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MULTICULTURALISM IN THE WORK OF PSYCHOLOGISTS: ETHICS AND PRACTICE IN A CONTEXT OF CLINICAL DIAGNOSIS AND THERAPEUTIC WORK

Abstract: The article contains a review of basic notions connected with the consequences of an increasing multiculturalism of Polish society for the professional ethics of a psychologist in a clinical context. In the first part the issues connected with a psychological diagnosis of people of different cultural background are presented. Also, a notion of a culturally sensitive diagnosis and a specificity of interpersonal communication in a multicultural environment are described. In the second part, issues regarding psychotherapy and psychological help for people of different cultural backgrounds, with a particular attention drawn to a therapy of families culturally diverse, where the rules of communicative school of the system therapy gain an additional value are described. In both parts of the article, a particular attention is given to the contemporary understanding of the notion of cultural competency in the work of psychologists-practitioners.

Keywords: cultural factors in psychological diagnosis, psychological diagnosis, ethics of psychologists' profession, intercultural communication, cultural differences.

INTRODUCTION

The impact of the socio-cultural perspective on research into the diagnosis and treatment of mental disorders has contributed to the fact that within behavioural sciences it has become clear that patterns of both physical and psychological disorders in a given society can change over time with changes in socio-cultural conditions. It is now explicitly stated that mental disorders are defined only in relation to cultural, social and family norms and values (APA, 2013). The influence of urbanization, modernization and industrialization processes on cultural variables, which have thus become multifaceted (Hogan, 2007; Wakefield, Garner, Pehrsson, Tyler, 2010), is also emphasized. These discoveries introduced new, important threads to contemporary views on mental disorders, which in consequence placed the need for psychologists and psychother-

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apists to develop a new level of self-awareness and new requirements for their knowledge (Wakefield et al., 2010, p. 2).

First, it has been shown that despite the occurrence of certain universal symptoms and their patterns, socio-cultural factors most often decide which disorders will develop, what form they will take, how often they will occur and how they will occur. Cultural differences may also apply to the prognosis or effects of mental disorders (Butcher, Hooley, Mineka, 2017). Second, it was found that in addition to the influence of culture on the symptoms of individual disorders, there are also cultural differences in the entire symptom patterns between cultures of different parts of the world referred to as "folk illnesses", "cultural illnesses" (cultural illnesses, culture specific illnesses) that cannot be referred to biomedical disease entities.

These diseases are sometimes specific to a given culture, sometimes for a wider geographical and ethnic region, and sometimes their counterparts can also be found in distant cultures (Penkala-Gawęcka, 1994). The term 'culture-bound syndromes' (Simons, Hughes, 1985) was created to describe them, which nowadays in the classification of mental health disorders (DSM-5; ICD-10) is called culture-related syndromes (Shahrokh, Hales, 2009). In addition, DSM-5 also defines cultural idiom of distress, i.e. culturally embedded terms for suffering, as well as cultural explanation or perceived cause, which allows the diagnosis to cover the entire spectrum of psychopathological conditioned phenomena culturally (APA, 2013). According to the authors of DSM-5, these three concepts include cultural ways of understanding and describing disease experiences that may occur during a clinical meeting.

CULTURAL COMPETENCES OF A PSYCHOLOGIST

In addition to the diagnosis taking into account cultural issues postulated, among others by APA as a part of psychological assistance, talk began about therapy sensitive to cultural differences, also called multicultural, transcultural therapy, taking into account cultural differences (Mohamed, 2013). Collecting data from reports presented at the Western Association of Counsellor Education and Supervision (WACES) Conference 2008 and Association for Counsellor Education and Supervision (ACES) Conference 2009, the American Counselling Association published a model of analysis of cultural spheres particularly relevant for the development of competences of persons dealing with psychological counselling in various fields (Wakefield et al., 2010). The publication of official guidelines of this kind demonstrates the importance of the issue. It emphasizes again, referring to earlier literature, the importance of knowledge of research in the field of specific cultural dimensions. The important role of critical reasoning and self-awareness as well as improvement of diagnostic capabilities in a multicultural environment was pointed out. This is important not only for effective practice, but also for social trust among representatives of other fields towards the profession of a psychologist (Wakefield et al., 2010). Therefore, according to these guidelines, in an era of a diverse and open society, a culturally unaware psychologist, and even less ethnocentric, is doomed to lose social respect. According to the authors of the publication (The Critical Counsellor Domain Model, in short CCDM provides a structure for self-analysis in the context of the development of culturally competent psychological counselling (Wakefield et al., 2010).

