

DSM-5 Outline for Cultural Formulation and the Cultural Formulation Interview: Tools for Culturally Competent Care

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Outline

- Cultural competence: what is it and why is it important?
 - Quality of care
 - Patient-centered care
 - Equitable care
 - Training
 - ACGME standards for child and adolescent fellowship psychiatry training programs (7/20)

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Outline

- Cultural issues in DSM-5
 - Roadmap
 - DSM-5 Outline for Cultural Formulation (OCF)
 - DSM-5 Cultural Formulation Interview (CFI)
 - CFI Supplementary Modules
 - Highlighting changes from DSM-IV (1994) to DSM-5 (2013)

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“Cultural Competence” (Joint Commission, 2010)

- “The ability of health care providers and health care organizations to understand and respond effectively to the cultural and language needs brought by the patient to the health care encounter.”

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“Cultural Competence” Essential Elements of the Journey

- Self-assessment about one’s own cultural identity, values, prejudices, biases, etc.
- Humility about the limits of one’s assessment and treatment knowledge/skills
- Valuing diversity via awareness of and sensitivity to cultural differences
- Ensuring safety about the power dynamics influenced by cultural differences
- Responsiveness to cultural diversity via adaptation of assessment and treatment

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Crossing The Quality Chasm: A New Health System For The 21st Century
(Institute of Medicine, 2001)



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6 Quality outcomes as goals

- **Safe:** avoiding injuries to patients from the care that is intended to help them.
- **Effective:** providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit.
- **Patient-centered:** providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions. [Culturally/linguistically competent]

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6 Quality outcomes as goals

- **Timely:** reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Efficient:** avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable:** providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status. [Eliminating Disparities]

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Unequal Treatment: Confronting Racial And Ethnic Disparities In Health Care

Controlling for income, insurance status, age, severity of illness, racial/ethnic minorities receive lower quality health care (IOM, 2002)



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Clinical Encounter Factors Contributing to Disparities

- **Biases and prejudice** –some evidence suggests that unconscious biases may exist.
- **Stereotyping** – evidence suggests that physicians, like everyone else, use these ‘cognitive shortcuts.’
- **Clinical uncertainty** – a plausible hypothesis, particularly when providers treat patients that are dissimilar in cultural or linguistic background.

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Biases: Intended/Conscious/Explicit and Unintended/Unconscious/Implicit

- Racism
- Bias against immigrants/refugees
- Sexism
- Classism
- Ageism
- Homophobia
- Bias against religion/spirituality
- Other biases

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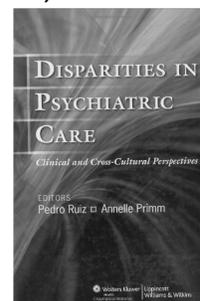
Mental Health: Culture, Race, And Ethnicity (USDHHS-Office of the Surgeon General, 2001)

- Striking disparities in mental health care are found for racial and ethnic minorities
 - Minorities have less access to, and availability of, mental health services.
 - Minorities are less likely to receive needed mental health services.
 - Minorities in treatment often receive a poorer quality of mental health care.
 - Minorities are underrepresented in mental health research.
- These disparities create an increased disability burden for racial/ethnic minorities.

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Disparities in Psychiatric Care, Ruiz and Primm (eds.), 2009

- Racial/ethnic minorities
- Women
- LGBT
- Children and adolescents
- Older adults
- Migrants and refugees
- Rural populations
- Incarcerated
- Chronically mentally ill
- Dually diagnosed
- Developmentally disabled



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ACGME standards: Patient Care

- “Fellows must demonstrate competence in the evaluation and treatment of patients from diverse cultural backgrounds and varied socioeconomic levels.”

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ACGME standards: Medical Knowledge

- “Fellows must demonstrate competence in their knowledge of:
 - recognition and management of domestic and community violence, including physical and sexual abuse, as well as neglect, as it affects children and adolescents
 - diversity and cultural issues pertinent to children, adolescents, and their families”

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ACGME standards: Interpersonal and Communication Skills

- “Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.”

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ACGME standards: Systems-based Practice

- “Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care.”

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Cultural Issues in DSM-5

- Section 1: Introduction: “Cultural Issues” and “Gender Differences” (p. 14-15)
- Section 2: Disorder narrative sections:
 - Culture-Related Diagnostic Issues (index p. 923-924)
 - Gender-Related Diagnostic Issues
- Diagnostic criteria (some disorders)
- Other Conditions (V codes)

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Cultural Issues in DSM-5

Section 3

- Outline for Cultural Formulation (OCF): revised from DSM-IV
- Cultural Formulation Interview (CFI): new Appendix
- Glossary of Cultural Concepts of Distress replaced the Glossary of Culture-Bound Syndromes

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Introduction: DSM-5 definition of culture

- Values, orientations, knowledge, and practices that individuals use to understand their experiences, based on their identification with diverse groups, such as:
 - Ethnic groups, faith communities, occupational groups, veterans, etc.
- Aspects of a person’s background, experience, and social contexts that may affect his or her perspective, such as:
 - Geographical origin, migration, language, religion, sexual orientation, race/ethnicity, etc.
- The influence of family, friends, and other community members (the individual’s *social network*) on the individual’s illness experience

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Culture in mental health

- Culture is NOT ONLY geographic origin, race or ethnicity.
- Culture is dynamic, not static.
- Cultural identity varies from person to person.
- **Cultural Competence** refers to the ability of mental health professionals and services to provide **person-centered** care to patients by taking into account the multiple, ever-changing, and **highly individualized cultural identity of each person receiving services**.

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Schizophrenia - 1

- Culture-Related Diagnostic Issues: “Cultural and socioeconomic factors must be considered, particularly when the individual and the clinician do not share the same cultural and socioeconomic background. Ideas that appear to be delusional in one culture (e.g., witchcraft) may be commonly held in another.”

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Schizophrenia - 2

- “In some cultures, visual or auditory hallucinations with a religious content (e.g., hearing God’s voice) are a normal part of religious experiences....In certain cultures, distress may take the form of hallucinations or pseudo-hallucinations and overvalued ideas that may present clinically similar to true psychosis but are normative to the patient’s subgroup.” (p. 103)

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Panic Disorder

- Culture-Related Diagnostic Issues:
 - Cultural variations in onset, severity, symptom expression
 - Relationship to cultural concepts of distress (Ataque de nervios, Khyal cap)
- Diagnostic Criteria change: “Culture-specific symptoms (e.g., tinnitus, neck soreness, headache, uncontrollable screaming or crying) may be seen. Such symptoms should not count as one of the four required symptoms.”

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Other Conditions That May Be a Focus of Clinical Attention (V codes)

- “This discussion covers other conditions and problems that may be a focus of clinical attention or that may otherwise affect the diagnosis, course, prognosis, or treatment of a patient’s mental disorder... A condition or problem in this chapter may be coded if it is a reason for the current visit or helps to explain the need for a test, procedure, or treatment “

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Other Conditions That May Be a Focus of Clinical Attention (V codes)

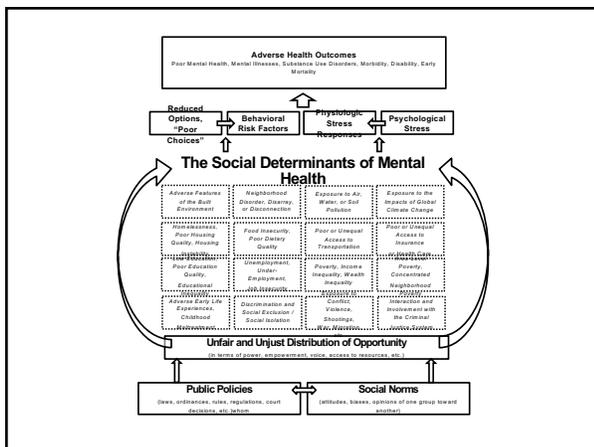
- “The conditions and problems listed in this chapter are not mental disorders. Their inclusion in DSM-5 is meant to draw attention to the scope of additional issues that may be encountered in routine clinical practice and to provide a systematic listing that may be useful to clinicians in documenting these issues.”

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Other Conditions That May be a Focus of Clinical Attention (V codes)

- Relational Problems
- Abuse and Neglect
- Educational and Occupational Problems
- Housing and Economic Problems
- Problems Related to the Social Environment
- Problems Related to Crime or Interaction with the Legal System
- Problems Related to Other Psychosocial, Personal, and Environmental Circumstances
 - Next slide: Compton and Shim, 2019

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Abuse and Neglect

- Child Physical Abuse
- Child Sexual Abuse
- Child Neglect
- Child Psychological Abuse
- Spouse or Partner Violence, Physical
- Spouse or Partner Violence, Sexual
- Spouse or Partner
- Spouse or Partner Abuse, Psychological

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V62.4 Acculturation Difficulty

- “This category should be used when difficulty in adjusting to a new culture (e.g., following migration) is the focus of clinical attention or has an impact on the individual’s treatment or prognosis.” (p. 724)

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V62.4 Target of (Perceived) Adverse Discrimination or Persecution

- “This category should be used when there is perceived or experienced discrimination against or persecution of the individual based on his or her membership (or perceived membership) in a specific category. Typically, such categories include gender or gender identity, race, ethnicity, religion, sexual orientation, country of origin, political beliefs, disability status, caste, social status, weight, and physical appearance.” (p. 724)

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V62.89 Religious or Spiritual Problem

- “This category can be used when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of other spiritual values which may not necessarily be related to an organized church or religious institution.” (p. 725)

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The DSM-5 Outline for Cultural Formulation - 1 (p. 749-750)

- A. Cultural identity of the individual
- B. Cultural conceptualizations of distress (Cultural explanations of the individual’s illness)
- C. Psychosocial stressors and cultural features of vulnerability and resilience (Cultural factors related to psychosocial environment and functioning)

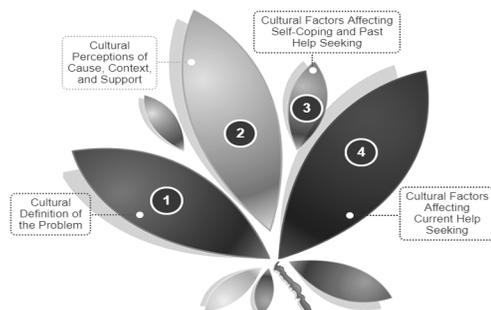
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The DSM-5 Outline for Cultural Formulation - 2

- D. Cultural features (elements) of the relationship between the individual and the clinician
- E. Overall cultural assessment (for diagnosis and care)

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DSM-5 Cultural Formulation Interview



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DSM-5 Cultural Formulation Interview

- Patient version: 16 questions (p. 750-754)
- Informant version (p. 755-757)
- 12 Supplementary Modules
(Google “Supplementary Modules DSM-5”):
 - Cultural Identity
 - Explanatory Model
 - Coping and Help-Seeking
 - Psychosocial Stressors
 - Social Network
 - Caregivers
 - Level of Functioning

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12 Supplementary Modules

- Patient–Clinician Relationship
- School-Age Children and Adolescents
- Older Adults
- Religion, Spirituality, and Moral Traditions
- Immigrants and Refugees

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Cultural Formulation

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Cultural Formulation Interview (CFI)

Supplementary modules used to expand each CF subtopic are noted with underline.

