THE CONCEPT OF CULTURE IN THE CONTEXT OF PSYCHOTHERAPY

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Abstract

Demographic changes have led to increased interactions between people with diverse cultural backgrounds. Accordingly, the need for culturally sensitive mental health services has increased. The current literature review discusses theoretical and empirical publications issued in the last decade with the aim to explore how culture and cultural skills are approached in the field of psychotherapy. The context of psychotherapy comes with a set of roles, vulnerabilities and responsibilities. Analyzing how culture is brought into existence in this context can be of great value for the research on mental health. The analyzed literature suggests that the traditional views of culture are prevailing in this area of science. It is identified that a significant number of publications uncritically relies on the social constructs such as the dichotomy "the West" versus "non-West". These categories are often used to explain the differences among patients in a therapy room. Moreover, a lot of generalizations are made about certain cultures and these are transformed into advice on how to behave with the members of these cultural groups. Addressing the existing gaps in the literature is an essential step for making improvements in the field. This Master's thesis provides an understanding of the current state of knowledge and it provides suggestions for future research.

Keywords

culture, cross-cultural, psychotherapy, literature review

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In winter 2019 I was reading Irvin Yalom's autobiography, and it was then when I came up with the idea to write about culture and psychotherapy. Yalom's desire to answer some existential questions such as fear of death, issues of freedom and isolation led him through his work and research. His book inspired me to reflect on my thoughts and to explore topics which had been making me feel bewildered and excited at the same time.

As a person living abroad, it comes naturally to me to think about different processes that happen in our minds when we move from one cultural context to another one. On many occasions, I felt completely lost and misunderstood. Now, when I look back I am happy that I chose this topic. I enjoyed reading the literature and I learned a lot about the difficulties of intercultural encounters in psychotherapy, and most importantly I am inspired to study this matter further.

I would like to thank my mentor, Marko Siitonen, for supporting my choice and my writing process. Furthermore, I am more than grateful to my family for supporting my journey. They showed a great understanding for my aspirations and believed in me.

Dedicated to my family...

Mojoj porodici…

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1 INTRODUCTION

We live in a globalized world, where intercultural encounters happen on a daily basis. Mass migrations have led to increased interactions between people coming from different cultural backgrounds (see Andermann, 2010; Gallardo, 2013; Lester et al, 2018). The reasons why people migrate are multifold, but a significant number of people are forced to leave their homes due to fierce political conflicts, natural disasters or lack of opportunities in their home countries. Accordingly, there is a growing need for mental health practitioners trained to work with diverse populations (see Reichardt et al., 2018; Saleem & Martin, 2018; Johnston, 2019). Although psychotherapists are professionals trained to provide mental health services in an objective way, it is not always easy to overcome biased thoughts and prejudices. Being judgmental towards patients can have harmful consequences as it directly affects the therapist-patient relationship, mental illness assessment, treatment, and therapy outcome (Jani et al., 2016).

The relationship between the patient and the therapist represents the essence of psychotherapy (APA, 2017). This relationship is reflected in the set of expectations, responsibilities, and roles and as such it is succulent to power abuse. Introducing interculturality into this picture makes the context of psychotherapy even more complex to grasp. The first studies related to multiculturalism in psychotherapy occurred in the late 1960s and the early 1970s, and the second wave of interest happened in the 1990s (Lee & Ramirez, 2000; Quinn, 2013). This area

of science has been in a constant change since and the attitudes towards mental illness have altered significantly.

In addition, our understandings of culture come as a consequence of continuing discussions, reflections, and research. There is no unique understanding or definition on what culture is. However, some attitudes have prevailed over time and they have worked their way into the psychotherapy-related research and eventually, practice. For example, the traditional views of culture have been dominating the field. Ample studies use social constructs such as nationality or ethnicity to define cultural groups and to explain behavior that occurs in a therapy room (i.e. Channa et al., 2019; Lester et al, 2018; Srour, 2015). Defining an individual based on one cultural category and ignoring the complexity of one's cultural identities is problematic in many ways.

It is obvious, by only looking at certain titles, how dominant using nationality or ethnicity as the main feature of one's identity is. It is not unusual to see studies on mental health that compare, for instance, Africans and Americans, or Germans and Iranians, or Muslims and Christians (i.e. Chao et al., 2012; Neftci & Barnow, 2016; Reichardt et al., 2018; Zora et al., 2019). Similarly, one of the concepts that is seldom problematized in the literature but often used to explain or justify differences between patients' behavior is the dichotomy "the West" versus "non-West" (the notions of the West and non-West are addressed in the Chapter 2). Addressing the uncritical adoption and use of these concepts is important in order to understand the current state of knowledge and to make improvements in the field. More specifically, it is essential to analyze how these kinds of views reflect on the patient-therapist relationship, diagnosis, treatments, and therapy outcomes.

The American Psychological Association (APA) recognized that the inextricable connection between culture and psychotherapy should be addressed. Therefore, APA published

the first Multicultural Guidelines for therapists in 2002. The guidelines were revised and updated in 2017 in order to keep up with the new research and knowledge in the field. The updated APA (2017) Multicultural Guidelines are summarized in Table 1.

TABLE 1 APA's Multicultural Guidelines-Summarized (APA, 2017, pp. 4-5).

Guideline	**Description**
Guideline 1	Psychologists should be aware that one's identity and self-definition are fluid and dynamic categories. Thus, intersectionality is created through one's social reality.
Guideline 2	Psychologists should be aware that they are also subjected to biased views and therefore, they should put conscious efforts to move beyond their own biases, prejudices, and categorical assumptions.
Guideline 3	Psychologists should endeavor to understand the role of language and communication from their own and also from client's point of view. This should be done in a way which respects the client's life experience.
Guideline 4	Psychologists should be aware of the social and physical contexts of the client's life.
Guideline 5	Psychologists should be aware of historical and present circumstances which are related to power, oppression, and privileges. Psychologists should operate in respectful ways which promote human rights and equality.
Guideline 6	Interventions done by psychologists should be culturally adaptive and should promote prevention and recovery.
Guideline 7	Psychologists should question and evaluate their own professional identity, role and purpose in an intercultural context.

Guideline	Description
Guideline 8	Psychologists should be aware of the developmental phases in which one's identity and worldviews change.
Guideline 9	Research, teaching, diagnosis and similar activities should be done in a culturally appropriate way and according to these guidelines.
Guideline 10	Psychologists should operate in a way which decreases feelings of distress and trauma in the given sociocultural context.

Although the APA's Multicultural Guidelines represent a good groundwork for psychotherapists working with diverse populations, some of the formulations are quite vague. To begin with, it is not clearly defined when the context becomes intercultural. Traditionally, this can refer to the situations when the therapist and the patient are from different countries, speak different languages, or do not share religious views. On the other hand, since each person has unique cultural identities, one can say that every therapist-patient relationship is intercultural. This is in accordance with Holliday's views (2018) that in today's world all cultural encounters can be interpreted as intercultural. Additionally, the phrases "culturally adaptive" and "culturally appropriate" are not explained. These can be easily misappropriated by mental health practitioners which can eventually have harmful effects on therapy.

Nowadays, training in cultural sensitivity for psychotherapists is quite common. However, this training should be critically approached especially if it oversimplifies culture. For instance, learning about "the characteristics of specific cultures" and using that information to explain patients' behavior can lead to harmful outcomes. The question remains how to address cultural issues in therapy and in which situations is this necessary. Moreover, it is important to identify

how to engage in the conversation about cultural differences in a natural and humane way, and not just by mechanically following some script or guidelines.

Understanding the recent trends in this area of science can help in the future studies. Furthermore, this can be useful for advancing psychotherapy treatments. The knowledge about cultural skills in mental health services can be utilized for upgrading cultural sensitivity training for mental health practitioners.

2 THEORETICAL BACKGROUND

In order to properly analyze a phenomenon, one should have a clear understanding of the terms and definitions that are being used. Countless definitions of both culture and psychotherapy have been proposed by scholars and practitioners over time. These definitions differ on many levels and they should be analyzed in the context in which they are shown.

The aim of this chapter is to provide general understanding of psychotherapy and culture in order to establish a framework for the literature analysis that follows. Two definitions of psychotherapy are introduced; one definition is proposed by the American Psychiatry Association and the other one is introduced by the American Psychological Association. They provide a good framework for understanding what psychotherapy is as they put into perspective different aspects of therapy. The reason for choosing these definitions is because these two institutions are among the most influential institutions in the world when it comes to mental health. Furthermore, basic ideas behind the essentialist and non-essentialist understanding of culture are introduced. Discussing the differences between the essentialist and non-essentialist approaches to culture provides a framework for further discussions on how culture is addressed in psychotherapy-related research. Finally, this chapter briefly discusses the idea of “the West” as this concept is commonly referred to in the literature and hence, it is relevant to this study.

2.1 What is Psychotherapy?

Humankind has been faced with mental illnesses and emotional distress since time immemorial and in the past, people used different types of healing practices to treat mental disorders (Hamlyn, 2007). Modern psychotherapy is grounded in these methods. According to Jackson (1999), the term *psychotherapy* is coined from the Greek words "psyche" meaning *soul* and "therapeia" meaning *medical service*, *attendance*, or *carrying for someone*. This term was introduced in the late 19th century (see Jackson, 1999, for more detail).

According to the American Psychiatry Association (2020), the aim of psychotherapy is to help people overcome or control symptoms of a mental disease and help increase their quality of life. Their definition emphasizes the dialogic component:

> Psychotherapy, or talk therapy, is a way to help people with a broad variety of mental illnesses and emotional difficulties. Psychotherapy can help eliminate or control troubling symptoms so a person can function better and can increase well-being and healing.[1]

The American Psychological Association (2020) defines psychotherapy through the relationship between a therapist and a client. This definition highlights the importance of the therapy room as the safe environment where an individual can share his or her problems without being judged and exposed to prejudices and stereotypes:

> Psychotherapy is a collaborative treatment based on the relationship between an individual and a psychologist. A psychologist provides a supportive environment that allows you to talk openly with someone who is objective, neutral and nonjudgmental.[2]

These definitions imply that psychotherapy relies on the interpersonal interaction between the patient and the "unbiased and supportive" therapist. However, they do not reveal the real complexity behind this institution-based relationship. For example, many studies show that there

[1] The American Psychiatry Association, 2020.
[2] The American Psychological Association, 2020.

is power abuse and discrimination in these institutions (see Dass-Brailsford, 2012; Dhillon-Stevens, 2011; Chu et al., 2016; Curtis-Boles, 2017). Additionally, they do not problematize the complex set of expectations, roles, and responsibilities that are tied to this relationship.

The psychotherapist-patient relationship becomes even more complicated to analyze when culture is added to the picture. In order to understand better how cultural realities are brought into existence in psychotherapy research, it is essential to be aware of some of the major ideas about what culture is.

2.2 Essentialist and Non-essentialist Understandings of Culture

Different definitions draw attention to different aspects of culture. In traditional views, culture is seen as an entity someone possesses and most often relies on simplistic views where culture is equated with the social constructs such as nationality, ethnicity, or social categories such as religion or gender. A significant number of scholars have adopted this viewpoint where culture is seen as a system of beliefs and values shared by a group of people and they utilize it in their research (see Asnaani & Hofmann, 2012; Chao et al., 2012; Neftci & Barnow, 2016). An essentialist definition of culture is, for instance, offered by Matsumoto and Juang (2013, p. 15):

> We define human culture as a unique meaning and information system, shared by a group and transmitted across generations, that allows the group to meet basic needs of survival, pursue happiness and well-being, and derive meaning from life.[3]

In this case, culture is seen as an entity transferred from one generation to another, which implies that culture can be inherited. This definition introduces an interesting viewpoint that the meaning of life is negotiated through culture. This definition treats culture as an entity that is possessed by a group of people which is problematic for many reasons. Briefly, it acknowledges culture as a closed system bound to a group that is transferred over time, while it ignores

[3] Matsumoto and Juang, 2013, p. 15.

interpersonal and intergroup interactions in which culture emerges and dissolves. Moreover, it ignores a possibility that an individual might "have" more than one culture hence, more than one cultural identity. Lastly, this definition presumes that this closed system of shared meanings determines people's expectations and needs.

According to Piller (2017), culture cannot be seen as an entity but it should rather be seen as a dynamic process. She criticizes essentialist views and suggests:

> Culture is an ideological construct called into play by social actor to produce and reproduce social categories and boundaries, and it must be the central research aim of critical approach to intercultural communication to understand the reasons, forms and consequences of calling cultural difference into play.[4]

Piller (2017) argues that it is essential to understand who decides on when culture becomes relevant and for what reason. Culture can be manipulated and used to justify harmful actions such as othering, demonstration of power, exclusion, and patronizing.

One of the most common essentialist understandings of culture, that is visible both in everyday life and research, is that culture equals nationality. According to Piller (2017), one of the important figures in the field of intercultural communication that contributed to this view was the Dutch social psychologist Gerrt Hofstede. His research produced a lot of books and guidelines that suggest how to behave with people from certain cultures, and in his notion, this meant from certain countries. These simplistic views of culture are also visible in the field of psychotherapy both on theoretical and practical level. To be more specific, when this "cultural knowledge" is put into use with vulnerable clients it can eventually lead to harmful outcomes.

[4] Piller, 2017, p. 10.

2.3 The Issue of the West

Although "the West" is commonly used both in formal and informal discourse, clarifying what this concept denotes is not an easy task. Despite being vague and problematic, the West is treated as a fixed and closed entity and it is uncritically used in the literature. Piller (2018) advices that when approaching culture, one should consider who is using the term, in what context, and for what reason. It is useful to apply the same rules when analyzing how the West is brought up in the literature.

To begin with, the Cambridge dictionary (n.d) gives a simple definition where the West refers to the geographical region of North America and Western Europe. Although, it is true that these regions are often seen as the epitome of the West, the definition is obsolete because it is simplistic and it reduces the West to a geographical area without clarifying the features or values that make a culture "Western". Traditionally, many scholars have described Western societies as individualistic and non-Western societies as collectivistic (Kpanake, 2018; Neftci & Barnow, 2016; Postert et al., 2012). Despite being an oversimplification, this characterization is one of the most emphasized differences between the West and non-West in the literature. There are more characterizations of the West, for example, Lester et al. (2018) state that linear rationality and appreciation of material possessions are typical for Western societies. These views are problematic as they imply that the West is a homogeneous space where all Westerners share the same unique experiences, values, and beliefs.

