Cite as: Eiroa-orosa, F. J. (2025). *Psychological treatment in contemporary societies [teaching material]*. Universitat de Barcelona

Psychological treatment in contemporary societies

Francisco José Eiroá Orosa

Section of Personality, Evaluation and Psychological Treatment

Department of Clinical Psychology and Psychobiology

University of Barcelona

Contents

1. Learning Objectives

This section is organised around the concept of intersectionality, addressing various sociocultural aspects within which psychological interventions take place, as well as the influence that Information and Communication Technologies (ICTs) have had on psychological treatment. The objectives are:

1. To understand the main axes of transformation in mental health care systems.
2. To recognise the importance of social justice and a gender perspective in contextualising psychological treatments.
3. To analyse how stigma leads to discrimination against people with experiences of psychological distress.
4. To understand how different social movements have proposed alternative models of care.
5. To analyse how various transcultural factors influence the way psychological care is delivered and received.
6. To become familiar with the main applications of Information and Communication Technologies (ICTs) in psychological treatment.

2. Intersectional aspects

2.1. Towards a critical and transformative psychological treatment

One of the greatest challenges in the field of contemporary mental health care lies in the difficulties that services and professionals face in promoting the autonomy and empowerment of the people who use them. The development of mental health professions, including psychotherapy and clinical and health psychology, has led to the creation of a technical language that is sometimes removed from the narratives of those who experience psychological distress. In some cases, this has resulted in the dissemination of messages that, even if unintentionally, contribute to stigma and social discrimination. In this regard, the use of terms such as “psychopathology” or “abnormal psychology” reflects an understanding of mental health primarily focused on deficits and the drawing of boundaries between what is considered normal and abnormal, an approach that, while still prevalent today, some professionals believe should be transformed.

Furthermore, the way we refer to people receiving psychological treatment has also been a subject of debate. The term “patient” implies being the passive recipient of another’s actions and has been criticised by various organisations. As a result, alternative terms such as “client”[1], “service user”, “consumer”[2], and even “survivor” or “victim” have been proposed. In contexts where there is no reference to engagement with the care system, expressions such as “people with lived experience of psychological distress” or “affected individuals”[3] are often used.

In this text, we have chosen to refer simply to “people” and will specify whether we are referring to those who have received a mental disorder diagnosis or, more generally, to those with lived experience of psychological distress. When referring to individuals in the context of interaction with the healthcare system, we will use the term “service users”. Although this expression is perhaps more established within the social care sector (McLaughlin, 2009), it is the term most consistently promoted by user-led movements in collaboration with professionals (Barker & Peck, 1996; Storm & Edwards, 2013; Tait, 2005). It does not necessarily imply system failure, as might be suggested by “consumer”, nor does it carry the connotations of adverse experiences associated with “survivor” or “victim”. Our intention is not to deny the existence of shortcomings or negative experiences but rather to use a term that conveys optimism, one that recognises that when we provide psychological treatment, we are engaging with autonomous individuals who hold the same rights as anyone else and who seek support in managing particular difficulties. This does not imply that they should be passive recipients of our intervention or that our expertise grants us any form of authority. We believe it is essential that the person seeking help takes an active role in their recovery, in accordance with their abilities and willingness.

An increasing number of activist groups are advocating for rights-based approaches to mental health care. These groups include people with lived experience of psychological distress, as well as their families and health professionals. In addition, there are various local and international campaigns seeking to combat stigma in mental

---

[1] The term *client* is more commonly used in the Anglo-Saxon context than *patient*, partly due to differences in access to psychological services within healthcare systems.

[2] The consumer movement emerged in the United States during the 1970s to demand improvements in mental health services.

[3] In German-speaking countries, the terms *Erfahrene* and *Betroffene* are commonly used.

health. All of these groups highlight the intersectional nature of discrimination against people labelled with mental health diagnoses, whose experiences are also shaped by other factors such as skin colour, ethnicity, gender, or social class (Mora-Ríos & Bautista, 2014). For this reason, we consider it important to consider the context of social exclusion in which many forms of psychological distress develop, as well as the spread of stereotypes that reinforce discrimination. It is also important to recognise that psychological distress is interpreted within a particular cultural framework, and therefore the extent to which a person's actions are judged as dysfunctional will depend on the normative and power relations of that context. We tend to judge the external expression of distress as dysfunctional according to its cultural meaning and the extent to which such actions are perceived as unusual.

For all these reasons, the following sections aim to provide tools for the training of therapists who are firmly committed to working in mental health from a perspective of respect, collaboration, and empowerment. The goal is to promote an understanding that goes beyond the focus on psychological distress, particularly in contexts where its presence and intensity may influence access to services[4]. This is expressed in several ways. Firstly, as a sign of respect, we propose avoiding the use of diagnosis as a synecdoche: people who use mental health services should be understood as whole individuals, and their diagnosis should not be used as an explanatory theory for part or all of their behaviour. When we refer to someone as "psychotic" or "depressive", we are naming the part for the whole and reinforcing stereotypes that assume, wrongly, that people with a given diagnosis share identical characteristics and behaviours. Secondly, following models that place emphasis on examining imbalances of power and resources in mental health care (Chapman, 2010; Johnstone & Boyle, 2018), we consider it increasingly important to apply psychological intervention techniques from a collaborative perspective. In this regard, we propose recognising that service users are the experts in their own experience, and that professionals do not possess automatic or magical solutions but rather are trained to facilitate processes in which service users should play the leading role.

---

[4] One hypothesis explored in various lines of research is that the mental health care system allocates more resources to individuals who express their distress more intensely, while neglecting those who do so in less disruptive ways, even though this does not mean they have fewer needs.

Thirdly and finally, in line with the principle of collaboration, throughout this text we will advocate the need to combine interventions that help to alleviate distress with approaches that foster empowerment. To achieve this, it is essential to promote autonomy and community cohesion, to strengthen collaboration between different services, and to understand, as the World Health Organization's motto states, that empowerment is not a destination but a journey (World Health Organization Regional Office for Europe, 2010). For this reason, various human rights initiatives in the field of mental health propose coercion-free spaces where co-designed interventions can be developed together with service users, grounded in personal experience and community support (Porsdam Mann et al., 2016).

To address these challenges, alternative models to that of "abnormal psychology" provide tools for critical analysis of the psychological treatment literature and for collaborative practice. In this regard, the evidence increasingly supports the view that psychological distress is a dimensional variable (Biondi et al., 2018; Haslam et al., 2020). This means that it cannot be reduced to one or several binary categories but rather exists along a continuum. Within this context, we must understand that categories and cut-off points, although useful for planning interventions or services, are simply conventions established in meetings of experts often influenced by corporate interests such as the pharmaceutical and medical insurance industries.

The dimensional understanding of psychological suffering challenges the categorical framework represented by the Diagnostic and Statistical Manual of Mental Disorders (DSM)[5] and the International Statistical Classification of Diseases and Related Health Problems (ICD) of the World Health Organization, which inevitably divide the population into those who are ill and those who are healthy. Furthermore, some public campaigns[6] remind us that it is common to experience moments of sadness or anxiety, to see or hear things that others do not perceive in the same way, or to feel estranged from one's own body. It is estimated that one in four people will experience such distress at a level of intensity and duration that interferes with everyday life, although the boundaries of

---

[5] Diagnostic and Statistical Manual of Mental Disorders.

[6] "One in Four" is a campaign named after the idea that one in every four people will experience a mental health problem at some point in their lives. http://www.1decada4.es

what is considered "clinically significant" remain the subject of ongoing debate. Indeed, there are differing views on the use of diagnostic manuals in professional practice. The greatest consensus lies in recognising their usefulness as learning tools, providing an entry point to explore the complex world of mental health, which is why they are included here. However, we also agree that every case is unique and that, as health professionals, we must consider the personal characteristics of service users and the sociocultural context in which their difficulties have developed.

A diagnosis can be a useful tool to facilitate communication between professionals and to guide the choice of treatment, but it should not become an immutable label applied to people who, in all cases, no matter how severe they may appear, have the potential for recovery.

In this text, we aim to provide tools to support a critical analysis of literature on psychological intervention and treatment. By "critical analysis" we mean reflecting without accepting dogma, understanding the context in which theories have been developed, identifying the research methods used to validate them, and maintaining a questioning stance towards their content and conclusions. This allows us to apply them in practice with an awareness of their strengths, as well as their limitations and potential harmful effects. Although it may be difficult to imagine that a well-trained and well-intentioned health professional could cause harm to a service user, certain psychological intervention techniques may be contraindicated in particular situations (Lilienfeld, 2007). In general, psychological intervention should be applied with careful consideration of the factors that make the use of language itself a potential source of recovery for other human beings.

2.2. Social justice and psychological treatment

When considering the influence of factors related to social justice in psychological treatment, we can reflect on the possible effects of inequality and social exclusion at two overlapping but distinct levels: firstly, their potential aetiological role in the development of the problem that leads an individual to seek professional help, and secondly, the specific barriers to access and adherence faced by people who are excluded from healthcare systems for socioeconomic reasons.

Regarding the aetiological aspect, research has examined the role of social inequalities, both chronic and those arising from sudden political upheaval or economic crises that drastically alter people's lives. This area has a long research tradition dating back to the French and American revolutions, represented by the work of Philippe Pinel and Benjamin Rush, respectively (Rosen, 1968), and extending to the more recent financial crisis, which had a particularly severe impact on Mediterranean countries (Economou et al., 2013; Gili et al., 2013).

At a psychological level, the specific mechanisms through which economic adversity and social inequality increase psychological distress appear to be related to the subjective evaluation of one's own resources, perceptions of the social climate, and pre-existing beliefs about self-efficacy (Eiroa-Orosa, 2013). In the face of such factors, and when confronted with difficult situations such as job loss, people develop an action plan with varying degrees of awareness. If the plan fails, one may experience learned helplessness (Seligman, 1972) or, from a subjective perspective, the perception of having no predictive control over the events that surround us (Botella & Feixas, 1998). This can lead to anxiety, stress, and depression. According to this conceptualisation of coping with difficulties of socioeconomic origin, individuals who have benefited from adequate developmental opportunities tend to show higher levels of self-efficacy, an internal locus of control, and more flexible coping strategies. In contrast, those who have not enjoyed such opportunities are more likely to disengage socially, since engagement in these circumstances often leads to frustration and discouragement. In this regard, Tomasik and colleagues (2010) found that young people who were less socially involved in economically deprived areas with high unemployment rates reported greater life satisfaction than those who were more involved, while the opposite was true in regions with stronger economies. In other words, social engagement and initiative in the form of active pursuit of education and employment increase life satisfaction when opportunities for growth are real but reduce it when such opportunities are absent.

Moreover, the objective availability of resources is not as decisive for psychological wellbeing and health as the subjective perception of fairness and of receiving one's due. The subjective perception of injustice has been associated with poorer mental health

(Kivimäki et al., 2003), psychosomatic health (Schmitt & Dörfel, 1999), physical health (De Vogli et al., 2007), and increased sickness absence (Elovainio et al., 2004). However, the behavioural sciences have paid less attention to conditions of social justice than fields related to public health. Prilleltensky (2012) proposed a model for contextualising distress and the capacity for psychological wellbeing according to each person's objective and subjective experience of justice, which is highly useful for incorporating these factors into treatment. Under optimal conditions of justice, we can help people to reach their fullest potential, whereas under suboptimal conditions, interventions should focus on coping. In situations of vulnerability, Prilleltensky refers to this as confrontation, and in contexts of persistent injustice, as suffering. This suggests that the mental health care system should adapt to the needs of service users who face the greatest barriers to accessing services (such as lacking health insurance or having work schedules incompatible with clinic hours) and the greatest challenges in meeting the expectations of psychological treatment (for example, due to lower levels of education or inability to afford private care).

