

# [Culture and psychopathology: new perspectives on research, practice, and clinical...](https://assignbuster.com/culture-and-psychopathology-new-perspectives-on-research-practice-and-clinical-training-in-a-globalized-world/)

[Health & Medicine](https://assignbuster.com/essay-subjects/health-n-medicine/)

It has never been truer that cultural context has a prominent role in understanding and treating psychopathology. In a globalized world, it is currently widely recognized that it is the cultural context that defines (mal)adjustment of human behavior, which includes how people usually behave, think, feel, and relate in social interactions. It also shapes the threshold of distress, and the range and forms of its expressiveness that are acceptable and adaptive. As with overall health and illness, psychological suffering implies an understanding of a complex, multi-dimensional process of biopsychosocial variables, which is culturally situated. Similarly, most treatments or interventions in face of psychopathology require the recognition of their historical roots in specific cultural perspectives, as culture also shapes psychotherapy models ( [1](#B1) ) and patient care in psychiatry, influencing every moment and every process in patient narratives of their suffering ( [2](#B2) ). In addition, culture also determines how credible and/or acceptable are treatment types in the eyes of a patient and his/her family ( [3](#B3) ), and consequently treatment adherence. Thus, culture is a key, undeniable current perspective on psychopathology and, for many authors, it has moved to the forefront in the study of psychopathology ( [4](#B4) ), parallel to the emerging impact of social neuroscience ( [5](#B5) ).

## New Perspectives on the Definitions of Psychopathology and of Culture

The focus on culture when understanding psychopathology has not always been present and it is still not mainstreamed in clinical psychology and psychiatry. In fact, throughout most of its history, psychopathology has neglected to address cultural diversity, as health sciences have easily labeled behaviors, cognitions, emotional, and social functioning as psychopathological for their deviance from social norms—usually defined in a Western, Eurocentric perspective. An illustration of this perspective lies on the tradition of “ deviant” or “ abnormal psychology” in the literature - attempts to understand and control behavior deemed to be aberrant or deviant from a statistical, functional, or moral standard ( [6](#B6) ).

Moving away from more traditional conceptions of statistical and social norms as indicators of psychopathological functioning, main psychopathology classification systems ( [7](#B7) , [8](#B8) ) currently focus on the role of subjective distress, dysfunction and impairment ( [6](#B6) ). In other words, the presence of clinically significant subjective distress that is experienced by the patient, and the experience of impairment to one or more of the patient's areas of functioning (i. e., social, occupational or educational functioning) are core elements for conceptualizing psychopathology [see ( [7](#B7) )]. In the DSM-5, APA ( [7](#B7) ) conceptualizes mental disorders as those conditions with clinically significant dysfunction in the individual, underlined by patterns of functioning in cognition, emotional regulation, or behavior that are associated with distress or disability. APA ( [7](#B7) ) adds that (i) this pattern must not be merely an expected and culturally sanctioned response to a particular event, stressor or situation; and that (ii) deviant behavior (e. g., political, religious, sexual) in relation to society does not represent psychopathology in itself. This definition seeks to acknowledge the interaction of biological and psychological processes, and sociocultural systems.

Even after its expansion in the 80's [see ( [9](#B9) )], efforts to mainstream cross-cultural psychiatry were not present until recent years, and its impact on clinical practice and training has been slow to observe. Nonetheless, in recent years we have witnessed a growth in the literature on social and cultural psychiatry, with increasing recognition of the influence of culture as a key factor in the prevalence, clinical manifestation, diagnosis, treatment response and outcomes of mental illnesses for individuals [see ( [2](#B2) , [10](#B10) , [11](#B11) )]. This has also resulted in a quite novel perspective on the conception of culture itself, in light of critics of group-based definitions of culture (based usually on nationality or racial/ethnic background), mostly arising from social sciences (e. g., anthropology). Two key novel elements in the conception of culture ought to be highlighted. First, current definitions of culture in mental health research and practice acknowledge the role of multiple collective influences that combine to constitute a person's identity. These influences arise from diverse origins, not only nationality, migration status, racial and/or ethnic origin, language, religion, and spirituality, but also age, gender identity, sexual orientation, socioeconomic and educational class, and functional status. These influences overlap in unique or particular ways, resulting in specific experiences of a given individual or group, for instance, with impacts on interdependent systems of discrimination or disadvantage [i. e. intersectionality—( [12](#B12) , [13](#B13) )]. In all, these multiple lenses influence how a patient views the world, how he/she experiences it emotionally, and how he/she behaves in relation to other people. Secondly, recent conceptualizations of culture regard it as processual ( [11](#B11) ). This process of meaning-making is dynamic and interpersonal, as those multiple facets of one's identity become more or less prominent at any given moment, in the presence of some social interactions and contexts, and not others. This includes the clinical encounter. This notion underlies the most recent revision of the DSM [DSM-5, ( [3](#B3) )], which recognizes the importance of a cultural case formulation of any patient's presenting complaint and clinical history, and the understanding of culture as a process, rather than synonymous with static group membership.

