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On the Need for Cultural Competence in Psychology and Psychotherapy. Part II: From Theory to Clinical Practice

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Abstract

Objective: This article builds on the issues discussed in the first part of the series (*On the Need for Cultural Competence in Psychology and Psychotherapy. Part I: From Ethnocentrism to Cultural Sensitivity*) and aims to present the key diagnostic and therapeutic challenges that arise in work with individuals with migration experience and members of ethnic minority groups.

Theses: Based on a review of the literature, the article discusses: (1) problems arising from the cultural inadequacy of diagnostic instruments, (2) culturally variable patterns of psychological distress expression that may lead to misdiagnosis, and (3) the limited universality of therapeutic protocols grounded in Western theoretical models. The Supplement also presents a set of good practices, including the development of cultural competence, the use of the Cultural Formulation Interview, engagement in cultural consultation, and the cultural adaptation of evidence-based interventions, complemented by a discussion of the importance of systemic solutions within diversity management policies.

Conclusions: The analyses presented indicate that accurate diagnosis and effective psychological support in work with migrants and members of ethnic minority groups require the integration of practitioners' cultural competence with the adaptation of diagnostic tools, therapeutic procedures, and systemic solutions to the specific characteristics of diverse populations. The integration of these elements is a prerequisite for building a more equitable, accessible, and effective psychological practice.

Keywords: intercultural psychotherapy, cultural competence, cultural sensitivity, evidence-based practice, cultural differences in psychotherapy

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This article continues the reflections initiated in the first part of the series (*On the Need for Cultural Competence in Psychology and Psychotherapy. Part I: From Ethnocentrism to Cultural Sensitivity*), which addressed the ethnocentric limitations of contemporary psychology and the necessity of developing cultural competence among psychologists and psychotherapists. The second part focuses on the practical implications of these issues, including diagnostic challenges in work with individuals with migration experience and members of ethnic minority groups. The article presents recommendations for culturally sensitive practices in psychological and psychotherapeutic work that may support professionals operating in culturally diverse settings (see Supplement 1).

Mental Health of Migrants

Although migration does not necessarily lead to the development of mood disorders, the specific challenges and stressors associated with the adaptation process may increase the risk of their onset or influence their course (Beiser, 2009). Among the numerous factors that may intensify acculturative stress are sociodemographic variables (e.g., older age, gender—women are more vulnerable to stress—lower levels of education, or lower socioeconomic status), the nature of migration (particularly forced migration[2]), low perceived social support, and cultural distance (Berry, 1997), understood as the degree of difference between the country of origin and the host country. According to the cultural distance hypothesis, the greater the cultural distance, the higher the likelihood of adaptation difficulties—both psychological and sociocultural (Babiker et al., 1980; Searle & Ward, 1990). For example, Babiker, Cox, and Miller (1980) demonstrated that greater cultural distance was associated with higher levels of anxiety and a greater number of medical consultations among international students.

Although available data indicate that, in the short term, migrants do not exhibit higher levels of psychopathological symptoms than the host population, Kirmayer et al. (2011) note that this relationship changes over time. Some studies have even documented the so-called *healthy immigrant effect*—for example, migrants in Canada have been shown to display overall better health than both native-born Canadians and individuals in their countries of origin (Beiser, 2009). Lower prevalence rates of mental disorders have also been observed among migrants compared with the Canadian population (Ali et al., 2004), particularly with regard to depression and alcohol-related disorders. However, these findings applied primarily to individuals who had resided in the host country for one to four years. Importantly, these indicators varied by migrants' region of origin—being highest among Europeans and lowest among migrants from Africa and Asia. Over time, however, this effect diminishes, and migrants' health tends to

[2] Although refugees—due to the forced nature of migration, loss of safety, and exposure to multiple stressors—typically experience elevated levels of acculturative stress, research shows that most refugees regain psychological equilibrium and that, for the majority, mental health prognoses are generally favorable (Copeland et al., 2007).

deteriorate, converging with the health levels of the host population. Similar patterns have been reported in studies conducted in the United States (Breslau et al., 2007).

Migrants constitute a highly heterogeneous population, and some migrant groups exhibit an elevated risk of developing mental disorders (Pottie et al., 2011). This is particularly evident with regard to an increased incidence of psychotic disorders (Morgan et al., 2008). A meta-analysis conducted by Cantor-Graae and Selten (2005) showed that first-generation migrants have, on average, a 2.7-fold higher risk of developing schizophrenia compared with the reference population[3]; in the second generation, these rates were even higher (4.5; see also Bourque et al., 2011). Although some studies suggest that migrants are more vulnerable than the general population to affective disorders (Chakraborty & McKenzie, 2002) or anxiety disorders (Mak & Rosenblatt, 2002), these findings are not conclusive. For example, a meta-analysis by Swinnen and Selten (2007) demonstrated that, overall, migrants in the United Kingdom do not develop affective disorders more frequently than the general population. The only group for which a statistically significant increased risk of depression was observed comprised British individuals of Caribbean origin—a finding linked, among other factors, to systemic inequalities and racism (see Supplement 2).