Finally, it is important to note that psychological intervention practice does not develop in isolation from fluctuations in the wider social context (Cushman, 1990). For instance, the COVID-19 pandemic, beyond the immediate consequences of lockdowns, has had a clear impact on the mental health of the population (Kumar & Nayar, 2021; Torales et al., 2020; Xiong et al., 2020). The medium-term impact of the pandemic, combined with a global cost of living crisis (Broadbent et al., 2023; Keith Neal, 2022), carries significant implications for public health, placing social care and mental health services, their staff, and service users under pressures that substantially alter the contexts in which interventions take place (Cogan et al., 2022).

2.3. Gender perspective

Although most Western societies have incorporated full equality of rights and responsibilities for men and women into their legislation, true equality is still far from being achieved. Persistent inequality is evident in areas such as access to employment, income levels, the distribution of caring responsibilities, and representation in positions of power, to name a few examples. Patriarchy, the concept that explains the persistence of these differences, refers to a social system in which men have privileged access to positions of power in political, economic, cultural, religious, and military spheres. This structure involves a sexual division of labour that assigns different roles according to gender, with men occupying the public sphere and women the private one. Although this inequality is present in many societies, its intensity and form vary (Compañ Felipe, 2023).

In Western societies, there has been a shift from a system of coercive patriarchy to one of consensual patriarchy. In this new paradigm, women appear to adopt the roles imposed upon them as if by choice (Puleo García, 2005). Thus, although society at large explicitly claims to move towards gender equality, implicit mechanisms continue to operate, particularly within parenting and education, where gender norms are transmitted. Gender norms are cultural constructions that establish expectations, often binary, about the behaviour and social roles of men and women. These norms reflect and perpetuate male dominance by valuing and privileging characteristics associated with masculinity over those associated with femininity (Risberg et al., 2009).

It is clear that all these factors play a decisive role both in the expression of distress and in its treatment. For this reason, various proposals have been developed to incorporate a gender perspective into psychological treatments. Sebastián Herranz (2001) proposes three fundamental questions:

- How do psychological difficulties differ between women and men?
- In what ways is gender present in the therapeutic process?
- Is it therapeutically relevant to include a gender perspective in understanding and treating a particular psychological issue?

While some perspectives of therapeutic feminism, traditionally focused on issues that have more markedly affected women in recent decades such as sexual abuse or eating disorders, have addressed these elements, psychological treatment knowledge in general continues to be produced without a gender perspective. Consequently, the biases imposed by the patriarchal lens of society are reproduced within this field.

Therapeutic perspectives that integrate gender in their approach consider the differences between female and male socialisation as key to understanding experiences of distress and their treatment. Traditional female socialisation emphasises being for others, promoting the importance of pleasing and being agreeable to the male gaze. This is reflected in prioritising the needs of others and striving to be “good” and “pleasant”. Although contemporary society promotes emancipatory messages encouraging women to be autonomous and self-determined, this duality generates contradictions and complexity in women’s self-image and self-esteem. This tension can lead to emotional and evaluative instability, with mixed feelings of devaluation and self-worth. In therapy, it is crucial to address these issues to foster autonomy and emotional stability. In heterosexual relationships, female socialisation may lead to expressions of anger when a woman feels neglected or disregarded, in an attempt to bring about change directed towards the other (Compañ Felipe, 2023; Lagarde, 2001).

As for men, it is essential to recognise that traditional conceptions of masculinity are being challenged in contemporary societies. However, this shift has not eliminated gender inequality, which compels us to consider how masculinity is adapting to new circumstances. As therapists, we must pay attention not only to what men verbalise in therapy but also to their actions and relational patterns with women. Male socialisation is characterised by an ethic of self, which allows prioritisation of one’s own goals and personal space. This manifests in behaviours such as a lack of communication about one’s own actions, acting without considering consequences, and pursuing multiple opportunities without accountability. This ethic of self can produce internal conflict in situations involving help-seeking or relational difficulties. It is also important to understand the impact of gender socialisation on male identity, which is reflected in existential beliefs, such as the aforementioned ethic of self, and in frameworks such as prestigious self-sufficiency, combative heroism, respect for hierarchy, and superiority and opposition towards women[7]. These beliefs influence interpersonal relationships and may generate resistance in therapy, making it necessary to address them to promote more egalitarian relationships and greater male involvement in domestic and caring responsibilities (Bonino, 2002; Compañ Felipe, 2023).

---

[7] Prestigious self-sufficiency refers to the belief that men must be independent and stand out within society. Warlike heroism involves the legitimisation of violence and the promotion of a life centred on challenge and competition. Respect for hierarchy reflects a vertical understanding of relationships, in which men strive to attain a higher position and to obey figures of authority. Superiority and opposition to women involve the belief that men should hold authority over women, differentiate themselves from them, and avoid participation in activities associated with femininity.

3. Stigma and Discrimination

Stigma is linked to the human tendency to seek simple explanations for behaviours that are considered unacceptable, abnormal, or deviant from socially accepted norms. For instance: “he attacked the police officer because he had a fit of madness.” Such explanations, rather than considering the complex and multifactorial causes of behaviour, stigmatise people experiencing psychological distress and perpetuate the false idea that they are inherently violent. These stereotypes can lead to prejudice and discrimination against individuals who use mental health services or even deter them from seeking help due to fear of rejection.

Goffman (1963) defined stigma as an “attribute that is deeply discrediting.” Although he was not the first to address the concept, he is regarded as a pioneer in its systematic study (Link & Stuart, 2017). From a sociocognitive perspective, stigma comprises three components: stereotypes, prejudice, and discrimination (Sheehan et al., 2017). Stereotypes are generalised and simplified beliefs that attribute negative characteristics to a specific group—for example, the belief that “people diagnosed with mental disorders are dangerous.” Prejudice involves emotional reactions that arise from accepting such stereotypes, such as feeling discomfort when sharing space with someone identified as mentally ill. Discrimination refers to behaviours that result from stereotypes and prejudice, such as avoiding contact with people diagnosed with mental disorders (Krupchanka & Thornicroft, 2017). In summary, stigma functions by generating negative stereotypes about marginalised groups, which in turn create social narratives that justify their discrimination (Livingston & Boyd, 2010).

López et al. (2008) describe the stigmatisation process as a sequence of interconnected stages: labelling, associating negative attributes with group members, creating a distinction between “us” and “them,” and emotional reactions in both the stigmatising and stigmatised groups. This process results in a loss of status and social power for those who are stigmatised (Link & Phelan, 2001). It is important to understand that from the perspective of the person who stigmatises, prejudice may be expressed through emotional reactions such as fear, which leads to rejection, or through compassion, which results in paternalistic attitudes.

As mentioned earlier, an example of an unpleasant characteristic frequently attributed to people with a mental health diagnosis is dangerousness; that is, the belief that they are more likely to be violent or to commit criminal acts than people without a diagnosis. Dangerousness is one of the most problematic stereotypes in terms of discrimination, as it influences people's willingness to have contact with those diagnosed with mental health conditions (Angermeyer & Matschinger, 2005). Unfortunately, cases such as the Germanwings pilot[8] or the student from the Joan Fuster Institute in Barcelona[9] have contributed to an uncritical association between mental health diagnosis and violence, although real data do not support this relationship. While it is true that, in absolute terms, the commission of violent acts by people with a mental health diagnosis is slightly higher than in the general population, major meta-analyses have demonstrated that mental health problems in general (Lam, 2014), psychosis (Witt et al., 2013), and even the specific diagnosis of schizophrenia (Fazel et al., 2009), which is often linked to dangerousness due to the loss of contact with reality, do not have a direct relationship with the commission of violent acts. The difference in the number of violent acts committed by people diagnosed with psychosis compared with the rest of the population can be explained by exposure to risk situations, such as substance use, which is associated with the social exclusion these individuals face. In contrast, experiencing psychological distress is directly associated with a higher likelihood of being a victim of violence (Trevillion et al., 2012) or of self-harm (Swanson et al., 2015).

Apart from dangerousness, the most common stereotypes regarding people diagnosed with mental health conditions are unpredictability, responsibility or blame, incompetence, and permanence (Hayward & Bright, 1997; Sheehan et al., 2017). Unpredictability, a stereotype closely related to dangerousness, is based on the idea that people with diagnoses are more likely to behave impulsively or to have volatile reactions. This stereotype tends to be applied to the entire group without considering personal or situational characteristics. The stereotype of responsibility or blame refers to the belief

---

[8] A plane crashed in the French Alps in 2015. The main hypothesis regarding the cause of the crash was that the co-pilot, Andreas Lubitz, who had recently been diagnosed with depression, deliberately caused the aircraft to crash.

[9] That same year, a student armed with a crossbow opened fire in a classroom, resulting in the death of a teacher and injuries to four students. The Catalan Minister for Education was quick to claim that the pupil had suffered a "psychotic episode."

that people experiencing psychological distress lack the willpower to overcome it. This stereotype is often applied to people with substance use problems or those experiencing intense sadness or anxiety. Incompetence refers to the belief that people with mental health conditions are incapable of working or living independently (Sheehan et al., 2017). This is reflected in the workplace, where disparaging comments are often made about the abilities of people who use mental health services (Jenkins & Carpenter-Song, 2009). Finally, permanence refers to the view that mental health conditions are irreversible (Hayward & Bright, 1997). Consequently, this perception may influence the type of support provided to people considered to have a “chronic” problem, reducing their potential to develop an autonomous life project. There is scientific evidence demonstrating that all these attributions are false or, at the very least, unrepresentative of people with lived experience of psychological distress.

Finally, three interactive levels of mental health stigma are distinguished: institutional or structural, interpersonal or social, and individual or personal (Livingston & Boyd, 2010). Structural or institutional stigma refers to the rules, policies, and procedures of public and private entities in positions of power that restrict the rights and opportunities of people diagnosed with mental health conditions. Social stigma, also known as public stigma, describes the phenomenon of creating stereotypes that act against a stigmatised group (Corrigan et al., 2005). In this way, public stigma becomes the main barrier to the social participation of people diagnosed with a mental health condition. Finally, individual or personal stigma refers to the person’s own perspective (Gerlinger et al., 2013). Personal stigma includes experienced, perceived, and internalised stigma. Experienced stigma is defined as the experience of discrimination and real restrictions faced by the affected person (Corrigan et al., 2005; Livingston & Boyd, 2010). Perceived stigma refers to the subjective perception of being despised and marginalised (Link et al., 2001). Finally, internalised stigma, also known as self-stigma, is the acceptance of social stigma (Corrigan & Watson, 2002). This is a subjective process in which people absorb the stereotypes created by society, anticipate rejection, consider these stereotypes relevant, and see themselves as devalued members (Corrigan et al., 2005; Livingston & Boyd, 2010).