One of the first books that thoroughly contested the meaning of the West was "Orientalism", written by Edward W. Said, first published in 1978. The focus of this book are discussions about the Orient, which is according to Said (2003) an ideological concept that originated in the West. Briefly, Said (2003) argues that the West is the side that holds power and

it is using this power to manipulate reality and tell a story about the East. The narrative of the modern West and underdeveloped East that is described by Said (2003) is still alive and it is used to divide the world on “us” and “them”. That being said, it is impossible to use the West as an individual entity without referring to its counterpart the non-West. Both terms represent social constructs and their use depends on social, historical, and cultural contexts. According to Jouhki and Pennanen (2016), there are no clear boundaries when it comes to the West and hence, certain entities can be excluded from or counted as Western based on the circumstances or intentions. Additionally, they claim that sometimes features ascribed to the West are contradictory (Jouhki & Pennanen, 2016). Said (2003) argues that the West constructed the concept of the Orient to serve Western purposes and to justify oppression.

Despite being vague, the West is also unproblematically used in the psychotherapy-related research. The prevailing view is that there is a clear line between the West and non-West and these entities are used to define and divide cultures. The West is mostly described as an oppressive and colonizing force that is trying to impose Western values to non-Western world. In the context of this study, this means that efforts are put to export psychotherapy to non-Western countries as the only right approach to mental illness. For example, some scholars claim that the West ignores the non-Western methods for facing mental illnesses, despite them being used successfully long before psychotherapy was developed (Bedi, 2018; Dass-Brailsford, 2012). These views ignore that even within the West, there are competing discourses on mental health and how illnesses should be treated. A lot of strong claims that utilize these views have been made in the literature. For example, Bedi (2018) asserts that psychotherapy will always be more effective with Western than non-Western patients. Similarly, Johnston (2019) concludes based on her research that patients

from non-Western societies can express negative attitudes towards Western therapeutics. This will be thoroughly discussed in the chapters that follow.

3 METHOD

This Master's thesis is written in a form of a literature review. A well-written literature review provides an understanding of the current knowledge in the field. In addition, it gives an overview of what has already been explored and which topics need to be addressed in the future (Booth et al., 2012; Creswell, 2014; Hart, 2018). In order to reduce bias, a literature review should be done in a systematic, reproducible and transparent way (Booth et al., 2016; Fink 2010).

This thesis represents a review of publications in the field of psychotherapy published between 2010 and 2020 that focus on culture. The aim is to explore and assess both theoretical and empirical literature in order to identify how culture and cultural skills are approached by scholars and practitioners in this area of science. According to Boland et al. (2014), a systematic literature review is the best option for analyzing the findings of the studies that aim attention at similar questions. Hence, this study relies on the methods for conducting a systematic literature review introduced by Boland et al. (2014).

3.1 Databases

A literature search was conducted using the databases available through the university network, namely MEDLINE, PubMed, ERIC, ProQuest. According to Booth et al. (2016), MEDLINE and PubMED are widely acknowledged databases that cover publications related to healthcare and general health sciences and are therefore relevant to this study. ERIC and ProQuest are utilized in

this study to help reduce search bias and increase the diversity of analyzed publications. While they are not specialized in healthcare, psychology and related topics, they are well-known databases that cover publications from a wide array of research fields.

Finally, in order to increase the trustworthiness of the search, one external database (PsycNET) was used. PsycNET focuses on the articles in the field of psychology that are published by the American Psychological Association.

3.2 Selection Criteria

The publications used in this review include 41 journal articles and 2 books. All the selected journal articles fulfill the following criteria: 1) they are peer-reviewed; 2) they are issued between 2010 and 2020; 3) they are published in English; 4) they belong to the field of psychotherapy and they focus on culture. The selected books are not peer-reviewed but they meet all other above-mentioned criteria.

The decision to include two books in this study was made after reading the introduction chapters and the tables of contents. Although they are not peer-reviewed, the selected books thoroughly discuss how culture affects psychotherapy sessions and as such they bring value to this study. These books focus on the topics highly related to the ones studied in this thesis, and their holistic approach contributes to enhancing the body of knowledge about the role of culture in the field of psychotherapy.

The American Psychological Association's Multicultural Guidelines (APA, 2017) are also included since a significant number of studies in the field rely on them. Lastly, conference proceedings and doctoral dissertations are not included in this review because they excessively vary in quality (Creswell, 2014) and they are not necessarily peer-reviewed.

3.3 Search Process

The search process consisted of ten steps which are depicted in Figure 1. The first step was conducting a preliminary search. This was done in order to find background literature, to establish search criteria, to make certain that this topic is appropriate for review, and to identify research questions (Boland et al., 2014; Booth et al., 2016). The preliminary search was done with "culture" and "psychotherapy" as the keywords since these represent the central idea of this thesis. This was an essential step because it showed that the topic is relevant and that there is a plethora of studies in this area of science.

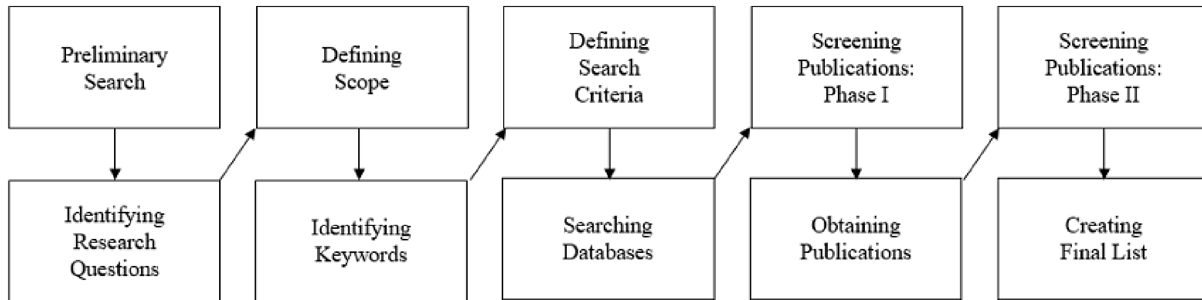

FIGURE 1 Ten Steps in Searching the Literature.

The research questions and the scope of the study were created based on the information gained by reading the publications which emerged in the preliminary search. Next, the words "psychotherapy", "culture" and "cross-cultural" were identified as the final keywords. The term "cross-cultural" was added as a third keyword because it was identified that "cross-cultural" was used in a significant number of articles that address culture in psychotherapy. The following step was defining search criteria.

Searching the accessible databases gave an excessive number of publications. For this reason, the search was narrowed down to the publications issued between 2010 and 2020.

Moreover, it was decided that the screening of the publications will consist of two phases. These phases are explained in detail in the Figure 2 and the Figure 3.

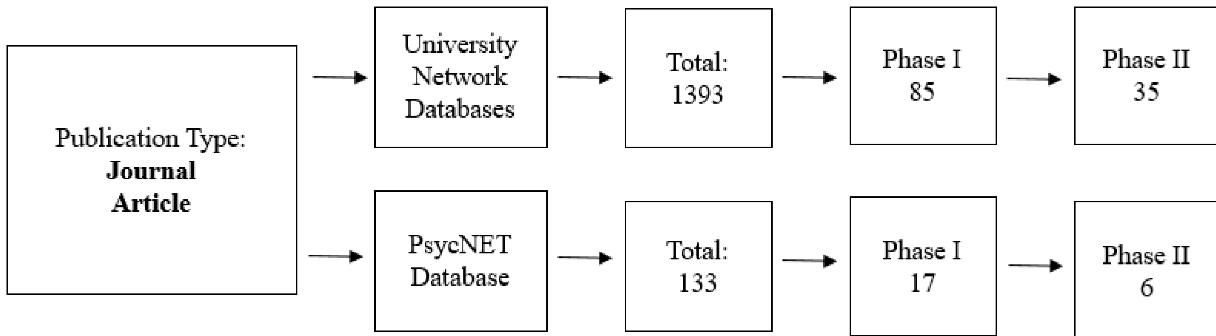

FIGURE 2 Phase I and Phase II of Screening the Journal Articles.

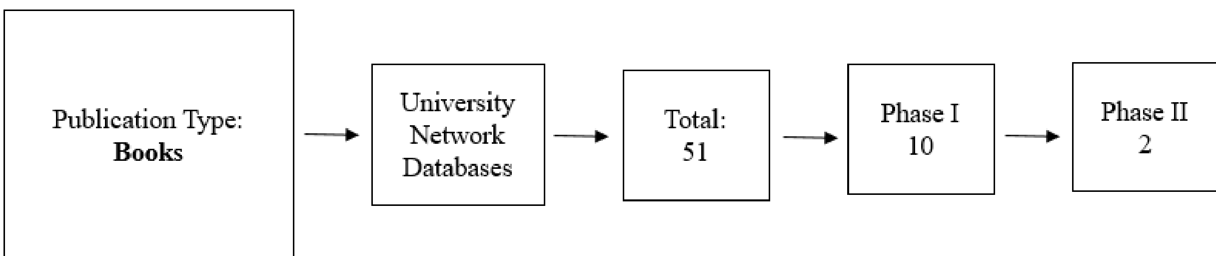

FIGURE 3 Phase I and Phase II of Screening the Books.

The databases available through the university network gave 1393 journal articles (Figure 2) and 51 books (Figure 3). PsycNET gave 133 journal articles and 6 were selected for the final review (Figure 2).

In Phase I, the screening was done by reading the titles and abstracts. A significant number of publications were eliminated because the title or the abstract did not match the scope of this thesis. Although the search criteria had been set up to peer-reviewed publications in English issued between 2010 and 2020, some papers that did not match this criteria still appeared in the search results. These publications were eliminated. Furthermore, the identified duplicates were removed in this step. A significant number of studies that focus on pharmacological aspects of psychotherapy were excluded as this thesis does not discuss the uses and effects of medication in

psychotherapy. Finally, the number of publications was reduced to 85 journal articles and 10 books obtained through the university network databases, and 17 journal articles found in PsycNET. The next step was obtaining the full-text articles and books.

In Phase II, the screening was done by rereading the titles and abstracts, reading the conclusions, and when necessary the body of the article. The publications that did not strictly match the scope of this study were removed. In order to reduce redundancy, in cases where two or more publications were too similar to each other in the sense that they looked at the same phenomena and discussed highly similar issues, only one publication was kept. Phase II was the most time-consuming step.

The last step was creating the final list of publications for the review. This list consists of 41 journal articles, 2 books, and the American Psychological Association's Multicultural Guidelines (APA, 2017). The full list of publications included in this study can be found in the appendix.

3.4 Research Scope

This Master's thesis focuses on exploring the field of psychotherapy from the cultural perspective. The aim is to explore the role of culture and cultural skills when it comes to mental health services. This thesis encompasses various cases in which mental health interventions are needed. A broad definition of psychotherapy will be introduced but psychotherapy itself does not represent the central idea of the thesis and hence, it will not be thoroughly discussed. Moreover, specific psychotherapy orientations and methods will not be analyzed.

This study does not focus on one specific country, ethnicity, or cultural group. Quite the contrary, it includes many cases of people with different cultural backgrounds. Lastly, explanations of mental disorders and pharmacological aspects of treatments will not be discussed.

3.5 Research Questions

Booth et al. (2012) differentiate three types of questions when it comes to writing a literature review: effectiveness questions, methodology questions, and conceptual questions (p. 24). Brief explanations of these three types of questions are presented in Table 2 (see Booth et al., 2012, for more detail).

TABLE 2 Three Types of Questions in a Literature Review (Booth et al., 2012, p. 24).

Type	**Purpose**
Effectiveness Questions	Comparing what kind of effects different variables have on a specific outcome.
Methodological Questions	Identifying research methods used in specific studies and discussing their upsides and downsides.
Conceptual Questions	Putting a phenomenon into a context by exploring its definitions or theories that are used to describe it.

After considering the purpose of all three types of questions, the conceptual questions were identified as the most suitable for the current thesis. The objective of this type of questions is to explore how a certain phenomenon is presented or defined in the field (Booth et al., 2012). This thesis aims to explain how culture and cultural skills are approached in the field. To that end, two conceptual research questions are chosen to guide this literature review.

Research Question 1

How is culture approached in the field of psychotherapy?

Psychotherapists work with vulnerable clients and hence, this job entails a great responsibility. This is especially important when working with culturally diverse populations. There is a lot of discrimination, power abuse, and injustice in this field of work. For example, there are cases when the institutions make harmful decisions on the behalf of their vulnerable clients

who belong to minority groups. In order to avoid these and similar deleterious practices, it is important to understand how culture is addressed in the field as this can help in improving the conditions in which intercultural psychotherapy is performed.

The previous chapter briefly summarizes the differences between the essentialist and non-essentialist understandings of culture. Moreover, it discusses the idea of the West and it introduces some of the issues related to this concept. This research question aims to provide an overall understanding of how culture is presented in the academic research and literature in the past decade in terms of essentialism and non-essentialism. The aim is to identify how culture is treated and what kind of implications this has on psychotherapy research and practice. Identifying how culture is understood in the field can be useful for improving mental health services in the intercultural setting.

Research Question 2

How are cultural skills approached in the field of psychotherapy?

Initially, some of the ways cultural differences in psychotherapy were tackled were similar to following a diagnostic code but instead of symptoms of mental disorders, the patient's cultural identity was considered. To be more specific, once the patient's cultural identity was identified, it was possible to follow the guidelines specific for that cultural group. However, following a manual can be harmful when it comes to culture because each person has a unique set of cultural identities and no manual can cover all possible cases. Approaching cultural differences in a more natural and humanized way requires learning how to be a culturally skillful therapist.