Key Challenges in the Mental Health Care of Migrants and Members of Ethnic Minority Groups

Migrants often face substantial barriers to accessing health care, including psychological services (Gulgun et al., 2024; Pottie et al., 2011). The most difficult situation concerns individuals with an irregular migration status, who in many European Union countries are entitled only to emergency health services. This may result in delays in the diagnosis and treatment of disorders, including mental health conditions (European Union Agency for Fundamental Rights, 2012).

Beyond structural barriers—such as limited availability of services and their low affordability (Chakawa et al., 2022)—migrants face a range of additional difficulties in accessing appropriate psychological support. These include language barriers, lack of trust in the health care system and the associated fear of stigmatization, the previously discussed acculturative stress, and cultural differences. The latter encompass, among other factors, culturally specific models of understanding mental health and culturally patterned ways of expressing symptoms (e.g., tendencies toward symptom somatization or differing explanatory models of psychological problems)[4]. Gulgun et al. (2024) further add low levels of mental health literacy (e.g., lack of knowledge about available forms of support as well as difficulties in recognizing symptoms of mental disorders), limited

[3] That is, individuals born in the host country who are not migrants.

[4] Cultural differences may also include, among other factors, differing expectations regarding the role of the therapist, culturally varied communication styles, and distinct ways of seeking social support (e.g., differences in family structure and function).

transportation options for migrants, and culturally insensitive health care systems. These problems are further exacerbated by the lack of appropriate and culturally adapted diagnostic instruments (Kirmayer et al., 2011; Price, 2008). Collectively, these factors significantly influence both the decision to seek help and the accuracy of diagnosis, as well as the effectiveness of the therapeutic process.

Diagnostic Problems

Systemic Diagnostic Errors

One of the key challenges that may hinder effective prevention, diagnosis, and treatment of mental health problems in migrant populations is the insufficient level of cultural competence among mental health professionals (European Union Agency for Fundamental Rights, 2012). Kirmayer et al. (2007) suggest that the low rate of utilization of psychological services may indicate underdiagnosis and unmet mental health needs among immigrants. Cultural and language barriers, culturally inadequate diagnostic tools, and insufficient cultural competence among professionals contribute to systemic diagnostic errors, which may result in chronic distress and a deterioration in quality of life within this population. Kirmayer et al. (2007) emphasize the importance of culturally shaped ways of expressing and interpreting symptoms of psychological distress, which may lead to misdiagnosis or non-recognition within Western diagnostic systems.

Adam Anczyk and Halina Grzymała-Moszczyńska (2021), discussing the studies conducted by Kaiser and colleagues (2013) among residents of Haiti following the 2010 earthquake, point to a similar problem. Kaiser et al. (2013) carried out research aimed at developing reliable and culturally valid tools for assessing mental health that could effectively identify individuals in need of psychosocial support after the disaster. It emerged that the terms used in standard diagnostic instruments were incomprehensible to respondents—literal translations of concepts such as "depression" or "anxiety" had no equivalents in the local language or lived experience. Discrepancies were also observed in the connotations attributed to specific questionnaire items. For example, in the *Beck Depression Inventory* (BDI; Beck et al., 1988), questions concerning changes in appetite and sleep were interpreted by respondents primarily as indicators of physical illness, pregnancy, aging, or poverty rather than as symptoms of depression.

Consequently, the authors emphasize the importance of functional diagnosis, as identifying symptoms alone—without understanding how they affect everyday functioning—is insufficient. What is crucial is an assessment of the degree of disruption in an individual's life, bearing in mind that what is considered normative is deeply culturally embedded[5]. The scope of mental health problems

[5] For example, in Nepal, experiences of trauma are highly stigmatized, as local beliefs strongly associate trauma with karma and interpret adverse events as manifestations of

among migrants and members of minority groups can be fully understood only by analyzing how an individual's experiences diverge from what is regarded as normal and acceptable within a given cultural context. Some authors also highlight the risk of overdiagnosing schizophrenia in migrant populations, where observed symptoms may in fact reflect affective experiences, brief reactive disorders, or culturally appropriate expressions of psychological distress in response to adverse life circumstances (McKenzie et al., 2008). Kaiser et al. (2013) further stress the necessity of cultural adaptation of diagnostic instruments (see also Kwiatkowska, 2014), alongside the development of locally grounded assessment tools.

Another example of insufficient cultural competence among mental health professionals working with culturally diverse populations is the overrepresentation of Roma children in special education schools in Central and Eastern Europe (UNICEF, 2011, 2024), including Poland (Grzymała-Moszczyńska et al., 2011; Nowicka-Rusek, 2011). In 2011, Halina Grzymała-Moszczyńska and her research team conducted a study aimed, among other objectives, at comparing the level of intellectual functioning of Roma children diagnosed with intellectual disability—most of whom attended special schools—with Roma children without such a diagnosis who were enrolled in mainstream schools. Cognitive abilities were assessed using nonverbal Raven's Progressive Matrices tests, both the Colored version (Szustrowa & Jaworowska, 2003) and the Standard version (Jaworowska & Szustrowa, 2000).