Anti-stigma awareness campaigns usually include educational components and initiatives that promote contact with people who have lived experience of psychological distress. Educational elements, including first-person accounts, help to demystify misconceptions, while direct contact with people with diagnoses helps to break down stereotypes surrounding different forms of psychological distress. Although there is evidence supporting the effectiveness of both individual use and combination of these approaches, the long-term sustainability of the impact of anti-stigma interventions has not yet been demonstrated (McCullock & Scrivano, 2023). Therefore, to improve long-term effectiveness, it has been suggested that interventions should be local, targeted at a specific audience, gain credibility through the participation of people with lived experience, and maintain ongoing contact (Corrigan, 2011).

4. Recovery, Rights-Based Care, and Citizenship Models

As previously discussed, the various social movements led by people with lived experience of psychological distress have gained increasing prominence, particularly since the 1970s. In addition to contributing to the struggle for the acquisition and restoration of social rights and against the stigmatisation of people experiencing psychological distress, it is important to note that many of these organisations have driven profound changes in the mental health care system.

As a result of the synergies created between the demands of service users, their families, and professionals, the *Recovery* movement emerged in the early 1990s (Anthony, 1993). This movement advocates for a shift from a treatment approach primarily focused on symptom remission towards an understanding of recovery as a personal and idiosyncratic process grounded in hope (Substance Abuse and Mental Health Services Administration, 2012). The movement differs from other tendencies within psychosocial or community rehabilitation by proposing a comprehensive reform of the mental health care system across all types of services (Singh et al., 2016). Its main objective is to promote the participation of service users and their families in decision-making processes.

Some strategies employed by mental health professionals working within the Recovery model include separating the person from the diagnosis, exploring individual needs, respecting personal styles of autonomy, negotiating personalised recovery plans, examining power dynamics between professionals and service users, reducing coercion, and promoting teamwork that recognises the person in recovery as part of the team (Davidson, 2016). To facilitate this paradigm shift, continuous professional training and awareness-raising initiatives have been developed (Eiroa-Orosa & García-Mieres, 2019). In addition, the integration of peer support workers has been encouraged—people who use their own lived experience to support others within the system (Eiroa-Orosa & Sánchez-Moscona, 2023). These new professionals engage in accompaniment, organise mutual aid groups, and provide guidance to other professionals.

The Recovery model represented an important step forward in improving mental health care provision. Its approach offers a strong theoretical and practical justification for moving away from a system based solely on diagnosis and symptom remission. However, critiques from many service user movements have emphasised the need to develop ideas less vulnerable to "colonisation" (Thomas, 2016). That is, the concept of Recovery has been adopted by many service providers seeking to renew their image by adopting politically correct language. Yet, in some cases, this adoption has been superficial, limited to the use of terminology without meaningful changes in everyday practice. Many professionals have replaced the word "patient" with "non-recovered" (in the same way that, in the field of disability, terms such as idiocy or imbecility were replaced by subnormality without any real substantive change), but this has not led to a significant reduction in paternalism or coercion. In fact, the term Recovery was used in campaigns promoting compulsory community treatment, a measure clearly inconsistent with rights-respecting care. For this reason, more recent alternatives have proposed a shift from viewing service users as objects of care and welfare policy to recognising them as subjects of rights.

The enactment of legislation such as the Americans with Disabilities Act (National Council on Disability, 1990) and the Convention on the Rights of Persons with Disabilities (United Nations, 2006) has led to a proliferation of initiatives aimed at implementing rights-based mental health projects (Porsdam Mann et al., 2016). Coercive practices, such as mechanical restraints or involuntary admissions, which were once considered standard, are now being questioned, and numerous studies are underway to evaluate the effectiveness of methods designed to reduce or eliminate such practices (Goulet & Larue, 2016; Scanlan, 2010; Stewart et al., 2010). The impact of these developments on specific international frameworks is evident. Building on this momentum, the World Health Organization (2012, 2021) has published a series of guidelines and technical documents on mental health services to promote rights-based approaches.

An example of a rights-based model emerged in response to the failure of social integration approaches that relied on quantifiable outcomes. While such models often achieved material success (for example, securing housing or employment), they did not always lead to a genuine sense of belonging within the communities where people were "integrated". In some cases, individuals even returned to situations of severe social exclusion. Through a process of reflection, earlier approaches were redefined, and a new concept, Citizenship, was formulated (Rowe et al., 2001). The Citizenship model proposes working across five main dimensions, known in English as the five Rs: rights, responsibilities, roles, resources, and relationships. This model has been applied in empowerment processes as a framework for creating opportunities for the social participation of members of stigmatised groups (Rowe et al., 2009), through interventions that have demonstrated effectiveness in a range of contexts (Rowe, 2015). Rather than being viewed as an alternative to the Recovery movement, the Citizenship model has been conceived as an approach that seeks to strengthen it and address its limitations (Rowe & Davidson, 2016). In Citizenship-based intervention programmes, instead of viewing people diagnosed with mental health conditions as problems to be managed by others, they are recognised as experts on their own difficulties and, consequently, as the main agents in identifying solutions. Therefore, the central task of professionals working within this model is to engage people experiencing psychological distress and at risk of social exclusion in redefining their challenges from their own perspectives.

5. Transcultural Aspects

The increase in migratory movements and the exodus of refugees from regions in continuous conflict have led to the development of an extensive field of study concerning cultural differences in the aetiology and expression of psychological distress, as well as the differing therapeutic needs of people from non-Western backgrounds. This approach is embodied in disciplines such as transcultural psychology and psychiatry. From an aetiological perspective, it is important to consider the varying significance attributed to symptoms depending on cultural background. For example, in Western societies we tend to be far more tolerant of someone displaying obsessive traits than of someone exhibiting psychotic symptoms. This may be because order is perceived as something positive, whereas a "moment of madness" or "psychotic episode" is regarded as dangerous. However, this is not universal, as there are places where psychosis is tolerated or even integrated into religious practices.

Additionally, there are what have been termed "cultural syndromes" or "culture-bound syndromes". A classic example is Koro syndrome, or genital retraction syndrome, which is defined as the belief that one's genitals are shrinking and will eventually disappear, despite the absence of any actual or lasting physical changes. This syndrome occurs almost exclusively among people from India, China, Japan, and certain regions of Africa.

Qureshi and Eiroa-Orosa (2012) note that the ability to be sensitive to the diverse needs of people from different backgrounds, particularly in terms of the relationship between the professional and the service user (known as cultural or intercultural competence) appears to be one of the key factors in healthcare inequalities affecting ethnic minority groups. The theoretical foundations of cultural competence lie in two highly debated concepts: "culture" and "race". The term culture refers to a shared social construct that is dynamic, constantly evolving, and subject to multiple interpretations. Culture therefore arises from human interaction and is neither fixed nor stable. Furthermore, not everyone conforms to cultural stereotypes to the same degree. Not all people from Andalusia dance sevillanas (although they are perhaps more likely to use olive oil rather than sunflower oil for frying), nor do all people of Arab origin wear a veil or practise Islam (although it is indeed uncommon for them to eat pork out of habit).

Omi and Winant (1993) challenge the old dichotomy of race as an objective versus ideological construct, proposing instead a critical understanding of the use of "race" based on its sociohistorical context. Race has historically been used as a form of social classification, although from a scientific standpoint there is no solid biological basis to support the idea of separate human races. However, racism cannot be ignored as a real social problem (Smedley & Smedley, 2005). Ultimately, regardless of whether races are a valid biological concept or not, therapists, like anyone else, tend to stereotype people from different social and ethnic groups. This means that a client's experience of psychological treatment may be influenced by our own prejudices if we fail to recognise and address them.

There are objective differences in access to healthcare, and particularly to psychological treatment, among people from ethnic minorities, migrant populations, and refugees. These disparities are not only due to differing financial means to afford treatment, but also to a lack of understanding among some individuals of the purpose of psychological therapies, as well as to experiences of racism. This leads us to consider that the effectiveness of psychological treatments may vary depending on sociocultural factors. Many people may lack the resources needed to access therapy, psychosocial stress levels may interfere with the therapeutic process, or they may simply not believe that therapy can help with their problems and therefore do not actively engage in treatment. To overcome these barriers, there are two main approaches within cultural competence. The first, known as the "culturalist" approach, focuses on aligning the cultural codes of the professional and the service user, seeking to objectify the different ways of expressing and making sense of suffering. The second approach focuses on addressing and overcoming the practitioner's racial biases through work on prejudice, stereotypes, and preconceptions.

In general, models of cultural competence, like most competence-based frameworks, comprise three domains: knowledge or cognitive competence, skills or procedural competence, and attitudes or attitudinal competence (Sue et al., 2009). While knowledge is particularly relevant to the culturalist perspective, attention to prejudice and racial countertransference is central to the bias-focused perspective.

5.1. Working with culturally diverse people: ethnic minorities, migrants and refugees

As we have seen, there are two main approaches when intervening with people from cultures different from our own. The first involves facilitating intercultural communication, while the second focuses on becoming aware of one's own biases to prevent racist attitudes. In any case, the process requires personal work on the part of the therapist, who must become conscious of their own ways of thinking about people from other cultures and of how they communicate with service users. This process promotes open and honest discussion with them to reach a shared working space.

Despite the considerable amount of literature on the various aspects to be considered when working with these groups, evidence regarding differences in access to and uptake of psychological treatment continues to reveal certain shortcomings in the quality of mental health care provision (McGuire & Miranda, 2008). To try to reduce barriers to psychological treatment in this context, two main approaches have been developed. The first involves adapting evidence-based treatments originally validated with Western populations. These adaptations are applied both to meet the needs of cultural minorities in Western countries and to make therapies developed in these countries applicable elsewhere in the world. In addition, elements are incorporated to promote understanding and the exchange of diverse conceptions of distress and psychological change. This is achieved through mutual exploration and understanding between therapists and service users, rather than relying solely on academic knowledge. Adaptations have shown a substantial increase in the effectiveness of interventions (Griner & Smith, 2006) and may include:

- Explicit incorporation of cultural values into the intervention.
- Racial and/or ethnic matching between service users and therapists.
- Provision of services in the person’s native language.
- Explicit cultural or multicultural paradigm underpinning the intervention.
- Occasional consultation between therapists and individuals familiar with the person’s culture.
- Outreach activities aimed at connecting people with difficulties accessing services.
- Provision of additional services designed to improve adherence (for example, childcare during sessions).
- Oral administration of materials for those who have difficulty with written content.
- Cultural sensitivity training for both clinical and administrative staff.
- Referral to external cultural consultancy services.

It is interesting to note that the emergence of third-wave cognitive behavioural therapies, particularly Acceptance and Commitment Therapy and mindfulness-based approaches, has marked a shift in direction by acknowledging the influence of Eastern philosophies on Western psychotherapy (Hwang, 2011).

A second approach consists of culturally specific therapies (Moodley & West, 2005; Qureshi, 2013). Examples include Morita (1919) therapy, inspired by Zen Buddhism; Storytelling therapy from Latin America (Costantino et al., 1986); and the Afrocentric NTU therapy, derived from a Bantu term referring to a universal unifying life force, popular among African Americans (Phillips, 1990).

In reality, whether or not one has specific multicultural training, many interventions carried out in developed countries involve multicultural interactions. Therefore, the following sections present examples of common challenges encountered in such situations.