## Explaining Psychopathology: The Role of Culture, Discrimination and Minority Stress on Mental Health

Culture has a recognized role in not only conceptualizing psychopathology, but also in explaining and accounting for experienced distress, health and illness ( [14](#B14) , [15](#B15) ). Certain conditions surrounding minority stress [gender; sexual orientation; e. g., ( [16](#B16) )] and migration processes [e. g., ( [17](#B17) )] may increase vulnerability, and stigmatized groups may be exposed to a higher number of risk factors for psychological distress [e. g., related to legal status, perceived discrimination, social exclusion, stigmatization, and victimization; ( [18](#B18) )]. For instance, lesbian, gay, bisexual and transgender (LGBT) populations have been found to present increased risk for suicide ( [19](#B19) , [20](#B20) ), traumatic stress reactions ( [21](#B21) ), major depression disorders ( [22](#B22) , [23](#B23) ), anxiety disorders ( [24](#B24) , [25](#B25) ), among others [e. g., ( [26](#B26) )]. Also, socio-economic adversities, including poverty and environmental risk factors, have been associated with the onset and maintenance of psychopathological symptoms and low life satisfaction ( [27](#B27) ). This relationship has been explained through material deprivation but also increased adverse life events (such as unemployment, abuse and neglect), with consequences for treatment outcomes, including among children and adolescents [e. g., ( [28](#B28) )]. Given the recent recession period and current socio-economic strain for many individuals, it seems relevant to recognize that people living in poverty are more likely to experience mental health problems ( [29](#B29) ), less likely to access treatment ( [30](#B30) ) and less likely to achieve full recovery from emotional psychopathological problems ( [31](#B31) ).

In addition, contemporary migration has an unprecedented mobility with an estimated number of 232 million international migrants in the world [World Migration Report; ( [32](#B32) )]. Forced migration, steadily increasing as a result of armed conflict (both within and between nations), but also political, economic, social, and climate changes, has most recently been discussed in the mental health field, with undeniable impacts on health and psychological functioning ( [33](#B33) ). The effects of pre-migration and migration-related trauma among refugees have been acknowledged and documented ( [34](#B34) ).

Recent literature has emphasized the role of not only explicit discrimination, but also implicit attitudes in interpersonal interactions [evaluations automatically activated by the actual or symbolic presence of a social object; ( [35](#B35) – [38](#B38) ); see Hall et al., ( [39](#B39) ) for a systematic review]. Micro-aggressions in daily life [continuous experiences of aggression, often invisible to the perpetrator, who unconsciously holds biases and prejudice; ( [40](#B40) – [42](#B42) )] have also been investigated, and have been found to have significant effects on an individual's well-being.

In sum, culture and other related socio-contextual factors, such as minority stress, discrimination and exposure to interpersonal violence, influence the development of clinically significant distress and resulting disability.

## On Culturally-sensitive Assessment of Psychopathology

Assessment bias [called “ cultural malpractice” by Dana ( [43](#B43) )] has been identified as an issue in a variety of measures of personality and psychopathology among individuals from diverse backgrounds. This construct and method bias has a variety of sources (e. g., including instrument development, standardized test norms that under-represent social minority groups, neglect for language barriers and acculturation processes), and permeate the assessment process and results, and treatment recommendations. For instance, the use of the Minnesota Multiphasic Personality Inventory (MMPI-2; one of the most widely used and researched psychodiagnostic self-report measures in the world) among diverse patients has raised concerns (related to conceptual, metric, and functional equivalence) as it may not be appropriate among those whose worldviews differ from the Euro-American culture ( [43](#B43) ).