The introduction chapter presents the APA's Multicultural Guidelines (2017) as a framework for psychotherapists working with clients from different cultural backgrounds. Numerous publications that analyze cultural skills in psychotherapy rely on the APA's

Multicultural Guidelines. Being able to identify and address cultural differences in a therapy room respectfully and mindfully, requires a culturally skillful therapist. The purpose of this research question is to identify how cultural skills are defined in the literature, how are they taught and applied. This research question is also analyzed in the context of essentialism and non-essentialism.

4 FINDINGS

The literature analyzed in this chapter comes from the sample data. The full list of the used publications can be found in the appendix. The chapter is split into three major sections. Section 4.1 focuses on the information related to how culture is approached in the field. These findings are further organized in the following categories: race and ethnicity; the role of language; religion; family and society; socio-historical context; low-income patients; and gender. Section 4.2 describes the findings related to cultural skills. Lastly, section 4.3 focuses on practical issues identified in the field and these are categorized in two segments: symptoms, diagnosis, and treatment; and distrust, stigma, and acceptance of mental illness.

The aim of this chapter is to present some of the key concepts that have emerged in the field in the last decade. The findings will be further analyzed and contested in Chapter 5.

4.1 Approaching Culture

The abovementioned cultural dimensions are intertwined and they affect one another. Age, level of education, and professional identity are sporadically discussed in the selected literature and hence, they are not discussed separately in this thesis.

4.1.1 Race and Ethnicity

To begin with, although race and ethnicity are mostly used as synonyms in the literature, they do not have the same meaning. According to the Oxford Learner's Dictionaries (n.d.), while race

refers to a group of people who share similar physical features such as skin color, ethnicity refers to a group of people who share similar cultural or national traditions. Obviously, these vague definitions are reflections of traditional views since these concepts represent social constructs and as such they should be approached critically. Scholars define race, ethnicity, and nationality in different ways, and the notions of these constructs are seldom questioned. Some of the identified views are presented in this section.

According to Lee and Na (2011), racial/ethnic identity refers to one's sense of belonging to a certain racial or ethnic group and it is developed in interaction with other members of that group. These authors go as far to claim that therapeutic alliance is challenged when a therapist and a client do not share racial/ethnic identity (Lee & Na, 2011). When analyzing these views, one must have in mind the context in which they occur. For example, a lot of analyzed publications come from the USA context where racial tensions are very strong.

As mentioned in the previous chapters, many scholars rely on the concept of the West and use it to explain certain phenomena in the field. For example, Bedi (2018) raises an ethical question on whether psychotherapy as a Western concept should be used with minority groups in Western countries. This question can be justified by the claims made by Fung and Lo (2017) that ethnic minorities are more likely to stop attending therapy prematurely. Similarly, Bedi (2018) asserts that they attend therapy less often than the dominant group, and have less successful therapy outcome. There are valid reasons for this kind of behavior and negative attitudes towards therapy. For example, it is identified that ethnic minorities in the USA often feel that therapists judge them based on their race or ethnicity (Krupnick & Melnikoff, 2012). One illustration is the case of an African American patient with bipolar disorder who reported that she and other African American women were mentally and physically abused by the hospital staff and exposed to sexism (Mizock

& Russinova, 2013). Undoubtedly, many patients have negative experiences with psychotherapy such as discrimination or maltreatment. These problems must be tackled properly and with care. However, when reading these studies one should have in mind the socio-historical context of racial intolerance in the USA. It remains unclear whether the above-mentioned statements related to dropout rates and therapy outcome would be applicable in other places or countries. Lastly, Bedi (2018) uncritically refers to psychotherapy as a Western concept. This view implies that the West is one homogenous space where everyone shares the same values and beliefs and it implies that everyone in the West has the same views on how mental illnesses should be treated in psychotherapy.

Some studies address this issue by analyzing the situations when therapists and patients are matched based on their ethnicity. The opinions on whether ethnic matching in therapy leads to a more successful therapy outcome are opposing. While Chu et al. (2016) claim that ethnic matching between a patient and a therapist leads to a better relationship, Dass-Brailsford (2012) argues that the therapist's ability to express empathy, understanding, and respect towards a patient is more important.

According to the research done by Chao et al. (2012), patients who were ethnically matched with their therapists had better therapeutic relationships, and their therapy outcomes were more successful than patients who were not ethnically matched with their therapists. The results of this study also imply that a strong working alliance can contribute to lower dropout rates. Chu et al. (2016) agree that ethnic matching gives better results and that more patients express that they want to work with a therapist who belongs to their ethnic and cultural groups. In these cases, there is a higher rate of retention and lower dropout rates. Besides the fact that these studies use the concept

of ethnicity as something that *de facto* exists, another issue can be defining one's ethnicity, especially in cases with people with "multiethnic" background.

Lee and Na (2011) give examples of possible obstacles for therapeutic alliance when a therapist is white and a patient is black, and vice versa. According to their example, difficulties might occur if a black patient expresses anger about being discriminated against in job interviews by white employers. In this case, the therapist might not be able to empathize with the client. Therefore, he or she must be able to encourage the patient to openly discuss racial issues in a way which is respectful and supportive. This example can be contested by arguing that in reality two people never have completely the same life experiences. In that sense, there are always situations when the psychotherapist has never experienced something that his or her client has experienced. However, mental health professionals are trained to be neutral, and to express empathy and understanding for the client's circumstances regardless of the fact that they have never experienced similar events. Furthermore, Sturm et al. (2010) discuss, for example, that when a therapist is European and a client is African, issues of power and dominance should be properly addressed. Nevertheless, it should be considered that people who come to therapy are in distress and they want to feel better, and a lot of times ethnicity and race might not be something that they find relevant to discuss.

The experience Coetzee et al. (2019) had with a South African Muslim woman and a Christian Afrikaner therapist shows that strong therapeutic relationship can be built even when a client and a therapist belong to different ethnic groups. Interestingly, the relationship between the therapist and the client was based on some common experiences such as being misunderstood by their own communities. Coetzee et al. (2019) explain that the therapist and the client had different identities but being marginalized by their cultural groups helped them understand each other. This

example shows how multilayered our identities are and how depending on which element of our identities we single out, we can hinder or support the therapeutic alliance.

Freund and Band-Winterstein (2017) discuss advantages and disadvantages of having a psychotherapist from the same cultural group within the Haredi community. On the one hand, a therapist from the same cultural group has a better insight when it comes to context and cultural identity. On the other hand, an outsider therapist is more neutral and more likely to keep the therapy confidential. In this example, culture is seen in a traditional way and it is presumed that a person can have only one cultural identity, which is in this case being a member of the Haredi community. The other presumption is that everyone within the Haredi community has the same values and beliefs.

Interestingly, there are numerous examples where ethnic matching did not have the expected outcome. For example, Jones et al. (2017) worked with adolescent patients with depression symptoms. They measured how satisfied the patients were with the therapy outcome in regard to the practitioners' cultural skills. The authors conclude that ethnic match is not necessary if a mental health professional is able to provide culturally sensitive therapy. Results of the study done by Laher and Padayachee (2012) also oppose general assumptions that people feel more comfortable with therapists who belong to their cultural group. In this study, Hindu patients expressed that they were tired of seeking help from Hindu therapists.

Some scholars use the idea of the West to discuss racial issues and to criticize certain practices in the field. For example, Ryde (2011) writes that white people see their race as "normal" and "neutral". Additionally, Ryde (2011) explains that the wealth of the modern Western world rests on enslavement and colonization of other countries. She says that the West and white people are still benefiting from these unfortunate events. Therefore, a mental health professional must be

aware of this privilege. He or she must be able to properly process it within and to adequately address it with a client (Ryde, 2011). Oppression, power abuse, and racism should undoubtedly be addressed. However, being white might refer to many people, from a manager from Ukraine, or a secretary from France, to a farmer in Canada. Therefore, this term must be used carefully due to its ambiguity. To this end, it is problematic to make a generalization and claim that all white people see themselves as neutral as it is unclear what it means to be white.

Dhillon-Stevens (2011) provides a different perspective by discussing the challenges therapists who are not white might face, especially when working with white patients. She gives an example of a racist comment her client made. She said that the first interaction with the client was over the phone where he identified her Indian accent in speaking English. First time they met, the client said that he expected that she would be wearing “funny clothes and smell on curry” (Dhillon-Stevens, 2011). She affirms that it is very difficult to maintain professional attitude and stay emotionally available for the client, while facing discrimination and racist comments. Eleftheriadou (2010) confirms that therapists who belong to minority groups should be prepared to receive inappropriate questions or comments from clients. Nevertheless, while white mental health professionals are not exposed to questions about their race, Eleftheriadou (2010) claims that patients always have certain assumptions about the therapist’s background, marital status, or sexual orientation. While therapists are trained to be neutral and respectful, people who come to therapy come from different backgrounds and might not be that respectful nor mindful. Racist comments towards patients, and vice versa, racist comments towards psychotherapists are equally unacceptable. Interestingly, not many studies discuss patients’ responsibility when it comes to culturally sensitive behavior. To be more specific, it remains unclear whether only a therapist

should be mindful when it comes to cultural differences in a therapy room, or in general being respectful.

Some studies link racial/ethnic identity to the way people interpret illness. For example, Reichardt et al. (2018) done a cross-cultural comparison of mental illness representations between German and Iranian patients and identified that Iranian patients often interpreted the illness cause through religious beliefs. Jani et al. (2016) discuss one study that showed that black clients are less often diagnosed with the Borderline Personality Disorder (in further text BPD) than white clients. However, there are no differences between white and Asian or Hispanic patients when it comes to this disorder. These studies should be approached critically as they use ethnicity to divide people into groups and they ignore other parts of patients' cultural identities. Moreover, it is questionable if the results of these studies could be generalized.

According to Kissil et al. (2013), immigrant therapists working in the USA often experience the feeling of otherness, especially if their physical appearance does not match with the characteristics of the dominant group. Srour (2015) adds that if there is a political conflict between the client's and the therapist's ethic group, the therapist's ability to feel empathy might be affected. Furthermore, there might be internal conflict in the therapist's mind related to his or her professional and personal identity. As a professional, a therapist should be able to empathize with a patient, but in some cases, this can make the therapist feel that he or she is betraying his/her own country, nation, or ethnic group (Srour, 2015). On the other hand, being an immigrant therapist can be taken as an advantage as immigrant history and similar life experiences can bring clients and psychotherapists together (Kissil et al., 2013). As emphasized previously, when analyzing these studies one should take into consideration the context in which they are presented. Moreover,

some of these studies are based on personal experiences with one client and therefore, research with bigger sample is needed in order to understand this issue better.

Curtis-Boles (2017) asserts that when working with African American patients, a mental health professional should not presume the patient's cultural identities. The author claims that the therapist should approach the client's cultural identities based on his or her personal story. One can argue that presuming one's cultural identities is not a good practice not only when working with African American clients, but in general. In the study conducted by Chao et al. (2012), the participants were asked to decide whether their therapist belonged to their ethnic groups. This is important because they took into consideration the clients' views on their ethnic groups. This way the researchers avoided misidentification of ethnic groups and matching based on incorrect beliefs or generalizations.

4.1.2 The Role of Language

The American Psychiatry Association (n.d.) refers to psychotherapy as talk therapy. Obviously, talking is an integral part of psychotherapy as a patient should be able to express his or her feelings, thoughts, and experiences. Of course, there are therapies which focus on some other forms of expression, such as dance, movement, music, or writing. However, in the majority of cases therapy is based on verbal communication between a therapist and a client. Language is a complex category as cultural elements such as history, tradition, and familial values are stored in it (Frie, 2013). Therefore, in the intercultural research in psychotherapy, different linguistic properties and elements should be taken into consideration when analyzing language issues. According to Guideline 3 of the APA's Multicultural Guidelines (2017), psychotherapists must keep in mind the impact language has on therapeutic processes.

In the intercultural setting, situations where a therapist and a client do not have a common language are frequent. In fact, the analyzed literature implies that the lack of language skills is one of the major reasons why minority groups do not have access to mental health services (Andermann, 2010; Bedi, 2018; Bryant-Davis, 2019; Curtis-Boles, 2017). According to Tribe (2011), being able to work with interpreters is one of the major skills which a therapist should possess. Even though having an interpreter in a mental care institution can be seen as an advantage, the literature suggests that there are some downsides.

The role of the interpreter can be problematic for many reasons. Demarque et al. (2015) write about a therapy session with a family of Chinese origin, living in France. Even though the father had obvious problems to express his thoughts in French, he refused the services of the interpreter. Demarque et al. (2015) explain that this person did not feel that his language skills were poor which is why he viewed the interpreter's help as insulting and humiliating.

Guregård and Seikkula (2014) argue that finding a qualified interpreter is often challenging since the role of interpreter is not only to translate but also to provide cultural context. They add that having an interpreter reduces spontaneity which has a significant effect on therapeutic alliance (Guregård & Seikkula, 2014). On the other hand, Andermann (2010) discusses women's rights and she claims that the role of interpreters is crucial in the situations where a female immigrant does not speak the language of the host country. In this case, having an interpreter is a better option than having a husband translating for his wife. Saleem and Martin (2018) confirm this by describing cases where interpreters tried to hide violence women were exposed to by purposely translating their words incorrectly. On the other hand, when working with Chaldean Americans if a client expresses that he or she wants a family member as an interpreter, it is advisable for therapists to accept that (Zora et al., 2019). Tribe (2011) lists confidentiality violations,

misinterpretations of the client's words, and lack of training as some of practices that can lead to unprofessional behavior. Lastly, she adds that a client might feel uneasy about having a third person listening to his or her personal story (Tribe, 2011).

A completely different perspective on language in therapy is introduced by Frie (2013). This psychotherapist describes his own experiences in working with a second generation Holocaust survivor. This demonstrates that cultural elements which are embedded in language can have a tremendous influence on the therapeutic alliance. Briefly, both Frie and his patient were bilingual and spoke German and English. Frie (2013) identified that his client used German when he talked about strong emotions, especially his traumatic childhood, but otherwise he would spontaneously shift from one language to another. The situation changed when the client found out about the therapist's grandparents who took the oppressor's side in the WWII. From that moment, the client used exclusively English. The patient's choice to use exclusively English was made because in that context English represented a neutral language of the present moment (see Frie, 2013, for more detail). This helped the client to distant himself from the painful past. Frie's experience shows how language can be used to create emotional and temporal distance in therapy.

