Editorial

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The unseen difference: Transcultural psychiatry and the Sri Lankan diaspora in contemporary Australia

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Abstract

Transcultural psychiatry has emerged as an indispensable discipline for understanding the complex interplay between culture, migration, and mental health in an era of unprecedented global mobility. This editorial examines the evolution and contemporary relevance of transcultural psychiatry within the Australian context, with a particular focus on the Sri Lankan diaspora. It highlights persistent systemic failures in the early identification of neurodevelopmental disorders (NDDs) among Culturally and Linguistically Diverse (CALD) youth, and the downstream pathway from undetected NDD to severe mental illness. Drawing on clinical experience, empirical data, and the emerging literature on CALD mental health in Australia, the editorial advocates for culturally humble clinical frameworks, structured transcultural assessment tools, and a preventative model of care that prioritises equity and early intervention.

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1. Introduction: The Historical and contemporary imperative

Transcultural psychiatry, as a formal discipline, arose in the mid-twentieth century in the aftermath of World War II and the decolonisation movements that reshaped global sociopolitical landscapes (Antic, 2021). It sought to transcend Eurocentric psychiatric paradigms by integrating cultural, social, and anthropological insights into the understanding of mental illness and healing practices. Early pioneers grappled with the fundamental tension between universalist frameworks – asserting common psychopathological mechanisms across cultures – and the recognition of culturally specific expressions and idioms of distress (Cox, 1991). The concurrent rise of social psychiatry further emphasised broader determinants of mental health, including socioeconomic status, political pressures, and group dynamics (Fernando, 1988; Kleinman, 1980).

Today, transcultural psychiatry remains vital in addressing the mental health needs of increasingly multicultural societies. In Australia, this imperative is acute. The 2021 Census confirmed that over 29.1% of the population was born overseas and that nearly half of all Australians are first- or second-generation migrants. Migration from Asian nations – particularly India, China, Vietnam, and Cambodia – now significantly surpasses traditional European sources. For example, in the South-eastern Melbourne catchment area, this demographic shift has produced a complex clinical landscape of families from CALD backgrounds, including economic migrants and refugees, often residing side by side in communities with histories of inter-country conflict. Despite this reality, training curricula and clinical frameworks across Australian mental health services remain predominantly Eurocentric, leaving clinicians ill-equipped to navigate the cultural expressions of distress encountered daily in practice (Kirmayer & Pedersen, 2014).

2. The Sri Lankan diaspora: A case study in cultural complexity

The Sri Lankan community in Australia provides a particularly instructive case study for contemporary transcultural psychiatry, precisely because it defies simple categorisation. Sri Lanka itself is a microcosm of cultures – the product of historical invasions, colonial settlements, and centuries of coexistence. Its people encompass Burgher, Catholic, Sinhalese Buddhist, and Tamil populations, each carrying distinct histories, languages, and traditions. In recent generations, this complexity has deepened further, with families of mixed

heritage – such as those with Sri Lankan-Sindhi backgrounds – whose histories are interwoven with the understudied migration that followed the Partition of India. Understanding the migration of the family and their migration *within* Sri Lanka is, therefore, not merely an academic exercise; it is a clinical necessity for accurate formulation.

When these families arrive in Australia, they present a spectrum of experiences and capacities. Some parents are highly educated professionals who speak English impeccably and navigate healthcare systems with confidence. Others require professional interpreters and face significant barriers in accessing, understanding, and engaging with services (Mudunna et al., 2022). This heterogeneity creates a clinically important divide in help-seeking behaviour, mental health literacy, and engagement with formal services. Research by Mudunna and colleagues (2022) found that young Sri Lankan-Australians – particularly those born overseas – hold more stigmatising attitudes towards mental illness and professional help-seeking compared with their Australian-born counterparts, with gender, family background, and length of residence emerging as significant moderating variables. A subsequent study by Daluwatta and colleagues (2024) further demonstrated that help-seeking intentions and depression treatment beliefs within the Sri Lankan-Australian community are strongly shaped by cultural values, with religious and community practices often serving as preferred first pathways to support rather than formal psychiatric services. These findings reinforce the necessity of culturally tailored public health strategies and service designs that acknowledge and work within, rather than against, community structures.