Although the authors caution that the obtained results should not be interpreted as questioning the competence of the diagnosticians who had previously assessed the children's functioning, the discrepancies between the earlier diagnoses and the study findings—when considered alongside the described diagnostic practices—raise serious concerns. The results showed that only six out of 31 Roma children with a prior diagnosis of intellectual disability actually met the criteria for this diagnosis, whereas in 52% of the children in this group the level of functioning fell within the normative range of intellectual ability. Importantly, no statistically significant differences were found between the results of Roma children attending special schools and those of their peers in mainstream schools.

The authors further point to serious shortcomings in earlier diagnostic practices. Among other issues, the WISC-R test was administered to children with limited proficiency in Polish, and substantial discrepancies between verbal and nonverbal scale scores were averaged, which constitutes a significant methodological error (see Krasowicz-Kupis & Wiejak, 2006). Moreover, diagnostic procedures also relied on instruments that had not undergone standardization or cultural adaptation—for example, the Stanford–Binet Intelligence Scale, whose Polish adaptation was published only in 2017. As emphasized by Nowicka-Rusek (2011), the use of culturally inappropriate diagnostic tools in psychological and educational counseling centers represents a systemic problem.

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bad karma—stemming from sins committed in a previous life or transgressions of family members. This belief system may lead individuals to avoid seeking psychological help due to fear of stigmatization (Kohrt & Hruschka, 2010).

Cultural Expression and Perception of Symptoms

The process of diagnosing mental disorders in individuals from different ethnic and cultural backgrounds involves significant challenges, arising in part from differences in clinical presentation. Culture plays a crucial role in shaping how individuals experience, interpret, and communicate their symptoms. Even symptoms regarded as universal in Western classification systems may manifest in markedly different ways across cultural contexts.

For example, earlier cross-cultural research conducted in the United Kingdom demonstrated differences in the clinical presentation of schizophrenia across cultural groups: positive symptoms, specifically auditory and visual hallucinations, were more frequent among African, West Indian, and Asian patients than among English patients (Ndetei & Vadher, 1984). These differences may stem both from culturally distinct patterns of experiencing psychological distress and from contextual factors such as social stigmatization, diagnostic bias, and culturally conditioned styles of emotional communication.

Similar phenomena have been observed in the case of eating disorders. In studies conducted in Hong Kong, individuals diagnosed with anorexia did not report the fear of weight gain typically emphasized in Western diagnostic classifications; instead, they cited lack of appetite or sensations of bloating as the primary reasons for restricting food intake (Lee et al., 1993).

Another example of culturally distinct symptom expression concerns depression in the Chinese context. The lower prevalence of this disorder in China compared with other regions of the world (Kessler et al., 1994) may be partly explained by the dominant pattern of symptom somatization characteristic of East Asian populations (Chang et al., 2017). Patients with depression in this cultural context more frequently report somatic complaints, such as chronic fatigue or sleep disturbances, whereas psychological symptoms are relatively less emphasized compared, for example, with Canadian patients (Ryder et al., 2008). Importantly, these differences cannot be reduced solely to a somatization versus psychologization dichotomy—research also points to variation in specific psychological symptoms. Euro-Canadians more often report depressed mood, whereas Chinese patients more frequently experience and report emotional suppression (Dere et al., 2013).

An additional noteworthy phenomenon is the tendency of Chinese patients to emphasize somatic complaints particularly when interacting with a new or unfamiliar physician. This pattern may be interpreted as a culturally shaped help-seeking strategy that enables access to health care while simultaneously reducing the risk of stigmatization associated with disclosing psychological problems (Dere et al., 2013). Similarly, research by Choi and colleagues (2016) demonstrated that Korean respondents who used somatic language to describe their difficulties elicited higher levels of empathy than those who employed psychological terminology—an effect that was not observed among participants of American origin.

Although the biological foundations of human functioning are universal, mental disorders manifest differently depending on the cultural context. This is

reflected in conditions that are characteristic of specific cultural milieus, referred to as *cultural concepts of distress*. For example, bulimia is virtually absent in India and in countries of West, East, and South Asia, yet it is considerably more prevalent in societies influenced by Western culture (Heine, 2020). Other examples include *hikikomori*—a phenomenon of prolonged social withdrawal observed in Japan that is not explicitly included in the DSM-5 (Sakai et al., 2004)—and *dhat syndrome*, found in South Asia and associated with anxiety about semen loss (Heine, 2020).

Heine (2020) further notes that while it seems obvious that applying Asian diagnostic categories would be inappropriate in the American context, the reverse situation is far less often subjected to reflection—namely, the fact that Western classifications, regarded as universal, have for decades shaped the practice of cross-cultural psychiatry in ways marked by ethnocentrism (Kleinman, 1988). As a consequence, local experiences of distress are often forced into the framework of Western diagnostic categories such as depression, anxiety disorders, or schizophrenia, which entails the risk of diagnostic errors and the loss of culturally meaningful aspects of the lived experience.