5.1.1. Biases and limitations in psychometrics

The use of standardised instruments in clinical and psychosocial practice is common. However, the psychometric assessment of an individual can be significantly biased if their cultural background is not taken into account (van de Vijver & Tanzer, 2004). Some of these biases are illustrated below.

5.1.1.1. Construct bias

Concepts may differ or manifest differently across cultures, as in the case of bereavement. Similarly, certain behaviours may occur with differing intensity depending on the cultural context, such as crying, which is more commonly expressed in Latin cultures than in Eastern ones (Eisenbruch, 1984a, 1984b).

In addition, the particular circumstances of migrants may lead to misinterpretations of certain items in widely used questionnaires. For example, some items from the Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1988) and the Millon Clinical Multiaxial Inventory-III (MCMI-III; Millon, 1997) can be problematic.

SCL-90-R

16. Hearing voices that other people do not hear
18. The idea that one cannot trust others
21. Shyness or discomfort with the opposite sex
29. Feeling lonely
68. Having ideas or beliefs that others do not share

77. Feeling lonely even when with other people
83. The impression that people would take advantage of you if they could

MCMI-III

27. In the past year or two I have begun to feel lonely and empty
53. Lately I have been feeling weak, even in the morning
69. I believe some people use telepathy to influence my life
78. I always try to understand others, even if I do not like them
99. In the last two years I have become very discouraged and sad about life

As can be seen, these items may indicate symptoms of anxiety, depression or psychosis in someone who has not recently relocated. However, for a person who has migrated, they might reflect normal adaptation processes.

5.1.1.2. Biases in validation methods and data collection

Although there has been growing interest in cross-cultural validation of instruments in recent decades (Bhui et al., 2003), most tools are still validated using ethnically homogeneous samples. Moreover, many instruments are biased by design, as members of some minority groups may be unfamiliar with paper-based questionnaires. In the field of intelligence testing, research has shown that people of African origin may perform better at identifying miniature models (Deregowski & Serpell, 1971) or constructing three-dimensional figures rather than producing drawings with pencil and paper (Serpell, 1993). It has also been observed that different populations show varying preferences for response anchors, tending more or less towards extremes depending on their origin (Hui & Triandis, 1989).

5.1.1.3. Biases in administration

Test instructions and explanations can be an initial barrier to accurate completion, particularly when the interviewer and interviewee speak different languages and cannot fully understand each other. In such cases, there is a high likelihood that the instrument will not be completed as intended. In addition, while the use of cameras and other recording devices may be relatively normal for Western participants, people from countries where such practices are uncommon may respond differently (Tanzer et al., 1995). It has also been shown that the mere presence of someone from another culture can influence behaviour during testing (Singer & Presser, 1989).

5.1.1.4. Biases in item construction

Anything from poor translation of terms to culturally specific connotations of words can affect responses. For instance, the phrase “butterflies in the stomach” is associated with anxiety in Anglo-Saxon culture but with romantic feelings in the Netherlands (Geisinger, 1994). Such discrepancies may lead to measurement differences between people who do not interpret the intended meaning, resulting in non-comparable scores.

5.1.1.5. Limits of the professional’s cultural knowledge

Professionals who specialise in working with migrants often strive to understand their cultures. Travelling or taking part in academic or professional exchanges is a privilege that allows direct contact with distant cultures and provides valuable learning experiences, offering insight into the realities of migrants’ countries of origin. However, a few weeks or even months abroad does not make one an expert on a culture. Even those who specialise in a particular culture may make mistakes by applying generalisations to an individual case.

Imagine a person from Galicia (Spain), agnostic, with no clear political affiliation, and a particular interest in literature and electronic music, visiting a health centre in Central Asia due to an illness. By chance, the doctor treating them had once spent a few months in Santiago de Compostela through a scholarship decades earlier. The doctor begins to share memories about Galician food, bagpipes and regional costumes, as well as political observations and the peculiarities of the language. Trying to establish a connection, the doctor asks whether the Galician patient plays the bagpipes or dances the “muñeira”. Such comments might make the person uncomfortable. Although that might not always be the case, it is clear that the doctor is assuming greater cultural homogeneity among Galicians than actually exists. Still, it is possible to find professionals who gain patients’ trust through travel anecdotes about their region of origin, which can be accepted as an invitation to openness.

Knowledge of different cultures is valuable and contributes to personal growth. However, each individual is a unique combination of cultural elements that go beyond their origin, as they are also shaped by globalisation and factors such as family, politics and ethnic or racial dynamics. As we have seen, elements often considered characteristic of a culture, internalised by travellers and systematised by experts, can lead to stereotyping. In short, there are no strict rules about using cultural references, but it is certainly risky to employ them without recognising individual diversity.

In both formal and informal contexts, we may hear discriminatory remarks about people of certain ethnic origins. When this comes from someone who claims to be "non-racist", it can be surprising. However, as therapists, if we feel discomfort with certain behaviours, such as lateness or particular ways of speaking associated with a given background, we may have an issue, especially when we must interact regularly with such individuals.

In psychotherapy, a body of work has emerged focusing on countertransference between people from racially conflicted groups (Suchet, 2004). For example, psychotherapies involving people of Jewish and Arab origin have been conducted (Gorkin, 1996). These approaches often debate whether to address the tensions stemming from the different sociopolitical positions of those involved in therapy. There is no universal solution, and each case requires thoughtful reflection. At times, not addressing these tensions may be experienced as a betrayal, whereas in others, the issue might go unnoticed or be deliberately avoided. Nonetheless, countertransferential elements must undoubtedly be considered as part of therapeutic analysis and supervision.

5.2. The limits of the Western perspective

It is not uncommon to hear debates on controversial aspects of multicultural coexistence, such as the use of religious symbols in educational settings or the fact that some people attend therapy accompanied by their partners. Among both the general public and a large part of the academic community, the idea of historical linearity in the West is widely accepted. This notion assumes a historical causality, meaning that events occur as a consequence of previous ones that justify them. However, it is important to point out that this view has not always been dominant in history. Although it is difficult to conceptualise and beyond the scope of this text, it is useful to illustrate this perspective.

Most ancient cultures, including the Greek, regarded history as a cyclical process in which periods of light and darkness alternated. The Enlightenment, however, introduced the notion of "progress", arguing that humanity was advancing towards a more developed society. During the colonial period, this idea was used to justify the invasion of numerous territories under the pretext of bringing civilisation to places supposedly lacking it. From an academic standpoint, these ideas were reflected in social Darwinism, which applied evolutionary principles to societies. According to this theory, societies compete for survival and only the strongest prevail. However, the Western concept of "progress" has often clashed with reality and with the geopolitical uses made of it in different contexts. An illustrative example is the French colonial use of the hijab as a political symbol in Algeria. France, as the colonial power, claimed that the veil represented gender inequality, while the Algerian independence movement used it as a symbol of Muslim identity and resistance against the coloniser. In other words, Algerian women activists of the time wore it as a form of political resistance and an assertion of their independence. This example illustrates that what appears obvious is not always so, and that the social reality of so-called "less developed" countries can be far more complex. In other words, the supposed exportation of progress by Western nations has, at times, led to regression, at least from a Western perspective.

Following the philosopher Gadamer (1960), when analysing the problems and inequalities faced by communities living alongside us, we tend to apply filters shaped by our own history and worldview. As a result, when expressing opinions about an entire group, we risk adopting a simplistic view of complex historical processes, since we often rely on specific contexts to make generalisations that in fact require deeper and more nuanced reflection.

5.3. Mental health work and human rights

Traumatic experiences related to disasters or political violence, as well as histories of human rights violations and even torture, are familiar issues for those working with ethnic minorities, particularly asylum seekers. It is common for professionals to assume that having experienced a traumatic event is a central feature in the lives of those who have lived through such circumstances. However, as discussed in the section on stress, the impact of traumatic experiences does not necessarily correspond to their objective severity or the threat suffered by the individual; it is largely influenced by subjective appraisal.

Imagine that some years ago a person from the Basque Country spoke with someone unfamiliar with the region. They might conclude that life there must have been unbearable, much as Spaniards might think about Colombia during times of conflict. Yet, when visiting these places, most people lead relatively routine lives despite hardship and atrocities. Even in severe conflicts such as those in Syria or Sudan, some people manage to maintain their daily routines despite the adversity of war. When working with people from countries affected by disasters or political violence, it is essential not to assume that their lives have been completely defined by those events or that trauma is the only reason they seek help. Moreover, a therapeutic stance based on “pity” or “sympathy” can be counterproductive. Listening is essential before understanding can take place.

Lack of legal status generates mental health difficulties both in migrants (Barro Lugo et al., 2004; Salaberría et al., 2008) and, to a greater extent, in asylum seekers (Lears & Abbott, 2005; Mueller et al., 2011). Living without regularised status causes stress that affects various aspects of identity and limits possible activities. Nevertheless, it has been shown that people in irregular situations can benefit from therapy just as much as those with legal status. Although they may experience higher levels of psychosocial stress, treatment can still be effective for them (Brune et al., 2014).

In summary, within psychological treatment, it is essential to consider each person’s individual problems and experiences without assuming these will obstruct the therapeutic process. It is important to discuss and address contextual aspects relevant to treatment, and to collaborate with other professionals where appropriate.

6. Information and communication technologies (ICTs)

6.1. The influence of ICTs on psychological treatment

The development of information and communication technologies (ICTs) during the late twentieth and early twenty-first centuries has transformed human life and, albeit more slowly than in other areas, has also influenced psychological interventions and treatments. Not long ago, the first step in seeking help for psychological distress typically involved turning to a trusted person, such as a family member, priest or general practitioner. Nowadays, this responsibility often falls to Internet search engines. The extent of this change is such that studies can now be conducted on variations in certain forms of distress using search data extracted from these engines (e.g., Ayers et al., 2013). Online searches for psychological services, the full or partial delivery of therapy through videoconferencing, and the use of virtual reality devices for exposure techniques are further examples of ICT use in psychological treatment.

At the same time, professionals also use online searches and Large Language Models (LLMs) artificial intelligence models to find evidence and ideas for interventions. Although it is clear that this is happening, the practice has received little attention from academia. Despite the lack of formal discussion, professionals frequently turn to the Internet to compare approaches and explore innovations, probably in diverse ways. While researchers tend to search almost exclusively in databases of peer-reviewed academic journals, prioritising impact factor and prestige, practitioners providing care often use a wider variety of materials: clinical guidelines, specific manuals, audio-visual resources for presentations, case studies shared by other professionals, and training course materials, among others.

Furthermore, both national and international institutions dedicated to public mental health have begun to provide open and free access through their websites to reports on the efficacy and effectiveness of different types of psychological interventions. Examples include the Cochrane Collaboration[10], the National Institute for Health and Care Excellence (NICE)[11] in the United Kingdom, the American Psychological Association (APA)[12], the Evidence-Based Practices Resource Center of the Substance Abuse and Mental Health Services Administration (SAMHSA)[13], and in Spain, the Clinical Practice Guidelines (GPC) Library of the National Health System (SNS)[14]. Additionally, academic

---

[10] International non-profit organisation dedicated to reviewing evidence on health interventions, http://www.cochrane.org

[11] The National Institute for Clinical Excellence (NICE) merged with the Health Development Agency in 2005 to become the National Institute for Health and Care Excellence, although it retained the acronym, http://www.nice.org.uk

[12] https://www.apa.org

[13] https://www.samhsa.gov

[14] https://portal.guiasalud.es

evaluation systems that prioritise publications in high-impact journals have led to a decline in the production of general manuals on psychological treatment.