In an effort to strengthen culturally-sensitive assessment practices, aligned with the DSM-5 ( [7](#B7) ), the Cultural Formulation Interview ( [3](#B3) ) was developed. This interview represents a proposal for cultural assessment for use in routine clinical care. It presents a conceptual framework for clinicians to identify the role of culture on the patient's clinical presentation and care, in four domains: (1) cultural identity of the individual; (2) cultural explanations of the experienced signs and symptoms (i. e., explanatory models of illness); (3) cultural factors that may be associated with the psychosocial environment and levels of functioning (i. e., protective and risks factors); and (4) cultural features involved in the communication and the clinical relationship between the patient and the psychiatrist or psychologist.

The concept of explanatory models of the experienced distress was introduced in psychiatry by Kleinman ( [10](#B10) ), highlighting the clinical relevance of eliciting the patient's understanding of his/her own symptoms. These models stressed the predictive value of the patient representations of his/her illness (causes of the problems and its effects over time on different realms of life) on coping and help-seeking behaviors, and consequently treatment adherence and outcome [see ( [44](#B44) ), for a review]. Addressing the patient's explanatory models may, hence, maximize engagement and adherence; improve therapeutic alliance; strengthen empathy and positive expectations, while decreasing stigma, shame and other catastrophic beliefs [i. e., “ weakness,” “ going mad,” ( [3](#B3) )].

Even though the evaluation of specific psychosocial stressors has been emphasized, a strength-based approach has also been pointed out as a valuable perspective on culturally-sensitive assessment among patients of stigmatized social groups ( [3](#B3) ). This includes the evaluation of the social network of the patient (e. g., extended family, migrant and religious communities, LGBT associations), as it may play a pivotal role in both the onset and development of psychopathology, as well as a buffer of the effects of risk or stressful factors and the course and outcomes of mental health conditions ( [45](#B45) ).

In light of the aforementioned definition of culture, cultural identity is conceptualized in a intersectional perspective, and encompasses (i) aspects related to national, ethnic, and racial background, including language and migration, as well as social economic and educational status; (ii) spirituality, religion, and moral traditions; and (iii) gender, gender identity, and sexual orientation. Hence, a particular example of an important aspect to assess is patient's religiosity and spirituality. Indeed, religion and spirituality represent key dimensions when aiming a complete understanding of an individual [e. g., ( [46](#B46) )], as well as having a potential positive impact on both physical and mental health. Purpose, meaning making and connection to others and the transcendent (through religion and spirituality) may influence one's core beliefs, emotions and behaviors ( [47](#B47) ). Religiosity and spirituality may have different impacts across one's life spam, on mental health outcomes and to the psychological treatment process, with some positive and some negative impacts ( [46](#B46) – [48](#B48) ). However, religious and spiritual dimensions have been separated from mental health care in the nineteenth century ( [49](#B49) ) and patients' spiritual experiences oftentimes labeled as “ bizarre” and pathologized.

Another particular example of a key dimension to consider in culturally-sensitive assessment is related to gender roles, gender identity and sexual orientation, as culture clearly shapes the roles of women and men in a society, their expressions of distress, and their interpersonal relations ( [14](#B14) , [50](#B50) ). Culture also determines the way diversity in gender identities and expressions are understood, as well as diversity in human sexuality (i. e., sexual orientation). In addition, mental health research has mainly treated sexual and ethnic identities separately, focusing on either of these two domains, with a few studies in the field addressing the experiences of individuals whose minority cultural/ethnic identities intersect with non-normative sexuality/gender expression [e. g., coping and resilience among Black lesbians; ( [51](#B51) )].

In sum, culturally-sensitive psychopathology assessment will require the clinician to identify the cultural identities of the patient; conceptualizing his/her distress in a cultural lens; evaluate psychosocial stressors and protective factors; and be mindful of the cultural features of the relationship between the patient and the clinician and how the clinical encounter plays a role in the overall evaluation process ( [52](#B52) ).