Applying a measure of culture to the relationship of psychological or therapeutic help between a psychologist and a client / patient is a complex process. Both clients / patients and psychologists at any latitude can be influenced by many different cultures. In the era of globalization, migration and new media, it cannot be assumed that each of the participants in this relationship was shaped by one culture, undisturbed by other influences. The same applies to the context of treatment, which can also reflect a mosaic of diverse cultural influences (Wakefield et al., 2010). Therefore, challenges related to the clinical evaluation of patients in hospitals and outpatient clinics, as well as clients of therapeutic offices coming from other cultures, concern both the features of the test tools themselves and socio-cultural factors, such as relationships, behaviours and types of psychopathology occurring in a given culture (Butcher, Hooley and Mineka, 2017). The growing number of clients / patients with a two- or multi-ethnic identity should be taken into account (Diller, 2007). What is more, it should sensitize professionals to the dangerous temptation to maintain traditional principles of contact with clients developed on the basis of predominantly Eurocentric ideas, perceived as leading to best practices (Wakefield et al., 2010, p. 2).

Psychologists experience various difficulties in contact with clients / patients from foreign cultures. The authors of this publication draw attention to communication problems and problems resulting from a lack of understanding of clients' worldview, including their values (Wakefieldal et al., 2010, p. 3). Cultural norms exert a great influence on the way people seek help and on the factors that determine what is considered problematic in a given culture, and thus requires medical intervention. It is therefore very important for the psychologist to be aware of issues that may be relevant when making clinical assessments and diagnoses of people from different cultures, and to use test procedures tailored to the needs of such clients and having confirmed psychometric accuracy. These skills fall under the so-called cultural competence of the psychologist (Hays, 2008) and determine the professionalism of the clinician (Gabbard et al., 2013). Therefore, two areas of special importance in psychological assistance and therapy sensitive to cultural differences, to which we would like to pay special attention in the following part of the text are: (1) language and manner of communication with the client, and (2) dynamics of power in the therapeutic relationship (Mohamed, 2013).

Therefore, the literature on the subject speaks of the following competences (knowledge and skills) to provide psychological help and culturally sensitive therapy:

- awareness of the assumptions that the specialist brings to the therapeutic process (including recognition of all prejudices, attitudes, stereotypes and manifestations of racism both in himself and in the society in which the therapeutic activity takes place);
- knowledge of the history of one's own culture and knowledge about other cultures;
- knowledge of the history of oppression and racism, which is the context of working with clients from different cultures;
- ability to function in various cultural contexts;
- willingness to verify and change one's beliefs and attitude on issues related to racism and culture;
- dedication and perseverance in conducting anti-discrimination activities (Mohamed, 2013, p. 413).

In turn, Deralda W. Sue with colleagues (1995, pp. 624–644) indicates the following competences of a culturally sensitive therapist:

- a sense of comfort in dealing with clients of a different race, from a different ethnic group or culture or with a different worldview;
- understanding the impact of race, culture and ethnicity on personality development, choice of profession, mental disorder, as well as how to seek help and choosing a therapeutic approach;
- awareness of one's own negative emotional reactions towards certain social groups, which may adversely affect clients or patients. The therapist should be prepared for the fact that he will have to confront his beliefs and attitudes with the beliefs and attitudes of clients (patients) from other cultures;
- recognizing one's own restrictions on professional competences and skills;
- readiness to consult with healers or religious or spiritual leaders in cooperation with clients (patients) who belong to different cultures.

It should also be emphasized that professionalism within cultural competences also means resistance to excessive submission to cultural expectations and therefore exceeding certain ethical professional boundaries (see Gabbard et al., 2013). Norwegian cultural anthropologist Unni Wikan (2002) conducted very important analyses in this regard, discussing the attitudes of Norwegian society towards cultural practices not accepted in Norway in immigrant groups (circumcision of girls, child marriages). These behaviours were sometimes left unsaid or tolerated "in the name of respect for the specificity of a given culture" of a given group of immigrants. Such attitudes, sometimes found in some European countries, show a dead end to social practice, which treats culture as a reason for accepting any behaviour. In this context, Article 3 of the Code of Ethics of the Psychologist of the Polish Psychological Association, concerning the primacy of Human Rights over culture, is gaining importance (PTP, 2018).