Language can also be used to demonstrate power and privilege. Gallardo (2013) claims that using the dominant language when working with Latino patients in the USA can be understood as further oppression of this marginalized cultural group. Therefore, it is absolutely essential to discuss preferred language at the beginning of therapy. In this case, individual differences are ignored and the implication is made that all people who consider themselves as "Latinos" would behave in the same way. Another interesting illustration is provided by Srour (2015) who is a therapist of Arab origin, working in Israel. He speaks both Arabic and Hebrew. However, since Hebrew has privileged status in Israel, he explains that he had no courage to discuss language of

therapy with patients and his supervisors. For this reason, he would always choose to speak Hebrew. He argues that the status language has in the society is by default projected on the therapeutic setting. This is one of the seldom articles which presents the case where the therapist belongs to the minority group. Similarly, Kissil et al. (2013) discuss cases with immigrant therapists working in the USA whose first language is not English. They express concern that this can cause issues such as feeling of otherness and also misinterpreting or misunderstanding what is said by the client.

Problems can arise when a therapist or a patient lacks certain linguistic knowledge. Postert et al. (2012) approach language by analyzing semantics of the English word “sadness” and the Laotian Hmong word “tu siab” which, literally translated, means “broken liver”. These authors assert that collectivistic and individualistic values of these two cultural groups can be seen in semantics. While “sadness” refers to an event which causes an individual to feel sad, “tu siab” is tightly connected to one’s community and relationship with his or her relatives. “Tu siab” is used by community members to express disapproval towards one’s actions. Moreover, it is used to express parents’ disappointment towards their disobedient child. Similarly, Chaldean American patients express their symptoms somatically, also using metaphors which include phrases with “burning liver” (Zora et al., 2019).

The word “sad” is crucial for assessing patients’ depressive moods. Getting familiar with these kind of nuances in meaning usually requires a lengthy acculturation process. According to Postert et al. (2012), if a patient is not familiar with the correct meaning of the word, then he or she will not be able to accurately answer the therapist’s questions. Hence, they claim, this person is more likely to be misdiagnosed (see Postert et al., 2012, for more detail).

Krupnick and Melnikoff (2012) add that a practitioner and a client must be able to understand both figurative and literal meanings of the used language. For example, Buse et al. (2013) claim that in some collectivistic cultures, metaphors are often used to help clients articulate their emotions if they are not used to openly talk about them. This is in accordance with Johnston's (2019) research which shows that clinical psychologists in South Africa have problems with clients who have problems in understanding the semantics of the words such as "denial" or "transference". Moreover, Johnston (2019) writes that mental health professionals expressed that clients had different understanding of word definitions and had difficulties expressing emotions in their non-native language.

Many practitioners who work with diverse populations are concerned with self-reporting processes. Self-reporting is a standard way in collecting information about the patient's condition and it is important for setting the right diagnosis. Nevertheless, even when a patient is fluent in language, he or she might feel uneasy about sharing personal information with a stranger. This is identified in many studies done with patients coming from collectivistic cultures (see Freund & Band-Winterstein, 2017; Lester et al., 2018; Saleem & Martin, 2018; Zheng & Gray, 2015). Furthermore, some studies show that putting one's feelings in focus in collectivistic societies is not appreciated (Zheng & Gray, 2015; Zora et al., 2019). Additionally, Jani et al. (2016) claim that mental health workers often have problems with patients not being able to clearly express symptoms. They either exaggerate or mitigate symptoms which creates difficulties in making an accurate diagnosis. In addition, some patients from collectivistic cultures might express agreement with the therapist's words even if they disagree (Zora et al., 2019).

Lastly, miscommunication can happen when clients do not understand what is expected from them and how they should answer the therapist's questions. Guregård and Seikkula (2014)

describe a situation where a therapist had difficulties communicating with refugee family living in Sweden. Their answers to the therapist's questions were inadequate in a sense that they were too short and formal. The therapist's assumption was that this due to this family attending numerous meetings with authorities where they had to give formal answers (Guregård & Seikkula, 2014).

In conclusion, the abovementioned studies show that language is linked to one's cultural identities as cultural values are stored in it. The way language is used in a therapy room can affect many aspects of therapy. The literature suggests that language can be used for manipulation of vulnerable groups, othering or power demonstration. Some of the studies analyzed in this chapter, emphasize the existence of individualistic and collectivistic societies (i.e. Freund & Band-Winterstein, 2017; Lester et al., 2018; Zheng & Gray, 2015) and they use this dichotomy to explain the differences in the way language is used. Labeling a cultural group as collectivistic or individualistic and interpreting patients' behavior based on this oversimplification can be harmful as the patient's individualistic needs, values, and opinions are not taken into consideration.

4.1.3 Religion

Religion and spirituality are important components of one's cultural identity. Numerous studies explore connection between spiritual beliefs and therapeutic processes (i.e. Chu et al., 2016; Reichard et al., 2018; Saleem & Martin, 2018). Religion and spirituality can be of extreme value for people who come to psychotherapy, and they gain in importance in the intercultural setting. Having this in mind, it is critical to understand how religion and spirituality are approached in the field. Similarly to race and ethnicity, religiosity is often uncritically explained through the concept of the West. For example, Laher and Padayachee (2012) claim that Western societies are less religious than non-Western societies.

Some scholar use this as a basic premise and they apply this view in their research. According to Laher and Padayachee (2012), the South African Hindu community, spiritual beliefs have stronger influence on people's minds than in the West. They go as far to claim that ignoring this information could lead to misinterpretation of symptoms and incorrect diagnosis (Laher & Padayachee, 2012).

Bedi (2018) argues that indigenous healers should be consulted when possible. Bryant-Davis (2019) agrees that consulting religious figures and community leaders can be useful in overcoming certain disorders such as trauma. The author adds that integration of local cultural understanding of remedy and treatments can be used as a resource in therapy (Bryant-Davis, 2019). This is problematic as it implies that everyone in the community has the same understanding of how certain mental health issue should be treated.

Asnaani and Hofmann (2012) present the case when one female patient disagreed with the views provided by her religious group. She was discouraged from seeking help outside of their society and church. The client felt guilty for failing to find comfort within her religious group. Instead of creating further inner conflict, the therapist suggested to her that it was good to follow inner feelings. And if her feeling was to seek therapy, then that was the right thing to do (see Asnaani & Hofmann, 2012, for more detail). In this example, the therapist found a way to encourage the client's choice to seek help and to justify that so it is in accordance with her religious beliefs. This shows how important it is to approach people as individuals but also to understand the religious aspects of their cultural identities.

Freund and Band-Winterstein (2017) analyzed the way mental illness is approached by the members of the Haredi community. They describe this society as a Jewish-Ultra Orthodox, highly collectivistic, and religious. Interestingly, unlike other collectivistic societies, the authors assert

that this cultural group believes that mental illness is an individual's responsibility and fault. Nevertheless, the society participates actively in the treatment. Individualism and the Judeo-Christian traditions are often tied to the West. Describing this Jewish-Ultra Orthodox society as non-Western and collectivistic is an excellent example of how vague the boundaries of the imaginary West are. This shows how easily an entity can be included or excluded from the West, depending on the context or the intentions.

Religion does not only affect the therapeutic alliance but it can also be the cause of the therapist's inner conflict. For example, Laher and Padayachee (2012) conducted interviews with South African Hindu psychologists so as to explore how they see culture and psychotherapy. These interviews showed that there was a conflict between psychologists' professional identity and their religious beliefs. On the one hand, their education was rooted in "the Western system of values". On the other hand, they were raised in the Hindu society which is religious. These psychologists expressed that they had difficulties in combining these two opposing worlds. This study implies that there is "the non-religious West" and "the religious non-West". In this context, it would be useful to analyze whether "Western psychotherapists" have an inner conflict when it comes to personal religious beliefs and the psychotherapy methods they apply at work.

Resistance towards concepts which do not fit one's system of beliefs can be manifested in many ways. Lester at al. (2018) write about mental health services in the Kingdom of Bhutan. These authors also rely on the idea that the West is characterized by individualistic values and non-Western world is collectivistic. In the example provided by Lester et al. (2018), mental health professionals from the USA were invited to this country in order to transfer their knowledge to their Bhutanese colleagues. Lester at al. (2018) describe the culture of Bhutan as collectivistic and highly influenced by Buddhism. The local therapists were eager to acquire knowledge brought by

their colleagues from the USA. However, they claimed that the increased need for mental health services in their country was a direct consequence of westernization of their society.

Spiritual beliefs have an impact on how people understand and interpret their illness. An example for this could be a female patient who saw her illness as God's punishment for not being good enough as a mother and wife (Chu et al., 2016). Even in this context, essentialist views on culture prevail and culture is seen as an entity owned by a group of people. Strong statements are made about how people in the West behave and how this differs from the non-West. For example, Buse et al. (2013) write that while in the West people tend to eliminate suffering and bring pleasure, in some non-Western societies, traumatic events might be seen as a journey to spiritual transcendence. Moreover, they claim that while Westerners appreciate having control, non-Westerners might feel that they need to accept the given circumstances (Buse et al., 2013).

Similar generalizations are made by Saleem and Martin (2018) who claim that in some collectivistic cultures patients might try to bond with a practitioner even outside a therapy room. More specifically, they write that Muslim women in Canada have tendency to invite their therapist to social gatherings. Chu et al. (2016) describe that Hispanic clients in the USA expect therapist to become members of their community by adding that this is not common among Western patients. These authors do not explain what makes the Hispanic non-Western.

According to Saleem and Martin (2018), therapists who work with Muslim patients must have knowledge about Islam due to its tremendous effect on attitudes, worldviews, and behavior. However, it is important to acknowledge that there are different branches and schools of thought when it comes to Islam. More importantly, the same as in other religions, not all Muslims are equally religious and not all Muslims have the same notion of being religious.

Coetzee et al. (2019) describe psychotherapy done by a Christian South African therapists of Afrikaner origin with a Muslim South African female client, whose ethnicity is described as Indian according to the local legislation. Both the client and the therapist come from very religious cultural groups which are apparently very different, one is Christian and the other one Muslim. Interestingly, in some cases differences can bring the patient and the therapist together. In this example, the therapist and his client were both marginalized by their cultural groups. Hence, their relationship was built on this common element and despite all the differences in their cultural background.

Being religious has a different meaning for different people. For instance, Coetzee et al. (2019) write about a patient who expressed that she was not religious. They identified that although she did not believe in organized religion, she believed that her problem was a test or even a punishment from God (Coetze et al., 2019). It is important to recognize how spirituality is integrated in the patient's cultural identities.

According to Johnston's (2019) research, the patient's unwillingness to talk openly about his or her problems can be caused by religious beliefs. For example, Saleem and Martin (2018) write that Muslim women hesitate to share personal information with a therapist. Furthermore, topics related to sexual relations, domestic violence, and suicide are also avoided. These topics are also considered as shameful among Chaldean Americans and patients might feel offended if they are faced with questions related to these topics (Zora et al., 2019). As mentioned previously, one should be aware that not all Muslim women share the same worldviews. The same rule applies to Chaldean Americans. Moreover, one can argue that these topics are sensitive for all people not just for the members of certain cultural groups.

Integrating the patient's religious beliefs into treatment is desirable but it can be problematic. For instance, Curtis-Boles (2017) writes that in the USA most therapists express that they do not believe in God, while most of African Americans express that religion is important to them. Curtis-Boles (2017) cites two major obstacles which emerge from this. Firstly, mental health workers do not have enough knowledge about religion and they do not identify with religious values, so they are unable to empathize with or to understand the client's viewpoints and feelings. Secondly, some therapists have a negative attitude towards religion and consider religious people as ignorant and are unable to overcome this bias. These claims are based on one single study and more importantly, they are generalizations. Even the wording is problematic as the way they report implies that there is the USA context and that African Americans do not fully belong there.

4.1.4 Family and Society

The role family has in mental health is undeniable. Upbringing and familial relationships are just one more layer in one's cultural identity. Values and beliefs acquired within the family and the way person is treated play a major role in mental health. In the analyzed literature, the role of the family is mainly uncritically interpreted through differences between Western and non-Western worldviews, and between collectivistic and individualistic values. Additionally, culture is interpreted in a traditional way. In the analyzed publications, people are mostly ascribed to certain cultural groups and their behavior is interpreted based on their membership in that group.

Ignoring that people from collectivistic cultures are heavily reliant on their families by Western mainstream psychotherapists, is identified as one of the major obstacles in intercultural psychotherapy by Neftci & Barnow (2016). In addition, these authors insist that Western psychotherapy practices should integrate principles and values of collectivistic cultures.

Some scholars claim that the interpretation of trauma depends on whether a patient belongs to a collectivistic or individualistic society (Buse et al., 2013; Schnyder et al, 2016). It is said that in collectivistic cultures people tend to minimize their personal feelings. Therefore, a more suitable treatment would be the one that includes the patient's family and community, rather than the one that focuses on one's individual goals (Buse et al., 2013). Schnyder et al. (2016) write that trauma victims often feel disconnected from their community because they have a feeling that they do not fulfil their social roles. Hence, participating in social events and activities should be encouraged by a psychotherapist (Schnyder et al., 2016). In addition, according to Lester et al. (2018), an issue of confidentiality is common when it comes to therapy in collectivistic cultures. The authors explain that in collectivistic societies family and society play major role which is why a patient is often concerned that the information shared in therapy will be shared with members of that community (Lester et al., 2018). Nevertheless, attending psychotherapy is still considered as a taboo in many parts of the world. Many people are afraid of being labeled as "crazy" and they feel uncomfortable of people knowing that they attend psychotherapy. To conclude, the issue of confidentiality is definitely present globally and not only in collectivistic cultures.