## Psychotherapy: Working With Cultural Diversity

Since the seminal work by Frank and Frank ( [53](#B53) ), psychotherapy has been compared with diverse healing practices or treatments across different times and different cultures ( [54](#B54) ). Still, in a globalized world, even though the need for culturally competent mental health services has been well recognized, health and mental health care disparities have been largely documented. While meta-analysis have shown a moderate effect size of culturally adapted interventions ( [55](#B55) ), studies in psychotherapies across many disorders have concluded that outcomes for minority cultural groups are not as good as for the majority populations and found greater rates of premature termination ( [1](#B1) , [52](#B52) ). The sources of these disparities in healthcare are complex and exist in a broader historical and contemporary context of social and economic inequality, prejudice, and systematic bias ( [18](#B18) ). In fact, the Western biomedical health model has created a professional culture, based on specific values (e. g., power, agency, objectivity, individualism), which may differ from the diverse cultures of those attending health services. Psychotherapeutic theoretical models (e. g., psychoanalytic, psychodynamic, humanistic, cognitive-behavioral, systemic approaches) have also been historically rooted in concepts and developed in contexts that were not sensitive to the current cultural diversity. In other words, the healthcare system itself can be less in accordance with the cultural perspectives of some patients than others. Therefore, clinicians' sense of social responsibility and social justice concerns have arisen as a response to social inequalities in mental health care, and specific culturally-sensitive treatments have been developed [e. g., multicultural counseling; LGBT affirmative psychotherapies; ( [56](#B56) )].

A recent special issue of the Journal of Contemporary Psychotherapy critically reviewed the practice and development of psychotherapy in Nigeria ( [57](#B57) ), China ( [58](#B58) ), India ( [59](#B59) ), Saudi Arabia ( [60](#B60) ), Pakistan ( [61](#B61) ), and Israel ( [62](#B62) ). Iwakabe ( [63](#B63) ) had already done so for the Japanese context. These authors discuss the relevance and applicability of “ Western” psychotherapies in different populations, considering distinct cultural, religious, political, social, familial, and individual features, with implications not only for treatment outcomes, but also the clinical therapeutic relationship. Another relevant, recent example is a special issue of Counseling and Psychotherapy Research ( [27](#B27) ), which brings light to the role of social inequalities in psychotherapy research and practice, acknowledging that, for a long time, psychotherapy was seen as an endeavor for the middle- and upper-class of educated and psychologically minded clients.

Moreover, only recently the impact of cultural diversity on practitioner-patient interactions has been examined, for instance in medicine ( [64](#B64) ). However, the American Institutes for Research had already acknowledged in 2002 that “ *social issues such as stereotyping, institutionalized racism, and dominant-group privilege are as real in the examining room as they are in society at large* ” [( [65](#B65) ), p. 8]. That is, issues of stereotyping and discrimination may be as real in the clinician-patient relationship as in any other interpersonal relationship. Indeed, social, educational and economic disparities between patients and clinicians are often evident ( [27](#B27) ). Moreover, there is evidence of stereotyping and bias among healthcare providers [e. g., ( [39](#B39) , [66](#B66) , [67](#B67) )], and diverse micro-aggressions in the health care systems ( [42](#B42) ). This is due to the fact that, even though negative explicit attitudes toward stigmatized groups have been declining, substantial implicit negative attitudes still exist and exert influence on behavior, from everyday encounters to clinical interactions ( [64](#B64) ). Still, blatant examples persist in the practices of many clinicians in helping patients redirect or change same-sex sexual orientation ( [68](#B68) ).

## Mainstreaming Culture in Research on Psychopathology and in Clinical Training

The present paper argues for mainstreaming culture in research and clinical training in psychopathology, acknowledging that each clinical interaction is a cultural one. As aforementioned, different characteristics of one's identity are salient in different contexts and interactions. In the practitioner-patient interaction, this is no exception and thus clinicians need to be able to be responsive to this cultural encounter—i. e., to be culturally competent.