TOWARDS A CULTURALLY SENSITIVE DIAGNOSIS

The basis of culturally sensitive therapy and psychological counselling is undoubtedly culturally sensitive diagnosis (Guindon, Sobhany, 2001). The American Counselling Association also indicates the need for a diagnosis that takes into account the cultural context (Wakefield et al., 2010). Statistics show a growing need to develop skills in this area. James N. Butcher, Jill M. Hooley, Susan Mineka (2017) state in their research that in recent years more and more psychological opinions have been made for clients of various ethnic backgrounds. This is due to the growing number of immigrants and refugees both in Poland and in other European countries that require such an assessment for the needs of medical treatment or legal proceedings (e.g. Poland in 2017 issued the most residence permits for non-EU immigrants from among European Union countries: "In 2017, one out of five first residence permits was issued in Poland (683 000, or 22% of total permits issued in the EU") (EUROSTAT, 2018). Many of them have difficulty adapting to new living conditions in a culturally different environment.

People culturally unsuitable for the environment in which they live receive tests and interviews that indicate more serious disorders (Okazaki, Okazaki, Sue, 2009). For example, this may happen in the case of Asians, in whom a high level of collectivism can lead to a diagnosis of dependent personality or in the case of psychotic disorders in members of cultures, where belief in the possibility of ghost interference in the

physical world is more common (Anczyk, Grzymała-Moszczyńska, 2013). Therefore, it is very important for the clinician to accurately assess which environment the client (patient) comes from, what values and what attitudes he presents – then it becomes possible to reduce the negative impact of these factors on the decision making process regarding diagnosis and treatment (Wakefield et al., 2010).

For example, the psychological suitability of a test for a given population should be determined, because the sense or cultural significance of individual test elements should be similar for different cultural groups, and the standards adopted for comparing clients (patients) – appropriate. When using tests developed in Western culture, factors such as the client's (patient's) language, socio-economic status, ethnicity, gender, religion, and sexual orientation should be taken into account. To assess whether a version adapted to the conditions of another culture measures the same variables, a psychologist in the name of professionalism should know the available research results on the use of the tool in the target population. In addition, clinicians must also pay attention to the reliability of the test tools used and their impact on clients or patients from various ethnic and cultural groups.

For example, the formulation of test items may have completely different emotional overtones depending on the culture of origin of the subject. As a consequence, representatives of individual groups may achieve different or even out-of-norm results on individual test scales (see Butcher, Han, 1996; Butcher, Tsai, Coehlo, Nezami, 2006; Hays, 2008). The Code of Ethics of the American Psychological Association (APA, 2002) therefore recommends that in order to treat people from a different cultural background or ethnic minority fairly and effectively, psychologists should take into account various factors that may affect the way the test is resolved. It is important that any aggravating factors do not affect reasoning in the overall assessment process. For example, it can be a way of understanding and context of individual concepts, how to perceive space, and even the ability to solve a test. Not to mention such seemingly obvious matters as other traits of the assessed person, such as situational, linguistic and cultural differences that may affect their judgments or limit the accuracy of their interpretation.

Diagnosis is therefore the beginning of a common path of a psychologist or psychotherapist and patient towards agreed goals. It should be absolutely remembered that the correct purpose of diagnosis is help, which in itself may avoid many ethically questionable strategies in a diagnostic situation. For example, provoking undesirable emotional reactions. Of course, the diagnosis, especially psychiatric or psychological, in terms of cultural differences is much more difficult and carries a greater risk of abuse. The most obvious of these is the assessment of customer behaviour from an ethnocentric perspective, which is associated with a lack of awareness of the relativism of cultural norms.

COMMUNICATION WITH THE CLIENT / PATIENT IN THE AGE OF MULTICULTURALISM

The means to achieve the goal of diagnosis is to obtain information that allows adequate treatment. Language is the first barrier here, which is only partly solved by the knowledge of adequate words or the help of an interpreter. It is worth remembering that the presence of an interpreter is the third element of a diagnostic meeting and,

like any other element, has a significant impact on the interaction effect, even by its very presence or possible change in the atmosphere of the meeting (de Barbaro, 1999; Wądołowska, 2014).