6.2. Working with Information and Communication Technologies

The possibilities of ICT in psychological intervention are broad and encompass various approaches. One of the most relevant aspects concerns the advantages they offer compared with face-to-face treatments. Interventions delivered through ICT enable greater access to intervention services, reducing costs and geographical barriers. This provides the opportunity to receive interventions from highly qualified professionals in remote areas, or for people with mobility or access difficulties. It is important to note that ICT-based interventions are generally well received. Current evidence indicates that the therapeutic alliance developed through remote contact is similar to that of face-to-face therapy (Jenkins-Guarnieri et al., 2015).

There are several modalities of psychological intervention and treatment using ICT. Some examples include remote psychological consultations, online treatment programmes, mobile applications, the use of virtual reality, and interventions based on artificial intelligence. These modalities may combine different approaches and are related to concepts such as telemental health or teletherapy, which encompass prevention, assessment, diagnosis, treatment and follow-up in mental health through the use of ICT systems to provide remote assistance (Aboujaoude et al., 2015). Below are some examples.

6.2.1. Remote Psychological Consultation

Remote psychological consultation through ICT involves conducting the psychotherapeutic process in a virtual environment. This can be achieved using various technologies, such as telephone consultations or videoconferencing systems. Videoconferencing is particularly useful, as it allows much of the non-verbal communication to be maintained, which is important in the intervention process. The specialist literature has demonstrated that similar outcomes can be achieved to those of traditional face-to-face therapy across a wide range of problems (Backhaus et al., 2012).

Email is an additional way of providing remote psychological consultation through ICT. It allows written communication between the therapist and the person, offering a means of interaction and support. Although it has been debated whether warmth, care and compassion can be communicated through this medium, given the lack of non-verbal information in a textual format, the use of email has several advantages (Murphy & Mitchell, 1998). Firstly, written communication helps people organise their thoughts and express their difficulties clearly. Secondly, it allows the process to be asynchronous, meaning that the person can write in their own time and the therapist can respond in the same way within an agreed timeframe. This offers convenience and enables the person to express their feelings and thoughts at the moment they occur, which can provide more accurate information for the therapist. Furthermore, the asynchronous nature of this method allows the therapist to consult different sources to provide a more informed response. Thirdly, the use of email facilitates the recording of what has been worked on throughout the process, which can be useful in several ways, such as helping people remember what has been discussed, assessing changes over time, and revisiting supportive messages from the therapist. It is also possible to combine different uses of ICT to enhance the accessibility of psychological interventions, which is common nowadays, particularly since the COVID-19 pandemic, which prompted an accelerated use of technologies to facilitate remote access to health services (Abraham et al., 2021).

The security of the media used in ICT-based work in general, and in remote psychological consultation in particular, is a matter of great importance. Although ICT continues to advance rapidly, it is not without limitations in terms of security. Therefore, if these technologies are to be used, it is essential to ensure that the chosen platform meets the legal requirements concerning data confidentiality. Particular attention should be paid to any material that may remain stored on the medium used.

6.2.2. Multicomponent Online Treatment Programmes

Regarding the use of ICT aimed at offering online treatment programmes for specific problems, commonly referred to in the specialist literature as internet-based or web-based interventions (Barak et al., 2009), there is a wide range of programmes with diverse objectives. This group includes everything from primary prevention programmes, where psychology can provide integrated elements within a multidisciplinary framework, to tertiary intervention programmes adapted to a virtual environment with the aim of replicating what would take place in a face-to-face context.

These programmes usually combine a psychoeducational component with a variety of elements that may vary depending on the specific problem being addressed. For instance, they may include training in relaxation techniques, communication skills, or problem-solving, among others. In terms of specific tools, they may use videos, forums to facilitate communication among participants, interactive image maps, and other resources. In general, these interventions are delivered through a website composed of different chapters or sections, simulating various sessions. Each chapter or section focuses on a particular aspect of the programme through written material and different multimedia resources.

It is important to highlight that these interventions may be self-directed or involve the participation of a professional who communicates with the service user to discuss the work sessions or the tasks to be completed. A determining factor in the inclusion of specific components within these programmes is the available budget for their development. In general, the more resources and professional support included, the more comprehensive the programme will be, which facilitates adherence and is likely to result in better outcomes. However, it is also important to bear in mind that such programmes will be more expensive to develop and maintain.

Evidence regarding these types of programmes has increased significantly in recent years, and available reviews clearly demonstrate their usefulness, with many achieving results comparable to face-to-face interventions. In the field of mental health, mood and anxiety disorders have been the most frequently addressed, and their effectiveness has been demonstrated across various interventions (Cunningham et al., 2014; Lal & Adair, 2014).

6.2.3. Psychological Intervention Using Smartphones

The proliferation of smartphones in society provides an excellent opportunity to deliver accessible psychological interventions. These devices allow instant access to the internet and applications in almost any location, and are easy to use for most people. Applications can send information and reminders in a straightforward manner, alerting users to specific tasks that need to be completed. In addition, these applications can provide support and reinforcement for individuals undergoing treatment. Given these advantages, it is unsurprising that a multitude of applications related to general health, and mental health in particular, have been developed.

However, this phenomenon also carries certain potential risks. In many cases, these applications are created without following a standardized procedure to ensure minimum levels of quality, and the majority have not undergone scientific studies to evaluate their effects (Neary & Schueller, 2018). For this reason, recent work has presented recommendations for the development of mental health applications (Bakker et al., 2016) and guidelines for evaluating the quality of available applications (Chan et al., 2015).

Regarding their use for specific difficulties, the scientific literature to date has focused on the use of smartphone applications for managing stress, anxiety, depression, borderline personality disorder, and substance misuse (Donker et al., 2013). However, it is important to note that many more applications are available in the main repositories. Furthermore, it is crucial to recognise the potential these applications have for conducting real-time assessments in the context in which certain events occur. For example, using a smartphone to record negative thoughts at the exact moment they arise may be easier than doing so in a traditional diary.

6.2.4. Virtual and Augmented Reality

We also want to briefly address the use of virtual reality (VR) in psychological treatments. Virtual reality refers to a set of technologies that allow the simulation of reality by creating environments in which people experience a sense of presence, as if they were actually there. This sense of being present in the virtual environment leads individuals to experience sensations and emotions similar to those they would have in real life. Furthermore, immersion in this virtual world results in isolation from other stimuli and greater focus of attention. The sense of presence in virtual reality is primarily due to two characteristics of these environments. Firstly, virtual environments are three-dimensional, providing a sense of depth and volume. Secondly, there is interaction between the individual and the environment, with the latter responding to the person's movements and actions.

VR has been widely used in the field of psychological intervention, particularly in the treatment of phobias. Virtual reality exposure therapy (VRET) offers several advantages compared with in vivo exposure or traditional imaginal exposure (Baus & Bouchard, 2014). Firstly, VRET facilitates exposure to phobias that would otherwise be difficult or impossible to address. For example, in the case of a fear of flying, in vivo exposure is costly in terms of time and money, and it is challenging to arrange feared situations for treatment. VRET allows the creation of specific situations in a graduated manner, such as flying in adverse weather conditions, which rarely occur in reality. This ability to grade and create situations is a key advantage of VRET. Secondly, VRET may be better accepted by individuals compared with in vivo exposure. In vivo exposure can be perceived as more threatening, generating fear and potentially preventing engagement with the therapeutic process. For example, in the case of a fear of spiders, simply thinking about facing a real spider can provoke considerable anxiety and make it difficult to start treatment. VRET can reduce this perception of threat and facilitate participation in exposure. Thirdly, VRET overcomes difficulties some individuals may have in imagining feared situations. VRET does not rely on imagination, allowing these difficulties to be bypassed and ensuring a more realistic and effective experience. In addition, VRET provides safety advantages for both the therapist and the individual, as it avoids exposure to real situations that could involve risk, such as traffic accidents in the case of a fear of driving. VRET has been successfully applied to a range of specific phobias, including arachnophobia, fear of flying, driving phobia, and social phobia, and it has even been shown to achieve results superior to in vivo exposure (Powers & Emmelkamp, 2008).

Technological advances have also led to the development of augmented reality (AR). AR combines virtual images with the real environment, incorporating virtual elements created by humans into the specific physical environment in which the person is located (Baus & Bouchard, 2014). Unlike virtual reality, where the individual is immersed in an artificial world, in AR it is the artificial elements that are integrated into the real environment. This allows the person to be exposed to feared virtual elements in their own environment through augmented reality exposure therapy (ARET). A significant advantage of ARET compared with VRET is that it requires less development. There is no need to create a complete virtual environment, only specific elements, which reduces costs. Furthermore, ARET allows experiences to occur within the person's physical environment, without relying on their sense of presence in a virtual setting. It is also worth noting that interaction with virtual objects in the real environment can provide a more ecologically valid experience.

In summary, it is important to emphasise that the use of virtual reality in health is not limited to phobias. VR has been shown to be an effective tool for a range of objectives and difficulties. For instance, it has been used to reduce pain perception by diverting attention, leading to a decrease in pain intensity (Mahrer & Gold, 2009). It has also been employed in the treatment of individuals with panic disorder and post-traumatic stress disorder by exposing them to anxiety-provoking situations (Meyerbröker & Emmelkamp, 2010). Additionally, VR has demonstrated utility in managing eating disorders by helping adjust body image perceptions and providing exposure that contributes to reducing cravings for certain foods (Gutiérrez-Maldonado et al., 2016), among many other applications.

6.2.5. Artificial Intelligence

To conclude, we would like to provide a brief introduction to artificial intelligence (AI), which aims to perform tasks that normally require human intelligence. AI uses elements and processes such as decision algorithms and neural networks to equip software with properties similar to human intelligence, including reasoning, planning, learning, and understanding language. Although AI has been discussed for a long time and applied in various domains, we are arguably now witnessing an exponential growth in its presence in daily life, particularly in health care in general and mental health in particular. This growth is partly due to significant improvements in the processing capacity of computer systems. In addition, there is greater availability of data (sometimes provided voluntarily and other times unknowingly) for AI to process. For example, social media platforms use AI algorithms to display advertising based on information they collect about users.

There are numerous applications of AI, ranging from data processing for automated decision-making to the simulation of human behaviour for therapeutic purposes. A notable example in the field of diagnosis is the development of applications that, through machine learning, create conversational patterns to conduct interviews and provide diagnoses (Graham et al., 2019). Another prominent example is the creation of a human-like figure in augmented virtual reality environments, designed to help adults with autism spectrum disorders practise job interviews. Although research in this field is still at an early stage, the results obtained so far are promising (Hartholt et al., 2019).

The application of artificial intelligence to psychological treatment is a rapidly growing field and is expected to continue evolving in the coming years. Despite technological advances and the applications mentioned above, many professionals remain cautious, as they consider human contact to be a fundamental ingredient.