Cultural competence is generally defined in a tri-dimensional model, as the extent to which clinicians possess appropriate awareness, relevant knowledge, and practical skills in working with individuals from diverse cultural backgrounds ( [11](#B11) , [15](#B15) , [18](#B18) ). The first dimension—awareness—refers to the way the clinicians' attitudes, beliefs, values, assumptions, and self-awareness affect how they interact with those patients who are culturally different from themselves. It involves the exploration of the self as a cultural being, and of one's own cultural preconceptions. The second dimension—knowledge—relates to the informed understanding of cultures that are different from one's culture, including their histories, traditions, values, practices, and so forth. It also involves knowledge about such concepts and processes as cultural impacts on psychosocial development, acculturation models and acculturation stress, social minority stress and identity development, cultural communication styles in the helping relationship, perceived discrimination and socioeconomic adversity as risks factors for well-being, among others. Finally, an important third dimension consists in the ability to engage in effective and meaningful interactions with diverse individuals, including the development of a relationship, by integrating one's awareness and knowledge into practical skills in the clinical relation, assessment and intervention. Cultural competence has been proposed as a strategy to respond to diversity in contemporary societies and make health care services more accessible, acceptable and effective for diverse communities. Initially intended for work with migrants and ethnic minorities, cultural competence has been extended to include other forms of client diversity, such as age, gender, sexual orientation, gender identity, religion, social class, language, and ability status [e. g., ( [69](#B69) , [70](#B70) )]. It has been proposed as a developmental process, both at an individual (i. e., the clinician) and an organizational (i. e., healthcare unit) levels. Despite recent debates and criticisms [cultural safety, cultural sensitivity, cultural responsiveness, and cultural humility; ( [11](#B11) )], developing cultural competence in psychopathology is a key process aligned with person-centered care, where patient narratives and meanings are shared and interpreted in the clinical encounter. However, research is still needed on the processes of implementation, clinical effectiveness, clinical communication, wider social impact, and outcomes of culturally competent services and interventions ( [11](#B11) , [39](#B39) ). Indeed, Delgadillo ( [27](#B27) ) argues for a better integration of the literature on social inequalities, power imbalance, and cultural competence into clinical training programmes. The recent aforementioned understandings of culture and of psychopathology in a social and cultural context, rather than an (exclusively) intra-individual process, provide a possible route to develop these clinical competences. While some have reported training pilot studies and their evaluation, and guidelines have been proposed [e. g., ( [3](#B3) , [17](#B17) )], clinical training in individual and cultural diversity is still scarce and unsystematic, both in the educational/academic process and in professional development. Addressing this gap and mainstreaming cultural competence in clinical training seems to be a key future development if we are to enable clinicians to provide support and address mental health concerns in a diverse world.

## Author Contributions

The author confirms being the sole contributor of this work and approved it for publication.

## Funding

This work was supported by the national Foundation for Science and Technology (FCT) in Portugal, under the Grant number UID/PSI/03125/2013.

## Conflict of Interest Statement

The author declares that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

## References

1. Rathod S. Contemporary psychotherapy and cultural adaptations. *J Contemp Psychother.* (2017) 47: 61–3. doi: 10. 1007/s10879-016-9344-5

2. Kirmayer LJ. Beyond the 'new cross-cultural psychiatry': cultural biology, discursive psychology and the ironies of globalization. *Transcult Psychiatry* (2006) 43: 126–44. doi: 10. 1177/1363461506061761

3. Lewis-Fernández R, Aggarwal NK, Hinton L, Hinton DE, Kirmayer LJ. *DSM-5® Handbook on the Cultural Formulation Interview* . Washington, DC: APA (2016).

4. López SR, Guarnaccia PJ. Cultural dimensions of psychopathology: The social world's impact on mental illness. In: Maddux JE, Winstead BA editors. *Psychopathology: Foundations for a Contemporary Understanding* . Mahwah, NJ: Lawrence Erlbaum Associates (2005). p. 19–38.

5. Manes F, Mendez MF editors. *Social Neuroscience of Psychiatric Disorders: A Special Issue of the Journal of Social Neuroscience* . New York, NY: Psychology Press (2013).

6. Maddux JE, Gosselin JT, Winstead BA. Conceptions of psychopathology: a social constructionist perspective. In: Maddux JE, Winstead BA editors. *Psychopathology: Foundations for a Contemporary Understanding* . Mahwah, NJ: Lawrence Erlbaum Associates (2005). p. 3–18.

7. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders 5th edn* . Arlington, VA: American Psychiatric Publishing (2013).

8. World Health Organization. *International Statistical Classification of Diseases and Related Health Problems 10th rev* . Geneva: Author (1992).

9. Kleinman A. *Rethinking Psychiatry: From Cultural Category to Personal Experience* . New York: Free Press (1988).

10. Kleinman A. *Patients and Healers in the Context of Culture: An Exploration of the Borderland between Anthropology, Medicine, and Psychiatry* . Berkeley: University of California Press (1980).

11. Kirmayer LJ. Rethinking cultural competence. *Transcult Psychiatry* (2012) 49: 149–64. doi: 10. 1177/1363461512444673

12. Crenshaw K. Mapping the margins: intersectionality, identity politics, and violence against women of color. *Stanf Law Rev.* (1991) 43: 1241–99.