It should also be remembered that diagnostic work with the interpreter has its own specificity and rules that must be followed. The quality of cooperation and the establishment of an alliance with the interpreter affect the quality of communication in the process of diagnosis and patient assistance, which in turn affects the quality of the diagnosis itself and the effectiveness of assistance. It is also worth remembering that the interpreter can also act as a cultural consultant, which can be a truly invaluable help (Wądołowska, 2014). The diagnosis, no matter what sphere of functioning it is, is always a transition from the phenomenon to the system (Wciórka, 2011).

In other words, everything that happens in the diagnostician's office and is experienced by him is a diagnosis base in which we finally group the symptoms to assign them to diagnostic units under the current classification and based on this classification we determine possible ways of help. Therefore, verifying the understanding of observed and experienced phenomena is the first step to effective help. Consultation, not only linguistic, but also cultural, understanding phenomena taking place in the comfort of the study can make it more adequate. In the process of diagnosis – therefore the communication situation – in addition to words alone, we are dealing with the language context and its cultural semantic layer. An inseparable feature of interpersonal communication is its multilevelness and complexity. And so we can come across its actual level, where exchange is free, instrumental, where the people involved pursue specific goals and the affective level, accompanied by a higher level of involvement and emotional exchange (Dobek-Ostrowska, 1999).

From the point of view of cognitive psychology, we can consider various processes involved in communication: thinking, coding and decoding a message (Shannon, Weaver, 1964). In interpersonal communication, one can also speak of verbal and nonverbal levels (Nęcki, 1992). Interpersonal communication is not only about information exchange. It is also an exchange at the symbolic level, which produces specific effects and leads to a series of feedback (Budzyna-Dawidowski, 1999). Therefore, it also has its clear systemic aspect – thus affecting many levels of social reality organization (Drożdżowicz, 1999). It is because of the possible effects not only for individuals but also for their entire groups that interpersonal communication has an important ethical dimension. The importance of the ethical dimension of appropriate communication by participants in psychological procedures is indicated by the Psychologist's Code of Ethics (PTP, 2018). Points regarding the need for clear information on procedures and results in the process of intercultural communication gain additional context.

The systemic dimension of interpersonal communication clearly corresponds to the issue of its context, in the sense of the influence of the social environment, but also in the sense of the cognitive context understood as a certain baggage of experience. Both understandings of the context include the so-called cultural context that enables accurate interpretation (decoding) of the message in a given culture. Culture carries with it a certain system of meanings and symbols shared by a given community (Hańderek, 2015). Therefore, the message has a symbolic dimension, inherent and necessary for its understanding. In some cultures, it is the context that determines the means of communication or the choice of language used (Matsumoto, 2007).

All these levels, aspects and processes between interlocutors or their groups are important for understanding the nature of intercultural communication, also in the

psychologist's office. In addition, migration experience, as a baggage of specific and often very difficult experiences, seems to complicate interpersonal communication. Knowledge of the language, which allows coding and decoding information, is the easiest barrier to cross. However, it should be remembered that language is, in its subtle layer, also a carrier of values characteristic for a given culture, and also in itself plays a culture-forming role (Chiu, Leong, Kwan, 2007). However, what really challenges us can be discovered beyond words. Classical cultural competence in the field of communication seems to be favoured not only by knowledge of cultural differences, but also by the knowledge of the complexity of interpersonal communication in general (Sue, Constantine, 2007). At the interface of these two areas of knowledge, awareness of ethical challenges of interpersonal communication is born in the era of growing multiculturalism of European societies, including Poland.

There are many challenges especially when interpersonal communication takes place at the instrumental level – individual persons or groups have specific intentions, pursue specific goals, which may or may not be supported by cooperation or agreement. It seems that neither free nor affective exchange carries such a high risk of communication abuse. An example of an unobvious instrumental situation can be the situation of using counselling or psychotherapy, where the apparent convergence of goals can be accompanied by completely different, culturally conditioned, but also related to the cognitive context – baggage of experiences – their understanding (Stangierska, Horst-Sikorska, 2007). Patient or client comes for help. An advisor or psychotherapist wants to provide this help. And here comes the first communication difficulty, and thus the ethical challenge. Understanding what "help" is and what it is not, and what its sanctioned cultural boundaries in a particular context can be very different if they use a different system of meanings, patterns of behaviour and values. It can also be said that often the cultural difference "takes place not in space, but in time" – a world in which one generation grows up is a world completely different from the one that shaped the other. This kind of look at cultural differences opens the way to a broader understanding of cultural competence as the ability to deal with all the differences, often of a much less obvious nature (Chiu, Hong, 2018; Hansen, Pepitone-Arreola-Rockwell, Greene, 2000, p. 653). The importance of an appropriate attitude towards cultural differences is also indicated in article 4 of the Polish Code of Ethics of a Psychologist (PTP, 2018).