It is also worth emphasizing that cultural differences in the expression of mental disorders have been reflected in the development of classification systems alternative to Western frameworks, such as the *Chinese Classification of Mental Disorders* (CCMD-3, 2001). This system includes diagnostic categories specific to the Chinese cultural context, such as *shenjing shuairuo* (neurasthenia)—a less stigmatizing local diagnostic category with a pronounced somatic component, functionally comparable to depression (Lee, 1999). Despite the growing prominence of international classification systems such as ICD-10/ICD-11 (used by 38.5% of specialists in China) and DSM-IV (7.7%), CCMD-3 remains the most frequently used diagnostic system in Chinese psychiatric practice. According to data reported by Zou et al. (2008), it is used by 63.8% of Chinese psychiatrists. Importantly, 35.8% of respondents expressed the view that ICD-10 and DSM-IV are excessively rooted in European cultural values and concepts, which may limit their diagnostic adequacy within the Chinese social and cultural context.

Effectiveness of Psychotherapeutic Interventions in an Intercultural Context

A psychologist for whom the ethical principle *primum non nocere* remains paramount is obliged to treat every client with equal respect and to take their individual needs into account. Fulfilling this obligation, however, requires an in-depth analysis of the individual's context of functioning, with particular attention to cultural determinants. Equality in psychological practice does not mean treating all individuals in the same way, but rather tailoring interventions to their specific characteristics. Empirical research indicates that the effectiveness of interventions developed within Western psychological models may be limited when applied to populations that are not part of WEIRD societies (Khanna & Singh, 2019).

Contemporary forms of psychotherapy—particularly those grounded in the verbal expression of emotions within the therapeutic relationship—originate

from Western, individualistic cultural traditions (Heine, 2020). Price (2008) notes that psychotherapy often encourages clients to express emotions more frequently, more intensely, and more explicitly. However, in some cultures—as illustrated by the case study described by Christopher et al. (2014)[6] – emotional suppression constitutes an adaptive social strategy that facilitates effective functioning within a given environment. In such cases, standard therapeutic interventions may prove not only ineffective but potentially harmful. Watters (2010) emphasizes that the ethnocentric application of Western therapeutic protocols in non-WEIRD societies has, at times, resulted in ineffective treatment of mental disorders and even contributed to the spread of certain diagnostic categories in contexts where they had previously been virtually unknown (as occurred, for example, with anorexia in Hong Kong).

Lee and colleagues (1992) note that in non-WEIRD societies, family and spirituality constitute the core pillars of traditional mental health support systems. The authors emphasize that mental health professionals need to recognize that Western-dominated therapeutic paradigms are not universal in nature and that effective psychological assistance requires openness to integrating family-based support systems, spiritual beliefs, and indigenous healing practices within culturally responsive psychotherapy. Zane (2008, as cited in Price, 2008) underscores that therapeutic practices that take cultural factors into account—so-called *culturally informed treatments*—are characterized by greater effectiveness than universal one-size-fits-all approaches. Similarly, Smith and Trimble (2016) highlight the importance of adapting therapeutic procedures to the cultural context, stressing that culturally diverse expressions of psychological suffering require flexibility and cultural adequacy in the design and implementation of treatment protocols.

At the same time, it should be emphasized that taking spirituality or indigenous practices into account in therapeutic work does not imply an uncritical incorporation of such elements into Western treatment models. Rather, this recommendation pertains to the development of cultural competence within an evidence-based framework, which assumes the necessity of empirical verification of intervention effectiveness and cultural validity—ultimately contributing to the effectiveness and ethical soundness of therapeutic practice. Some scholars (see Kirmayer, 2012) point to tensions between evidence-based practice (EBP) and approaches that emphasize the development of cultural competence. In particular, criticism has been directed at the limited generalizability of research based on WEIRD populations, as well as culturally embedded assumptions regarding

[6] The case study concerns the ethnocentrism of Western volunteers and specialists who arrived in Sri Lanka after the 2004 tsunami to provide assistance to the local community. Despite their good intentions, the specialists acted ethnocentrically, unreflectively transferring Western practices into the Sri Lankan context. They committed a number of errors, violated local norms, and consumed already scarce resources; as a result, they were referred to by the local community as a “second tsunami”. This case study is analyzed in detail in the article *On the Need for Cultural Competence in Psychology and Psychotherapy. Part I: From Ethnocentrism to Cultural Sensitivity*.

diagnosis, treatment efficacy, and intervention goals. The quality of research examining the effectiveness of evidence-based interventions in work with members of ethnic minority groups has also been questioned (Huey & Polo, 2008).

This does not imply an opposition between the two approaches, provided that EBP also incorporates cultural knowledge that reflects local ways of defining health, illness, and treatment effectiveness. Accordingly, both cultural adaptations of existing protocols and research on the effectiveness of interventions conducted outside Western cultural contexts are needed.

It is also important that, in the process of culturally adapting existing Western treatment protocols, locally rooted and culturally embedded forms of psychotherapy are not overlooked, such as Morita therapy used in Japan and China, Naikan therapy in Japan, Meseron in Nigeria, or Ubuntu-based approaches in South Africa. As emphasized by Koç and Kafa (2018), there is empirical evidence supporting the effectiveness of these therapeutic approaches.