The attitudes family and society have towards mental disorders can influence help-seeking behavior and therapy outcome. Some studies show that a person's desire to seek help outside of his or her community can be strongly discouraged (Asnaani & Hofman, 2012; Chu et al., 2016; Coetzee et al., 2019; Waite & Ramsay, 2010). The society can be quite extreme in attitudes towards trauma victims as in the case described by Schnyder et al. (2016). In their example, a rape victim was excluded from her community and forced to go abroad since rape was considered as a shameful event. After attending psychotherapy, the woman realized that cultural values are relative and that even among members of her cultural group there were people who disagreed with the

general attitude that rape victims should be exiled or excluded in some other way (see Schnyder et al., 2016, for more detail).

Some of the analyzed publications also suggests that working with female Muslim patients can be a challenge for a Western psychotherapist. This can be seen as othering as the Western views are presented as modern and liberal, while Muslim women are exposed to prejudices and biased views. To be more specific, Muslim women are stereotyped as unschooled and oppressed by their husbands and societies. Saleem and Martin (2018) claim that Westerners fail to understand that Muslim women have important familial role which is different from the role a woman might have in Western societies.

Lander et al. (2014) present one case with a Bedouin-Arab Muslim woman who was exposed to violence while living in a polygamous family. Based on this single case, the authors generalize that strong obedience to authority is typical for this specific cultural group. Moreover, they describe that male members of the society have more power than female members, and older members have dominance over younger members. It has been observed that the women in this community, especially senior wives, express higher dissatisfaction with life than women in monogamous marriages. Similarly, children of senior wives express violent or anti-social behavior, and are often less successful at school (see Lander, 2014, for more detail).

The literature suggests that familial or societal cultural beliefs can even be reflected in diagnosis. Waite and Ramsay (2010) write about a Hispanic woman with Attention-deficit/hyperactivity disorder (ADHD). She was misdiagnosed while her inability to focus was considered as plain laziness. This attitude was supported by the society (school, teachers, even therapists) and her family. Her family was also of opinion that help should not be sought externally. In addition, fear of failing to fulfill roles imposed by a family can lead to conflicting ideas of one's

identities. For example, Tummala-Narra's (2013) patient was afraid that if she did not marry an American Indian man, she would not be a good Indian woman in the eyes of her parents. Having a Caucasian partner also made her worried about her racial identity (Tummala-Narra, 2013).

Two studies show how broken relationships within the family combined with identity issues led to eating disorders. Demarque et al. (2015) write about a girl whose inability to bridge the gap between her Chinese and French identity, combined with disturbed relationships within her family resulted in developing a disorder called *anorexia nervosa*. Similar case is described by Channa et al. (2019), where a girl of Indian descent, born and raised in the UK developed a disorder called *bulimia nervosa*. In this case, cultural ideals of beauty in the United Kingdom combined with South Asian concept of having good appearance in order to find what her father and stepmother called "a good husband", led to developing eating disorder. On the surface, the cause of her illness was the Western standard of beauty and impact of social media (she compared herself with other girls at the university). Although this was true to some extent, deeper analysis showed that her familial relationships and attitudes her family members had towards beauty standards contributed to her illness. Both these cases demonstrate how family affects the way we build our identities and our self-image. On the other hand, these two studies use some vague ideas such as "the Western standard of beauty" or "the South Asian notion of good appearance" to explain the cause of illness.

4.1.5 Socio-historical Context

Understanding the socio-historical context in which the client was raised or lives currently is important because it helps in approaching the client's problem accurately. Das-Brailsford (2012) claim that both historical and the current circumstances should be analyzed. This author cites racial bigotry, intolerance and prejudice as some of the factors that jeopardize mental health promotion.

For instance, current political and social circumstances in South Africa are significantly affected by racial segregation in the past (Coetzee et al., 2019). Johnston (2019) agrees that therapists working in South Africa should be aware that this is a post-Apartheid society with a lot of ongoing political conflicts. Racism, discrimination, misdiagnosis and overmediaction in the USA are among the reasons why African American patients rather seek help among their own family or community (Curtis-Boles, 2017). Uphoff (2011) approaches her clients by familiarizing herself with the current circumstances that might affect her client's emotional state such as demonstrations, natural disasters, or epidemics. Studies which deal with culture and psychotherapy are mostly done with minority groups in the USA or other Western countries (Zora et al., 2019).

Guregård and Seikkula (2014) describe what happens when a mental health professional is not familiar with the socio-historical context in which the client has lived. An immigrant family living in Sweden was forced to attend a family therapy session. Due to their negative experiences with immigration authorities and lack of knowledge on how therapy works, they had difficulties in establishing therapeutic dialogue. In this case, the therapist failed to acknowledge the clients' experiences related to a life of a refugee in Sweden. According to Guregård and Seikkula (2014), the therapist failed to understand the clients' life circumstances and hence, did not show empathy towards them. Moreover, there was an obvious power gap which was not addressed adequately by the therapist. All these cultural factors led to miscommunication, mistrust and an unsuccessful therapy outcome.

History is embedded in culture and historical elements of identity can be expressed in various ways. Cultural groups have different histories, but problems might occur when a mental health worker and a client come from different sides of a political conflict. For example, in the situation described by Frie (2013), the client's father survived the Holocaust and Frie's

grandparents fought on the aggressor's side. The author explains that he felt guilt while his client was talking about the torture his father went through in the World War II.

The power gap where a client belongs to the dominant group is seldom discussed in the literature. According to Srour (2015), if the patient feels superior to the therapist, he or she might refuse the therapist's help. Kissil et al. (2013) explain that when a therapist is an immigrant, he or she has to adjust to the dominant culture. They add that an immigrant therapist must be familiarized with sociocultural context, healthcare system and related regulations. According to Kissil et al. (2013), immigrant therapists are often exposed to prejudices and stereotypes. They are often seen as less competent than therapists from the dominant culture which can lead to emotions such as anger and frustration (Kissil et al., 2013).

Srour (2015) is an Arab-Christian psychotherapist working in Israel where he belongs to the minority group as in Israel most of therapists are Jewish. Srour (2015) writes about the difficulties he faces with his Jewish patients and colleagues. He emphasizes the importance of addressing issues which are linked to political conflicts when working with Arab or Muslim clients. Although Frie (2013) writes about the conflict from the past, and Srour (2013) writes about the ongoing political conflict, both therapists write about addressing guilt. In both cases, there were a lot of issues to be overcome due to historical background. Both authors talk about their relationship with the client and about the language used in therapy. Lastly, in both cases, their patients were looking for the midpoint or common ground which could help them to put differences aside so as to build trust between them and the therapists. These examples illustrate the difficulties which occur when psychotherapist and clients belong to the "enemy" side.

In some cases, therapy can be successful even without bringing up issues related to socio-historical context. Lander's (2014) patient expressed at the end of therapy that she feared that their

differences concerning religion, ethnicity, and the Arab-Jewish conflict would cause difficulties in therapy. Nevertheless, the therapy outcome was successful, and the client emphasized that forgiveness therapy helped her not only with her personal problem, but it also helped her to forgive Palestinians. This case demonstrates how focusing on commonalities can contribute to having a strong working alliance and successful therapy outcome. Tummala-Narra (2013) had a different experience as she and her patient had a lot in common when it comes to their background. They were both second generation immigrants from India, living in the USA. However, Tummala-Narra explains that she often felt disconnected with her patient. One of the reasons was that her patient believed that Tummala-Narra could not identify with her social-class background.

4.1.6 Low-Income Patients

Socio-economic status is tightly linked to one's access to education, healthcare, job opportunities, ability to travel, and as such it affects a person's worldviews, attitudes, and behaviors. For this reason, it is included in this study as one of the cultural categories. This section focuses on vulnerable groups with low income as the analyzed literature suggests they face practical barriers in seeking help such as not being able to afford therapy or transportation to the therapist's office.

Krupnick and Melnikoff (2012) explain that people with low income have difficulties in adjusting their work schedule with therapy sessions, or they do not have anyone to take care of their children while they are attending therapy which often leads to high dropout rates. In some cases, they are not even aware of mental health services. A lot of low-income patients with illegal status in the USA fear deportation and therefore, do not seek help (Krupnick & Melnikoff, 2012; Zora et al., 2019). While empathy is one of the key elements of psychotherapy and it is based on shared life experiences, it is not always easy to achieve it. Dass-Brailsford (2012) claim that a lot of therapists have troubles to identify with life experiences of low-income patients. They add that

clients who do not feel connected with their therapist are more likely to terminate their therapy prematurely (Dass-Brailsford, 2012).

In addition, Dass-Brailsford (2012) explains that in the USA minority groups often not only do not have an access to mental health care, but are also exposed to racism and discrimination. Being familiar with the support that is offered by the local community is especially useful with low-income patients. Curtis-Boles (2017) explain that many African American patients with lower income come to therapy with a mental problem combined with stress caused by living in a violent environment. The authors emphasize that psychotherapists working with this group need to go beyond usual methods. This means that they need to be equipped with knowledge associated with crisis management and client advocacy (Curtis-Boles, 2017).

Zora et al. (2019) advise therapists working with Chaldean Americans to openly discuss therapy costs at the very beginning of the treatment. Chaldean Americans might feel exploited if they are not clearly presented with the process. Zora et al. (2019) explain that due to colonial history and oppression, Chaldean American clients might have negative feelings towards American or European therapists.

The studies analyzed in this section are conducted in the USA. Further research with bigger and more diverse sample is needed in order to understand the problems people with low-income face when it comes to psychotherapy.

4.1.7 Gender

Although gender is a category which significantly determines our identity, there is only one identified article which focuses exclusively on gender. Anderman (2010) claims that even though the status of women has improved globally, there are still problems to be tackled, especially in poor countries. In research, gender is usually taken into consideration as a demographic category.

Bryant-Davis (2019) expresses concern about the research being mostly done with white, male, middle-class, educated participants, yet the results are generalized and applied to all groups.

Johnston's (2019) research with clinical psychologists in South Africa shows that mental health professionals in this country have certain difficulties when working with culturally diverse clients. To be more specific, the participants expressed that they faced multicultural issues while discussing female's roles in marriage and family in general.

When talking about gender, Andermann (2010) refers to a social and cultural construct. She claims that this field is dominated by men and their values and hence, female therapists have to adjust to it which affects their professional identity.

Sturm et al. (2010) write about a female client whose trauma was caused by the way women and children were treated by the society. The authors claim that it is important to give the client an opportunity to actively discuss cultural norms, to question or to reject them (Sturm et al., 2010). Lander's (2014) female client was content that the therapist asked her how she felt about disclosing personal information to a male therapist. This Bedouin-Arab woman expressed that being female is a great part of her identity and hence, she appreciated the therapist's sensitivity towards gender and power differences.

4.2 Cultural Skills

In the analyzed literature, the authors use phrases: *cultural skills*, *cultural competence*, and *cultural awareness*. The phrase *cultural competence* is criticized in the literature because the word *competence* implies achieving the level of expertise in being a culturally sensitive therapist (see Fung & Lo, 2017, for more detail). However, although there are some nuances, the meanings of these phrases significantly overlap. Since most authors write about cultural skills, this term will consistently be used in this paper.

Fung and Lo (2017) differentiate three levels of cultural skills: *macro* (societal), *meso* (institutional or programmatic), and *micro* (individual clinical) level (p. 66). The macro and micro levels are explained in Table 3 and Table 4, respectively. The authors do not give further explanations of the meso level.

Examples provided by Andermann (2010) show how cultural skills could be applied in all three levels suggested by Fung and Lo (2017). On the micro level: when a female client is provided with an opportunity to choose a female therapist to work with. On the meso level: there is a clinic within a hospital focusing solely on female's mental health. On the macro level: there is a hospital specialized in female's mental health.

TABLE 3 Macro (Societal) Levels of Cultural Competence (Fung & Lo, 2017, pp. 66-67).

Domain	**Explanation**
Advocacy	Leaving the neutral therapist's position and taking specific actions which promote equity for the client and his or her diverse community.
Community Engagement and Development	Participating in activities which promote the importance of mental health such as educational programs and workshops.
Research	Conducting a research which can help in raising awareness about the existing issues in the community which are commonly ignored in the research done by the dominant culture.

TABLE 4 Micro (Individual/Clinical) Levels of Cultural Competence (Fung & Lo, 2017, pp. 66-67).

Domain	**Example**
Skills	Being able to work with interpreters.
Knowledge	Being aware of the circumstances of the client's life (socio-political or historical context).
Attitude	Being aware of personal prejudices and biased opinions.

Different scholars have different views on cultural skills. However, most of them agree on the importance of attitudes, practices, and working standards (Andermann, 2010; Carmichael, 2012; Chu et al., 2016; Waite and Ramsay, 2010). According to Hinz-Rommel's definition, cultural skills refer to maintaining a successful communication between a therapist and a client in a culturally diverse setting, when the client belongs to a different ethnic group (as cited in Mösko et al., 2013).

Carmichael (2012) agrees that culturally sensitive therapy can be achieved only by making improvements on the all three above-mentioned levels. Cultural skills are not a set of rules to be followed, they rather refer to a tendency to constantly learn and improve. Passive knowledge about one's cultural identities is not enough, a culturally skillful therapist is the one who is able to put knowledge into practice.

Although being neutral is one of the core values of psychotherapy, some scholars think that therapists should advocate their clients' rights and take an active role in promoting equity and human rights (Andermann, 2010; Bryant-Davis, 2019; Chu et al., 2016; Fung and Lo, 2017; Zora et al., 2019). This is in accordance with the APA' Multicultural Guideline 5 (2017). According to Dass-Brailsford (2012), patients should be encouraged to take an active role in therapy and to learn how to rely on their own strengths and abilities. Furthermore, they should learn to acknowledge

the tensions that exist in the external world and to find a constructive way to cope with them (Dass-Brailsford, 2012). Empowerment and advocating client's rights is especially important when working with clients who belong to minority groups and who have experienced discrimination, racism or sexism (Chu et al., 2016). Mösko et al. (2013) discuss the situation in Germany and emphasize that in order to make mental health services accessible to minority groups, a change should also happen on the political and educational level.