RELATION OF HELP AND AUTHORITY DYNAMICS

The relationship of helping a person from another culture brings many specific, potential disturbances in the communication process related to stereotypes or ideas about other cultures (Wakefield et al., 2010). The basic issue is the potentially unconscious ethnocentric attitude of the diagnostician, which, although natural at some stage of contact, at a subtle level may interfere with the relationship of help (Barzykowski, Grzymała-Moszczyńska, Dzida, Grzymała-Moszczyńska, Kosno, 2013). Assessing other cultures from your own perspective can lead not only to a lack of real understanding and therapeutic alliance, but even to a more severe diagnosis. Where we are accompanied by a sense of superiority, we go beyond the relationship of help, and even unconsciously and unknowingly enter into the relationship of domination over another person.

The traditionally understood goal of psychotherapy and psychological help is the good of the patient or client. And this can be understood in many culturally shaped as well as very individual ways. Does the psychologist have the right to help the patient in violation of his understanding of help and using his own definition of "patient's good"? In the context of multiculturalism or modern value pluralism, the answer is not clear. The right of recipients of psychological assistance to their own definition of good and happiness is an important subject of discussion in the literature on the subject (Sikora, Bogatyńska-Kucharska, Szafrański, 2017).

Issues seemingly clear in the context of multiculturalism can become a challenge: not everyone values their own comfort, which in the world of "Western" individualism seems so obvious. Communication, which comes from the point of view of collectivist values, may use other meanings, if only because these values affect the scope of freedom of expression or openness to new ideas (Hitchock, 1994). These values define what "I" means and what "we" means for a given person. In this context, it is easy to confuse the cultural difference with tendencies to excessive dependence on the environment or even with some kind of difficulty at the level of sense of identity. In addition, it should also be noted how the so-called communication issues in psychotherapy are influenced by the so called high- or low-context culture – emphasis placed on verbal or non-verbal elements of communication (Matsumoto, 2007).

Culture is also a source of communicative behaviour. What in one cultural perspective is an important context for the words spoken, in another is just an information noise that should be ignored for the sake of understanding between the parties to the discourse (Głodowski, 2006). The counsellor, and especially the psychotherapist, must therefore pay special attention to controlling the non-verbal aspects of his communication with the client or patient, especially when dealing with a person from a high context culture. In high context cultures, it is mainly appropriate behaviours under certain conditions that form the content of the message. Unaware of this difference, a psychologist or psychotherapist can become a proverbial elephant in a china shop. Apart from information outside the language, he can cross the customer's borders without even knowing it.

Therefore, the key to agreement with the client or patient and joint implementation of the objectives agreed in this discourse seems to be high self-awareness, but also awareness of the complexity of communication in the conditions of multiculturalism, as well as its importance for the functioning of individuals and entire social groups as various types of interconnected systems (Budzyna-Dawidowski, 1999). In some respects, this property is called the cultural competence of a person dealing professionally with help (Kwiatkowska, Grzymała-Moszczyńska, 2008). More philosophically, we can talk about a kind of going beyond our own cultural conditions to meet another person, where dialogue has a community-forming dimension, because it is a form of joint search for values (Dróżdż, 2015; Kłoczowski, 2006).

Problems in communication with the patient may be an incentive to supervise possible diagnostic and therapeutic problems. Ethnocentrism, or the often stereotypical perception of representatives of other cultures, may hide in its core the problem for deeper supervision work, as well as its own therapeutic work. No therapist is free from the individual cognitive context of his own experience and it should be subject to constant reflection. Without this reflection, in the diagnosis process you can mistake information noise for relevant contextual information or assign completely different, culturally or relatively conditioned meaning to information flowing from the patient (Kaslow, 2004).

An anecdotic, though true example, in psychodynamic psychotherapy is confusing a sense of humour, which is a mature but culturally specific defence mechanism, with cheerfulness, which can be a symptom of psychosis. This can happen when the diagnostician did not understand the joke told by the client / patient, and at the same time did not have sufficient cultural competence to draw attention to his own cultural background and to question his understanding of the statement he heard. Namely – in the situation cited – a healthy person from a different cultural background almost received a diagnosis of psychosis.