GUIDE TO INTERVIEWER

The following questions aim to clarify key aspects of the presenting clinical problem from the point of view of the patient and other members of the patient's social network (i.e., family, friends, or others involved in current problem). This includes the problem's meaning, potential sources of help, and expectations for services.

INSTRUCTIONS TO THE INTERVIEWER ARE ITALICIZED.

INTRODUCTION FOR THE PATIENT:

I would like to understand the problems that bring you here so that I can help you more effectively. I want to know about *your* experience and ideas. I will ask some questions about what is going on and how you are dealing with it. Please remember there are no right or wrong answers.

CULTURAL DEFINITION OF THE PROBLEM

CULTURAL DEFINITION OF THE PROBLEM

Explanatory Model, Level of Functioning

Elicit the patient's view of core problems and key concerns.

Focus on the patient's own way of understanding the problem.

Use the term, expression, or brief description elicited in question 1 to identify the problem in subsequent questions (e.g., "your conflict with your son").

Ask how patient frames the problem for members of the social network.

Focus on the aspects of the problem that matter most to the patient.

1. What brings you here today?

IF PATIENT GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE:

People often understand their problems in their own way, which may be similar to or different from how doctors describe the problem. How would you describe your problem?

2. Sometimes people have different ways of describing their problem to their family, friends, or others in their community. How would you describe your problem to them?

3. What troubles you most about your problem?

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CULTURAL DEFINITION OF THE PROBLEM

1. What brings you here today?
2. Sometimes people have different ways of describing their problem to their family, friends, or others in their community. How would you describe your [PROBLEM] to them?
3. What troubles you most about your [PROBLEM]?

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CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT

Causes

4. Why do you think this is happening to you? What do you think are the causes of your [PROBLEM]?
5. What do others in your family, friends, or others in your community say are the causes of your [PROBLEM]?

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OCF B: Cultural conceptualizations of distress

- “Describe the cultural constructs that influence how the individual experiences, understands, and communicates his or her symptoms or problems to others. These constructs may include cultural syndromes, idioms of distress, and explanatory models or perceived causes”

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OCF B: Cultural conceptualizations of distress

- “The level of severity and meaning of the distressing experiences should be assessed in relation to the norms of the individual’s cultural reference groups. Assessment of coping and help-seeking patterns should consider the use of professional as well as traditional, alternative, or complementary sources of care.”

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Glossary of Cultural Concepts of Distress (p. 833-837)

- “Provides [9] examples of well-studied cultural concepts of distress that illustrate the relevance of cultural information for clinical diagnosis.”
- Replaces DSM-IV-TR Glossary of Culture-Bound Syndromes

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Examples

Includes description, DSM differential diagnosis, related categories in other cultures, and sometime prevalence/distribution

Concept	Main Type	Region
Ataque de nervios	Cultural syndrome	Latin America
Dhat syndrome	Explanation of illness	South Asia
Khyal cap	Cultural syndrome	Cambodia
Kunfungisisa	Idiom of distress	Zimbabwe
Maladi moun	Explanation of illness	Haiti
Nervios	Idiom of distress	Latin America
Shenjing shuairuo	Cultural syndrome	China
Susto	Explanation of illness	Latin America
Taijin kyofusho	Cultural syndrome	Japan/Korea

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Recommended

- Fadiman, Anne. *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors and the Collision of Two Cultures*. New York: Farrar Straus & Giroux, 1997

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CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT Stressors and Supports

6. Are there any kinds of support that make your [PROBLEM] better, such as support from family, friends, or others?
7. Are there any kinds of stresses that make your [PROBLEM] worse, such as difficulties with money, or family problems?

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OCF Part C: Psychosocial stressors and cultural features of vulnerability and resilience

- “Identify key stressors and supports in the individual’s social environment (which may include both local and distant events) and the role of religion, family, and other social networks (e.g., friends, neighbors, coworkers) in providing emotional, instrumental, and informational support.”

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OCF Part C: Psychosocial stressors and cultural features of vulnerability and resilience

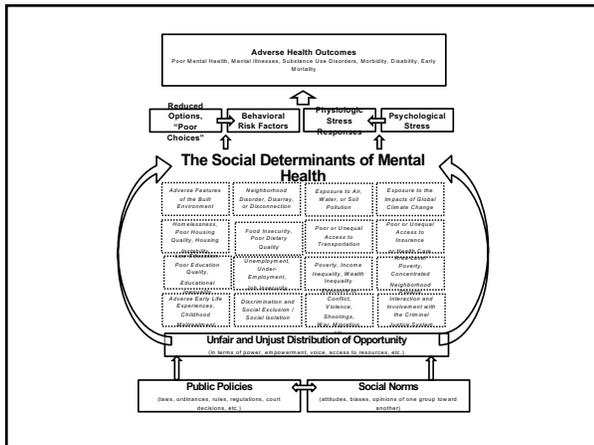
- “Social stressors and social supports vary with cultural interpretation of events, family structure, developmental tasks, and social context. Levels of functioning, disability, and resilience should be assessed in light of the individual’s cultural reference groups.”

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Potential psychosocial stressors

- Interpersonal relationships
 - Religion, spirituality, moral traditions
 - Family
 - Social network
- Social determinants of mental health

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Culturally related strengths and supports: *Personal strengths* (Pamela Hays, 2016)

- Pride in one’s culture
- Religious faith or spirituality
- Artistic or musical abilities
- Bilingual and multilingual skills
- Group-specific social skills
- Sense of humor
- Culturally-related knowledge and practical skills
- Culture-specific beliefs that help one cope
- Respectful attitude toward the natural environment
- Commitment to helping one’s own group
- Wisdom from experience

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Culturally related strengths and supports: *Interpersonal supports*

- Extended families, including non-blood related kin
- Cultural- or group-specific networks
- Religious communities
- Traditional celebrations and rituals
- Recreational, playful activities
- Storytelling activities that make meaning and pass on history of the group
- Involvement in political or social action group
- A child who excels in school

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Culturally related strengths and supports: *Environmental conditions*

- An altar in one’s home or room to honor deceased family members and ancestors
- A space for prayer and meditation
- Culture-specific art or music
- Foods related to cultural preferences for cooking and eating
- Caring for animals
- Access to outdoors for gardening, subsistence or recreation
- Communities that facilitate social interaction

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Religion, Spirituality, and Moral Traditions

- Religious, spiritual, and moral identity
- Roles in everyday life:
Practices/rituals/ceremonies individually, with family, and with faith leaders and communities
- Relationship with the problem: How has these practices/rituals/ceremonies helped with coping with the problem?
- Potential stresses or conflicts

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Family

- Who is in the family? Genogram
- Nuclear family: parents, patient as oldest son, younger sister
- Extended family
- Ethnicity and acculturation
- Ethnicity and Family Therapy, 3rd edition. Monica McGoldrick, et. al. (eds.). Guilford Press, 2005

56

Recommended

Compton M and Shim R (eds.). The Social Determinants of Mental Health. Washington, DC: American Psychiatric Press, 2015

Hays P. Addressing Cultural Complexities in Practice, 3rd ed. Washington, DC: American Psychological Association Press, 2016

Peteet J et. al. (eds.). Religious and Spiritual Issues in Psychiatric Diagnosis: A Research Agenda for DSM-V. Washington, DC: American Psychiatric Press, 2011

McGoldrick M et. al. (eds.). Ethnicity and Family Therapy, 3rd ed. New York: Guilford Press, 2005

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CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT

Role of cultural identity

*Sometimes, aspects of people's background or identity can make their [PROBLEM] better or worse. By **background or identity**, I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, or your faith or religion.*

8. For you, what are the most important aspects of your background or identity?

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CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT

Role of cultural identity

9. Are there any aspects of your background or identity that make a difference to your [PROBLEM] ?

10. Are there any aspects of your background or identity that are causing other concerns or difficulties for you?

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OCF Part A: Cultural identity of the individual (DSM-IV)

- “Describe the individual’s racial, ethnic, or cultural reference groups”
- “For immigrants and racial or ethnic minorities,...degree of involvement with both the culture of origin and the host or majority culture”
- “Language abilities, preferences, patterns of use...”

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OCF Part A: Cultural identity of the individual (added in DSM-5)

- “Other clinically relevant aspects of identity may include religious affiliation, socioeconomic background, personal and family places of birth and growing up, migrant status, and sexual orientation.”

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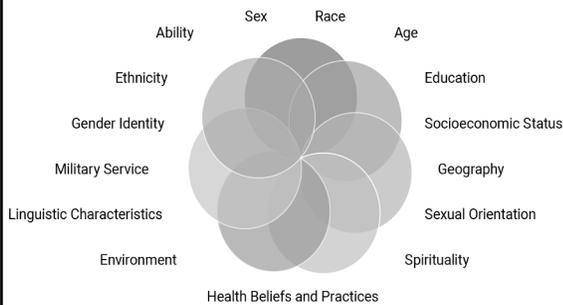
“Addressing” Framework

- Age and generational influences
- Developmental and acquired
- Disabilities
- Religion and spiritual orientation
- Ethnic and racial identity
- Socioeconomic status [Language]
- Sexual orientation
- Indigenous heritage
- National origin
- Gender

Source: Hays, 2016

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Intersectionality of Cultural Identity Variables with Health Beliefs and Environment



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Cultural identity:

“Ask, don’t assume!”

- “Asian” encompasses 30 Asian subgroups and 21 Pacific Islander groups.
- National origin does not define a homogeneous ethnic group. Example: 54 distinct ethnic groups in Vietnam.
- Ask the person: “What are the most important aspects of your background or identity?”

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Cultural identity: Why is it important to understand for clinical care?