When discussing culturally sensitive therapy, the focus is usually put on culturally diverse patients. However, cultural diversity should also exist among therapists. This means that mental health institutions should be more open towards hiring professionals with different cultural backgrounds. Mösko et al. (2013) explain that professionals with a migration background might have practical difficulties such as recognizing diploma from a foreign university or acquiring a license to practice psychotherapy. Uphoff (2011) claims that even across Europe there is no consensus on counselling standards. Therefore, it does not mean that a therapist migrating from one European country to another one will easily acquire a license to apply psychotherapy in that country.

There is a progress in the field in working with culturally diverse populations (Bryant-Davis, 2019). Dass-Brailsford (2012) explains that knowledge about the client's local community is important for building trust and connection with a patient. If a patient lives in a supportive community, that can be used to support therapy. This is especially important for low-income patients (Dass-Brailsford, 2012). According to Bryant-Davis (2019), a therapist should be sensitive towards a patient's financial status and accessibility to services.

A therapist should be able to estimate which dimension of his or her identity should be disclosed or concealed (Bryant-Davis, 2019). According to Asnaani and Hofmann (2012),

knowledge of the clients' cultural identities can help the therapist in making this decision. They explain that talking about personal life and experience might be interpreted as incompetent behavior by members of some cultural groups. Lander et al. (2014) provide an example which illustrates how disclosing personal information by a therapist can have a positive impact on the therapeutic alliance. Lander et al. (2014) write how a traumatic life event experienced by a Bedouin-Arab woman led to disconnection from her religion. After the therapist disclosed that he was an atheist too, the bond between the therapist and the client became stronger (Lander et al., 2014). Curtis-Boles (2017) identified that African American patients appreciate the therapist's self-disclosure. She explains that her patient had difficulties with raising an adolescent daughter. Instead of making a general statement that most parents face difficulties with adolescents, Curtis-Boles chose to make that statement personal and to say that she also faced challenges with her adolescent child. Nevertheless, the claim made by Curtis-Boles (2017) about African Americans appreciating the therapist's self-disclosure should be critically approached as she makes a generalization based on her personal experience with clients and very little data.

Therapists should be aware of their own cultural biases towards the client's culture and should avoid stereotypes (Bryant-Davis, 2019; Chu et al., 2016). Moreover, psychotherapists should not assume the client's needs based on the knowledge they have about specific cultures. A psychotherapist should rather be a careful listener and assess the needs based on what the client says (Buse et al., 2013). Tummala-Narra (2013) agrees that self-evaluation is an integral part of successful psychotherapy. She writes how her own need to belong and to be accepted affected the therapeutic alliance. Uphoff (2011) writes that she endeavors to approach the client with empathy and acceptance, and without using her own culture as a criterion for "normal" or "right".

When discussing cultural skills, many scholars uncritically divide the world into the West and non-West and use these categories to explain different phenomena such as symptom expression. For example, a lot of scholars claim that a mental health worker must take into consideration that people from non-Western societies might express symptoms differently than people from the West (Buse et al., 2013; Demarque et al., 2015; Freund and Band-Winterstein, 2017; Jani et al., 2016; Waite & Ramsay, 2010). Mentorship and counseling with other therapists are seen as an integral part in developing cultural skills (Asnaani & Hofmann, 2012; Buse et al., 2013; Carmichael, 2012). Carmichel (2012) goes as far to claim that educational activities for therapists should be organized in a way that they can learn by being able to hear non-Western perspectives. Nevertheless, the author does not define what "non-Western perspectives" denote.

Moreover, the therapist's power and privilege must be acknowledged and addressed adequately (Carmichael, 2012). Western psychotherapists who are training non-Western practitioners should avoid establishing psychological colonialism by imposing Western values (Lester et al., 2018). Curtis-Boles' (2017) experience with psychology students shows that they often feel uneasy when working with African American patients. She explains that they fear that their privileged status of belonging to a dominant cultural group might deteriorate the relationship with African American clients. On the one hand, it is evident that the there is a lot of power abuse, discrimination, and oppression in the field and this should be addressed with care. On the other hand, the fact that scholars use the terms such as "the West" or "Western values" to justify or explain certain phenomena, in a way promotes segregated society because it divides the world on "us" and "them".

In addition, Carmichael (2012) extends the definition of cultural skills by saying that it is not only a skill, but also a therapist's willingness to go beyond his or her comfort zone and

theoretical knowledge and to actively seek the best ways to approach cultural obstacles in therapy. For instance, problems might occur when a therapist and a client come from groups which are in political conflict. Srour (2015) says that in those cases, being culturally sensitive is not enough because a therapist must be able to overcome feelings such as anger or sense of threat.

Asnaani and Hofmann (2012) define cultural skills by taking into consideration both therapist's and patient's viewpoints. According to them, cultural sensitivity refers to how a therapist feels about his or her ability to handle culturally sensitive situations. Nevertheless, it also refers to the client's perception of the therapist's ability to handle these situations.

The importance of having a culturally skillful therapist is also recognized by patients. Eleftheriadou (2010) claims that in mental health centers which are recognized as culturally sensitive, patients feel more comfortable to talk about issues such as discrimination and racism. For instance, Sturm et al. (2010) describe the case where the Avicenne Hospital in Paris was approached by a female client from West Africa who expressed that she was dissatisfied with the therapists she had worked with and wanted to have therapy exclusively with the staff from this metal institution. The patient had information that the therapists in this hospital were familiar with West African cultures. She also said that her previous therapists were not familiar with African issues which made her feel misunderstood (see Sturm et al., 2010, for more detail).

According to Andermann (2010), a culturally sensitive approach can be applied twofold. A culturally skillful therapist can have in-depth knowledge of a particular cultural group. Another option is to possess generic skills, which means that a therapist follows a set of generic rules. These rules help the therapist to work in a culturally appropriate way with groups he or she is not familiar with. On the other hand, Asnaani and Hofmann (2012) claim that it is not enough for a therapist to simply be informed about the client's cultural identities in order to work in a culturally skillful

way. Sturm et al. (2010) explain that asking questions about the cultural context where the patient can confirm or modify the therapist's assumptions about the patient's cultural background is desirable. This helps in creating a deeper relationship and provides better understanding for the therapist (Sturm et al. 2010). This is in accordance with the results of the study conducted by Rogers-Sirin et al. (2015) where the interviewed immigrant patients expressed appreciation when therapists were willing to learn about their cultures. Furthermore, they appreciated when therapists admitted that they had no knowledge about that cultural group but showed interest by asking appropriate questions (Rogers-Sirin et al., 2015).

In addition, asking relevant questions which allow clients to express their problems is crucial in meeting patients' needs (Andermann, 2010; Waite and Ramsay, 2010). Discussing stigma and how the patient understands the illness can help in understanding cultural barriers which might prevent the acceptance of having a mental disorder (Mizock & Russinova, 2013). Chu et al. (2016) claim that patients must feel that they are understood. In some cases, the therapist's personal experience can be helpful in order to empathize with the patient. For instance, Andermann (2010) says that she started understanding better her single-parent patients after she became a mother. Moreover, that helped her gain another perspective when working with child abuse cases. According to the study done by Rogers-Sirin et al. (2015), immigrant patients expressed that empathy is an integral part of successful therapy. One patient emphasized that it was crucial for him that his therapist was a good listener. He was very content that she remembered details of his case even after many years (see Rogers-Sirin et al., 2015, for more detail).

The Bhutanese counselors who participated in the research conducted by Lester et al. (2018), hope that in the future there will be more unity in the field when it comes to the working standards and guidelines. Jani et al. (2016) suggest an ambitious idea that mental illness assessment

criteria should be culturally universal. This is difficult to achieve because the meaning of the phrase culturally universal is not clearly defined.

Jones et al. (2019) did a research on the effects of multicultural skills in school psychology. They assumed that the clients who were exposed to culturally sensitive therapy would be more satisfied with therapy. The results show that the group of students who was exposed to the traditional Cognitive Behavioral Therapy (in further text CBT), needed more time to achieve the feeling of comfort in therapy than the group who was exposed to culturally sensitive CBT. However, there were no differences between the groups when it comes to the way they perceived the impact of therapy. The most interesting finding is that the group with traditional CBT expressed higher rates of excitement and enthusiasm at the end of the treatment than the group with culturally sensitive CBT (see Jones et al., 2019, for more detail). This study was done with a small sample size and further research is needed in order to gain better understanding of the role that cultural skills play in CBT.

Although immigrant therapists face plenty of obstacles in adjusting to the way things are done in the dominant culture, they do possess certain advantages. For instance, Kissil et al. (2013) write that as outsiders they can provide clients with an alternative perspective and they can also be better-informed when it comes to the relativity of certain cultural practices.

Working with culturally sensitive groups sometimes requires going beyond what is acceptable in traditional psychology. Beeber et al. conducted a study with low-income mothers which showed that activities such as a physical touch and a lot of encouragement can have a positive impact on therapy outcome (as cited in Krupnick & Melnikoff, 2012).

Rogers-Sirin et al. (2015) did a research with immigrant college students who attended psychotherapy sessions with an aim to explore their views on the therapists' cultural skills. This is

an illustration of how immigrant clients feel when therapists behave in a culturally sensitive or insensitive way. Although this study is done with a small sample size, it provides a partial view of what happens in psychotherapy. The results of the study related to culturally incompetent behavior are presented in Table 5.

TABLE 5 Consequences of Culturally Incompetent Behavior (Rogers-Sirin et al., 2015, pp. 261-264).

Culturally Incompetent Behavior	**Example**
Failing to clearly explain what is therapy, how is it organized, and what is expected from the client.	The client felt shocked and uneasy because she did not know what was expected from her. She did not understand how talking about herself could help with her problem.
Culturally Incompetent Behavior	**Example**
Expressing discrimination and microagression towards the client.	The therapist would not look at the client and she was distracted by other activities such as looking at her phone. The client felt that the reason for this was her nationality.
Alienating the client by making assumptions about his or her culture	The therapist kept comparing the client from Lebanon with the client from Egypt. She did not make an effort to openly discuss cultural differences.
Interpreting cultural differences as a pathological state.	The way the client disciplined her children was interpreted as problematic but the client claimed that was normal in her culture.

Discussing issues of privilege and racial differences is always challenging. APA's Guideline 2 suggests that a therapist should acknowledge his or her own biased thoughts towards the patient's culture. Curtis-Boles (2017) says that this issue should be discussed at the very beginning of therapy. She emphasizes that difficulties in addressing this issue with a client might become problematic if a therapist did not properly process the issues he or she might have with that cultural group.

Tribe (2011) suggests that all psychotherapists should undergo training in how to work with interpreters. Being able to effectively cooperate with an interpreter in therapy is important in working with minority groups who are not fluent or do not speak the language of the dominant group. In addition, Tribe (2011) underlines that psychotherapists who do not have this training as a mandatory part of their education should attend it privately.

It should not be forgotten that mental health professionals are also humans and they need to handle their own emotions. Working with culturally diverse patients might be overwhelming. Eleftheriadou (2010) emphasizes that having a mentor is especially important when working with refugees, people who survived violent events, or trauma because this can also be stressful for therapists. Supervision should be done regularly (Eleftheriadou, 2010).

4.3 Practical Issues

The way culture is approached in therapy has direct implications on diagnosis, treatment, and therapeutic alliance. In the analyzed literature, client's cultural background is often used to explain stigma, symptom expression and the client's attitude towards mental illness.

4.3.1 Symptoms, Diagnosis and Treatment

Some scholars make a strong correlation between culture and symptom expression and go as far to claim that when working with clients from diverse cultures, a therapist must be aware that

expression of symptoms can be culturally conditioned (Demarque et al., 2015; Freund and Band-Winterstein, 2017; Jani et al., 2016; Waite & Ramsay, 2010). They emphasize that if the symptoms are misunderstood, the client is likely to be misdiagnosed and to receive inadequate treatment. Similarly, Reichardt et al. (2018) claim that in order to have a successful outcome, therapy must be in accordance with the patient's cultural beliefs.

Bryant-Davis (2019) emphasizes that the therapist must take into consideration not only the patient's cultural background, but also the sociopolitical setting. Neftci and Barnow (2016), express that cultural differences between the therapist and the patient can lead to misunderstandings in problem perception, needs and expectations. Saleem and Martin (2018) write about one Muslim woman who was misdiagnosed with a mental illness because her therapist failed to understand her cultural circumstances. After the patient's husband had passed away, she became responsible for finances. She was misdiagnosed because the therapist was not aware of the fact that in many Muslim societies males are responsible for financial issues.

Post-traumatic Stress Disorder (in further text PTSD) is commonly discussed in the literature and claims are being made that its symptoms vary across cultures. Moreover, this disorder is often linked to marginalized groups and migration (Bryant-Davis, 2019; Buse et al., 2013). PTSD must be treated while taking into consideration different dimensions of the patient's cultural identities. Schnyder et al. (2016) ignore individual differences and the fact that people have multiple cultural identities and make a claim that being a member of individualistic or collectivistic society defines how one will interpret trauma.

As discussed in previous chapters, a lot of studies presume cultural homogeneity of certain geographical areas. For example, Kpanake (2018) explored how "Western values" rooted in psychotherapy affect help-seeking behaviors, understanding of mental disorders, and therapy

expectations of the patients coming from what he calls “African cultures”. Kpanake (2018) identifies three common elements which define personality in African cultures are the way person expresses Self, religious beliefs, and the importance of family. He concludes that a precondition for a successful therapy requires that the therapist is aware of all these categories. The aim of the therapy is to help the client to have a good life. Kpanake (2018) asserts that the definition of a good life is determined by the patient’s society and culture and if the therapist fails to understand that, the therapy cannot have a successful outcome. Similar generalizations are made by Neftci and Barnow (2016) who state that the notion of Self depends on one’s cultural background, and it might be quite different for members of individualistic and collectivist societies.

Zheng and Gray (2015) compared how PTSD symptoms are expressed among the Americans and the Chinese. They analyzed the connection between values and the expression of symptoms. According to their study, while the Americans expressed personal pleasure as basic human value, the Chinese were more oriented towards their community and the importance of making other members of the community happy. Zheng and Gray (2015) identified that the Chinese express physical symptoms when it comes to PTSD, while the Americans express mood symptoms. They argue that this is due to different life philosophies these two groups have. They explain that the way the Chinese interpret PTSD is affected by Confucianism and Buddhism, while Ancient Greek philosophy postulates the American views. According to the authors, these dimensions interplay with each other and determine the views of trauma and traumatic events in both cultures (Zheng & Gray, 2015).