The approach most frequently mentioned in the literature on the subject to the diagnosis of a patient from a different culture is quite obvious – the clinician must acquire knowledge about the patient's cultural background in order to be able to approach it competently. If such competences are lacking, it is suggested that during meetings with a given client (patient) he should ask for instruction in this matter (Gabbard et al., 2013). However, the cultural competence of the psychologist in the role of a diagnostician is understood not only as knowledge about differences and their possible consequences. It is also the ability to reflect on one's own cultural background, which, supported by language and cultural consultations, as well as a deeper supervision consultation, would allow to avoid various types of threats. The focus of attention should be on awareness of the primary purpose of the diagnosis, which is help free from the desire to dominate resulting from unknowing and natural ethnocentrism (Barzykowski et al., 2013).

PSYCHOLOGICAL COUNSELLING AND THERAPY TOWARDS THE CHALLENGES OF MULTICULTURALISM

The effectiveness of psychological counselling and therapy depends to a large extent on whether a specialist can create together with a client (patient) a bond based on mutual trust and willingness to cooperate (Cooper, 2010). To obtain cultural competence, clinicians must refer to a particular model of conduct. One of them is cultural awareness and sensitivity, which is an honest attempt to see that each client (patient) has grown in a specific cultural context that must be taken into account when creating his overall profile. In this case, DSM-5 (APA, 2013) proposed a structured interview diagram that focuses on understanding the patient (client) approach to their own problems.

Interview on Cultural Formulation Interview (CFI, Polish version see Krzysztof-Świderska, 2015) contains sixteen questions that the clinician can use during the process of evaluating the patient (client) to obtain information on the potential impact of the culture from which the patient (client) is on decisions regarding his mental state. These are questions about the attitude of the client (patient) to his current problems, about his perception of the influence of other people on his problems and about how the culture from which it originates can affect his ability to cope with the hardships experienced. In addition, the interview also includes questions about the client's (patient's) experience related to seeking help in currently worrying problems within their own culture. The purpose of the interview is to try to find out the views of the subject on their own disorders from their cultural perspective, without labelling these problems from the diagnostician's perspective.

Another model of clinical management is the so-called cultural empathy (Gabbard et al., 2013), which consists in authentic appreciation of the client (patient) experience

gained on a life path, different from the path taken by the clinician. Mentalizing the inner and outer world of another person is the basic skill that a clinician must have if he wants to be a good specialist in assessment, diagnosis and psychological help. For in order to see the point of view of another person without undue judgment or hidden disdain, one must go beyond one's prejudices and narcissism. In this model, great emphasis is placed on developing ongoing awareness of how at any time the interaction between the clinician and the client (patient) their cultural experiences interact, or – using the language of psychoanalysis – on culturally sensitive transference and countertransference analysis, and resistance (Mohamed, 2013).

According to some theoretical concepts, focused on less directive methods of working with clients, both psychoanalytical and humanistic, therapists should wait to raise certain issues until clients take up the topic themselves. Others, in turn, emphasize that it is for therapists to indicate the differences between them and clients (patients), and thus to encourage them to talk about this subject while marking the asymmetrical division of power in the therapeutic relationship. It is believed that therapists who work through these issues will be able to cooperate more creatively with people from other cultures (Mohamed, 2013).

FAMILY THERAPY AS A SPECIAL CHALLENGE IN THE AGE OF MULTICULTURALISM

In the context of therapy, the issue of culture is connected with the issue of family in at least two ways. First, the family is the environment in which the culture-forming process takes place (Dyczewski, 2003). Culture is transmitted, revised and reproduced in the family and other social systems and institutions (APA, 2013). Secondly, the multicultural context of diagnosis and therapy, as well as the ethical dilemmas arising from it, also affect the process of diagnosis and therapy of families, where, especially according to representatives of the communication school that has developed as part of systemic therapy, communication problems are behind almost every experienced difficulty (Harwas-Napierała, 2014).

The media example of how seemingly obvious concepts are culturally conceived in relation to the family is the situation of Polish families in Norway. Understanding the good of the child in the local cultural context is highly individualized, while in Poland, even in the context of the letter of the law, it is closely linked to the family system in which the child develops and grows towards the ability to perform various social roles (Krzysztof-Świderska, 2018). The consequence of this difference is the choice of how to help the child. In the Norwegian cultural context, it is easier to decide to move a child to another family, who will take care of him, ensuring him an optimal level of development during the period of work on improving family conditions. In the Polish context, on the other hand, help for a child is implemented through the support that his whole family receives, of which he is a part.