13. Iyer A, Sen G, Ostlin P. The intersections of gender and class in health status and health care. *Glob Public Health* (2008) 3: 13–24. doi: 10. 1080/17441690801892174

14. Eisler RM, Hersen M editors. *Handbook of Gender, Culture and Health* . Mahwah, NJ: Lawrence Erlbaum Associates (2000).

15. Sue DW, Sue D. *Counseling the Culturally Diverse: Theory and Practice* 5th ed. New Jersey: Wiley (2008).

16. Meyer I. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychol Bull.* (2003) 129: 674–97. doi: 10. 1037/0033-2909. 129. 5. 674

17. Bhugra D, Gupta S, Bhui K, Craig T, Dogra N, Ingleby D, et al. WPA guidance on mental health and mental health care in migrants. *World Psychiatry* (2011) 10: 2–10.

18. Sue S, Zane N, Hall GC, Berger LK. The case for cultural competency in psychotherapeutic interventions. *Annu Rev Psychol.* (2009) 60: 525–48. doi: 10. 1146/annurev. psych. 60. 110707. 163651

19. Maguen S, Shipherd J. Suicide risk among transgender individuals. *Psychol Sex.* (2010) 1: 34–43. doi: 10. 1080/19419891003634430

20. Mustanski B, Liu RT. A longitudinal study of predictors of suicide attempts among lesbian, gay, bisexual, and transgender youth. *Arch Sex Behav.* (2013) 42: 437–48. doi: 10. 1007/s10508-012-0013-9

21. D'Augelli AR, Pilkington NW, Hershberger SL. Incidence and mental health impact of sexual orientation victimization of lesbian, gay, and bisexual youths in high school. *School Psychol Q.* (2002) 17: 148–67. doi: 10. 1080/10538720. 2011. 561474

22. Cochran SD, Mays VM. Relation between psychiatric syndromes and behaviourally defined sexual orientation in a sample of the U. S. population. *Am J Public Health* (2000) 92: 516–23.

23. Nuttbrock L, Hwahng S, Bockting W, Rosenblum A, Mason M, Macri M, et al. Psychiatric impact of gender-related abuse across the life courseofmale-to-female transgenderpersons. *J Sex Res.* (2010) 47: 12–23. doi: 10. 1080/00224490903062258

24. Bostwick WB, Boyd CJ, Hughes TL, West BT, McCabe SE. Discrimination and mental health among lesbian, gay, and bisexual adults in the United States. *Am J Orthopsychiatry* (2014) 84: 35–45. doi: 10. 1037/h0098851

25. Mustanski BS, Garofalo R, Emerson EM. Mental health disorders, psychological distress, and suicidality in a diverse sample of lesbian, gay, bisexual, and transgender youths. *Am J Public Health* (2010) 100: 2426–32. doi: 10. 2105/AJPH. 2009. 178319

26. King M, Semlyen J, Tai SS, Killaspy H, Osborn D, Popelyuk D, et al. A systematic review of mental disorder, suicide, and deliberate self-harm in lesbian, gay and bisexual people. *BMC Psychiatry* 8: 70. doi: 10. 1186/1471-244X-8-70

27. Delgadillo J. Worlds apart: social inequalities and psychological care. *Counsel Psychother Res.* (2018) 18: 111–3. doi: 10. 1002/capr. 12168

28. Blackshaw E, Evans C, Cooper M. When life gets in the way: systematic review of life events, socioeconomic deprivation, and their impact on counselling and psychotherapy with children and adolescents. *Counsel Psychother Res.* (2018) 18: 143–53. doi: 10. 1002/capr. 12156

29. Lund C, Breen A, Flisher AJ, Kakuma R, Corrigall J, Joska JA, et al. Poverty and common mental disorders in low and middle income countries: A systematic review. *Soc Sci Med.* (2010) 71: 517–28. doi: 10. 1016/j. socscimed. 2010. 04. 027

30. Saxon D, Fitzgerald G, Houghton S, Lemme F, Saul C, Warden S, et al. Psychotherapy provision, socioeconomic deprivation, and the inverse care law. *Psychother Res.* (2007) 17: 515–21. doi: 10. 1080/10503300601063246

31. Delgadillo J, Asaria M, Ali S, Gilbody S. On poverty, politics and psychology: The socioeconomic gradient of mental healthcare utilisation and outcomes. *Br J Psychiatry* (2016) 209: 429–30. doi: 10. 1192/bjp. bp. 115. 171017

32. International Organization for Migration. *World Migration Report 2015. Migrants and cities: new partnerships to manage mobility* . Brussels: Author (2015).