- Cultural identity is related to:
 - Cultural concepts of distress including health beliefs and practices
 - Psychosocial stressors and supports in the person’s life
 - Cultural features of the relationship with the healthcare provider

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Cultural identity can be a potential source of stress or support

- Intrapsychic: Cultural identity conflict
 - Ethnicity, acculturation, and biculturality
 - Sexual orientation
 - Religious identity
- Interpersonal relationships with family and social network
- Social: Discrimination, war, migration, etc.

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Cultural Identity Exercise

- Reflect on “what is my cultural identity or background?”-1 minute
- Write down your thoughts-1 minute

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CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING

Self-Coping

11. Sometimes people have various ways of dealing with problems like your [PROBLEM]. What have you done on your own to cope with your [PROBLEM]?

Past Help Seeking

12. Often, people look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing have you sought for your [PROBLEM]?

What types of help or treatment were most useful? Not useful?

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CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING

Barriers

13. Has anything prevented you from getting the help you need?

For example, money, work or family commitments, stigma or discrimination, or lack of services that understand your language or background?

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CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING

Help-seeking preferences

Now let's talk some more about the help you need.

14. What kinds of help do you think would be most useful to you at this time for your [PROBLEM]?

15. Are there other kinds of help that your family, friends, or other people have suggested would be helpful for you now?

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OCF B: Cultural Concepts of Distress

- “Assessment of coping and help-seeking patterns should consider the use of professional as well as traditional, alternative, or complementary sources of care.”

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Help-seeking behavior and Treatment pathways: Past history and current expectations of care

- None
- Primary care
- CAM or indigenous healing practices
- Religious/spiritual healer
- Mental health (See CFI #11-15)

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Examples of treatment pathways involving CAM or indigenous healing practices - 1

- Alternative medical systems: ayurveda, homeopathy, naturopathy, acupuncture, cupping, and coining.
- Mind-body interventions: meditation, hypnosis, dance/music/art therapy, prayer, and mental healing (e.g., shamanism).

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Examples of treatment pathways involving CAM or indigenous healing practices - 2

- Biologically-based therapies: herbal therapies, diets, and vitamins.
- Manipulative and body-based methods: osteopathic manipulations, chiropractic, and massage therapy.
- Energy therapies: such as qi gong, reiki, therapeutic touch, and magnets.

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CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING

Clinician-Patient Relationship

Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations.

16. Have you been concerned about this and is there anything that we can do to provide you with the care you need?

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OCF Part D: Cultural features of the relationship between the individual and the clinician-1

- “Identify differences in culture, language, and social status between an individual and clinician that may cause difficulties in communication and may influence diagnosis and treatment. Experiences of racism and discrimination in the larger society may impede establishing trust and safety in the clinical diagnostic encounter.

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OCF Part D: Cultural features of the relationship between the individual and the clinician-2

- “Effects may include problems eliciting symptoms, misunderstanding of the cultural and clinical significance of symptoms and behaviors, and difficulty establishing or maintaining the rapport needed for an effective clinical alliance.”

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Step 1: Understand the cultural identity of the clinician through self-reflection

- Be aware of and understand one's own personal and professional cultural identity development.
- Be aware of biases and limitations of knowledge and skills that might affect the clinical encounter.

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Step 2: Compare the cultural identity of the patient to the that of the clinician

- Compare cultural identity variables looking for both differences and similarities.
- Go beyond a categorical approach to understanding of self-construal of identity.
- Consider the context of the encounter.
- Look for problems in the clinical encounter, assessment and treatment that might arise from either differences or similarities.

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Step 3: Assess the cultural features of the relationship

- Respect, degree of intimacy, rapport, and empathy
- Communication
 - verbal including limited English proficiency
 - non-verbal
 - health literacy
- Eliciting symptoms and history gathering
- Dealing with stigma and shame
- Transference and Counter-transference

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Biases: Intended/Conscious or Unintended/Unconscious

- Racism
- Bias against immigrants/refugees
- Sexism
- Classism
- Ageism
- Homophobia
- Religion/spirituality
- Other biases

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What would help the clinician to provide optimal care?

- Cultural identity matches and/or
- Increased knowledge/skills concerning:
 - Race/Ethnicity
 - Gender
 - Migration/acclulturation
 - Language
 - Sexual orientation
 - Socioeconomic status
 - Religion/Spirituality and more

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Cultural features of the relationship

- Between patients and clinicians
- Between trainees and supervisors
- Between supervisors and patients

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School-Age Children and Adolescents SM

- Feelings of age appropriateness in different settings (#1-7)
- Age-related stressors and supports (#8-10)
- Age-related expectations (#11-14)
- Transition to adulthood/maturity (#15-20): for adolescents only

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Feeling of age appropriateness

- 1. Do you feel you are like other children/youth your age? In what way?
- 2. Do you sometimes feel different from other children/youth your age? In what way?
- 3. IF THE CHILD/YOUTH ACKNOWLEDGES SOMETIMES FEELING DIFFERENT: Does this feeling of being different happen more at home, at school, at work, and/or some other place?
- 4. Do you feel your family is different from other families?
- 5. Do you use different languages? With whom and when?
- 6. Does your name have any special meaning for you? Your family? Your community?
- 7. Is there something special about you that you like or that you are proud of?

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Age-related stressors and supports

- 8. What do you like about being a child/youth at home? At school? With friends?
- 9. What don't you like about being a child/youth at home? At school? With friends?
- 10. Who is there to support you when you feel you need it? At home? At school? Among your friends?

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Age-related expectations

- 11. What do your parents or grandparents expect from a child/youth your age? (CLARIFY: For example, chores, schoolwork, play, religious observance.)
- 12. What do your school teachers expect from a child/youth your age?
- 13. IF INDIVIDUAL HAS SIBLINGS: What do your siblings expect from a child/youth your age? (CLARIFY: For example, babysitting, help with homework, dating, dress.)
- 14. What do other children/youth your age expect from a child/youth your age?

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School-Age Children and Adolescents SM (Parents)

- Child's particular place in the family
- Process of naming the child
- Developmental milestones in the culture of origin
- Perceptions of age – appropriate behaviors
- Child – adult relations

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School-Age Children and Adolescents SM (Parents)

- Gender relations
- Languages spoken at home
- The importance of religion, spirituality, and community in family life and related expectations for the child

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OCF Part E: Overall cultural assessment

“Summarize the implications of the components of the cultural formulation identified in earlier section of the outline for diagnosis and other clinically relevant issues or problems as well as appropriate management and treatment intervention.”

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Differential diagnosis: Issues

- We want to make an accurate and complete diagnosis by having a complete differential diagnosis.
- Misdiagnosis can lead to mistreatment due to:
 - Misunderstanding cultural idioms of distress/ syndromes/explanatory models/coping and help-seeking.
 - Inadequate relationship to gather history
 - Clinician bias, stereotyping, clinical uncertainty

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Differential diagnosis: Issues

- Review Culture-Related and Gender-Related Diagnostic Issues sections
 - Differential diagnosis issues for both phenomena and disorders
 - Prevalence may vary by culture/gender
 - Course and outcome may vary by culture/gender
- Review and add V codes that map to social determinants of mental health so they can be addressed in the treatment plan.

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APA Resource Document on Religious/Spiritual Commitments and Psychiatric Practice (December 2006)

- Psychiatrists should foster recovery by making treatment decisions with patients in ways that respect and take into meaningful consideration their cultural, religious/spiritual, and personal ideals

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Treatment planning - 1

- Process
 - Negotiate and manage a treatment plan to maximize adherence/compliance
- Content
 - Biological
 - Psychological
 - Sociocultural

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Treatment planning - 2

Biological

- Medication pharmacodynamics and pharmacokinetics may vary due to:
 - Genetics related to race/ethnicity, gender
 - Age
 - Environment: Diet, smoking, pollution, etc.
 - Interaction with herbal medications
- Medication adherence/compliance strategies
- Medication combined with other biological approaches such as acupuncture?

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Treatment planning - 3

Psychotherapy

- Respect patient/family expectations
 - “Be the Tiger Balm oil at the first interview.” - Evelyn Lee, EdD.
- Family vs. Individual vs. Group Rx
- Supportive vs. CBT vs. Insight-oriented
- What cultural modifications in therapy would help?
- What therapist characteristics would facilitate/hinder treatment?

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Treatment planning - 4

- Sociocultural Approaches
 - Utilize cultural strengths/address cultural stressors:
 - Family
 - Spiritual/religious beliefs/practices
 - Social network
 - Address social determinants of mental health through structural competency. (Hansen and Metzl, 2019)

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2015 APPI Resources

- **Clinical Manual of Cultural Psychiatry, Second Edition** edited by Russell Lim, which focuses on the DSM-5 Outline for Cultural Formulation
 - Includes video vignettes
 - Twice the size as 1st edition with new chapters on women, LGBT, and religion/spirituality
 - 2015 Creative Scholarship Award, Society for the Study of Psychiatry and Culture

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2015 APPI Resources

- **DSM-5 Handbook on the Cultural Formulation Interview** edited by Roberto Lewis-Fernandez, et al.
 - Includes video vignettes

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Using the DSM-5 Cultural Formulation Interview

Online Training Module

<https://nyculturalcompetence.org/cfionlinemodule/>

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National CLAS Standards

- Culturally and Linguistically Appropriate Services Standards (2001, 2013)
- Office of Minority Health, Dept. of Health and Human Services, Federal Govt.
- Improving Cultural Competency for Health Professionals E-Learning Programs (Behavioral Health-2019) www.thinkculturalhealth.hhs.gov

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Society for the Study of Psychiatry and Culture

- 41st Annual Meeting (virtual): Sept. 25,
October 9 and 10
- Transcultural Psychiatry journal
- Webinars including Cultural Psychiatry 101
on the OCF
- Mentorship
- www.psychiatryandculture.org



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AAP Bulletin July 2013

Cultural Issues in DSM-5: A Roadmap

Francis Lu, MD, UC Davis, 7/18/2013

DSM-5 includes cultural issues in significant ways in all three sections of the manual. Roberto Lewis-Fernandez, MD, chaired the Cultural Issues Workgroup, in which I was a member. Here is a roadmap that I hope readers might find useful.

Section I: DSM-5 Basics

In the Introduction on pages 14 and 15, there are sections on "Cultural Issues" and "Gender Differences." This is good place to start for a concise overview.

Section II: Diagnostic Criteria and Codes

As can be found in the index on pages 923 to 924, some of the disorders have in their narrative descriptions sections on "Culture-Related Diagnostic Issues" and "Gender-Related Diagnostic Issues." The index is a wonderful tool to rapidly assess this information. Additionally, some of the diagnostic criteria have incorporated cultural issues as well.