The arrival of large language models (LLMs) has opened new frontiers in psychological treatment and mental health care, bringing both opportunity and caution. Recent work suggests that LLMs can serve as adjunctive tools in therapy, offering immediate conversational support, guided exercises (e.g. cognitive restructuring prompts), mood tracking, and psychoeducation. Hua et al. (2025) conducted a scoping review of LLMs in mental health and concluded that while initial results are promising, existing work is largely exploratory, using ad hoc metrics, and insufficient to support full autonomy in clinical settings. The first randomized controlled trial of a generative-AI therapy chatbot (Therabot) found significant symptom reductions in depression and anxiety, and users reported trust and therapeutic alliance comparable to human care (Heinz et al., 2025). However, other recent studies caution that human therapists still outperform AI in key domains: for example, human clinicians were rated superior to ChatGPT in delivering cognitive-behavioural therapy in a head-to-head comparison (Acevedo et al., 2025). In delivery of couple therapy vignettes, ChatGPT responses were sometimes indistinguishable from therapists' replies and even rated higher on certain therapeutic principles (Hatch et al., 2025), but these controlled settings may not generalize to real-world complexity.

At the same time, significant challenges remain. LLMs may hallucinate, offer inconsistent or biased responses, or fail to detect crisis states reliably. The "black box" nature of many proprietary models complicates transparency and accountability (Guo et al., 2024). Ethical concerns, particularly around data privacy, algorithmic bias, overreliance by users, and the potential weakening of therapeutic alliance, are widely discussed (Lawrence et al., 2024; Rousmaniere et al., 2025). Furthermore, AI therapy chatbots may introduce biases, dangerous outputs, or harmful reinforcement of stigma

(Moore et al., 2025). Regulatory bodies are increasingly scrutinizing AI mental health tools; for instance, the American Psychological Association has voiced concerns about generic AI chatbots posing as therapists. Despite the rapid advances, LLMs are best viewed not as replacements for human clinicians but as supplements; capable of extending care access, facilitating homework, and offering interim support between sessions. The path forward requires rigorous, longitudinal studies; standardized evaluation frameworks; integration of clinical oversight; ethical guardrails; and clear demarcation of scope (i.e., what AI can safely do vs. what requires human judgment). Only through cautious, evidence-based, multidisciplinary development can AI-augmented psychological treatment fulfil its promise without compromising safety, efficacy, or the central human bond at the heart of psychotherapy.

7. References

Aboujaoude, E., Salame, W., & Naim, L. (2015). Telemental health: A status update. *World Psychiatry*, *14*(2), 223–230. https://doi.org/10.1002/wps.20218

Abraham, A., Jithesh, A., Doraiswamy, S., Al-Khawaga, N., Mamtani, R., & Cheema, S. (2021). Telemental Health Use in the COVID-19 Pandemic: A Scoping Review and Evidence Gap Mapping. *Frontiers in Psychiatry*, *12*(November), 1–16. https://doi.org/10.3389/fpsyt.2021.748069

Acevedo, S., Aneja, E., Opler, D. J., Valera, P., & Jarmon, E. (2025). Evaluating the Efficacy of ChatGPT-3.5 Versus Human-Delivered Text-Based Cognitive-Behavioral Therapy: A Comparative Pilot Study. *American Journal of Psychotherapy*. https://doi.org/10.1176/appi.psychotherapy.20240070

Angermeyer, M. C., & Matschinger, H. (2005). Labeling—stereotype—discrimination. *Social Psychiatry and Psychiatric Epidemiology*, *40*(5), 391–395. https://doi.org/10.1007/s00127-005-0903-4

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, *16*(4), 11–23. https://doi.org/10.1037/h0095655

Ayers, J. W., Althouse, B. M., Allem, J.-P., Rosenquist, J. N., & Ford, D. E. (2013). Seasonality in Seeking Mental Health Information on Google. *American Journal of Preventive Medicine*, *44*(5), 520–525.

https://doi.org/10.1016/j.amepre.2013.01.012

Backhaus, A., Agha, Z., Maglione, M. L., Repp, A., Ross, B., Zuest, D., Rice-Thorp, N. M., Lohr, J., & Thorp, S. R. (2012). Videoconferencing psychotherapy: A systematic review. *Psychological Services*, *9*(2), 111–131. https://doi.org/10.1037/a0027924

Bakker, D., Kazantzis, N., Rickwood, D., & Rickard, N. (2016). Mental Health Smartphone Apps: Review and Evidence-Based Recommendations for Future Developments. *JMIR Mental Health*, *3*(1), e7. https://doi.org/10.2196/mental.4984

Barak, A., Klein, B., & Proudfoot, J. G. (2009). Defining Internet-Supported Therapeutic Interventions. *Annals of Behavioral Medicine*, *38*(1), 4–17. https://doi.org/10.1007/s12160-009-9130-7

Barker, I., & Peck, E. (1996). User Empowerment — A Decade of Experience. *Mental Health Review Journal*, *1*(4), 5–13. https://doi.org/10.1108/13619322199600036

Barro Lugo, S., Saus Arús, M., Barro Lugo, A., & Fons Martí, M. (2004). Depresión y ansiedad en inmigrantes no regularizados. *Atención Primaria*, *34*(9), 504–504. https://doi.org/10.1157/13069042

Baus, O., & Bouchard, S. (2014). Moving from Virtual Reality Exposure-Based Therapy to Augmented Reality Exposure-Based Therapy: A Review. *Frontiers in Human Neuroscience*, *8*. https://doi.org/10.3389/fnhum.2014.00112

Bhui, K., Mohamud, S., Warfa, N., Craig, T. J., & Stansfeld, S. A. (2003). Cultural adaptation of mental health measures: Improving the quality of clinical practice and research. *British Journal of Psychiatry*, *183*(03), 184–186. https://doi.org/10.1192/bjp.183.3.184

Biondi, M., Pasquini, M., & Picardi, A. (Eds.). (2018). *Dimensional Psychopathology*. Springer International Publishing. https://doi.org/10.1007/978-3-319-78202-7

Bonino, L. (2002). Masculinidad hegemónica e identidad masculina. *Dossiers Feministes. Masculinitats: Mites, de/ Construccions i Mascarades*, 7–37.

Botella, L., & Feixas, G. (1998). *Teoría de los Constructos Personales. Aplicaciones a la Práctica Psicológica*. Celesa.

Broadbent, P., Thomson, R., Kopasker, D., McCartney, G., Meier, P., Richiardi, M., McKee, M., & Katikireddi, S. V. (2023). The public health implications of the cost-of-living crisis: outlining mechanisms and modelling consequences. *The Lancet Regional Health - Europe*, *27*, 100585. https://doi.org/10.1016/j.lanepe.2023.100585

Brune, M., Eiroa-Orosa, F. J., Fischer-Ortman, J., & Haasen, C. (2014). Effectiveness of psychotherapy for traumatized refugees without a secure residency status. *International Journal of Migration, Health and Social Care*, *10*(1), 52–59. https://doi.org/10.1108/IJMHSC-07-2013-0022

Chan, S., Torous, J., Hinton, L., & Yellowlees, P. (2015). Towards a Framework for Evaluating Mobile Mental Health Apps. *Telemedicine and E-Health*, *21*(12), 1038–1041. https://doi.org/10.1089/tmj.2015.0002

Chapman, A. R. (2010). The social determinants of health, health equity, and human rights. *Health and Human Rights*, *12*(2), 17–30.

Cogan, N., Kennedy, C., Beck, Z., McInnes, L., MacIntyre, G., Morton, L., Tanner, G., & Kolacz, J. (2022). ENACT study: What has helped health and social care workers maintain their mental well-being during the COVID-19 pandemic? *Health and Social Care in the Community*, *30*(6), e6656–e6673. https://doi.org/10.1111/hsc.13992

Compañ Felipe, V. (2023). *Incorporació de la perspectiva feminista en psicoteràpia*. Fundació Universitat Oberta de Catalunya (FUOC).

Corrigan, P. W. (2011). Best Practices: Strategic Stigma Change (SSC): Five Principles for Social Marketing Campaigns to Reduce Stigma. *Psychiatric Services*, *62*(8), 824–826. https://doi.org/10.1176/ps.62.8.pss6208_0824

Corrigan, P. W., Kerr, A., & Knudsen, L. (2005). The stigma of mental illness: Explanatory models and methods for change. *Applied and Preventive Psychology*, *11*(3), 179–190. https://doi.org/10.1016/j.appsy.2005.07.001

Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry*, *1*(1), 16–20.

Costantino, G., Malgady, R. G., & Rogler, L. H. (1986). Cuento therapy: A culturally sensitive modality for Puerto Rican children. *Journal of Consulting and Clinical Psychology*, *54*(5), 639–645. https://doi.org/10.1037/0022-006X.54.5.639

Cunningham, J. a., Gulliver, A., Farrer, L., Bennett, K., & Carron-Arthur, B. (2014). Internet Interventions for Mental Health and Addictions: Current Findings and Future Directions. *Current Psychiatry Reports*, *16*(12), 521. https://doi.org/10.1007/s11920-014-0521-5

Cushman, P. (1990). Why the self is empty: Toward a historically situated psychology. *American Psychologist*, *45*(5), 599–611. https://doi.org/10.1037/0003-

066X.45.5.599

Davidson, L. (2016). The recovery movement: Implications for mental health care and enabling people to participate fully in life. *Health Affairs*, *35*(6), 1091–1097. https://doi.org/10.1377/hlthaff.2016.0153

De Vogli, R., Brunner, E., & Marmot, M. G. (2007). Unfairness and the social gradient of metabolic syndrome in the Whitehall II Study. *Journal of Psychosomatic Research*, *63*(4), 413–419. https://doi.org/10.1016/j.jpsychores.2007.04.006

Deregowski, J. B., & Serpell, R. (1971). Performance on a sorting task: a cross-cultural experiment. *International Journal of Psychology and Psychological Therapy*, *6*, 273–281.

Derogatis, L. R. (1988). *SCL-90-R*. TEA ediciones.

Donker, T., Petrie, K., Proudfoot, J., Clarke, J., Birch, M.-R., & Christensen, H. (2013). Smartphones for Smarter Delivery of Mental Health Programs: A Systematic Review. *Journal of Medical Internet Research*, *15*(11), e247. https://doi.org/10.2196/jmir.2791

Economou, M., Madianos, M., Peppou, L. E., Patelakis, A., & Stefanis, C. N. (2013). Major depression in the Era of economic crisis: A replication of a cross-sectional study across Greece. *Journal of Affective Disorders*, *145*(3), 308–314. https://doi.org/10.1016/j.jad.2012.08.008

Eiroa-Orosa, F. J. (2013). Cambio sociocultural y bienestar psicosocial: una propuesta para la investigación y la acción. *Psicología Política*, *47*, 39–53.

Eiroa-Orosa, F. J., & García-Mieres, H. (2019). A Systematic Review and Meta-analysis of Recovery Educational Interventions for Mental Health Professionals. *Administration and Policy in Mental Health and Mental Health Services Research*, *46*(6), 724–752. https://doi.org/10.1007/s10488-019-00956-9

Eisenbruch, M. (1984a). Cross-cultural aspects of bereavement. I: A conceptual framework for comparative analysis. *Culture, Medicine and Psychiatry*, *8*(3), 283–309. https://doi.org/10.1007/BF00055172

Eisenbruch, M. (1984b). Cross-Cultural aspects of bereavement. II: Ethnic and cultural variations in the development of bereavement practices. *Culture, Medicine and Psychiatry*, *8*(4), 315–347. https://doi.org/10.1007/BF00114661

Elovainio, M., Kivimäki, M., Steen, N., & Vahtera, J. (2004). Job decision latitude, organizational justice and health: multilevel covariance structure analysis. *Social Science & Medicine*, *58*(9), 1659–1669. https://doi.org/10.1016/S0277-9536(03)00366-6

Fazel, S., Gulati, G., Linsell, L., Geddes, J. R., & Grann, M. (2009). Schizophrenia and violence: Systematic review and meta-analysis. *PLoS Medicine*, *6*(8). https://doi.org/10.1371/journal.pmed.1000120

Gadamer, H. G. (1960). *Wahrheit und Methode. Grundzüge einer philosophischen Hermeneutik*. J. C. B. Mohr.