Although some meta-analyses have not unequivocally demonstrated that cultural competence increases intervention effectiveness (e.g., Benuto & O'Donohue, 2015), others indicate greater effectiveness of culturally adapted therapeutic interventions compared with standard psychotherapeutic approaches. Griner and Smith (2006) showed that culturally tailored interventions are more effective than standard ones, and that interventions delivered in clients' native languages are twice as effective. Smith et al. (2011), in turn, demonstrated that intervention effectiveness increases with the number of culturally adapted elements incorporated. Similar conclusions were drawn by Rathod (2016) on the basis of systematic literature reviews. Tao and colleagues (2015) found in a meta-analysis that psychotherapists' cultural competence was positively associated with, among other outcomes, symptom improvement, client satisfaction, general therapeutic skills, clients' perceptions of sessions, and the quality of the therapeutic alliance. Implementing evidence-based interventions in culturally adapted forms may not only improve therapeutic outcomes but also increase access to treatment and reduce the stigmatization of mental disorders (Koç & Kafa, 2018).

A meta-analysis conducted by Hall and colleagues (2016) showed that the mean effect size for culturally adapted interventions was 0.67. The most frequently culturally adapted therapeutic approach was cognitive-behavioral therapy (CBT). Other approaches were also adapted, albeit less often, including psychoeducation, interpersonal therapy, problem-solving therapy, and family therapy. Importantly, evidence-based interventions such as CBT, family therapy, interpersonal therapy, and selected third-wave therapies—such as Acceptance and Commitment Therapy (ACT)—have been shown to align well with values characteristic of many Asian cultures (Fung & Zhu, 2018). Empirical findings indicate that cultural adaptation of these protocols not only increases their accessibility and acceptability among clients, but may also significantly enhance their therapeutic effectiveness (Hall et al., 2016).

A well-established example of a culturally adapted intervention is the American Indian Life Skills program (AILS), developed by Teresa LaFromboise (1996). The program was designed to reduce risk factors and strengthen protective resources related to suicidal behaviors among American Indian youth. AILS

integrates contemporary intervention techniques—such as social skills training—with traditional cultural values of Indigenous American communities. The program focuses on developing key life skills, including communication, problem-solving, stress management, and emotional regulation, while simultaneously incorporating culturally central elements such as the concepts of "sanctuary" and "purification", as well as the role of family and tribal role models. Pilot studies indicate the effectiveness of the program, demonstrating a significant reduction in suicidal ideation among participants, who belong to one of the highest suicide-risk groups in the United States (Price, 2008).

The AILS program illustrates how important and beneficial it can be for members of ethnic minority groups and migrants to integrate therapeutic interventions with the local cultural context. The pursuit of effective treatment methods should not exclude these groups—every individual deserves access to the best possible, culturally appropriate psychological care.

An important component of ensuring equity in access to care is also taking patients' economic circumstances into account. Individuals from countries with lower socioeconomic status are often unable to afford long-term forms of therapy. In this context, the growing interest in short-term approaches, such as Solution-Focused Brief Therapy (SFBT), appears particularly well justified. In recent years, the number of studies on SFBT conducted in contexts outside the WEIRD world has been twice as high as in Western countries, which may indicate its high relevance and practical usefulness in settings with limited resources (Beyebach et al., 2021).

Summary

This article demonstrates that psychological and psychotherapeutic work in conditions of increasing cultural diversity requires moving beyond standard diagnostic and therapeutic frameworks developed within the WEIRD paradigm. The discussed examples of diagnostic errors, culturally shaped patterns of symptom expression, and the limited validity of clinical tools and classification systems show that, without reflection on cultural context, diagnostic mistakes are likely to occur, which in turn may lead to ineffective or even counterproductive therapy.

Therefore, the development of cultural competence cannot be treated as an optional add-on to "proper" clinical practice but must be understood as its integral dimension. This includes both the individual level—such as the therapist's cultural competencies and good practices, including the use of tools like the Cultural Formulation Interview or engagement in cultural consultations—and the societal level, related to integration policies, the availability of interpreters and cultural mediators, and the shaping of healthcare systems that address the needs of migrant populations. Only the integration of culturally competent, evidence-based practice with systemic actions—across education, healthcare, and diversity management policies—makes it possible to genuinely move toward the

realization of the principle of equity in mental healthcare. Supplement 1 offers a set of concrete good practices and identifies key structural conditions that may support psychologists and psychotherapists in translating theoretical reflection into everyday clinical practice.

Notes

The supplements are available at the following link: https://osf.io/khaxv/overview?view_only=699f6793c0474ede8f1e81358fe51c37

References

Ali, J. S., McDermott, S., & Gravel, R. G. (2004). Recent research on immigrant health from Statistics Canada's population surveys. *Canadian Journal of Public Health*, *95*(3), I9–I13. https://doi.org/10.1007/bf03403659

Anczyk, A., & Grzymała-Moszczyńska, H. (2021). *The psychology of migration: Facing cultural and religious diversity*. Brill. https://doi.org/10.1163/9789004465237

Babiker, I. E., Cox, J. L., & Miller, P. M. (1980). The measurement of cultural distance and its relationship to medical consultations, symptomatology and examination performance of overseas students at Edinburgh University. *Social Psychiatry*, *15*(3), 109–116. https://doi.org/10.1007/bf00578141

Beck, A. T., Steer, R. A., & Carbin, M. G. (1988). Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation. *Clinical Psychology Review*, *8*(1), 77–100. https://doi.org/10.1016/0272-7358(88)90050-5

Beiser, M. (2009). Resettling refugees and safeguarding their mental health: Lessons learned from the Canadian Refugee Resettlement Project. *Transcultural Psychiatry*, *46*(4), 539–583. https://doi.org/10.1177/1363461509351373

Benuto, L. T., & O'Donohue, W. (2015). Is culturally sensitive cognitive behavioral therapy an empirically supported treatment? The case for Hispanics. *International Journal of Psychology and Psychological Therapy*, *15*(3), 405–421.