Section III: Emerging Measures and Models

A Cultural Formulation section appears from pages 749 to 759. First, there is an enhanced and revised Outline for Cultural Formulation from the DSM-IV, which will serve as an important tool for every clinical case formulation. For example, the first part on cultural identity is much more fully described, and the second part has the more inclusive title of "Cultural conceptions of distress."

Second, the Cultural Formulation Interview (CFI) provides a detailed guide to interviewers in how to obtain information relevant to the Outline for Cultural Formulation. There is a second version for interviewing informants.

Finally, there is a description of "Cultural Concepts of Distress" that replaces the DSM-IV Glossary of Culture-Bound Syndromes.

[Editor's note: [The CFI is available for free on-line.](#)]

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Cultural Issues

Mental disorders are defined in relation to cultural, social, and familial norms and values. Culture provides interpretive frameworks that shape the experience and expression of the symptoms, signs, and behaviors that are criteria for diagnosis. Culture is transmitted, revised, and recreated within the family and other social systems and institutions. Diagnostic assessment must therefore consider whether an individual's experiences, symptoms, and behaviors differ from sociocultural norms and lead to difficulties in adaptation in the cultures of origin and in specific social or familial contexts. Key aspects of culture relevant to diagnostic classification and assessment have been considered in the development of DSM-5.

In Section III, the "Cultural Formulation" contains a detailed discussion of culture and diagnosis in DSM-5, including tools for in-depth cultural assessment. In the Appendix, the "Glossary of Cultural Concepts of Distress" provides a description of some common cultural syndromes, idioms of distress, and causal explanations relevant to clinical practice.

The boundaries between normality and pathology vary across cultures for specific types of behaviors. Thresholds of tolerance for specific symptoms or behaviors differ across cultures, social settings, and families. Hence, the level at which an experience becomes problematic or pathological will differ. The judgment that a given behavior is abnormal and requires clinical attention depends on cultural norms that are internalized by the individual and applied by others around them, including family members and clinicians. Awareness of the significance of culture may correct mistaken interpretations of psychopathology, but culture may also contribute to vulnerability and suffering (e.g., by amplifying fears that maintain panic disorder or health anxiety). Cultural meanings, habits, and traditions can also contribute to either stigma or support in the social and familial response to mental illness. Culture may provide coping strategies that enhance resilience in response to illness, or suggest help seeking and options for accessing health care of various types, including alternative and complementary health systems. Culture may influence acceptance or rejection of a diagnosis and adherence to treatments, affecting the course of illness and recovery. Culture also affects the conduct of the clinical encounter; as a result, cultural differences between the clinician and the patient have implications for the accuracy and acceptance of diagnosis as well as for treatment decisions, prognostic considerations, and clinical outcomes.

Historically, the construct of the culture-bound syndrome has been a key interest of cultural psychiatry. In DSM-5, this construct has been replaced by three concepts that offer greater clinical utility:

1. *Cultural syndrome* is a cluster or group of co-occurring, relatively invariant symptoms found in a specific cultural group, community, or context (e.g., *ataque de nervios*). The syndrome may or may not be recognized as an illness within the culture (e.g., it might be labeled in various ways), but such cultural patterns of distress and features of illness may nevertheless be recognizable by an outside observer.
2. *Cultural idiom of distress* is a linguistic term, phrase, or way of talking about suffering among individuals of a cultural group (e.g., similar ethnicity and religion) referring to shared concepts of pathology and ways of expressing, communicating, or naming essential features of distress (e.g., *kufungisisa*). An idiom of distress need not be associated with specific symptoms, syndromes, or perceived causes. It may be used to convey a wide range of discomfort, including everyday experiences, subclinical conditions, or suffering due to social circumstances rather than mental disorders. For example, most cultures have common bodily idioms of distress used to express a wide range of suffering and concerns.
3. *Cultural explanation or perceived cause* is a label, attribution, or feature of an explanatory model that provides a culturally conceived etiology or cause for symptoms, illness, or distress (e.g., *maladi moun*). Causal explanations may be salient features of folk classifications of disease used by laypersons or healers.

These three concepts (for which discussion and examples are provided in Section III and the Appendix) suggest cultural ways of understanding and describing illness experiences that can be elicited in the clinical encounter. They influence symptomatology, help seeking, clinical presentations, expectations of treatment, illness adaptation, and treatment response. The same cultural term often serves more than one of these functions.

Gender Differences

Sex and gender differences as they relate to the causes and expression of medical conditions are established for a number of diseases, including selected mental disorders. Revisions to DSM-5 included review of potential differences between men and women in the expression of mental illness. In terms of nomenclature, *sex differences* are variations attributable to an individual's reproductive organs and XX or XY chromosomal complement. *Gender differences* are variations that result from biological sex as well as an individual's self-representation that includes the psychological, behavioral, and social consequences of one's perceived gender. The term *gender differences* is used in DSM-5 because, more commonly, the differences between men and women are a result of both biological sex and individual self-representation. However, some of the differences are based on only biological sex.

Gender can influence illness in a variety of ways. First, it may exclusively determine whether an individual is at risk for a disorder (e.g., as in premenstrual dysphoric disorder). Second, gender may moderate the overall risk for development of a disorder as shown by marked gender differences in the prevalence and incidence rates for selected mental disorders. Third, gender may influence the likelihood that particular symptoms of a disorder are experienced by an individual. Attention-deficit/hyperactivity disorder is an example of a disorder with differences in presentation that are most commonly experienced by boys or girls. Gender likely has other effects on the experience of a disorder that are indirectly relevant to psychiatric diagnosis. It may be that certain symptoms are more readily endorsed by men or women, and that this contributes to differences in service provision (e.g., women may be more likely to recognize a depressive, bipolar, or anxiety disorder and endorse a more comprehensive list of symptoms than men).

Reproductive life cycle events, including estrogen variations, also contribute to gender differences in risk and expression of illness. Thus, a specifier for postpartum onset of mania or major depressive episode denotes a time frame wherein women may be at increased risk for the onset of an illness episode. In the case of sleep and energy, alterations are often normative postpartum and thus may have lower diagnostic reliability in postpartum women.

The manual is configured to include information on gender at multiple levels. If there are gender-specific symptoms, they have been added to the diagnostic criteria. A gender-related specifier, such as perinatal onset of a mood episode, provides additional information on gender and diagnosis. Finally, other issues that are pertinent to diagnosis and gender considerations can be found in the section "Gender-Related Diagnostic Issues."

Use of Other Specified and Unspecified Disorders

To enhance diagnostic specificity, DSM-5 replaces the previous NOS designation with two options for clinical use: *other specified disorder* and *unspecified disorder*. The other specified disorder category is provided to allow the clinician to communicate the specific reason that the presentation does not meet the criteria for any specific category within a diagnostic class. This is done by recording the name of the category, followed by the specific reason. For example, for an individual with clinically significant depressive symptoms lasting 4 weeks but whose symptomatology falls short of the diagnostic threshold for a major depressive episode, the clinician would record "other specified depressive disorder, depressive episode with insufficient symptoms." If the clinician chooses not to specify the

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Cultural Formulation

Understanding the cultural context of illness experience is essential for effective diagnostic assessment and clinical management. *Culture* refers to systems of knowledge, concepts, rules, and practices that are learned and transmitted across generations. Culture includes language, religion and spirituality, family structures, life-cycle stages, ceremonial rituals, and customs, as well as moral and legal systems. Cultures are open, dynamic systems that undergo continuous change over time; in the contemporary world, most individuals and groups are exposed to multiple cultures, which they use to fashion their own identities and make sense of experience. These features of culture make it crucial not to overgeneralize cultural information or stereotype groups in terms of fixed cultural traits.

Race is a culturally constructed category of identity that divides humanity into groups based on a variety of superficial physical traits attributed to some hypothetical intrinsic, biological characteristics. Racial categories and constructs have varied widely over history and across societies. The construct of race has no consistent biological definition, but it is socially important because it supports racial ideologies, racism, discrimination, and social exclusion, which can have strong negative effects on mental health. There is evidence that racism can exacerbate many psychiatric disorders, contributing to poor outcome, and that racial biases can affect diagnostic assessment.

Ethnicity is a culturally constructed group identity used to define peoples and communities. It may be rooted in a common history, geography, language, religion, or other shared characteristics of a group, which distinguish that group from others. Ethnicity may be self-assigned or attributed by outsiders. Increasing mobility, intermarriage, and intermixing of cultures has defined new mixed, multiple, or hybrid ethnic identities.

Culture, race, and ethnicity are related to economic inequities, racism, and discrimination that result in health disparities. Cultural, ethnic, and racial identities can be sources of strength and group support that enhance resilience, but they may also lead to psychological, interpersonal, and intergenerational conflict or difficulties in adaptation that require diagnostic assessment.

Outline for Cultural Formulation

The Outline for Cultural Formulation introduced in DSM-IV provided a framework for assessing information about cultural features of an individual's mental health problem and how it relates to a social and cultural context and history. DSM-5 not only includes an updated version of the Outline but also presents an approach to assessment, using the Cultural Formulation Interview (CFI), which has been field-tested for diagnostic usefulness among clinicians and for acceptability among patients.

The revised Outline for Cultural Formulation calls for systematic assessment of the following categories:

- **Cultural identity of the individual:** Describe the individual's racial, ethnic, or cultural reference groups that may influence his or her relationships with others, access to re-

sources, and developmental and current challenges, conflicts, or predicaments. For immigrants and racial or ethnic minorities, the degree and kinds of involvement with both the culture of origin and the host culture or majority culture should be noted separately. Language abilities, preferences, and patterns of use are relevant for identifying difficulties with access to care, social integration, and the need for an interpreter. Other clinically relevant aspects of identity may include religious affiliation, socioeconomic background, personal and family places of birth and growing up, migrant status, and sexual orientation.

- **Cultural conceptualizations of distress:** Describe the cultural constructs that influence how the individual experiences, understands, and communicates his or her symptoms or problems to others. These constructs may include cultural syndromes, idioms of distress, and explanatory models or perceived causes. The level of severity and meaning of the distressing experiences should be assessed in relation to the norms of the individual's cultural reference groups. Assessment of coping and help-seeking patterns should consider the use of professional as well as traditional, alternative, or complementary sources of care.
- **Psychosocial stressors and cultural features of vulnerability and resilience:** Identify key stressors and supports in the individual's social environment (which may include both local and distant events) and the role of religion, family, and other social networks (e.g., friends, neighbors, coworkers) in providing emotional, instrumental, and informational support. Social stressors and social supports vary with cultural interpretations of events, family structure, developmental tasks, and social context. Levels of functioning, disability, and resilience should be assessed in light of the individual's cultural reference groups.
- **Cultural features of the relationship between the individual and the clinician:** Identify differences in culture, language, and social status between an individual and clinician that may cause difficulties in communication and may influence diagnosis and treatment. Experiences of racism and discrimination in the larger society may impede establishing trust and safety in the clinical diagnostic encounter. Effects may include problems eliciting symptoms, misunderstanding of the cultural and clinical significance of symptoms and behaviors, and difficulty establishing or maintaining the rapport needed for an effective clinical alliance.
- **Overall cultural assessment:** Summarize the implications of the components of the cultural formulation identified in earlier sections of the Outline for diagnosis and other clinically relevant issues or problems as well as appropriate management and treatment intervention.