33. Ingleby D editor. *Forced Migration and Mental Health: Rethinking the Care of Refugees and Displaced Persons* . New York, NY: Springer (2005).

34. Hollifield M, Warner TD, Krakow B, Westermeyer J. Mental health effects of stress over the life span of refugees. *J Clin Med.* (2018) 7: 25. doi: 10. 3390/jcm7020025

35. Dovidio JF, Kawakami K, Gaertner SL. Implicit and explicit prejudice and interracial interaction. *J Pers Soc Psychol.* (2002) 82: 62–8. doi: 10. 1037/0022-3514. 82. 1. 62

36. Dovidio JF, Gaertner SL, Pearson AR. “ Racism among the well-intentioned: bias without awareness,” In: Miller AG, editors. *The Social Psychology of Good and Evil* (2nd ed.). New York: Guilford Press (2016), p. 95–118.

37. Hebl MR, Foster JB, Mannix LM, Dovidio JF. Formal and interpersonal discrimination: a field study of bias toward homosexual applicants. *Pers Soc Psychol Bull.* (2002) 28: 815–25. doi: 10. 1177/0146167202289010

38. Kawakami K, Phillis CE, Steele JR, Dovidio JF. (Close) Distance makes the heart grow fonder: Improving implicit racial attitudes and interracial interactions through approach behaviors. *J Pers Soc Psychol.* (2007) 92: 957–71. doi: 10. 1037/0022-3514. 92. 6. 957

39. Hall WJ, Chapman MV, Lee KM, Merino YM, Thomas TW, Payne BK, et al. Implicit racial/ethnic bias among health care professionals and its influence on health outcomes: a systematic review. *Am J Public Health* (2015) 105: 60–76. doi: 10. 2105/AJPH. 2015. 302903

40. Constantine MG. Racial micro aggressions against African American clients in cross-racial counselling relationships. *J Couns Psychol.* (2007) 54: 1–16. doi: 10. 1037/0022-0167. 54. 1. 1

41. Sheldon K, Delgado-Romero EA. Sexual orientation microaggressions: the experience of lesbian, gay, bisexual, and queer clients in psychotherapy. *J Couns Psychol.* (2011) 58: 210–21. doi: 10. 1037/a0022251

42. Sue DW. *Microaggressions in Everyday Life: Race, Gender, and Sexual Orientation* . Hoboken, NJ: Wiley (2010).

43. Dana R. *Handbook of Cross-Cultural and Multicultural Personality Assessment* . Mahwah, NJ: Lawrence Erlbaum Associates (2000).

44. Weiss MG, Somma D. Explanatory models in psychiatry. In: Rhugra D, and Bhui K editors. *Textbook of Cultural Psychiatry* . Cambridge: Cambridge University Press (2007). p. 127–40.

45. Cohen S, Underwood LG, Gottlieb BH. *Social Support Measurement and Intervention: A Guide for Health and Social Scientists* . New York, NY: Oxford University Press (2000).

46. Fallot RD. The place of spirituality and religion in mental health services. *New Dir Ment Health Serv.* (1998) 80: 3–12.

47. Koenig HG. Religion, spirituality, and health: the research and clinical implications. *ISRN Psychiatry* (2012) 2012: 278730. doi: 10. 5402/2012/278730

48. Rosmarin DH, Krumrei EJ, Pargament KI. Are gratitude and spirituality protective factors against psychopathology? *Int J Exist Psychol Psychother.* (2010) 3: 1–5. Available online at: https://www. existentialpsychology. org/index. php/ExPsy/article/view/148 (Accessed July 30, 2018).

49. Thielman SB. Spirituality and the care of madness: historical considerations. In: Huguelet P, Koenig HG editors *. Religion and Spirituality in Psychiatry* . Cambridge: Cambridge University Press (2009). p. 6–18.