Berry, J. W. (1997). Immigration, acculturation, and adaptation. *Applied Psychology*, *46*(1), 5–34. https://doi.org/10.1111/j.1464-0597.1997.tb01087.x

Beyebach, M., Neipp, M.-C., Solanes-Puchol, Á., & Martín-del-Río, B. (2021). Bibliometric differences between WEIRD and non-WEIRD countries in the outcome research on solution-focused brief therapy. *Frontiers in Psychology*, *12*, Article 754885. https://doi.org/10.3389/fpsyg.2021.754885

Bourque, F., van der Ven, E., & Malla, A. (2011). A meta-analysis of the risk for psychotic disorders among first- and second-generation immigrants. *Psychological Medicine*, *41*(5), 897–910. https://doi.org/10.1017/s0033291710001406

Breslau, J., Aguilar-Gaxiola, S., Borges, G., Kendler, K. S., Su, M., & Kessler, R. C. (2007). Risk for psychiatric disorder among immigrants and their US-Born descendants:

Evidence from the National Comorbidity Survey replication. *The Journal of Nervous and Mental Disease*, *195*(3), 189–195. https://doi.org/10.1097/01.nmd.0000243779.35541.c6

Cantor-Graae, E., & Selten, J.-P. (2005). Schizophrenia and migration: A meta-analysis and review. *American Journal of Psychiatry*, *162*(1), 12–24. https://doi.org/10.1176/appi.ajp.162.1.12

Cantor-Graae, E., Zolkowska, K., & McNeil, T. F. (2005). Increased risk of psychotic disorder among immigrants in Malmö: A 3-year first-contact study. *Psychological Medicine*, *35*(8), 1155–1163. https://doi.org/10.1017/s0033291705004721

Chakawa, A., & Shapiro, S. K. (2022). The association between problem recognition, race/ethnicity, and professional help-seeking intentions across psychological disorders. *Emerging Adulthood*, *10*(4), 891–909. https://doi.org/10.1177/21676968211000491

Chakraborty, A., & McKenzie, K. (2002). Does racial discrimination cause mental illness? *The British Journal of Psychiatry*, *180*(6), 475–477. https://doi.org/10.1192/bjp.180.6.475

Chang, M. X.-L., Jetten, J., Cruwys, T., & Haslam, C. (2017). Cultural identity and the expression of depression: A social identity perspective. *Journal of Community & Applied Social Psychology*, *27*(1), 16–34. https://doi.org/10.1002/casp.2291

Choi, E., Chentsova-Dutton, Y., & Parrott, W. G. (2016). The effectiveness of somatization in communicating distress in Korean and American cultural contexts. *Frontiers in Psychology*, *7*, Article 383. https://doi.org/10.3389/fpsyg.2016.00383

Christopher, J. C., Wendt, D. C., Marecek, J., & Goodman, D. M. (2014). Critical cultural awareness: Contributions to a globalizing psychology. *American Psychologist*, *69*(7), 645–655. https://doi.org/10.1037/a0036851

Copeland, W. E., Keeler, G., Angold, A., & Costello, E. J. (2007). Traumatic events and posttraumatic stress in childhood. *Archives of General Psychiatry*, *64*(5), 577–584. https://doi.org/10.1001/archpsyc.64.5.577

Dere, J., Sun, J., Zhao, Y., Persson, T. J., Zhu, X., Yao, S., Bagby, R. M., & Ryder, A. G. (2013). Beyond "somatization" and "psychologization": Symptom-level variation in depressed Han Chinese and Euro-Canadian outpatients. *Frontiers in Psychology*, *4*, Article 377. https://doi.org/10.3389/fpsyg.2013.00377

European Union Agency for Fundamental Rights. (2012). *Migranci o nieuregulowanym statusie pobytu: dostęp do opieki zdrowotnej w 10 krajach członkowskich Unii Europejskiej* [Migrants with irregular migration status: Access to healthcare in 10 European Union member states]. Urząd Publikacji Unii Europejskiej. https://doi.org/10.2811/33469

Fung, K., & Zhu, Z. (2018). Acceptance and commitment therapy and Asian thought. In R. Moodley, T. Lo, N. Zhu (Eds.), *Asian healing traditions in counseling and psychotherapy* (pp. 143–158). SAGE Publications. https://doi.org/10.4135/9781071800768.n14

Griner, D., & Smith, T. B. (2006). Culturally adapted mental health intervention: A meta-analytic review. *Psychotherapy*, *43*(4), 531–548. https://doi.org/10.1037/0033-3204.43.4.531

Grzymała-Moszczyńska, H., Barzykowski, K., Dzida, D., Grzymała-Moszczyńska, J., & Kosno, M. (2011). *Raport końcowy z projektu badawczego* [Final report from the

research project]. In M. Kołaczek, J. Talewicz-Kwiatkowska (Eds.). Funkcjonowanie poznawcze i językowe dzieci romskich uczęszczających do szkół podstawowych i masowych – konteksty społeczne (pp. 51–85). Stowarzyszenie Romów w Polsce.