There are more studies that uncritically interpret people’s behavior by ascribing them to certain categories such as belonging to a collectivistic or an individualistic society. For instance, Lester et al. (2018) describe the Bhutanese as a collectivistic society gathered around the same

nationality, while Freund and Band-Winterstein (2017) describe the Heredi society as collectivistic and gathered around religion. Both studies emphasize that in these two cultural groups talking about and putting oneself in focus is considered as selfish. In both cases, this is described as an obstacle to psychotherapeutic activities since talking about personal feelings and thoughts is an essential part of psychotherapy (Freund & Band-Winterstein, 2017; Lester et al., 2018).

Some studies show that practitioners working with minority groups can be biased in diagnosing BPD. Jani et al. (2016) discuss opposing results of the studies which are conducted cross-culturally with patients suffering from BPD. While the studies with immigrants coming from what they call "traditional cultures" in Switzerland and Hispanic immigrants in the USA show that acculturation processes and exposure to an unknown environment contribute to development of BPD, no connection between these two entities was identified in the similar studies done with immigrants in Germany (Jani et al., 2016).

For a long time, BPD was treated as "American disease". The justification was that the symptoms reflected the American culture between the 1960s and the 1970s (Jani et al., 2016). The study conducted by Demarque et al. (2015), presents the case where a girl of Chinese descent, born and raised in France, developed *anorexia nervosa*. The authors explain that the parents were perplexed by the fact that their daughter had this "Western disease". In order to understand their attitude towards anorexia nervosa, it is important to be familiar with the historical context of this disease. Until the 1970s, these kinds of eating disorders were considered as "Western diseases" because they represented the "Western ideal" of a perfect body (Channa et al., 2019; Demarque et al., 2015). In the case study presented by Demarque et al. (2015), the patient with anorexia nervosa expressed the symptom that is seen as atypical from "the Western point of view". She was not afraid of gaining the weight back. This is considered as an atypical symptom for the patients

belonging to Western societies but according to the authors, it is not that unusual for Chinese patients (Demarque et al., 2015). Zora et al. (2019) claim that eating disorders are not common among Middle Easterners because eating represents a social activity where people build their relationship with family and community. However, Zora et al. (2019) emphasize that eating disorders might occur among individuals who are influenced by Western values. However, one can argue that eating disorders exist globally and it is dangerous to interpret them through social constructs as this can have negative effects on patients.

Some authors claim that migration and acculturation are related to depression and anxiety (Neftci & Barnow, 2016; Rogers-Sirin et al., 2015). One study shows that Turkish population in Europe, one of the biggest immigration groups but least integrated, has high dropout rates and lower rates of treatment compliance (Neftci & Barnow, 2016). According to Krupnick and Melnikoff (2012), people with low-income are also at high risk of developing depression, anxiety, and PTSD, especially if they are exposed to discrimination. The authors emphasize that due to the lack of research when it comes to this social group, it is difficult to generalize which treatment is the most suitable. In addition, it is identified that marginalized groups develop more severe symptoms of PTSD (Bryant-Davis, 2019).

According to Sturm et al. (2010), mental health institutions often refuse providing treatments for refugee patients and they justify that decision by stating that there is no budget for interpreters, or that they cannot deal with patients who have no permanent address in their country. The authors say that the providers of mental health services think that these patients have complex needs and that the services are not adjusted to refugees (Sturm et al., 2010). Mösko et al. (2013) add that mental health practitioners express that working with immigrant populations might require additional efforts.

Practice has shown that working in a culturally diverse setting requires going beyond traditional methods. Schnyder et al. (2016) write about a man who fought in the Gulf war and suffered trauma. After he had tried different psychotherapies, he met the psychotherapists who spoke the same language and who had a similar cultural background. This therapist understood the reasons behind the patient's inability to express his trauma experiences verbally and he encouraged him to draw and write about it. Schnyder et al. (2016) explain that encouraging the patient to express himself in this alternative way had a positive impact on the therapy outcome.

Reichardt et al. (2018) explored cross-cultural differences in mental illness representations between German and Iranian patients. They say that some of the results were expected. For example, they identified that more Iranian patients believed that the cause of their illness was supernatural. Reichardt et al., (2018) explain that this is in accordance with other studies which show that Iranian culture is more religious than German culture. Interestingly, they discovered that there was not much difference in scores when it comes to control over mental illness and this is not in accordance with other studies. The authors explain that this might be because in this research, the Iranian participants were all educated and with higher income, and therefore, they had more possibility to be in control over their lives (Reichardt et al., 2018). It is interesting to claim that the differences between the Iranian and German patients were based on their nationalities but the similarities were based on their education level and financial status.

4.3.2 Distrust, Stigma and Acceptance of Mental Illness

A therapist should make an effort to understand the patient's attitude towards mental illness (Asnaani & Hofmann, 2012). According to Mizock and Russinova (2013), some mental health professionals are trying to promote the idea of recovery as opposed to the idea of overcoming

symptoms. They claim that the first step towards recovery is the acceptance of illness and culture is an integral part of this step (Mizock & Russinova, 2013).

According to Eleftheriadou (2010), building trust at the beginning of treatment is especially important when working with culturally diverse clients as they might already hold negative attitudes towards therapy. This author also claims that is necessary for the therapist to demonstrate that he or she is able to handle the client's problem. If a client feels that a therapist cannot handle listening about his or her problem, the client will be discouraged to try to tackle it (Eleftheriadou, 2010). This is very difficult because therapists should be emotionally involved but also stay professional and strong**.** Similarly, Gallardo (2013) states that building trust is especially important when working with the immigrants from Latin America. For instance, starting a therapy session with a small talk can have a positive impact on the working alliance. Similarly, the therapist's personal disclosure is also desirable and appreciated (Gallardo, 2013). As stated in Chapter 2, psychotherapy relies on the relationship between the therapist and the patient. To that end, one can argue that establishing trust is essential for a successful therapy outcome regardless of the client's cultural background.

Stigma is a social construct typical for all cultural groups but according to Mizock and Russinova (2013), it is expressed differently across cultures and it exists at various levels. Freund and Band-Winterstein (2017) make a strong claim that distrust towards therapists and concerns about confidentiality are more common in collectivistic societies. They explain that the reason for this is an active role of the family and community in therapeutic processes (Freund & Band-Winterstein, 2017). When it comes to stigma, patients are mostly afraid that the therapist will disclose private information and they are afraid of being labeled as mentally ill, which eventually affects help-seeking behavior. Some studies show that in some cultural groups, the whole family

can be labeled which can lead to some practical problems such as being avoided by community members, or having difficulties in finding a job or a spouse (Freund & Band-Winterstein, 2017; Krupnick and Melnikoff, 2012). Zora et al. (2019) claim that Chaldean Americans rather seek help within their community and family members and they are not open to Western mental health workers. Moreover, in this community stigma is closely associated with mental disorders and people who have mental illness are often characterized as "crazy" (Zora et al., 2019). The results of this study must be analyzed while taking into consideration the environmental and socio-historical contexts in which they are shown.

Channa et al. (2019) describe psychotherapy sessions with a female client of Indian origin, who expressed that discussing mental problems was unacceptable both in her culture and her family. In this case, help-seeking behavior was affected and the healing process was longer because the patient did not have any support from her family. According to Freund and Band-Winterstein (2017), stigma in the Heredi community and general attitude towards mental illness as something negative are so strong, that seeking help must be encouraged by the specially trained social workers. They add that in this Ultra-Orthodox Jewish community mental illness is usually kept as a secret until the symptoms become severe and the family is no longer able to hide them (Freund & Band-Winterstein, 2017). Due to fear of stigma, Chaldean Americans also seek help when symptoms become severe (Zora et al., 2019).

Negative attitudes towards therapy can also be a consequence of previous negative experiences with institutions. For example, Dass-Brailsford (2012) says that her low-income client believed that mental health institutions collaborated with the government and that their only goal was to take her children away.

Many studies agree that members of minority groups face difficulties when it comes to handling mental health problems. For instance, Asnaani and Hofmann (2012) express that the stigma of mental illness might be stronger within minority groups. Moreover, minority groups attend psychotherapy less often, they have higher dropout rates and have less successful outcome (Bedi, 2018; Neftci & Barnow, 2016). Immigrants and minority groups often have limited access to mental health services (Bryant-Davis, 2019; Mösko et al., 2013). Chu et al. (2016) write that in order to build a strong therapeutic alliance, a therapist should try to match his approach and methods to the client's preferred working style. In order to do that, he or she must be aware of the client's communication style, ways to express feelings, and worldviews (Chu et al., 2016).

5 DISCUSSION

This chapter discusses the findings and limitations of the study. The analysis shows that there is a plethora of research regarding culture in the context of psychotherapy. This implies that practitioners, scholars and relevant institutions have recognized the importance the role culture plays in treating mental disorders. However, there are multiple issues related to the way culture is approached in the field.

5.1 Interpretations and Implications

Research Question 1: *How is culture approached in the field of psychotherapy?*

To begin with, it is identified that a significant number of scholars approach culture in a traditional way, which means that they group people based on common traits and uncritically presume that all members of one cultural group would express the same behavior in a therapy room. This presumption is then used in research and a lot of times the results of the studies guided by this idea lead to very problematic generalizations. For instance, in the analyzed publications there are many statements such as: Muslim women avoid discussing sex-related topics in therapy (Saleem & Martin, 2018); African Americans appreciate when the therapist discloses personal information (Curtis-Boles, 2017); or Iranian patients are more religious than German patients and this is reflected in the way they interpret mental illnesses (Reichardt et al., 2018). These oversimplifications can even be harmful when applied by overly-zealous cultural psychotherapists.

Simply said, psychotherapists should not make any assumptions about their clients based on the clients' membership in a certain cultural group. In addition to this, a lot of presented studies ignore the fact that one has one more than one cultural identity. In practice, this means that an individual is judged by his or her membership in the ascribed cultural group without taking into consideration individual differences or the fact that one can belong to many different cultural groups.

The above-mentioned research conducted by Reichardt et al. (2018) discusses the differences between the Iranian and German patients related to the way they perceive mental illnesses. These differences were explained by referring to the participants' nationalities. However, the researchers also identified some similarities between these two groups and decided to explain them by saying that the similarities emerge from the fact that the interviewed Iranians had a higher level of education and higher income. The authors do not clarify why the differences emerge from the participants' nationalities and the similarities emerge from the level of education and the participants' socio-economic status.

Interesting research has been done on the effects of ethnic matching between patients and psychotherapists. While some studies show that ethnic matching leads to a more successful therapy outcome (Chao et al., 2012; Chu et al., 2016), other studies show that ethnic matching is not a crucial factor (Dass-Brailsford, 2012; Jones et al., 2017; Laher & Padayachee, 2012). Although the overall goal of these studies is to improve mental health services in an intercultural setting, they in a way promote the idea of the segregated society. The idea that one should choose a psychotherapist based on his or her skin color, ethnicity, or nationality is beyond obsolete. Moreover, the whole idea of using social constructs such as race and ethnicity to define cultural groups is questionable. Nevertheless, as presented in the previous section, ample studies unproblematically rely on these categories.

Moreover, there is some redundant advice for therapists working with culturally diverse patients. For instance, some authors say that psychotherapists working with patients coming from collectivistic cultures must maintain confidentiality of information (Band-Winterstein, 2017; Lester at al., 2018). The definitions of psychotherapy provided in this thesis imply that one of the core tasks is to provide the patient with a safe environment where he or she can share the problems with the psychotherapist. That being said, emphasizing that psychotherapists should maintain confidentiality of personal information with patients coming from collectivistic cultures is in a way unnecessary as confidentiality should be maintained with all patients regardless of their culture.

This being said, the dichotomy "collectivistic societies" versus "individualistic societies" is also uncritically used in the literature. Briefly, these two categories are linked to the idea of the West and non-West where Western societies are described as individualistic and non-Western societies are presented as collectivistic (see e.g. Buse et al., 2013; Freund & Band-Winterstein, 2017; Kpanake, 2018; Jani et al., 2016; Zheng & Gray, 2015). As discussed in the previous sections, although this is an oversimplification, the world is unproblematically divided in the modern West and the underdeveloped non-West and this dichotomy is also visible in psychotherapy-related research. This has practical implications as many scholars use this division to explain the phenomena related to psychotherapy. For example, many scholars claim that people in the West are less religious than non-Westerners (see Freund & Band-Winterstein, 2017; Laher & Padayachee, 2012; Lester at al., 2018; Reichardt et al., 2018; Saleem & Martin, 2018). Lester et al. (2018) use this assumption as universal truth to make a claim that the Bhutanese therapists have troubles in applying psychotherapy methods because they represent a collectivist and religious society and psychotherapy is rooted in the Western values and the West is non-religious.

Additionally, as stated in Chapter 2, the West is a social construct and the decision on which entity will be included or excluded from the West is often made arbitrarily. For example, in one study the Hispanic are described as non-Westerners without providing any additional explanation why (see Chu et al., 2016). In these studies the West is mostly uncritically presented as one homogenous space where everyone shares the same beliefs, values, and experiences. By reading these studies one can easily get an impression that there are no competing discourses in the West when it comes to the way mental disorders should be approached. To conclude, the idea of the West is commonly used by traditional scholars in the analyzed literature. The studies that rely on this concept should be critically approached.

When analyzing the literature, one should be aware of the fact that most of the research comes from the USA context. This is important because even nowadays there are a lot of racial tensions and discriminatory practices in the USA and this is also reflected in the psychotherapy related research. Moreover, there are a few reasons to be careful when trying to generalize the results of the presented studies. Firstly, a lot of studies are done with minority groups in the USA or Europe. Secondly, a lot of studies rely on a very small size. Lastly, a significant number of publications are based on individual case studies and the psychotherapist's personal experience with patients.

