone obviously not very happy but I called back after the time they said and there was a nurse who said that I could come that evening and there would be a guy who spoke English, she said to come after 7pm and I said OK. I came at 7pm my girlfriend traveled with me we waited, I brought all the papers, she said to bring. And then like three hours later I got to see the guy (chuckles).

You were waiting for three hours to get it?

Yes, at very least..and then the conversation lasted about thirty minutes. I could tell he probably had had a very long day by the time he got to me but he basically listened to what I had to say but the he seemed to just fall back on whatever was the easiest, he seemed to do just like a quick pseudodiagnosis and said ok, it seems like you have this issue so I can recommend…well, nothing actually. He gave me information for a private clinic where they have psychologists and psychiatrists and told me to contact them, something in Karlin. And he wrote me this paper, because whenever you go to a public crisis center you have to write this summary of what they learned about you. Obviously it was in Czech and obviously they do not tell you what is on this thing so you have to go home and google translate it which is so much fun… Also, I said that I had a hard time sleeping so he gave me this document and one sleeping pill to take that night and the number for this therapist place which I had to contact on my own so that was the experience with Bohnice, the three hours waiting and thirty minutes of conversation.

How did you feel about the environment there, it is quite a huge psychiatric hospital, was it easy to reach it for you?

Oh, not at all. First of all, it was quite an adventure to get there and then to find your way into the right building because it is quite a maze in there. Try asking for directions does not go very well so we just had to kind of guess from the Czech signs so we just kind of walked through the main road guessing… In the end we found it, it was this smallest, most hidden little building.

And in the building they were waiting for you already?

Well, no I knocked and there were some people in the waiting room sitting and reading so I knocked on the door and a lady came out speaking Czech, I started to speak in English and she was just like "oh ok wait." She obviously knew for whom I came because how many English speakers do they get crying on the phone everyday so yeah I talked to her gave her all my papers and she put me on the schedule and told me to wait and yeah the rest you know. The guy I saw was a psychiatrist and I was really disappointed because I was really messed up back then and I know that this crisis clinic they have more things that they can offer to someone who comes and is really really desperate than just a pill and a note. But there was not even a hint offering me any more help. The whole experience felt to me like I was bothering them, which you do not really want to feel like when you need help. But it was not just a very comfortable feeling but sadly not more or less than I had expected.

So they gave you the document, the pill, sent you home and suggested that you call another clinic.

Pretty much yeah. I did call them, there was a lady on the phone who could speak English and a week and a half later I had an appointment with their psychiatrist which I had to pay for. When I finally got to talk to him… well, he was not very friendly to begin with, but that might be just a personalities clash. Anyway, the psychiatrist suggested that I see their therapist who does speak English very well and takes foreign clients. But at the time it was sometime around April and he told me that I could have an appointment in the beginning of June and it would also cost something around 1000 crowns. So I politely declined and that was the only thing I got from that clinic.

And then?

So I decided that it was a waste of time so I went to see my GP again… he knows me quite well… you know most of my sick leaves when I'm ill or something..

Your GP in Prague?

Yeah.

And you said you would seen him again that means that you had seen him before?

Yeah, I've seen him many many times. I told him this whole story about the places that I'd been and he told me that I should go and see a psychiatrist who works at the hospital at the end of the green line, that giant hospital you know

Motol?

Yeah, and he said that I could just go there that I do not need an appointment and foolishly I believed him and traveled the journey to that hospital only to be told that I needed an appointment like six months in advance and I was sent back to my GP. So I went back and told him how well that went and that is when he told me about this another hospital somewhere between IP Pavlova and Karlovo namesti, do not remember exactly where it was.

You mean the VFN, Vseobecna fakultni nemocnice?

Yeah that's probable, that does not sound entirely wrong. Whatever it's called I went there and talked to someone because essentially what I was looking for was to be admitted somewhere where I could get a full time help for a little while, which I told them. They read the note and I told them everything I went through and they basically panicked and wanted to admit me on the spot which I told them I could not really do at the moment. I didn't have any things with me you know… So they made me promise them that I would go back home pack my stuff and return in the morning, they made me swear that I would be there at 9 am exactly. So I came the next day and I spent a week in the mental wing. (chuckles) That was probably the most pointless thing I've ever done.

Pointless?

There was one kind of doctor who spoke some English who came and dropped by once a day to ask me how I was doing. There were two nurses who kind of spoke English which meant that they could translate for me when they were people telling me some things or yelling at me all the time. I got lucky, though, that there was one patient who had a Swedish husband so her English was perfect so she helped me the first few days but essentially no know did anything for me during that week apart from stuffing me with drugs.

There was no therapeutic program?

No, you just had hours when I could go out for a walk, there was very low structure and supervision.

How did you feel like?

Alone and lonely. I was sharing room with some other people, at first we were four, then three and then just two in the room but in the entire wing we were like 30 people maybe.

But for the Czech patients there were some activities?

Well, they at least knew what was going on, to me no one gave me much information about anything, you know, no one tried to get me involved with other patients because hardly anyone from the staff could speak English. It was usually like, "oh here comes the English speaker what are we gonna do with her?"

So again, you probably felt like you were bothering?