Gulgun, D., van Ens, W., & Swildens, W. E. (2024). Change in care needs of people with severe mental illness with and without a non-Western migration background: Are their needs equally served throughout treatment? *Social Psychiatry and Psychiatric Epidemiology*, *60*, 1297–1309. https://doi.org/10.1007/s00127-024-02765-4

Hall, G. C. N., Ibaraki, A. Y., Huang, E. R., Marti, C. N., & Stice, E. (2016). A meta-analysis of cultural adaptations of psychological interventions. *Behavior Therapy*, *47*(6), 993–1014. https://doi.org/10.1016/j.beth.2016.09.005

Heine, S. J. (2020). *Cultural Psychology* (4th ed.). W. W. Norton.

Huey, S. J., & Polo, A. J. (2008). Evidence-based psychosocial treatments for ethnic minority youth: A review and meta-analysis. *Journal of Clinical Child & Adolescent Psychology*, *37*(1), 262–301. https://doi.org/10.1080/15374410701820174

Jaworowska, A., & Szustrowa, T. (2000). *Test Matryc Ravena w wersji standard. Formy: klasyczna, równoległa i plus* [Raven's Standard Progressive Matrices Test: Classic, parallel, and plus forms]. Pracownia Testów Psychologicznych PTP.

Kaiser, B. N., Kohrt, B. A., Keys, H. M., Khoury, N. M., & Brewster, A. R. T. (2013). Strategies for assessing mental health in Haiti: Local instrument development and transcultural translation. *Transcultural Psychiatry*, *50*(4), 532–558. https://doi.org/10.1177/1363461513502697

Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshleman, S., Wittchen, H.-U., & Kendler, K. S. (1994). Lifetime and 12-Month prevalence of DSM-III-R psychiatric disorders in the United States. *Archives of General Psychiatry*, *51*(1), 8–19. https://doi.org/10.1001/archpsyc.1994.03950010008002

Kirmayer, L. J. (2012). Cultural competence and evidence-based practice in mental health: Epistemic communities and the politics of pluralism. *Social Science & Medicine*, *75*(2), 249–56. https://doi.org/10.1016/j.socscimed.2012.03.018

Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., Hassan, G., Rousseau, C., & Pottie, K. (2011). Common mental health problems in immigrants and refugees: General approach in primary care. *Canadian Medical Association Journal*, *183*(12), E959–E967. https://doi.org/10.1503/cmaj.090292

Kirmayer, L. J., Weinfeld, M., Burgos, G., du Fort, G. G., Lasry, J. C., & Young, A. (2007). Use of health care services for psychological distress by immigrants in an urban multicultural milieu. *Canadian Journal of Psychiatry*, *52*(5), 295–304. https://doi.org/10.1177/070674370705200504

Kleinman, A. (1988). *The illness narratives: Suffering, healing, and the human condition*. Basic Books.

Koç, V., & Kafa, G. (2018). Cross-cultural research on psychotherapy: The need for a change. *Journal of Cross-Cultural Psychology*, *50*(1), 100–115. https://doi.org/10.1177/0022022118806577

Kohrt, B. A., & Hruschka, D. J. (2010). Nepali concepts of psychological trauma: The role of idioms of distress, ethnopsychology and ethnophysiology in alleviating suffering and preventing stigma. *Culture, Medicine and Psychiatry*, *34*(2), 322–352. https://doi.org/10.1007/s11013-010-9170-2

Krasowicz-Kupis, G., & Wiejak, K. (2006). *Skala inteligencji Wechslera dla dzieci (WISC-R) w praktyce psychologicznej* [The Wechsler Intelligence Scale for Children (WISC-R) in psychological practice]. Wydawnictwo Naukowe PWN.

Kwiatkowska, A. (2014). Problemy metodologiczne w badaniach międzykulturowych i kulturowych [Methodological problems in cross-cultural and cultural research]. *Psychologia Społeczna*, *1*(28), 8–27.

LaFromboise, T. D. (1996). *American Indian life skills development curriculum*. University of Wisconsin Press.