The role of the psychologist in supporting a culturally diverse family can be metaphorically defined as the role of the "interpreter of emotions" that may appear in various contexts of family life. This metaphor is even more important as part of a communicative approach to family therapy, in which each gesture, act or situation carries a message and leads to feedback in the system, which is the family (Budzyna-Dawidowski, 1999). Thus, all behaviours generated by family members are not only information for other

family members, but also carry a certain emotional load, which also causes their interaction in a way that makes it impossible to distinguish between effect and cause. The own psychological state of its individual members is also information about the importance of a given behaviour. In a monocultural family it is so subtle that it is almost imperceptible, and in a multicultural family it can be a real challenge.

Both intercultural psychology and modern family psychology based on a systemic approach lead us to the same conclusion: the correct reading of the meanings of behaviour within the family is the only way to its good functioning and development. The metaphor of the psychologist in support of a culturally diverse family as an "interpreter of emotions" shows that a psychologist working in the field of assistance to a multicultural family is subject to all these rules and restrictions that apply to interpreters working in providing psychological assistance to foreign-language persons from a different culture (Wądołowska, 2014). Therefore, he should take into account the moral differences in understanding the context of the utterance and giving them meanings that occur between the cultures of individual family members as well as those cultures and his own culture. The latter is very important not only to avoid misunderstandings, but also to avoid the trap of ethnocentrism as a natural response, especially in the case of multicultural counselling (Barzykowski et al., 2013). It should also be noted that in certain cultural configurations – when the psychologist shares the culture of origin with one of the family members – the risk of entanglement on one side of potential conflicts increases extremely, and therefore it is more difficult for the psychologist to maintain neutrality and position of a helping and accompanying professional family.

Reflection on one's own culture and its limitations may also have the value of a model of behaviour in the situation of intercultural differences, that is be a kind of standard. Within certain limits, it can therefore be open to people whom the psychologist provides help – we can talk to clients and patients about what makes us different. The boundaries of these conversations are related to the demarcation between reflection on one's own culture and personal reflection. The latter should be kept for the most part during supervision meetings.

It can therefore be said that working with a multicultural family requires even more self-reflection and better self-control than psychological work with a family from one's own culture. This is undoubtedly a significant part of the so-called cultural competence related to openness in situations of different types of differences (Hansen, Pepitone-Arreola-Rockwell, Greene, 2000). Children, whose identity is built by parents who are educationally aware, become richer and better integrated in terms of diversity, which prepares them to function in conditions of constantly growing cultural diversity (Schwartz et al., 2009).

When working with a family, especially with a multicultural family, some awareness of the systemic importance of their role as a psychologist is also extremely important. A psychologist, as a person with his own cognitive context, that is a certain baggage of experience and his own cultural background, never remains indifferent to the family, even with great importance attached to his own neutrality and professionalism (de Barbaro, 1999). It becomes, or at least should become, an additional element of the system, affecting it in a subtle, non-directive and thus extremely effective way. The psychologist, understanding his role as a kind of translator of otherness and a companion of a common path, does not show a tendency to exceed the limits of family intimacy and privacy, as well as to impose his vision of well-being of the family system or the nature of assistance provided.

It should be noted that these are current standards for working with the family in general. However, in a multicultural situation it is much more difficult to fulfil them. Especially that they require a huge cultural self-awareness, which is consistently followed by humility, mindfulness and sensitivity to different perceptions of reality resulting from different values (Hitchock, 1994). It is the maintenance of the role of such a "interpreter of emotions" that can appear in various contexts of family life, is the greatest challenge of working with a multicultural family. In a certain way, though not sufficient for the needs of clients with a different culture, it mentions respect for differences, including different value systems, point 4 of the current Code of Ethics of a Psychologist (PTP, 2018).

SUMMARY

Cultural competences enable an accurate diagnosis and increase the effectiveness of treatment. Sensitivity to cultural issues improves the level of sensitivity to the point of view of a person seeking psychological help and strengthens the therapeutic alliance. Thanks to cultural competences, the clinician's understanding of phenomena such as stigmatization, norms, differences, pathologies and deviations is sharpened, and thus clinical knowledge is broadened and the professionalism of services rendered. Cultural competences also allow for a better understanding of the various ways of functioning of the human psyche and the condition of a person who, seeking help, reported a specific problem to a mental health professional.

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