Yeah, I just spent a lot of time on my own reading and listening to music. Well, reading at first but when I got tired from the pills I was just sitting in a chair listening to music. That was not helpful and unbelievably lonely so after a week I basically said to them, look this is not helping I'm leaving tomorrow which took a lot effort but at least I finally got to talk to the real doctor whom I had seen only once since I got admitted. He spoke English very well which was great but it was again too late and it didn't really help either he actually had to just sign my discharge papers and that was it.

I was told in RIAPS, you know the crisis center, that they actually send forigners to VFN.

Yeah RIAPS is actually close to where I live, I almost went there a few times, I was in front of the door. I called them and asked if there was anyone who spoke English and they said no so I just gave up and went home. Because I was like if you really help foreigners someone on the phone would be able to speak English.

Well, even if you rang the bell they would probably sent you to VFN where you ended up anyway.

Yeah (chuckles), well the good thing that came out from my week in that hospital was that they gave me an information about a psychiatrist that I should see regularly for my prescriptions. And finally I got to see someone whose English was great, who actually listened to me when I talked and seemed to actually want to help me and be happy about offering me the services. That was awesome! I stopped looking for anything else, because I kind of gave up on therapists at this point, I mean there were therapist too but

they were also expensive and I thought it was not worth it until two months ago. I came to see him regularly, I mean the psychiatrist, for the prescriptions.

And these were covered by insurance?

Yeah, some of it, you know it didn't ruin me, I think they are mostly covered.

What kind of insurance do you have?

I have VZP, which provides my employer. It covers the prescriptions but it does not cover therapy.

Do you think if you would see a therapist who would accept VZP you could have therapy covered?

Well I've seen some but I think they cover the Czech therapy but they do not cover English therapy. That's kind of the general story.

Ok, so what was the think that made feel good about the new psychiatrist?

Just the fact that he was not trying to get rid of me and he seemed to understand when I was complaining about the Czech service I was getting, he just laughed and said yeah I get it because he clearly sees the same thing all the time with other foreigners. So basically, I could see that he knew how difficult it could be to find a good help and he seemed to generally want not to be part of that system. So that was great.

So you've seen him several times?

Yeah I still see him actually, he's still my psychiatrist and some time ago when things were getting really difficult again, I went to see him and we just agreed that it's probably time that I try therapy again so he suggested this guy who was working with him, he was there every Friday, he got me an appointment for only 800CZK an hour (irony) which was still way more than I could afford but at one point you're just so desperate that you have to do it. I think it's worth it because I've been seeing this guy for maybe two months and, his English is not perfect but he really really wants to help and that's great. But you know even this therapist if I was Czech the insurance would cover it and that would help.

How often do you see him?

Every Friday, it's also good that I can do it regularly now with my schedule.

So after the whole story, do you feel you've finally found help that you are happy with?

Yeah, you know I'm happy with the clinic and I feel comfortable with the therapist, or at least as comfortable as you one can be with any therapist. I also still see the psychiatrist and I think it is a good support system, it actually feels that I have somewhere to contact if I need.

Thank you for your time and good luck!

Appendix I: Email correspondence with Edwar, an example of a personal barrier.

Martin Tusl <mental.health.prague@gmail.com> Fri, Apr 14, 2017 at 8:19 PM
To:

Hello,

Thank you very much for your participation in my research. I would like to ask you for a brief clarification of your answers.

What do you exactly mean with your answer that mental health services are 'not good, damage, shameful and dangerous'?

Why would you recommend 'not to seek psychologists nor psychiatrists'?

Thank you!

Wishing you a nice evening,

Martin

Fri, Apr 14, 2017 at 8:25 PM
To: Martin Tusl <mental.health.prague@gmail.com>

Hello there,

I think that there is a damage for these sectors that I have studied about it in Research and in Newspaper reports

Better NOT TO SEEK or to NEED MENTAL HEALTH

Because it's something that will cause damage to the Patients and It's something abnormal and unacceptable for each person

This is Something very uncommon and Very rare to seek it

Because usually sexual Harrasors, Rapists and Other Criminals seek this help

Normal People shall not seek it

NOT to Seek Psychiatrist or Psychologists- this is Mainly Because that the Body shall not depend on the Medicine that can cause Very bad side Effects- Diabettes, Sickness, tiredness, stomachache- and Every Psychiatric Medicine can lead to death- and can lead to obesity

It can have very harmful Effects on the Patients

Better to Leave Mental Health Behind

Better to find alternative

Better to replace the traumatic Places like Dorms at the University, and Other crime rings and Crime places

Many Thanks

Best Wishes,
Edwar
[Quoted text hidden]

Appendix J: A complete list of adequate prices for psychotherapy that were provided by the participants who filled out the Questionnaire B.

Price (CZK)	Frequency	Percent
2000	2	2.7
1800	1	1.4
1500	2	2.7
1200	5	6.8
1000	10	13.5
900	4	5.4
800	4	5.4
700	3	4.1
600	6	8.1
500	12	16.2
450	1	1.4
400	3	4.1
350	1	1.4
300	4	5.4
250	3	4.1
200	3	4.1
Do not know	6	8.1
Insurance should cover it	4	5.4
Total	74	100.0
Mean	748	
Mode	500	12
Median	600	