Nevertheless, it is important to emphasize the positive sides and improvements in the field. The literature search showed that there is a plethora of research in the field which implies that it has been recognized that addressing the role of culture in the context of psychotherapy is important. There are clear intentions to address some important issues in the field such as discrimination, racism, oppression, and imposition of values. Furthermore, problems such as a limited access to

mental health institutions and high dropout rates among some minority groups are identified and efforts are put to make mental health services more accessible for diverse populations.

Research Question 2: *How are cultural skills approached in the field of psychotherapy?*

The findings confirm that cultural skills are essential when working with culturally diverse clients. However, there is no consensus on what it means to be a culturally skillful therapist. The APA's Multicultural Guidelines (2017) provide a framework for scholars and mental health professionals working with diverse populations. Nevertheless, these guidelines are not fully put into practice (Curtis-Boles, 2017) and they need to be updated (Carmichael, 2012). Although they are well-intended and they are offering some promising ideas, a lot of formulations are vague.

Many scholars approach cultural sensitivity as a multilayered set of skills, knowledge, and attitudes. It is important to acknowledge that cultural skills cannot be reached by simply following a set of fixed rules, but a therapist must constantly improve his or her knowledge (Carmichael, 2012).

One of the most discussed levels in intercultural psychotherapy is advocating for the client's rights. There is a consensus in the literature that in order to improve mental health services for minority groups and immigrants, mental health professionals should stand for their patients and take an active role in advocating equality (Andermann, 2010; Bryant-Davis, 2019; Chu et al., 2016; Fung and Lo, 2017; Zora et al., 2019). The APA's Guideline 5 supports this argument. In addition, culturally competent mental health professionals should be able to address personal biases by constantly questioning and evaluating their knowledge and feelings (Bryant-Davis, 2019; Chu et al., 2016; Uphoff, 2011). This is in accordance with the APA's Guideline 2.

A lot of scholars discuss going beyond traditional methods when working with culturally diverse patients. For example, it is thoroughly discussed whether a psychotherapist should disclose

personal information and the results are opposing depending on which cultural group they work with. For instance, Gallardo (2013) suggests that when working with immigrant clients from Latin America, disclosing some personal information by a therapist is desirable. Deciding whether to disclose or conceal the information about personal life based on the client's membership in a certain cultural group is problematic. The example provided by Gallardo (2013) ignores individual differences and presumes that all immigrants from Latin America share the same view when it comes to the therapist's disclosure of personal information.

According to Bryant-Davis (2019), being a culturally skillful therapist means being able to estimate when sharing personal information will lead to better therapeutic alliance. Beside personal information disclosure, another example for an unconventional method is physical touch as a sign of encouragement. Krupnick and Melnikoff (2012) assert that this can have a positive impact when working with low-income mothers. This statement can also be argued because assuming that all low-income mothers around the world would appreciate this kind of encouragement represent an overgeneralization.

Culturally incompetent behavior can negatively affect therapy (Rogers-Sirin et al., 2015). For instance, a patient can be misdiagnosed and hence, inadequately treated (Demarque et al., 2015; Freund and Band-Winterstein, 2017; Jani et al., 2016; Waite & Ramsay, 2010). For instance, Curtis-Boles (2017) discusses a research which shows that African American patients in the USA are often overmedicated. Failing to acknowledge the client's life circumstances and historical context can lead to mistrust and unsuccessful therapy outcome (Guregård & Seikkula, 2014).

Lastly, training and ongoing pursuit for knowledge are essential for culturally sensitive psychotherapy (Tribe, 2011). Moreover, psychotherapists should consult and work closely with colleagues and mentors (Eleftheriadou, 2010).

5.2 Limitations

Three major limitations are identified. Firstly, this literature review is based solely on articles and books that are published in English. This presents a certain paradox because on the one hand, the current thesis focuses on cultural issues and diversity. On the other hand, it excludes publications that are not in English. This means that the prevailing views, thoughts and attitudes in the analyzed literature might be biased as they mostly originate from the European and North American context. Secondly, although efforts were put to avoid bias in collecting the literature, a lot of material was dismissed, so it is possible that some relevant publications were omitted. Lastly, the presented findings rely on the way scholars collected the data in their research and many of them express problems with the sample size (i.e. Carmichael, 2012; Jani et al., 2016; Krupnick & Melnikoff, 2012; Saleem & Martin, 2018). Moreover, a lot of studies are based on the therapists' personal experiences with the clients (i.e. Coetzee et al., 2019; Frie, 2013; Tummala-Narra, 2013). Nevertheless, regardless of its limitations, this study provides a solid overview of the current body of knowledge in the field.

6 CONCLUSION AND FUTURE RESEARCH

The importance of studying culture in the context of psychotherapy was firstly recognized in the 1970s. Since then, there has been a plethora of research focusing on common cultural processes in psychotherapy. The literature suggests that even though significant progress has been made in the field, there should be a stronger shift towards culturally sensitive practices.

It is identified that traditional understandings of culture have been prevailing in the field. This means that culture is mostly approached as a fixed system of meanings that is shared by a group of people. Additionally, in the analyzed literature, social constructs such as race and ethnicity are uncritically ascribed to people and used to explain their behaviors in a therapy room. Similarly, the authors use the concepts such as “the West” versus “non-West” or collective societies versus individualistic societies to divide cultural groups and explain differences between them. The question remains why are these obsolete concepts still so dominant in psychotherapy research.

The therapist-patient relationship, therapy outcomes, expressions of symptoms, and attitudes towards illness are often uncritically explained through one’s membership in a certain cultural group. These cultural groups are usually linked to cultural categories such as religion, race, ethnicity, gender, socio-historical or socio-economic status. This approach is problematic as it ignores individual differences and presumes that a person has only one cultural identity.

To conclude, a more processed-based approach to culture is needed. Scholars should aim to identify methods for working with diverse populations which will take into consideration multiplicity of cultural identities. Future studies should try to integrate non-essentialist views of culture. The evaluation of the patient's problem should be both culturally informed and in accordance with the patient's individual needs. Being a culturally sensitive therapist requires stepping out of one's comfort zone, expressing empathy, and willingness to continuously learn by reading and asking mindful questions. In addition, training in psychotherapy should instruct practitioners how to be curious and non-judgmental about other people's cultural identities. Lastly, a culturally skillful therapist should be able to identify when to focus on symptomatology and when to focus on the client's cultural identities.

One should be mindful that most of the research analyzed in this study is conducted with minority groups in the USA and Europe, with a small sample size. Conducting new research with bigger and more diverse sample size would be useful for gaining additional information about culture and its role in psychotherapy.

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APPENDIX

	Year	Title	Author(s)	Publication Type
1.	2010	Cultural Proficiency: A Hispanic Woman With ADHD—A Case Example	R. Waite, J. R. Ramsay	Journal Article
2.	2010	Culture and the Social Construction of Gender: Mapping the Intersection with Mental Health	L. Andermann	Journal Article
3.	2010	Culture, Trauma, and Subjectivity: The French Ethnopsychoanalytic Approach	G. Sturm, T. Baubet, M. R. Moro	Journal Article
4.	2010	Psychotherapy and Culture: Weaving Inner and Outer Worlds	Z. Eleftheriadou	Book
5.	2011	The Handbook of Transcultural Counselling and Psychotherapy	C. Lago	Book
6.	2012	Beyond the Blues: Towards a Cross-Cultural Phenomenology of Depressed Mood	C. Postert, U. Dannlowski, J. M. Müller, C. Konrad	Journal Article
7.	2012	Collaboration in Multicultural Therapy: Establishing a Strong Therapeutic Alliance Across Cultural Lines	A. Asnaani, S. G. Hofmann	Journal Article
8.	2012	Context and Culture: The Initial Clinical Interview with the Latina/o Client	M. E. Gallardo	Journal Article
9.	2012	Culturally Sensitive Therapy with Low-Income Ethnic Minority Clients: An Empowering Intervention	P. Dass-Brailsford	Journal Article
10.	2012	Psychotherapy with Low-Income Patients: Lessons Learned from Treatment Studies	J. L. Krupnick, S. E. Melnikoff	Journal Article
11.	2012	South African Hindu Psychologists' Perceptions of Mental Illness	P. Padayachee, S. Laher	Journal Article
12.	2012	The Effects of Working Alliance and Client-Clinician Ethnic Match on Recovery Status	P. J. Chao, J. J. Steffen, E. Heiby	Journal Article

	Year	Title	Author(s)	Publication Type
13.	2012	Turning Towards Multicultural Diversity Competence in Dance/Movement Therapy	N. G. Carmichael	Journal Article
14.	2013	Cross-Cultural Opening in German Outpatient Mental Healthcare Service: An Exploratory Study of Structural and Procedural Aspects	M. Mösko, F. Gil-Martinez, H. Schulz	Journal Article
15.	2013	Cultural Variation in Resilience as a Response to Traumatic Experience	N. A. Buse, C. Bernacchio, E. J. Burker	Journal Article
16.	2013	Culture and Language: Bilingualism in the German–Jewish Experience and Across Contexts	R. Frie	Journal Article
17.	2013	Doing Therapy in a Foreign Land: When the Therapist Is "Not From Here"	K. Kissil, A. Niño, M. Davey	Journal Article
18.	2013	Psychoanalytic Applications in a Diverse Society	P. Tummala-Narra	Journal Article
19.	2013	Racial and Ethnic Cultural Factors in the Process of Acceptance of Mental Illness	L. Mizock Z. Russinova	Journal Article
20.	2014	Establishing Therapeutic Dialogue with Refugee Families	S. Guregård, J. Seikkula	Journal Article
21.	2014	Expanding the Horizons of Forgiveness Therapy: A Cross-Cultural Application with a Bedouin-Arab Woman	I. Lander	Journal Article
22.	2015	Anorexia Nervosa in a Girl of Chinese Origin: Psychological, Somatic and Transcultural Factors	M. Demarque, G. Guzman, E. Morrison, J. Ahovi, M. R. Moro, C. Blanchet-Collet	Journal Article
23.	2015	Immigrant Perceptions of Therapists' Cultural Competence: A Qualitative Investigation	L. Rogers-Sirin, F. Melendez, C. Refano, Y. Zegarra	Journal Article
24.	2015	Posttraumatic Coping and Distress: An Evaluation of Western Conceptualization of Trauma and Its Applicability to Chinese Culture	P. Zheng, M. J. Gray	Journal Article

	Year	Title	Author(s)	Publication Type
25.	2015	Transference and Countertransference Issues During Times of Violent Political Conflict: The Arab Therapist–Jewish Patient Dyad	R. Srour	Journal Article
26.	2016	A Model for the Theoretical Basis of Cultural Competency to Guide Psychotherapy	J. Chu, A. Leino, S. Pflum, S. Sue	Journal Article
27.	2016	Cross-cultural Bias in the Diagnosis of Borderline Personality Disorder	S. Jani, R. S. Johnson, S. Banu, A. Shah	Journal Article
28.	2016	Culture-sensitive Psychotraumatology	U. Schnyder, R. A. Bryant, A. Ehlers, E. B. Foa, A. Hasan, G. Mwiti, C. H. Kristensen, F. Neuner, M. Oe, W. Yule	Article
29.	2016	One Size Does Not Fit All in Psychotherapy: Understanding Depression Among Patients of Turkish Origin in Europe	N. B. Neftci, S. Barnow	Journal Article
30.	2017	An Integrative Clinical Approach to Cultural Competent Psychotherapy	K. Fung, T. Lo	Journal Article
31.	2017	Clinical Strategies for Working with Clients of African Descent	H. Curtis-Boles	Journal Article
32.	2017	Culturally Responsive Adaptations in Evidence-Based Treatment: the Impact on Client Satisfaction	J. Jones, L. Lee, J. Zigarelli, Y. Nakagawa	Journal Article
33.	2017	Cultural Psychiatry: A Spotlight on the Experience of Clinical Social Workers' Encounter with Jewish Ultra-Orthodox Mental Health Clients	A. Freund, T. Band-Winterstein	Journal Article
34.	2017	Multicultural Guidelines: An Ecological Approach – to Context, Identity, and Intersectionality	American Psychological Association	Guidelines

	Year	Title	Author(s)	Publication Type
35.	2018	A Phenomenological Exploration of Bhutanese Counselors' Experiences with Western Counseling	S.V. Lester, R. J. Horton-Parker, L. M. Craigen, J. C. Durham	Journal Article
36.	2018	Cultural Concepts of the Person and Mental Health in Africa	L. Kpanake	Journal Article
37.	2018	Racial, Ethnic, Cultural, and National Disparities in Counseling and Psychotherapy Outcome Are Inevitable but Eliminating Global Mental Health Disparities With Indigenous Healing Is Not	R. P. Bedi	Journal Article
38.	2018	"Seeking Help is Difficult:" Considerations for Providing Mental Health Services to Muslim Women Clients	F. Saleem S. L. Martin	Journal Article
39.	2018	Why is This Happening to Me? – a Comparison of Illness Representations Between Iranian and German People with Mental Illness	J. Reichardt, A. Ebrahimi, H. N. Dehsorkhi, R. Mewes, C. Weise, H. Afshar, P. Adibi, S. M. Dehkordy, G. Yeganeh, H. Reich W. Rief	Journal Article
40.	2019	Beyond Western Paradigms: A Culturally Grounded Approach to Psychotherapy With Chaldean Americans	A. N. Zora, T. C. Tisdale, J. M. Bustrum, C. Chege, S. Alaichamy	Journal Article
41.	2019	Finding Common Ground in the Context of Difference: A South African Case Study	O. Coetzee, C. Adnams, L. Swartz	Journal Article
42.	2019	Overlaps and Disjunctures: A Cultural Case Study of a British Indian Young Woman's Experiences of Bulimia Nervosa	S. Channa, A. Lavis, C. Connor, C. Palmer, N. Leung, M. Birchwood	Journal Article

	Year	Title	Author(s)	Publication Type
43.	2019	South African Clinical Psychologists' Multicultural Clinical and Supervisory Experience	E. R Johnston	Journal Article
44.	2019	The Cultural Context of Trauma Recovery: Considering the Posttraumatic Stress Disorder Practice Guideline and Intersectionality	T. Bryant-Davis	Journal Article