Lee, S. (1999). Diagnosis postponed: Shenjing shuairuo and the transformation of psychiatry in post-mao China. *Culture Medicine and Psychiatry*, *23*(3), 349–380. https://doi.org/10.1023/a:1005586301895

Lee, S., Ho, T. P., & Hsu, L. K. G. (1993). Fat phobic and non-fat phobic anorexia nervosa: A comparative study of 70 Chinese patients in Hong Kong. *Psychological Medicine*, *23*(4), 999–1017. https://doi.org/10.1017/S0033291700026465

Lee, C. C., Oh, M. Y., & Mountcastle, A. R. (1992). Indigenous models of helping in Nonwestern Countries: Implications for multicultural counseling. *Journal of Multicultural Counseling and Development*, *20*(1), 3–10. https://doi.org/10.1002/j.2161-1912.1992.tb00557.x

McKenzie, K., Fearon, P., & Hutchinson, G. (2008). Migration, ethnicity and psychosis. In C. Morgan, K. McKenzie, P. Fearon (Eds.), *Society and psychosis* (pp. 143–160). Cambridge University Press. https://doi.org/10.1017/cbo9780511544064.010

Morgan, C., Kirkbride, J., Hutchinson, G., Craig, T., Morgan, K., Dazzan, P., Boydell, J., Doody, G. A., Jones, P. B., Murray, R. M., Leff, J., & Fearon, P. (2008). Cumulative social disadvantage, ethnicity and first-episode psychosis: A case-control study. *Psychological Medicine*, *38*(12), 1701–1715. https://doi.org/10.1017/s0033291708004534

Ndetei, D. M., & Vadher, A. (1984). A comparative cross-cultural study of the frequencies of hallucination in schizophrenia. *Acta Psychiatrica Scandinavica*, *70*(6), 545–549. https://doi.org/10.1111/j.1600-0447.1984.tb01247.x

Nowicka-Rusek, E. (2011). Szkoła, rodzina i dzieci romskie [School, family, and Romani children]. In J. Talewicz-Kwiatkowska, M. Kołaczek (Eds.), *Funkcjonowanie poznawcze i językowe dzieci romskich uczęszczających do szkół podstawowych specjalnych i masowych – konteksty społeczne* (pp. 35–50). Stowarzyszenie Romów w Polsce.

Price, M. (2008). *Culture matters. Accounting for clients' backgrounds and values makes for better treatment*. American Psychological Association.

Rathod, S. (2016). Contemporary psychotherapy and cultural adaptations. *Journal of Contemporary Psychotherapy*, *47*, 61–63. https://doi.org/10.1007/s10879-016-9344-5

Ryder, A. G., Yang, J., Zhu, X., Yao, S., Yi, J., Heine, S. J., & Bagby, R. M. (2008). The cultural shaping of depression: Somatic symptoms in China, psychological symptoms in North America? *Journal of Abnormal Psychology*, *117*(2), 300–313. https://doi.org/10.1037/0021-843x.117.2.300

Sakai, M., Ishikawa, S., Takizawa, M., Sato, H., & Sakano, Y. (2004). The state of hikikomori from a family's point of view: Statistical survey and the role of psychological intervention. *Japanese Journal of Counseling Science*, *27*, 168–179.

Searle, W., & Ward, C. (1990). The prediction of psychological and sociocultural adjustment during cross-cultural transitions. *International Journal of Intercultural Relations*, *14*(4), 449–464. https://doi.org/10.1016/0147-1767(90)90030-z

Smith, T. B., Rodríguez, M. D., & Bernal, G. (2011). Culture. *Journal of Clinical Psychology*, *67*(2), 166–175. https://doi.org/10.1002/jclp.20757

Smith, T. B., & Trimble, J. E. (2016). *Foundations of multicultural psychology: Research to inform effective practice*. American Psychological Association. https://doi.org/10.1037/14733-000

Swinnen, S. G. H. A., & Selten, J.-P. (2007). Mood disorders and migration. *The British Journal of Psychiatry*, *190*(1), 6–10. https://doi.org/10.1192/bjp.bp.105.020800

Szustrowa, T., & Jaworowska, A. (2003). *Test Matryc Ravena w wersji kolorowej: TMK: formy klasyczna i równoległa: podręcznik* [Raven's Coloured Progressive Matrices (TMK): Classic and parallel forms: Manual]. Pracownia Testów Psychologicznych PTP.

Tao, K. W., Owen, J., Pace, B. T., & Imel, Z. E. (2015). A meta-analysis of multicultural competencies and psychotherapy process and outcome. *Journal of Counselling Psychology*, *62*(3), 337–350. https://doi.org/10.1037/cou0000086

UNICEF. (2011). *The right of Roma children to education: Position paper*. https://www.unicef.org/eca/media/1566/file/Roma%20education%20postition%20paper.pdf?embed=1

UNICEF. (2024). *Multi-country programme evaluation synthesis report of the childcare and deinstitutionalisation reforms from 2009 to 2022*. UNICEF ECARO. https://evaluationreports.unicef.org/GetDocument?documentID=18842&fileID=53881&utm

Ward, C., Bochner, S., & Furnham, A. (2001). *The psychology of culture shock* (1st ed.). Routledge. https://doi.org/10.4324/9780203992258

Watters, E. (2010). *Crazy like us: The globalization of the American psyche*. Free Press.

Zou, Y.-Z., Cui, J.-F., Han, B., Ma, A.-L., Li, M.-Y., & Fan, H.-Z. (2008). Chinese psychiatrists views on global features of CCMD-III, ICD-10 and DSM-IV. *Asian Journal of Psychiatry*, *1*(2), 56–59. https://doi.org/10.1016/j.ajp.2008.09.007