Cultural Formulation Interview (CFI)

The Cultural Formulation Interview (CFI) is a set of 16 questions that clinicians may use to obtain information during a mental health assessment about the impact of culture on key aspects of an individual's clinical presentation and care. In the CFI, *culture* refers to

- The values, orientations, knowledge, and practices that individuals derive from membership in diverse social groups (e.g., ethnic groups, faith communities, occupational groups, veterans groups).
- Aspects of an individual's background, developmental experiences, and current social contexts that may affect his or her perspective, such as geographical origin, migration, language, religion, sexual orientation, or race/ethnicity.
- The influence of family, friends, and other community members (the individual's *social network*) on the individual's illness experience.

The CFI is a brief semistructured interview for systematically assessing cultural factors in the clinical encounter that may be used with any individual. The CFI focuses on the individual's experience and the social contexts of the clinical problem. The CFI follows a person-centered approach to cultural assessment by eliciting information from the individual about his or her own views and those of others in his or her social network. This approach is designed to avoid stereotyping, in that each individual's cultural knowledge affects how he or she interprets illness experience and guides how he or she seeks help. Because the CFI concerns the individual's personal views, there are no right or wrong answers to these questions. The interview follows and is available online at www.psychiatry.org/dsm5.

The CFI is formatted as two text columns. The left-hand column contains the instructions for administering the CFI and describes the goals for each interview domain. The questions in the right-hand column illustrate how to explore these domains, but they are not meant to be exhaustive. Follow-up questions may be needed to clarify individuals' answers. Questions may be rephrased as needed. The CFI is intended as a guide to cultural assessment and should be used flexibly to maintain a natural flow of the interview and rapport with the individual.

The CFI is best used in conjunction with demographic information obtained prior to the interview in order to tailor the CFI questions to address the individual's background and current situation. Specific demographic domains to be explored with the CFI will vary across individuals and settings. A comprehensive assessment may include place of birth, age, gender, racial/ethnic origin, marital status, family composition, education, language fluencies, sexual orientation, religious or spiritual affiliation, occupation, employment, income, and migration history.

The CFI can be used in the initial assessment of individuals in all clinical settings, regardless of the cultural background of the individual or of the clinician. Individuals and clinicians who appear to share the same cultural background may nevertheless differ in ways that are relevant to care. The CFI may be used in its entirety, or components may be incorporated into a clinical evaluation as needed. The CFI may be especially helpful when there is

- Difficulty in diagnostic assessment owing to significant differences in the cultural, religious, or socioeconomic backgrounds of clinician and the individual.
- Uncertainty about the fit between culturally distinctive symptoms and diagnostic criteria.
- Difficulty in judging illness severity or impairment.
- Disagreement between the individual and clinician on the course of care.
- Limited engagement in and adherence to treatment by the individual.

The CFI emphasizes four domains of assessment: Cultural Definition of the Problem (questions 1–3); Cultural Perceptions of Cause, Context, and Support (questions 4–10); Cultural Factors Affecting Self-Coping and Past Help Seeking (questions 11–13); and Cultural Factors Affecting Current Help Seeking (questions 14–16). Both the person-centered process of conducting the CFI and the information it elicits are intended to enhance the cultural validity of diagnostic assessment, facilitate treatment planning, and promote the individual's engagement and satisfaction. To achieve these goals, the information obtained from the CFI should be integrated with all other available clinical material into a comprehensive clinical and contextual evaluation. An Informant version of the CFI can be used to collect collateral information on the CFI domains from family members or caregivers.

Supplementary modules have been developed that expand on each domain of the CFI and guide clinicians who wish to explore these domains in greater depth. Supplementary modules have also been developed for specific populations, such as children and adolescents, elderly individuals, and immigrants and refugees. These supplementary modules are referenced in the CFI under the pertinent subheadings and are available online at www.psychiatry.org/dsm5.

The APA is offering the Cultural Formulation Interview (including the Informant Version) and the Supplementary Modules to the Core Cultural Formulation Interview for further research and clinical evaluation. They should be used in research and clinical settings as potentially useful tools to enhance clinical understanding and decision-making and not as the sole basis for making a clinical diagnosis. Additional information can be found in DSM-5 in the Section III chapter “Cultural Formulation.” The APA requests that clinicians and researchers provide further data on the usefulness of these cultural formulation interviews at <http://www.dsm5.org/Pages/Feedback-Form.aspx>.

Measure: Cultural Formulation Interview (CFI)

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Cultural Formulation Interview (CFI)

Supplementary modules used to expand each CFI subtopic are noted in parentheses.

GUIDE TO INTERVIEWER

INSTRUCTIONS TO THE INTERVIEWER ARE *ITALICIZED*.

The following questions aim to clarify key aspects of the presenting clinical problem from the point of view of the individual and other members of the individual's social network (i.e., family, friends, or others involved in current problem). This includes the problem's meaning, potential sources of help, and expectations for services.

INTRODUCTION FOR THE INDIVIDUAL:

I would like to understand the problems that bring you here so that I can help you more effectively. I want to know about **your** experience and ideas. I will ask some questions about what is going on and how you are dealing with it. Please remember there are no right or wrong answers.

CULTURAL DEFINITION OF THE PROBLEM

CULTURAL DEFINITION OF THE PROBLEM

(Explanatory Model, Level of Functioning)

*Elicit the individual's view of core problems and key concerns.
Focus on the individual's own way of understanding the problem.
Use the term, expression, or brief description elicited in question 1 to identify the problem in subsequent questions (e.g., "your conflict with your son").

Ask how individual frames the problem for members of the social network.

Focus on the aspects of the problem that matter most to the individual.*

1. What brings you here today?
IF INDIVIDUAL GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE:
People often understand their problems in their own way, which may be similar to or different from how doctors describe the problem. How would you describe your problem?
2. Sometimes people have different ways of describing their problem to their family, friends, or others in their community. How would you describe your problem to them?
3. What troubles you most about your problem?

CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT

CAUSES

(Explanatory Model, Social Network, Older Adults)

*This question indicates the meaning of the condition for the individual, which may be relevant for clinical care.

Note that individuals may identify multiple causes, depending on the facet of the problem they are considering.

Focus on the views of members of the individual's social network. These may be diverse and vary from the individual's.*

4. Why do you think this is happening to you? What do you think are the causes of your [PROBLEM]?

PROMPT FURTHER IF REQUIRED:
Some people may explain their problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes.
5. What do others in your family, your friends, or others in your community think is causing your [PROBLEM]?

Cultural Formulation Interview (CFI)

STRESSORS AND SUPPORTS

(Social Network, Caregivers, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Cultural Identity, Older Adults, Coping and Help Seeking)

Elicit information on the individual's life context, focusing on resources, social supports, and resilience. May also probe other supports (e.g., from co-workers, from participation in religion or spirituality).

6. Are there any kinds of support that make your [PROBLEM] better, such as support from family, friends, or others?

Focus on stressful aspects of the individual's environment. Can also probe, e.g., relationship problems, difficulties at work or school, or discrimination.

7. Are there any kinds of stresses that make your [PROBLEM] worse, such as difficulties with money, or family problems?

ROLE OF CULTURAL IDENTITY

(Cultural Identity, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Older Adults, Children and Adolescents)

Sometimes, aspects of people's background or identity can make their [PROBLEM] better or worse. By *background* or *identity*, I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, or your faith or religion.

Ask the individual to reflect on the most salient elements of his or her cultural identity. Use this information to tailor questions 9–10 as needed.

8. For you, what are the most important aspects of your background or identity?

Elicit aspects of identity that make the problem better or worse.

9. Are there any aspects of your background or identity that make a difference to your [PROBLEM]?

Probe as needed (e.g., clinical worsening as a result of discrimination due to migration status, race/ethnicity, or sexual orientation).

Probe as needed (e.g., migration-related problems; conflict across generations or due to gender roles).

10. Are there any aspects of your background or identity that are causing other concerns or difficulties for you?

CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING

SELF-COPING

(Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors)

Clarify self-coping for the problem.

11. Sometimes people have various ways of dealing with problems like [PROBLEM]. What have you done on your own to cope with your [PROBLEM]?

PAST HELP SEEKING

(Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship)

Elicit various sources of help (e.g., medical care, mental health treatment, support groups, work-based counseling, folk healing, religious or spiritual counseling, other forms of traditional or alternative healing).
Probe as needed (e.g., "What other sources of help have you used?").
Clarify the individual's experience and regard for previous help.

12. Often, people look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing have you sought for your [PROBLEM]?
PROBE IF DOES NOT DESCRIBE USEFULNESS OF HELP RECEIVED:
 What types of help or treatment were most useful? Not useful?

BARRIERS

(Coping and Help Seeking, Religion and Spirituality, Older Adults, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship)

Clarify the role of social barriers to help seeking, access to care, and problems engaging in previous treatment.
Probe details as needed (e.g., "What got in the way?").

13. Has anything prevented you from getting the help you need?
PROBE AS NEEDED:
 For example, money, work or family commitments, stigma or discrimination, or lack of services that understand your language or background?

CULTURAL FACTORS AFFECTING CURRENT HELP SEEKING

PREFERENCES

(Social Network, Caregivers, Religion and Spirituality, Older Adults, Coping and Help Seeking)

Clarify individual's current perceived needs and expectations of help, broadly defined.
Probe if individual lists only one source of help (e.g., "What other kinds of help would be useful to you at this time?").
Focus on the views of the social network regarding help seeking.

Now let's talk some more about the help you need.
 14. What kinds of help do you think would be most useful to you at this time for your [PROBLEM]?
 15. Are there other kinds of help that your family, friends, or other people have suggested would be helpful for you now?

CLINICIAN-PATIENT RELATIONSHIP

(Clinician-Patient Relationship, Older Adults)

Elicit possible concerns about the clinic or the clinician-patient relationship, including perceived racism, language barriers, or cultural differences that may undermine goodwill, communication, or care delivery.
Probe details as needed (e.g., "In what way?").
Address possible barriers to care or concerns about the clinic and the clinician-patient relationship raised previously.

Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations.
 16. Have you been concerned about this and is there anything that we can do to provide you with the care you need?

The APA is offering the Cultural Formulation Interview (including the Informant Version) and the Supplementary Modules to the Core Cultural Formulation Interview for further research and clinical evaluation. They should be used in research and clinical settings as potentially useful tools to enhance clinical understanding and decision-making and not as the sole basis for making a clinical diagnosis. Additional information can be found in DSM-5 in the Section III chapter “Cultural Formulation.” The APA requests that clinicians and researchers provide further data on the usefulness of these cultural formulation interviews at <http://www.dsm5.org/Pages/Feedback-Form.aspx>.

Measure: Supplementary Modules to the Core Cultural Formulation Interview (CFI)

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Supplementary Modules to the Core Cultural Formulation Interview (CFI)

Guidelines for Implementing the CFI Supplementary Modules

These modules supplement the core Cultural Formulation Interview and can help clinicians conduct a more comprehensive cultural assessment. The first eight supplementary modules explore the domains of the core CFI in greater depth. The next three modules focus on populations with specific needs, such as children and adolescents, older adults, and immigrants and refugees. The last module explores the experiences and views of individuals who perform caregiving functions, in order to clarify the nature and cultural context of caregiving and how they affect social support in the immediate environment of the individual receiving care. In addition to these supplementary modules, an Informant version of the core CFI collects collateral information on the CFI domains from family members or caregivers.

Clinicians may use these supplementary modules in two ways:

- As adjuncts to the core CFI for additional information about various aspects of illness affecting diverse populations. The core CFI refers to pertinent modules under each subheading to facilitate such use of the modules.
- As tools for in-depth cultural assessment independent of the core CFI. Clinicians may administer one, several, or all modules depending on what areas of an individual's problems they would like to elaborate.

Clinicians should note that a few questions in the modules duplicate questions in the core CFI (indicated by an asterisk [*]) or in other modules. This makes it possible to administer each module independently. Clinicians who use the modules as an adjunct to the core CFI or who administer the modules independently may skip redundant questions.

As with the core CFI, follow-up questions may be needed to clarify the individual's answers. Questions may be rephrased as needed. The modules are intended as a guide to cultural assessment and should be used flexibly to maintain a natural flow of the interview and rapport with the individual. In situations where the individual cannot answer these questions (e.g., due to cognitive impairment or severe psychosis) these questions can be administered to the identified caregiver. The caregiver's own perspective can also be ascertained using the module for caregivers.

In every module, instructions to the interviewer are in *italics*. The modules may be administered during the initial clinical evaluation, at a later point in care, or several times over the course of treatment. Multiple administrations may reveal additional information as rapport develops, especially when assessing the patient-clinician relationship.

Please refer to DSM-5 Section III, chapter "Cultural Formulation," section "Outline for Cultural Formulation," for additional suggestions regarding this type of interview.

1. Explanatory Model

Related Core CFI Questions: 1, 2, 3, 4, 5 Some of the core CFI question are repeated below and are marked with an asterisk (*). The CFI question that is repeated is indicated in brackets.

GUIDE TO INTERVIEWER: *This module aims to clarify the individual's understanding of the problem based on his or her ideas about cause and mechanism (explanatory models) and past experiences of, or knowing someone with, a similar problem (illness prototypes). The individual may identify the problem as a symptom, a specific term or expression (e.g., "nerves," "being on edge"), a situation (e.g., loss of a job), or a relationship (e.g., conflict with others). In the examples below, the individual's own words should be used to replace "[PROBLEM]". If there are multiple problems, each relevant problem can be explored. The following questions may be used to elicit the individual's understanding and experience of that problem or predicament.*

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: I would like to understand the problems that bring you here so that I can help you more effectively. I will be asking you some questions to learn more about your own ideas about the causes of your problems and the way they affect your daily life.

General understanding of the problem

1. *Can you tell me more about how you understand your [PROBLEM]? [RELATED TO CFI Q#1-2.]
2. What did you know about your [PROBLEM] before it affected you?

Illness prototypes

3. Had you ever had anything like your [PROBLEM] before? Please tell me about that.
4. Do you know anyone else, or heard of anyone else, with this [PROBLEM]? If so, please describe that person's [PROBLEM] and how it affected that person. Do you think this will happen to you too?
5. Have you seen on television, heard on the radio, read in a magazine, or found on the internet anything about your [PROBLEM]? Please tell me about it.

Causal explanations

6. *Can you tell me what you think caused your [PROBLEM]? (*PROBE AS NEEDED: Is there more than one cause that may explain it?*) [RELATED TO CFI Q#4.]
7. Have your ideas about the cause of the [PROBLEM] changed? How? What changed your ideas about the cause?
8. *What do people in your family, friends, or others in your community think caused the [PROBLEM]? (*PROBE AS NEEDED: Are their ideas about it different from yours? How so?*) [RELATED TO CFI Q#5.]
9. How do you think your [PROBLEM] affects your body? Your mind? Your spiritual wellbeing?

Course of illness

10. What usually happens to people who have this [PROBLEM]? In your own case, what do you think is likely to happen?
11. Do you consider your [PROBLEM] to be serious? Why? What is the worst that could happen?
12. How concerned are other people in your family, friends or community about your having this [PROBLEM]? Please tell me about that.

Help seeking and treatment expectations

13. What do you think is the best way to deal with this kind of problem?
14. What do your family, friends, or others in your community think is the best way of dealing with this kind of problem?

2. Level of Functioning

Related Core CFI Question: 3

GUIDE TO INTERVIEWER: *The following questions aim to clarify the individual's level of functioning in relation to his or her own priorities and those of the cultural reference group. The interview begins with a general question about everyday activities that are important for the individual. Questions follow about domains important for positive health (social relations, work/school, economic viability, and resilience). Questions should be kept relatively broad and open to elicit the individual's own priorities and perspective. For a more detailed evaluation of specific domains of functioning, a standard instrument such as the WHO-DAS II may be used together with this interview.*

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: I would like to know about the daily activities that are most important to you. I would like to better understand how your [PROBLEM] has affected your ability to perform these activities, and how your family and other people around you have reacted to this.

1. How has your [PROBLEM] affected your ability to do the things you need to do each day, that is, your daily activities and responsibilities?
2. How has your [PROBLEM] affected your ability to interact with your family and other people in your life?
3. How has your [PROBLEM] affected your ability to work?
4. How has your [PROBLEM] affected your financial situation?
5. How has your [PROBLEM] affected your ability to take part in community and social activities?
6. How has your [PROBLEM] affected your ability to enjoy everyday life?
7. Which of these concerns are most troubling to you?
8. Which of these concerns are most troubling to your family and to other people in your life?

3. Social Network

Related Core CFI Questions: 5, 6, 12, 15

GUIDE TO INTERVIEWER: The following questions identify the influences of the informal social network on the individual's problem. Informal social network refers to family, friends and other social contacts through work, places of prayer/worship or other activities and affiliations. Question #1 identifies important people in the individual's social network, and the clinician should tailor subsequent questions accordingly. These questions aim to elicit the social network's response, the individual's interpretation of how this would impact on the problem, and the individual's preferences for involving members of the social network in care.

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: I would like to know more about how your family, friends, colleagues, co-workers, and other important people in your life have had an impact on your [PROBLEM].

Composition of the individual's social network

1. Who are the most important people in your life at present?
2. Is there anyone in particular whom you trust and can talk with about your [PROBLEM]? Who? Anyone else?

Social network understanding of problem

3. Which of your family members, friends, or other important people in your life know about your [PROBLEM]?
4. What ideas do your family and friends have about the nature of your [PROBLEM]? How do they understand your [PROBLEM]?
5. Are there people who do not know about your [PROBLEM]? Why do they not know about your [PROBLEM]?

Social network response to problem

6. What advice have family members and friends given you about your [PROBLEM]?
7. Do your family, friends, and other people in your life treat you differently because of your [PROBLEM]? How do they treat you differently? Why do they treat you differently?
8. (IF HAS NOT TOLD FAMILY OR FRIENDS ABOUT PROBLEM): Can you tell me more about why you have chosen not to tell family or friends about the [PROBLEM]? How do you think they would respond if they knew about your [PROBLEM]?

Social network as a stress/buffer

9. What have your family, friends, and other people in your life done to make your [PROBLEM] better or easier for you to deal with? (IF UNCLEAR: How has that made your [PROBLEM] better?)
10. What kinds of help or support were you expecting from family or friends?
11. What have your family, friends, and other people in your life done to make your [PROBLEM] worse or harder for you to deal with? (IF UNCLEAR: How has that made your [PROBLEM] worse?)

Social network in treatment

12. Have any family members or friends helped you get treatment for your [PROBLEM]?
13. What would your family and friends think about your coming here to receive treatment?
14. Would you like your family, friends, or others to be part of your treatment? If so, who would you like to be involved and how?
15. How would involving family or friends make a difference in your treatment?

4. Psychosocial Stressors

Related Core CFI Questions: 7, 9, 10, 12

GUIDE TO INTERVIEWER: *The aim of these questions is to further clarify the stressors that have aggravated the problem or otherwise affected the health of the individual. (Stressors that initially caused the problem are covered in the module on Explanatory Models.) In the examples below, the individual's own words should be used to replace "[STRESSORS]". If there are multiple stressors, each relevant stressor can be explored*

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: You have told me about some things that make your [PROBLEM] worse. I would like to learn more about that.

1. Are there things going on that have made your [PROBLEM] worse, for example, difficulties with family, work, money, or something else? Tell me more about that.
2. How are the people around you affected by these [STRESSORS]?
3. How do you cope with these [STRESSORS]?
4. What have other people suggested about coping with these [STRESSORS]?
5. What else could be done about these [STRESSORS]?

GUIDE TO INTERVIEWER: *Patients may be reluctant to discuss areas of their life they consider sensitive, which may vary across cultural groups. Asking specific questions may help the patient discuss these stressors. Insert questions about relevant stressors here. For example:*

7. Have you experienced discrimination or been treated badly as a result of your background or identity? By background or identity I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your racial or ethnic background, your gender or sexual orientation, and your faith or religion. Have these experiences had an impact on [STRESSORS] or your [PROBLEM]?