Geisinger. (1994). Cross-cultural normative assessment: Translation and adaptation issues influencing the normative interpretation of assessment instruments. *Psychological Assessment*, *6*(4), 304–312.

Gerlinger, G., Hauser, M., De Hert, M., Lacluyse, K., Wampers, M., & Correll, C. U. (2013). Personal stigma in schizophrenia spectrum disorders: A systematic review of prevalence rates, correlates, impact and interventions. *World Psychiatry*, *12*(2), 155–164. https://doi.org/10.1002/wps.20040

Gili, M., Roca, M., Basu, S., McKee, M., & Stuckler, D. (2013). The mental health risks of economic crisis in Spain: evidence from primary care centres, 2006 and 2010. *The European Journal of Public Health*, *23*(1), 103–108. https://doi.org/10.1093/eurpub/cks035

Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. Prentice-Hall.

Gorkin, M. (1996). Countertransference in cross-cultural psychotherapy. In R. M. P. Foster, M. Moskowitz, & R. A. Javiev (Eds.), *Reaching across boundaries of culture and class : widening the scope of psychotherapy* (pp. 159–176). J. Aronson.

Goulet, M. H., & Larue, C. (2016). Post-Seclusion and/or Restraint Review in Psychiatry: A Scoping Review. *Archives of Psychiatric Nursing*, *30*(1), 120–128. https://doi.org/10.1016/j.apnu.2015.09.001

Graham, S., Depp, C., Lee, E. E., Nebeker, C., Tu, X., Kim, H. C., & Jeste, D. V. (2019). Artificial Intelligence for Mental Health and Mental Illnesses: an Overview. *Current Psychiatry Reports*, *21*(11). https://doi.org/10.1007/s11920-019-1094-0

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

Guo, Z., Lai, A., Thygesen, J. H., Farrington, J., Keen, T., & Li, K. (2024). Large Language Models for Mental Health Applications: Systematic Review. *JMIR Mental Health*, *11*, e57400. https://doi.org/10.2196/57400

Gutiérrez-Maldonado, J., Wiederhold, B. K., & Riva, G. (2016). Future Directions: How Virtual Reality Can Further Improve the Assessment and Treatment of Eating Disorders and Obesity. *Cyberpsychology, Behavior, and Social Networking*, *19*(2), 148–153. https://doi.org/10.1089/cyber.2015.0412

Hartholt, A., Mozgai, S., Fast, E., Liewer, M., Reilly, A., Whitcup, W., & Rizzo, A. "Skip." (2019). Virtual Humans in Augmented Reality. *Proceedings of the 7th International Conference on Human-Agent Interaction*, 205–207. https://doi.org/10.1145/3349537.3352766

Haslam, N., McGrath, M. J., Viechtbauer, W., & Kuppens, P. (2020). Dimensions over categories: a meta-analysis of taxometric research. *Psychological Medicine*, *50*(9), 1418–1432. https://doi.org/10.1017/S003329172000183X

Hatch, S. G., Goodman, Z. T., Vowels, L., Hatch, H. D., Brown, A. L., Guttman, S., Le, Y., Bailey, B., Bailey, R. J., Esplin, C. R., Harris, S. M., Holt, D. P., McLaughlin, M., O'Connell, P., Rothman, K., Ritchie, L., Top, D. N., & Braithwaite, S. R. (2025). When ELIZA meets therapists: A Turing test for the heart and mind. *PLOS Mental Health*, *2*(2), e0000145. https://doi.org/10.1371/journal.pmen.0000145

Hayward, P., & Bright, J. A. (1997). Stigma and mental illness: A review and critique. *Journal of Mental Health*, *6*(4), 345–354. https://doi.org/10.1080/09638239718671

Heinz, M. V., Mackin, D. M., Trudeau, B. M., Bhattacharya, S., Wang, Y., Banta, H. A., Jewett, A. D., Salzhauer, A. J., Griffin, T. Z., & Jacobson, N. C. (2025). Randomized Trial of a Generative AI Chatbot for Mental Health Treatment. *NEJM AI*, *2*(4). https://doi.org/10.1056/AIoa2400802

Hua, Y., Na, H., Li, Z., Liu, F., Fang, X., Clifton, D., & Torous, J. (2025). A scoping review of large language models for generative tasks in mental health care. *Npj Digital Medicine*, *8*(1). https://doi.org/10.1038/s41746-025-01611-4

Hui, C. H., & Triandis, H. C. (1989). Effects of Culture and Response Format on Extreme Response Style. *Journal of Cross-Cultural Psychology*, *20*(3), 296–309. https://doi.org/10.1177/0022022189203004

Hwang, W.-C. (2011). Cultural Adaptations: A Complex Interplay Between Clinical and Cultural Issues. *Clinical Psychology: Science and Practice*, *18*(3), 238–241. https://doi.org/10.1111/j.1468-2850.2011.01255.x

Jenkins-Guarnieri, M. A., Pruitt, L. D., Luxton, D. D., & Johnson, K. (2015). Patient perceptions of telemental health: Systematic review of direct comparisons to in-person psychotherapeutic treatments. *Telemedicine and E-Health*, *21*(8), 652–660. https://doi.org/10.1089/tmj.2014.0165

Jenkins, J. H., & Carpenter-Song, E. A. (2009). Awareness of Stigma Among Persons With Schizophrenia. *The Journal of Nervous and Mental Disease*, *197*(7), 520–529. https://doi.org/10.1097/nmd.0b013e3181aad5e9

Johnstone, L., & Boyle, M. (2018). The Power Threat Meaning Framework: An Alternative Nondiagnostic Conceptual System. *Journal of Humanistic Psychology*, 002216781879328. https://doi.org/10.1177/0022167818793289

Keith Neal, P. W. (2022). The 'cost of living crisis.' *Journal of Public Health*, *44*(3), 475–476. https://doi.org/10.1093/pubmed/fdac080

Kivimäki, M., Elovainio, M., Vahtera, J., Virtanen, M., & Stansfeld, S. A. (2003). Association between organizational inequity and incidence of psychiatric disorders in female employees. *Psychological Medicine*, *33*(2), 319–326. https://doi.org/10.1017/s0033291702006591

Krupchanka, D., & Thornicroft, G. (2017). Discrimination and Stigma. In *The Stigma of Mental Illness - End of the Story?* (pp. 123–139). Springer International Publishing. https://doi.org/10.1007/978-3-319-27839-1_7

Kumar, A., & Nayar, K. R. (2021). COVID 19 and its mental health consequences. *Journal of Mental Health*, *30*(1), 1–2. https://doi.org/10.1080/09638237.2020.1757052

Lagarde, M. (2001). *Claves feministas para la autoestima de las mujeres*. horas y HORAS.

Lal, S., & Adair, C. E. (2014). E-mental health: a rapid review of the literature. *Psychiatric Services (Washington, D.C.)*, *65*(1), 24–32. https://doi.org/10.1176/appi.ps.201300009

Lam, H. P. (2014). *A meta-analysis of the prediction of violence among adults with mental disorders*. CUNY Academic Works.

Lawrence, H. R., Schneider, R. A., Rubin, S. B., Mataric, M. J., McDuff, D. J., & Bell, M. J. (2024). The Opportunities and Risks of Large Language Models in Mental Health.

JMIR Mental Health, *11*, 1–15. https://doi.org/10.2196/59479

Lears, L. O. S., & Abbott, J. S. (2005). The most vulnerable among us. *Health Progress (Saint Louis, Mo.)*, *86*(1), 22–25, 60.

Lilienfeld, S. O. (2007). Psychological Treatments That Cause Harm. *Perspectives on Psychological Science*, *2*(1), 53–70. https://doi.org/10.1111/j.1745-6916.2007.00029.x

Link, B. G., & Phelan, J. C. (2001). Conceptualizing Stigma. *Annual Review of Sociology*, *27*(1), 363–385. https://doi.org/10.1146/annurev.soc.27.1.363

Link, B. G., Struening, E. L., Neese-Todd, S., Asmussen, S., Phelan, J. C., Consequences, T., With, P., & Illnesses, M. (2001). The Consequences of Stigma for the Self-Esteem of People With Mental Illnesses. *Psychiatric Services*, *52*(12), 1–6.

Link, B. G., & Stuart, H. (2017). On Revisiting Some Origins of the Stigma Concept as It Applies to Mental Illnesses. In W. Gaebel, W. Rössler, & N. Sartorius (Eds.), *The Stigma of Mental Illness - End of the Story?* (pp. 3–28). Springer International Publishing. https://doi.org/10.1007/978-3-319-27839-1_1

Livingston, J. D., & Boyd, J. E. (2010). Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. *Social Science and Medicine*, *71*(12), 2150–2161. https://doi.org/10.1016/j.socscimed.2010.09.030

López, M., Laviana, M., Fernández, L., López, A., Rodríguez, A. M., & Aparicio, A. (2008). La lucha contra el estigma y la discriminación en salud mental: Una estrategia compleja basada en la información disponible. *Revista de La Asociación Española de Neuropsiquiatría*, *28*(1), 43–83. https://doi.org/10.4321/S0211-57352008000100004

Mahrer, N. E., & Gold, J. I. (2009). The use of virtual reality for pain control: A review. *Current Pain and Headache Reports*, *13*(2), 100–109. https://doi.org/10.1007/s11916-009-0019-8

McCullock, S. P., & Scrivano, R. M. (2023). The effectiveness of mental illness stigma-reduction interventions: A systematic meta-review of meta-analyses. *Clinical Psychology Review*, *100*(December 2022), 102242. https://doi.org/10.1016/j.cpr.2022.102242

McGuire, T. G., & Miranda, J. (2008). New Evidence Regarding Racial And Ethnic

Disparities In Mental Health: Policy Implications. *Health Affairs*, *27*(2), 393–403. https://doi.org/10.1377/hlthaff.27.2.393

McLaughlin, H. (2009). What's in a Name: "Client", "Patient", "Customer", "Consumer", "Expert by Experience", 'Service User'--What's Next? *British Journal of Social Work*, *39*(6), 1101–1117. https://doi.org/10.1093/bjsw/bcm155

Meyerbröker, K., & Emmelkamp, P. M. G. (2010). Virtual reality exposure therapy in anxiety disorders: a systematic review of process-and-outcome studies. *Depression and Anxiety*, *27*(10), 933–944. https://doi.org/10.1002/da.20734

Millon, T. (1997). *Manual for the Millon Clinical Multiaxial Inventory-III (MCMI-III)*. National Computer Systems.

Moodley, R., & West, W. (2005). *Integrating Traditional Healing Practices into Counseling and Psychotherapy*. Sage.