3. Diagnostic disparities in CALD youth: The NDD imperative

Within the sub-population of CALD youth, diagnostic disparities are most consequential in the domain of neurodevelopmental disorders. Clinical data from the Endeavour Clinic at Monash Health demonstrate that CALD children with NDDs – including Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) – are diagnosed significantly later than their non-CALD peers, if they receive a diagnosis at all. Their symptoms are routinely mislabelled as "behavioural problems" or attributed to "cultural differences," leaving the core neurodevelopmental vulnerability unaddressed (Basu & Isaacs, 2019; Cénat et al., 2021).

This diagnostic failure has severe downstream consequences. The evidence is unambiguous: individuals with NDDs carry a markedly elevated lifetime risk of developing psychosis, major affective disorders, and suicidal and self-harming behaviours (Lai et al., 2019; Hirvikoski et al., 2016). When undetected NDD intersects with acculturative stress and identity conflict – both well-established risk factors for psychopathology in migrant youth (Cantor-Graae & Selten, 2005; Pumariega, Rothe, and Pumariega, 2005) – the result is a compounded and dangerous vulnerability. The pathway that emerges is clinically recognisable and preventable: undetected NDD, compounded by acculturative stress, leads to school and social failure, which in turn produces increased isolation and distress, and ultimately escalates to severe mental illness, including psychosis, self-harm, and major depression. I have observed a spate of cases in which young adults presented with an initial diagnosis of psychosis or a major mood disorder, only for a retrospective assessment to reveal that the primary diagnosis of autism had been entirely missed in childhood. At this late stage, gathering an accurate developmental history is fraught with difficulty. Years of parental scaffolding and an enduring familial optimism have obscured the true burden of care, and the family's sense of responsibility – a cultural strength – has paradoxically deepened the diagnostic delay.

4. Cultural dimensions of parental scaffolding and diagnostic delay

Understanding why these delays occur requires moving beyond clinician training deficits to examine the cultural architecture of help-seeking within CALD families. Among many Sri Lankan-Australian families, parental accommodation of a child's difficulties reflects a deeply held, culturally sanctioned belief that familial responsibility is both a right and a duty (Daluwatta et al., 2024). This scaffolding – far from being pathological – is often an expression of profound love, resilience, and cultural integrity. However, when interpreted through a Western clinical lens, it may be misread as a lack of awareness, denial, or even neglect.

Simultaneously, internalised stigma constitutes a significant barrier to timely help-seeking. Within many South Asian and Sri Lankan communities, the disclosure of a child's neurodevelopmental or psychiatric difficulties carries risks to family honour and social standing (Antoniades & Brijnath, 2014). Parents may hesitate to seek a formal diagnosis for fear of being labelled, community judgment, or the implications for marriage prospects and family reputation. These are not irrational fears but culturally intelligible responses to genuine social risks. The clinician who fails to acknowledge this context is unlikely to form the therapeutic alliance necessary for effective assessment and intervention.

Toppelberg and Collins (2010) further demonstrated that language, culture, and adaptation in immigrant children are deeply intertwined, and that the challenges of bilingualism and differential parental acculturation can compound clinical presentation while simultaneously delaying help-seeking. The concept of "differential acculturation" – whereby parents and children acculturate at markedly different rates – introduces a further layer of family distress that both obscures the clinical picture and erodes the communicative bridges between child and parent (Pumariega et al., 2005).