5. Spirituality, Religion, and Moral Traditions

Related Core CFI Questions: 6, 7, 8, 9, 10, 11, 12, 14, 15

GUIDE TO INTERVIEWER: The following questions aim to clarify the influence of spirituality, religion, and other moral or philosophical traditions on the individual's problems and related stresses. People may have multiple spiritual, moral, and religious affiliations or practices. If the individual reports having specific beliefs or practices, inquire about the level of involvement in that tradition and its impact on coping with the clinical problem. In the examples below, the individual's own words should be used to replace "[NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)]". If the individual identifies more than one tradition, each can be explored. If the individual does not describe a specific tradition, use the phrase "spirituality, religion or other moral traditions" instead of the specific name of a tradition (e.g., Q5: "What role do spirituality, religion or other moral traditions play in your everyday life?")

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: To help you more effectively, I would like to ask you some questions about the role that spirituality, religion or other moral traditions play in your life and how they may have influenced your dealing with the problems that bring you here.

Spiritual, religious, and moral identity

1. Do you identify with any particular spiritual, religious or moral tradition? Can you tell me more about that?
2. Do you belong to a congregation or community associated with that tradition?
3. What are the spiritual, religious or moral tradition backgrounds of your family members?
4. Sometimes people participate in several traditions. Are there any other spiritual, religious or moral traditions that you identify with or take part in?

Role of spirituality, religion, and moral traditions

5. What role does [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] play in your everyday life?
6. What role does [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] play in your family, for example, family celebrations or choices in marriage or schooling?
7. What activities related to [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] do you carry out in the home, for example, prayers, meditation, or special dietary laws? How often do you carry out these activities? How important are these activities in your life?
8. What activities do you engage in outside the home related to [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)], for example, attending ceremonies or participating in a [CHURCH, TEMPLE OR MOSQUE]? How often do you attend? How important are these activities in your life?

Relationship to the [PROBLEM]

9. How has [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] helped you cope with your [PROBLEM]?
10. Have you talked to a leader, teacher or others in your [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] community, about your [PROBLEM]? How have you found that helpful?
11. Have you found reading or studying [BOOK(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S), (E.G. BIBLE, KORAN)], or listening to programs related to [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] on TV, radio, the Internet or other media [e.g., DVD, tape] to be helpful? In what way?
12. Have you found any practices related to [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)], like prayer, meditation, rituals, or pilgrimages to be helpful to you in dealing with [PROBLEM]? In what way?

Potential stresses or conflicts related to spirituality, religion, and moral traditions

13. Have any issues related to [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] contributed to [PROBLEM]?
14. Have you experienced any personal challenges or distress in relation to your [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] identity or practices?
15. Have you experienced any discrimination due to your [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] identity or practices?
16. Have you been in conflict with others over spiritual, religious or moral issues?

6. Cultural Identity

Related Core CFI Questions: 6, 7, 8, 9, 10 Some of the core CFI question are repeated below and are marked with an asterisk (*). The CFI question that is repeated is indicated in brackets.

GUIDE TO INTERVIEWER: *This module aims to further clarify the individual's cultural identity and how this has influenced the individual's health and well being. The following questions explore the individual's cultural identity and how this may have shaped his or her current problem. We use the word culture broadly to refer to all the ways the individual understands his or her identity and experience in terms of groups, communities or other collectivities, including national or geographic origin, ethnic community, racialized categories, gender, sexual orientation, social class, religion/spirituality, and language.*

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: Sometimes peoples' background or identity influences their experience of illness and the type of care they receive. In order to better help you, I would like to understand your own background or identity. By background or identity I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your racial or ethnic background, your gender or sexual orientation, and your faith or religion.

National, Ethnic, Racial Background

1. Where were you born?
2. Where were your parents and grandparents born?
3. How would you describe your family's national, ethnic, and/or racial background?
4. In terms of your background, how do you usually describe yourself to people outside your community? Sometimes people describe themselves somewhat differently to members of their own community. How do you describe yourself to them?
5. Which part of your background do you feel closest to? Sometimes this varies, depending on what aspect of your life we are talking about. What about at home? Or at work? Or with friends?
6. Do you experience any difficulties related to your background, such as discrimination, stereotyping, or being misunderstood?
7. *Is there anything about your background that might impact on your [PROBLEM] or impact on your health or health care more generally? [RELATED TO CFI Q#9.]

Language

8. What languages do you speak fluently?
9. What languages did you speak growing up?
10. What languages are spoken at home? Which of these do you speak?
11. What languages do you use at work or school?
12. What language would you prefer to use in getting health care?
13. What languages do you read? Write?

Migration

GUIDE TO INTERVIEWER: *If the individual was born in another country, ask questions 1-7. [For refugees, refer to the module on Immigrants and Refugees to obtain more detailed migration history.]*

14. When did you come to this country?
15. What made you decide to leave your country of origin?
16. How has your life changed since coming here?
17. What do you miss about the place or community you came from?
18. What are your concerns for your own and your family's future here?
19. What is your current status in this country (e.g., refugee claimant, citizen, student visa, work permit)?
Be aware this may be a sensitive or confidential issue for the individual, if they have precarious status.
20. How has migration influenced your health or that of your family?
21. Is there anything about your migration experience or current status in this country that has made a difference to your [PROBLEM]?
22. Is there anything about your migration experience or current status that might influence your ability to get the right kind of help for your [PROBLEM]?

Spirituality, Religion, and Moral Traditions

23. Do you identify with any particular religious, moral or spiritual tradition?

GUIDE TO INTERVIEWER: In the next question, the individual's own words should be used to replace "[NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)]".

24. What role does [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] play in your everyday life?

25. Do your family members share your spiritual, religious or moral traditions? Can you tell me more about that?

Gender Identity

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: Some individuals feel that their gender [e.g. the social roles and expectations they have related to being male, female, transgender, genderqueer, or intersex] influences their health and the kind of health care they need.

GUIDE TO INTERVIEWER: In the examples below, the individual's own words should be used to replace "[GENDER]". The interviewer may need to exemplify or explain the term "GENDER" with relevant wording (e.g., "being a man," "being a transgender woman").

26. Do you feel that your [GENDER] has influenced your [PROBLEM] or your health more generally?

27. Do you feel that your [GENDER] has influenced your ability to get the kind of health care you need?

28. Do you feel that health care providers have certain assumptions or attitudes about you or your [PROBLEM] because of your [GENDER]?

Sexual Orientation Identity

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: Sexual orientation may also be important to individuals and their comfort in seeking health care. I would like to ask you some questions about your sexual orientation. Are you comfortable answering questions about your sexual orientation?

29. How would you describe your sexual orientation (e.g., heterosexual, gay, lesbian, bisexual, queer, pansexual, asexual)?

30. Do you feel that your sexual orientation has influenced your [PROBLEM] or your health more generally?

31. Do you feel that your sexual orientation influences your ability to get the kind of health care you need for your [PROBLEM]?

32. Do you feel that health care providers have assumptions or attitudes about you or your [PROBLEM] that are related to your sexual orientation?

Summary

33. You have told me about different aspects of your background and identity and how this has influenced your health and well being. Are there other aspects of your identity I should know about to better understand your health care needs?

34. What are the most important aspects of your background or identity in relation to [PROBLEM]?

7. Coping and Help-Seeking

Related Core CFI Questions: 6, 11, 12, 14, 15 Some of the core CFI question are repeated below and are marked with an asterisk (*). The CFI question that is repeated is indicated in brackets.

GUIDE TO INTERVIEWER: This module aims to clarify the individual's ways of coping with the current problem. The individual may have identified the problem as a symptom or mentioned a term or expression (e.g., "nerves," "being on edge," "spirit possession), or a situation (e.g., loss of a job), or a relationship (e.g., conflict with others). In the examples below, the individual's own words should be used to replace "[PROBLEM]". If there are multiple problems, each relevant problem can be explored. The following questions may be used to learn more about the individual's understanding and experiencing of that problem.

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: I would like to understand the problems that bring you here so that I can help you more effectively. I will be asking you questions about how you have tried to cope with your problems and get help for them.

Self-coping

1. *Can you tell me more about how you are trying to cope with [PROBLEM] at this time? Has that way of coping with it been helpful? If so, how? [RELATED TO CFI Q#11.]
2. *Can you tell me more about how you tried to cope with the [PROBLEM] or with similar problems in the past? Was that way of coping with it helpful? If so, how? [RELATED TO CFI Q#11.]
3. Have you sought help for your [PROBLEM] on the internet, by reading books, by viewing television shows, or by listening to audiotapes, videos or other sources? If so, which of these? What did you learn? Was it helpful?
4. Do you engage by yourself in practices related to a spiritual, religious or moral tradition to help you cope with your [PROBLEM]? For example, prayer, meditation, or other practices that you carry out by yourself?
5. Have you sought help for your [PROBLEM] from natural remedies or medications that you take without a doctor's prescription, such as over-the-counter medicines? If so, which natural remedies or medications? Were they helpful?

Social network

6. *Have you told a family member about your [PROBLEM]? Have family members helped you cope with the [PROBLEM]? If so, how? What did they suggest you do to cope with the [PROBLEM]? Was it helpful? [RELATED TO CFI Q#15.]
7. *Have you told a friend or co-worker about your [PROBLEM]? Have friends or co-workers helped you cope with the [PROBLEM]? If so, how? What did they suggest you do to cope with the [PROBLEM]? Was it helpful? [RELATED TO CFI Q#15.]

Help- and treatment-seeking beyond social network

8. Are you involved in activities that involve other people related to a spiritual, religious or moral tradition? For example, do you go to worship or religious gatherings, speak with other people in your religious group or speak with the religious or spiritual leader? Have any of these been helpful in coping with [PROBLEM]? In what way?
9. Have you ever tried to get help for your [PROBLEM] from your general doctor? If so, who and when? What treatment did they give? Was it helpful?
10. Have you ever tried to get help for your [PROBLEM] from a mental health clinician, such as a counselor, psychologist, social worker, psychiatrist, or other professional? If so, who and when? What treatment did they give? Was it helpful?
11. Have you sought help from any other kind of helper to cope with your [PROBLEM] other than going to the doctor, for example, a chiropractor, acupuncturist, homeopath, or other kind of healer? What kind of treatment did they recommend to resolve the problem? Was it helpful?

Current treatment episode

12. What were the circumstances that led to your coming here for treatment for your [PROBLEM]? Did anyone suggest you come here for treatment? If so, who, and why did he or she suggest you come here?
13. What help are you hoping to get here [at this clinic] for your [PROBLEM]?

8. Patient–Clinician Relationship

Related Core CFI Question: 16 Some of the core CFI question are repeated below and are marked with an asterisk (*). The CFI question that is repeated is indicated in brackets.