Moore, J., Grabb, D., Agnew, W., Klyman, K., Chancellor, S., Ong, D. C., & Haber, N. (2025). Expressing stigma and inappropriate responses prevents LLMs from safely replacing mental health providers. *ACMF AccT 2025 - Proceedings of the 2025 ACM Conference on Fairness, Accountability,and Transparency*, 599–627. https://doi.org/10.1145/3715275.3732039

Mora-Ríos, J., & Bautista, N. (2014). Estigma estructural, género e interseccionalidad: Implicaciones en la atención a la salud mental. *Salud Mental*, *37*(4), 303–312. https://doi.org/10.17711/sm.0185-3325.2014.035

Morita, S. (1919). *Morita Therapy and the True Nature of Anxiety-Based Disorders (Shinkeishitsu)*. State University of New York Press.

Mueller, J., Schmidt, M., Staeheli, A., & Maier, T. (2011). Mental health of failed asylum seekers as compared with pending and temporarily accepted asylum seekers. *The European Journal of Public Health*, *21*(2), 184–189. https://doi.org/10.1093/eurpub/ckq016

Murphy, L., & Mitchell, D. (1998). When writing helps to heal: e-mail as therapy. *British Journal of Guidance and Counselling*, *26*(1), 21–32. https://doi.org/10.1080/03069889800760031

National Council on Disability. (1990). *Americans with Disabilities Act* (§ 12101).

Neary, M., & Schueller, S. M. (2018). State of the Field of Mental Health Apps. *Cognitive and Behavioral Practice*, *25*(4), 531–537.

https://doi.org/10.1016/j.cbpra.2018.01.002

Omi, M., & Winant, H. (2005). The Theoretical Status of the Concept of Race. In C. McCarthy, W. Crichlow, G. Dimitriadis, & N. Dolby (Eds.), *Race, Identity, and Representation in Education* (2nd ed., pp. 3–12). Routledge.

Phillips, F. B. (1990). NTU Psychotherapy: An Afrocentric Approach. *Journal of Black Psychology*, *17*(1), 55–74. https://doi.org/10.1177/00957984900171005

Porsdam Mann, S., Bradley, V. J., & Sahakian, B. J. (2016). Human Rights-Based Approaches to Mental Health: A Review of Programs. *Health and Human Rights Journal*, *16*(3), 263–276.

Powers, M. B., & Emmelkamp, P. M. G. (2008). Virtual reality exposure therapy for anxiety disorders: A meta-analysis. *Journal of Anxiety Disorders*, *22*(3), 561–569. https://doi.org/10.1016/j.janxdis.2007.04.006

Prilleltensky, I. (2012). Wellness as fairness. *American Journal of Community Psychology*, *49*(1–2), 1–21. https://doi.org/10.1007/s10464-011-9448-8

Puleo García, A. H. (2005). El patriarcado ¿una organización social superada? *Temas Para El Debate*, *133*(dic), 39–42.

Qureshi, A. (2013). Are specific psychotherapeutic orientations indicated with specific ethnic minority groups? In *Elements of Culture and Mental Health: Critical Questions for Clinicians* (pp. 21–26). Royal College of Psychiatrists.

Qureshi, A., & Eiroa-Orosa, F. J. (2012). Training for overcoming health disparities in mental health care: Interpretive-relational cultural competence. In S. Barnow & N. Balkir (Eds.), *Cultural Variations in Psychopathology. From Research to Practice* (pp. 248–269). Hogrefe Publishing.

Risberg, G., Johansson, E. E., & Hamberg, K. (2009). A theoretical model for analysing gender bias in medicine. *International Journal for Equity in Health*, *8*(September). https://doi.org/10.1186/1475-9276-8-28

Rosen, G. (1968). *Madness in Society: Chapters in the historical sociology of mental illness*. University of Chicago Press.

Rousmaniere, T., Zhang, Y., Li, X., & Shah, S. (2025). Large language models as mental health resources: Patterns of use in the United States. *Practice Innovations*. https://doi.org/10.1037/pri0000292

Rowe, M. (2015). *Citizenship and Mental Health*. Oxford University Press.

Rowe, M., Benedict, P., Sells, D., Dinzeo, T., Garvin, C., Schwab, L., Baranoski, M., Girard, V., & Bellamy, C. (2009). Citizenship, Community, and Recovery: A Group- and Peer-Based Intervention for Persons With Co-Occurring Disorders and Criminal Justice Histories. *Journal of Groups in Addiction & Recovery*, *4*(4), 224–244. https://doi.org/10.1080/15560350903340874

Rowe, M., & Davidson, L. (2016). Recovering Citizenship. *The Israel Journal of Psychiatry and Related Sciences*, *53*(1), 14–20.

Rowe, M., Kloos, B., Chinman, M., Davidson, L., & Cross, A. B. (2001). Homelessness, Mental Illness and Citizenship. *Social Policy and Administration*, *35*(1), 14–31. https://doi.org/10.1111/1467-9515.00217

Salaberría, K., Corral, P. De, Sánchez, A., & Larrea, E. (2008). Características sociodemográficas, experiencias migratorias y salud mental en una unidad de apoyo psicológico a inmigrantes. *Anuario de Psicologia Clinica y de La Salud*, *4*, 5–14.

Scanlan, J. N. (2010). Interventions To Reduce the Use of Seclusion and Restraint in Inpatient Psychiatric Settings: What We Know So Far a Review of the Literature. *International Journal of Social Psychiatry*, *56*(4), 412–423. https://doi.org/10.1177/0020764009106630

Schmitt, M., & Dörfel, M. (1999). Procedural injustice at work, justice sensitivity, job satisfaction and psychosomatic well-being. *European Journal of Social Psychology*, *29*(4), 443–453. https://doi.org/10.1002/(SICI)1099-0992(199906)29:4<443::AID-EJSP935>3.0.CO;2-C

Sebastián Herranz, J. (2001). Género, salud y psicoterapia. In *Género y psicoterapia* (pp. 11–36). Universidad Pontificia Comillas.

Seligman, M. E. P. (1972). Learned Helplessness. *Annual Review of Medicine*, *23*(1), 407–412. https://doi.org/10.1146/annurev.me.23.020172.002203

Serpell, R. (1993). *The Significance of Schooling: Life-journeys in an African Society*. Cambridge University Press.

Sheehan, L., Nieweglowski, K., & Corrigan, P. W. (2017). Structures and Types of Stigma. In *The Stigma of Mental Illness - End of the Story?* (pp. 43–66). Springer International Publishing. https://doi.org/10.1007/978-3-319-27839-1_3

Singh, N. N., Barber, J. W., & Sant, S. Van. (2016). *Handbook of Recovery in Inpatient*

Psychiatry (N. N. Singh, J. W. Barber, & S. Van Sant (Eds.)). Springer International Publishing. https://doi.org/10.1007/978-3-319-40537-7

Smedley, A., & Smedley, B. D. (2005). Race as Biology Is Fiction, Racism as a Social Problem Is Real: Anthropological and Historical Perspectives on the Social Construction of Race. *American Psychologist*, *60*(1), 16–26. https://doi.org/10.1037/0003-066x.60.1.16

Stewart, D., Van der Merwe, M., Bowers, L., Simpson, A., & Jones, J. (2010). A review of interventions to reduce mechanical restraint and seclusion among adult psychiatric inpatients. *Issues in Mental Health Nursing*, *31*(6), 413–424. https://doi.org/10.3109/01612840903484113

Storm, M., & Edwards, A. (2013). Models of User Involvement in the Mental Health Context: Intentions and Implementation Challenges. *Psychiatric Quarterly*, *84*(3), 313–327. https://doi.org/10.1007/s11126-012-9247-x

Substance Abuse and Mental Health Services Administration. (2012). *SAMHSA ' s Working Definition of Recovery*.

Suchet, M. (2004). A Relational Encounter with Race. *Psychoanalytic Dialogues*, *14*(4), 423–438. https://doi.org/10.1080/10481881409348796

Sue, S., Zane, N., Nagayama Hall, G. C., & Berger, L. K. (2009). The Case for Cultural Competency in Psychotherapeutic Interventions. *Annual Review of Psychology*, *60*(1), 525–548. https://doi.org/10.1146/annurev.psych.60.110707.163651

Swanson, J. W., McGinty, E. E., Fazel, S., & Mays, V. M. (2015). Mental illness and reduction of gun violence and suicide: bringing epidemiologic research to policy. *Annals of Epidemiology*, *25*(5), 366–376. https://doi.org/10.1016/j.annepidem.2014.03.004

Tait, L. (2005). Encouraging user involvement in mental health services. *Advances in Psychiatric Treatment*, *11*(3), 168–175. https://doi.org/10.1192/apt.11.3.168

Tanzer, N. K., Gittler, G., & Ellis, B. B. (1995). Cross-Cultural Validation of Item Complexity in a LLTM-Calibrated Spatial Ability Test. *European Journal of Psychological Assessment*, *11*(3), 170–183. https://doi.org/10.1027/1015-5759.11.3.170

Thomas, P. (2016). Psycho politics, neoliberal governmentality and austerity. *Self & Society*, *44*(4), 382–393. https://doi.org/10.1080/03060497.2016.1192905

Tomasik, M. J., Silbereisen, R. K., & Heckhausen, J. (2010). Is it adaptive to disengage from demands of social change? Adjustment to developmental barriers in opportunity-deprived regions. *Motivation and Emotion*, *34*(4), 384–398. https://doi.org/10.1007/s11031-010-9177-6

Torales, J., O'Higgins, M., Castaldelli-Maia, J. M., & Ventriglio, A. (2020). The outbreak of COVID-19 coronavirus and its impact on global mental health. *International Journal of Social Psychiatry*, *66*(4), 317–320. https://doi.org/10.1177/0020764020915212

Trevillion, K., Oram, S., Feder, G., & Howard, L. M. (2012). Experiences of Domestic Violence and Mental Disorders: A Systematic Review and Meta-Analysis. *PLoS ONE*, *7*(12), e51740. https://doi.org/10.1371/journal.pone.0051740

United Nations. (2006). Convention on the rights of persons with disabilities. *Treaty Series*, *2515*, 3.

van de Vijver, F., & Tanzer, N. K. (2004). Bias and equivalence in cross-cultural assessment. *Revue Européen de Psychologie Appliquée*, *54*, 119–135.

Witt, K., van Dorn, R., & Fazel, S. (2013). Risk Factors for Violence in Psychosis: Systematic Review and Meta-Regression Analysis of 110 Studies. *PLoS ONE*, *8*(2). https://doi.org/10.1371/journal.pone.0055942

World Health Organization. (2012). *QualityRights tool kit to assess and improve quality and human rights in mental health and social care facilities*. World Health Organization.

World Health Organization. (2021). *Guidance on Community Mental Health Services: promoting person-centred and rights-based approaches*. World Health Organization.

World Health Organization Regional Office for Europe. (2010). *User empowerment in mental health*.

Xiong, J., Lipsitz, O., Nasri, F., Lui, L. M. W., Gill, H., Phan, L., Chen-Li, D., Iacobucci, M., Ho, R., Majeed, A., & McIntyre, R. S. (2020). Impact of COVID-19 pandemic on mental health in the general population: A systematic review. *Journal of Affective Disorders*, *277*(August), 55–64. https://doi.org/10.1016/j.jad.2020.08.001