5. Towards a transcultural clinical framework

Addressing these systemic failures requires a fundamental reorientation of clinical practice, grounded in the principles of cultural humility and structured transcultural assessment (Shekhawat, 2024; Kirmayer, Guzder, & Rousseau, 2014). Cultural humility – as distinguished from the more static concept of cultural competence – demands an ongoing commitment to self-evaluation and self-critique, an awareness of power imbalances in the clinician-patient dynamic, and a willingness to learn from patients and families rather than assuming expertise (Tervalon & Murray-Garcia, 1998, as cited in attachment). This is particularly critical when clinicians encounter culturally unfamiliar expressions of distress or family dynamics that do not map neatly onto standard diagnostic frameworks.

At a practical level, clinicians must be equipped to conduct comprehensive biopsychosocial formulations that are free from perceived or actual prejudice. The DSM-5 Cultural Formulation Interview (CFI) provides a structured entry point, enabling clinicians to explore cultural identity, cultural conceptualisations of distress, psychosocial stressors, and the cultural dimensions of the clinician-patient relationship (Kirmayer et al., 2014). Critically, for CALD children presenting with possible NDDs, the CFI must be supplemented with NDD-specific prompts that help clinicians distinguish neurodivergent traits from culturally normative behaviours. The absence of such tools in current clinical practice represents a significant gap.

The Transcultural Mental Health Centre in New South Wales has articulated the need for culturally responsive emotional wellbeing services that address language barriers, incorporate cultural brokers, and provide education to families in accessible formats (TMHC, 2023). These principles are transferable to paediatric and adolescent mental health services across Victoria and nationally and provide a foundation for a preventive, biocultural model of NDD assessment.

6. Implications for training, policy, and research

The clinical imperative described above has clear implications for workforce development, health policy, and research priorities. At the level of training, transcultural psychiatry must be embedded as a core competency in all undergraduate and postgraduate mental health curricula, rather than remaining an elective or specialised interest (Chyung, McDermott, & Horner, 2016). Clinicians need structured opportunities to reflect on their own cultural biases and to develop the skills required for culturally informed assessment, including proficiency in working with professional interpreters and community cultural consultants (Kirmayer & Pedersen, 2014).

At the policy level, Victoria's Royal Commission into Mental Health (2021) explicitly emphasised the need for early intervention, culturally responsive care, and prevention-focused models for young people from diverse backgrounds. This mandate creates both an opportunity and an obligation for services such as a publicly funded Child and Adolescent Mental Health service to lead in developing and disseminating models that operationalise these principles. The WHO Mental Health Action Plan 2013-2020 similarly underscored the need to integrate mental health into primary care systems in a manner sensitive to cultural and social contexts (WHO, 2013).

In research, the intersection of NDD and CALD backgrounds remains a significantly understudied domain. Prospective, longitudinal studies examining the diagnostic trajectories of CALD children with NDDs – with appropriate attention to cultural, linguistic, and socio-economic variables – are urgently needed. Collaborative, international research partnerships, particularly with institutions such as the Division of Social and Transcultural Psychiatry at McGill University, which has developed a world-leading Cultural Consultation Service (Kirmayer, Guzder, & Rousseau, 2014), offer a pathway to benchmark best practices and adapt validated frameworks for the Australian context.

7. Conclusion

The high rates of severe mental illness observed among both CALD and NDD populations are not coincidental. They are, in significant part, a consequence of systemic failures in early-life care – failures rooted in a clinical culture that has not yet fully grappled with the complexity of cultural difference. The Sri Lankan diaspora in Australia serves as a poignant and instructive case study, not because its challenges are unique, but because they illuminate with particular clarity the consequences of a

mental health system that remains unprepared for the communities it serves.

The path forward demands more than awareness; it requires the development and implementation of structured, reproducible clinical frameworks that translate the lived experience of migration, colonisation, and cultural identity into robust clinical pedagogy and practice. Only by embracing this complexity – and by cultivating the cultural humility to learn from the families we serve – can we hope to provide equitable, effective, and genuinely preventative mental healthcare for all Australians.

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