50. Ussher JM. Diagnosing difficult women and pathologising femininity: gender bias in a psychiatric nosology. *Femin Psychol.* (2013) 23: 63–9. doi: 10. 1177/0959353512467968

51. Bowleg L, Craig ML, Burkholder G. Rising and surviving: a conceptual model of active coping among Black lesbians. *Cult Divers Ethnic Minor Psychol.* (2004) 10: 229–40. doi: 10. 1037/1099-9809. 10. 3. 229

52. Fung K, Lo T. An integrative clinical approach to culturally competent psychotherapy. *J Contemp Psychother.* (2017) 47: 65–73. doi: 10. 1007/s10879-016-9341-8

53. Frank JD, Frank JB. *Persuasion and Healing: A Comparative Study of Psychotherapy* 3rd ed. Baltimore: Johns Hopkins University Press (1993).

54. Tseng W-S. *Handbook of Cultural Psychiatry* . San Diego, CA: Academic Press (2001).

55. Griner D, Smith TB. Culturally adapted mental health intervention: a meta-analytic review. *Psychotherapy* (2006) 43: 531–48. doi: 10. 1037/0033-3204. 43. 4. 531

56. Ratts MJ, Pedersen PB. *Counseling for Multiculturalism and Social Justice: Integration, Theory, and Application* 4th ed. Alexandria, VA: American Counseling Association (2014).

57. Ebigbo PO, Elekwachi CL, Nweze FC. Cross cutting issues in the practice of psychotherapy in Nigeria. *J Contemp Psychother.* (2017) 47: 75–86. doi: 10. 1007/s10879-016-9356-1

58. Ng RMK, Lee CK, Liu J, Luo J, Zu S, Mi S. Psychotherapy services in China: current provisions and future development. *J Contemp Psychother.* (2017) 47: 87–94. doi: 10. 1007/s10879-016-9345-4

59. Bhargava R, Kumar N, Gupta A. Indian perspective on psychotherapy: cultural issues. *J Contemp Psychother.* (2017) 47: 95–103. doi: 10. 1007/s10879-016-9348-1

60. Algahtani H, Buraik Y, Ad-Dab'bagh Y. Psychotherapy in Saudi Arabia: its history and cultural context. *J Contemp Psychother.* (2017) 47: 105–17. doi: 10. 1007/s10879-016-9347-2

61. Irfan M, Saeed S, Awan NR, Gui M, Aslam M, Naeem F. Psychological healing in Pakistan: from Sufism to culturally adapted cognitive behaviour therapy. *J Contemp Psychother.* (2017) 47: 119–24. doi: 10. 1007/s10879-016-9354-3

62. Avisaar N. Israeli psychotherapy, politics and activism: Is there a way out of the trap? *J Contemp Psychother.* (2017) 47: 125–34. doi: 10. 1007/s10879-016-9346-3

63. Iwakabe S. Psychotherapy integration in Japan. *J Psychother Integr.* (2008) 18: 103–25. doi: 10. 1037/1053-0479. 18. 1. 103

64. West TV, Schoenthaler A. Color-blind and multicultural strategies in medical settings. *Soc Issues Policy Rev.* (2017) 11: 124–58. doi: 10. 1111/sipr. 12029

65. American Institutes for Research. *Teaching Cultural Competence in Health Care: A review of current concepts, policies and practices. Report prepared for the Office of Minority Health* . Washington, DC: Author (2002).

66. Bieschke KJ, Paul PL, Blasko KA. Review of empirical research focused on the experience of lesbian, gay, and bisexual clients in counseling and psychotherapy. In: Bieschke K, Perez R, DeBord K, editors. *Handbook of Counseling and Psychotherapy With Lesbian, Gay, Bisexual, and Transgender Clients* . Washington, DC: American Psychological Association (2006). p. 293–316.

67. Van Ryn M, Burke J. The effect of patient race and socio-economic status on physicians' perceptions of patients. *Soc Sci Med.* (2000) 50: 813–28. doi: 10. 1016/S0277-9536(99)00338-X

68. Bartlett A, Smith G, King M. The response of mental health professionals to clients seeking help to change or redirect same-sex sexual orientation. *BMC Psychiatry* (2009) 26: 9–11. doi: 10. 1186/1471-244X-9-11

69. Israel T, Selvidge M. Contributions of multicultural counseling to counselor competence with lesbian, gay, and bisexual clients. *J Multicult Couns Devel.* (2003) 31: 84–98. doi: 10. 1002/j. 2161-1912. 2003. tb00535. x

70. Swartz S. Feminism and psychiatric diagnosis: reflections of a feminist practitioner. *Femin Psychol.* (2013) 23: 41–8. doi: 10. 1177/0959353512467965