GUIDE TO INTERVIEWER: *The following questions address the role of culture in the patient–clinician relationship with respect to the individual’s presenting concerns and to the clinician’s evaluation of the individual’s problem. We use the word culture broadly to refer to all the ways the individual understands his or her identity and experience in terms of groups, communities or other collectivities, including national or geographic origin, ethnic community, racialized categories, gender, sexual orientation, social class, religion/spirituality, and language.*

The first set of questions evaluates four domains in the clinician-patient relationship from the point of view of the patient: experiences, expectations, communication, and possibility of collaboration with the clinician. The second set of questions is directed to the clinician to guide reflection on the role of cultural factors in the clinical relationship, the assessment, and treatment planning.

INTRODUCTION FOR THE PATIENT: I would like to learn about how it has been for you to talk with me and other clinicians about your [PROBLEM] and your health more generally. I will ask some questions about your views, concerns, and expectations.

QUESTIONS FOR THE PATIENT:

1. What kind of experiences have you had with clinicians in the past? What was most helpful to you?
2. Have you had difficulties with clinicians in the past? What did you find difficult or unhelpful?
3. Now let’s talk about the help that you would like to get here. Some people prefer clinicians of a similar background (for example, age, race, religion, or some other characteristic) because they think it may be easier to understand each other. Do you have any preference or ideas about what kind of clinician might understand you best?
4. *Sometimes differences among patients and clinicians make it difficult for them to understand each other. Do you have any concerns about this? If so, in what way? [RELATED TO CFI Q#16.]

GUIDE TO INTERVIEWER: *Question #5 addresses the patient-clinician relationship moving forward in treatment. It elicits the patient’s expectations of the clinician and may be used to start a discussion on how the two of them can collaborate in the individual’s care.*

5. What patients expect from their clinicians is important. As we move forward in your care, how can we best work together?

QUESTIONS FOR THE CLINICIAN AFTER THE INTERVIEW:

1. How did you feel about your relationship with the patient? Did cultural similarities and differences influence your relationship? In what way?
2. What was the quality of communication with the patient? Did cultural similarities and differences influence your communication? In what way?
3. If you used an interpreter, how did the presence of an interpreter or his/her way of interpreting influence your relationship or your communication with the patient and the information you received?
4. How do the patient’s cultural background or identity, life situation, and/or social context influence your understanding of his/her problem and your diagnostic assessment?
5. How do the patient’s cultural background or identity, life situation, and/or social context influence your treatment plan or recommendations?
6. Did the clinical encounter confirm or call into question any of your prior ideas about the cultural background or identity of the patient? If so, in what way?
7. Are there aspects of your own identity that may influence your attitudes toward this patient?

9. School-Age Children and Adolescents

Related Core CFI Questions: 8, 9, 10

GUIDE TO INTERVIEWER: This supplement is directed to adolescents and mature school-age children. It should be used in conjunction with standard child mental health assessments that evaluate family relations (including intergenerational issues), peer relations, and the school environment. The aim of these questions is to identify, from the perspective of the child/youth, the role of age-related cultural expectations, the possible cultural divergences between school, home, and the peer group, and whether these issues impact on the situation or problem that brought the youth for care. The questions indirectly explore cultural challenges, stressors and resilience, and issues of cultural hybridity, mixed ethnicity or multiple ethnic identifications. Peer group belonging is important to children and adolescents, and questions exploring ethnicity, religious identity, racism or gender difference should be included following the child's lead. Some children may not be able to answer all questions; clinicians should select and adapt questions to ensure they are developmentally appropriate for the individual. Children should not be used as informants to provide socio-demographic information on the family or an explicit analysis of the cultural dimensions of their problems. An Addendum lists cultural aspects of development and parenting that can be evaluated during parents' interviews.

INTRODUCTION FOR THE CHILD/YOUTH: We have talked about the concerns of your family. Now I would like to know more about how you feel about being ___ years old.

Feelings of age appropriateness in different settings

1. Do you feel you are like other children/youth your age? In what way?
2. Do you sometimes feel different from other children/youth your age? In what way?
3. **IF THE CHILD/YOUTH ACKNOWLEDGES SOMETIMES FEELING DIFFERENT:** Does this feeling of being different happen more at home, at school, at work, and/or some other place?
4. Do you feel your family is different from other families?
5. Do you use different languages? With whom and when?
6. Does your name have any special meaning for you? Your family? Your community?
7. Is there something special about you that you like or that you are proud of?

Age-related stressors and supports

8. What do you like about being a child/youth at home? At school? With friends?
9. What don't you like about being a child/youth at home? At school? With friends?
10. Who is there to support you when you feel you need it? At home? At school? Among your friends?

Age-related expectations

GUIDE TO INTERVIEWER: Concepts of childhood and age-appropriate behavior vary significantly across cultures. The aim of these questions is to elicit the normative frame(s) of the child /family and how this may differ from other cultural environments.

11. What do your parents or grandparents expect from a child/youth your age? (**CLARIFY:** For example, chores, schoolwork, play, religious observance.)
12. What do your school teachers expect from a child/youth your age?
13. **IF INDIVIDUAL HAS SIBLINGS:** What do your siblings expect from a child/youth your age? (**CLARIFY:** For example, babysitting, help with homework, dating, dress.)
14. What do other children/youth your age expect from a child/youth your age?

Transition to adulthood/maturity (FOR ADOLESCENTS ONLY)

15. Are there any important celebrations or events in your community to recognize reaching a certain age or growing up?
16. When is a youth considered ready to become an adult in your family or community?
17. When is a youth considered ready to become an adult according to your school teachers?
18. What is good or difficult about becoming a young woman or a young man in your family? In your school? In your community?
19. How do you feel about "growing up" or becoming an adult?
20. In what ways are your life and responsibilities different from the life and responsibilities of your parents?

ADDENDUM FOR PARENTS' INTERVIEW

GUIDE TO INTERVIEWER: *Information on cultural influences on development and parenting is best obtained by interviewing the child's parents or caretakers. In addition to issues directly related to presenting problems, it is useful to inquire about:*

- The child's particular place in the family (e.g., oldest boy, only girl)
- The process of naming the child (Who chose the name? Does it have special meaning? Who else is called like this?)
- Developmental milestones in the culture of origin of the mother (and father): expected age for weaning, walking, toilet training, speaking. Vision of normal autonomy/dependency, appropriate disciplining and so on
- Perceptions of age-appropriate behaviors (e.g., age for staying home alone, participation in chores, religious observance, play)
- Child-adult relations (e.g., expression of respect, eye contact, physical contact)
- Gender relations (expectations around appropriate girl-boy behavior, dress code)
- Languages spoken at home, in daycare, at school
- The importance of religion, spirituality, and community in family life and related expectations for the child.

10. Older Adults

Related Core CFI Questions: 5, 6, 7, 8, 9, 10, 12, 13, 15, 16

GUIDE TO INTERVIEWER: *The following questions are directed to older adults. The goal of these questions is to identify the role of cultural conceptions of aging and age-related transitions on the illness episode.*

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: I would like to ask some questions to better understand your problem and how we can help you with it, taking into account your age and specific experiences.

Conceptions of aging and cultural identity

1. How would you describe a person of your age?
2. How does your experience of aging compare to that of your friends and relatives who are of a similar age?
3. Is there anything about being your age that helps you cope with your current life situation?

Conceptions of aging in relationship to illness attributions and coping

4. How does being older influence your [PROBLEM]? Would it have affected you differently when you were younger?
5. Are there ways that being older influences how you deal with your [PROBLEM]? Would you have dealt with it differently when you were younger?

Influence of comorbid medical problems and treatments on illness

6. Have you had health problems due to your age?
7. How have your health conditions or the treatments for your health conditions affected your [PROBLEM]?
8. Are there any ways that your health conditions or treatments influence how you deal with your [PROBLEM]?
9. Are there things that are important to you that you are unable to do because of your health or age?

Quality and nature of social supports and caregiving

10. Who do you rely on for help or support in your daily life in general? Has this changed now that you are going through [PROBLEM]?
11. How has [PROBLEM] affected your relationships with family and friends?
12. Are you receiving the amount and kind of support you expected?
13. Do the people you rely on share your view of your [PROBLEM]?

Additional age-related transitions

14. Are there other changes you are going through related to aging that are important for us to know about in order to help you with your [PROBLEM]?

Positive and negative attitudes towards aging and clinician-patient relationship

15. How has your age affected how health providers treat you?
16. Have any people, including health care providers, discriminated against you or treated you poorly because of your age? Can you tell me more about that? How has this experience affected your [PROBLEM] or how you deal with it?
17. *[IF THERE IS A SIGNIFICANT AGE DIFFERENCE BETWEEN PROVIDER AND PATIENT:]* Do you think that the difference in our ages will influence our work in any way? If so, how?

11. Immigrants and Refugees

Related Core CFI Questions: 7, 8, 9, 10, 13

GUIDE TO INTERVIEWER: *The following questions aim to collect information from refugees and immigrants about their experiences of migration and resettlement. Many refugees have experienced stressful interviews with officials or health professionals in their home country, during the migration process (which may involve prolonged stays in refugee camps or other precarious situations), and in the receiving country, so it may take longer than usual for the interviewee to feel comfortable with and trust the interview process. When patient and clinician do not share a high level of fluency in a common language, accurate language translation is essential.*

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: Leaving one's country of origin and resettling elsewhere can have a great impact on people's lives and health. To better understand your situation, I would like ask you some questions related to your journey here from your country of origin.

Background information

1. What is your country of origin?
2. How long have you been living here in _____ (HOST COUNTRY)?
3. When and with whom did you leave _____ (COUNTRY OF ORIGIN)?
4. Why did you leave _____ (COUNTRY OF ORIGIN)?

Pre-migration difficulties

5. Prior to arriving in _____ (HOST COUNTRY), were there any challenges in your country of origin that you or your family found especially difficult?
6. Some people experience hardship, persecution, or even violence before leaving their country of origin. Has this been the case for you or members of your family? Can you tell me something about your experiences?

Migration-related losses and challenges

7. Of the persons important/close to you, who stayed behind?
8. Often people leaving a country experience losses. Did you or any of your family members experience losses upon leaving the country? If so, what are they?
9. Were there any challenges on your journey to _____ (HOST COUNTRY) that you or your family found especially difficult?
10. Do you or your family miss anything about your way of life in (COUNTRY OF ORIGIN)?

Ongoing relationship with country of origin

11. Do you have concerns about relatives that remain in (COUNTRY OF ORIGIN)?
12. Do relatives in (COUNTRY OF ORIGIN) have any expectations of you?

Resettlement and new life

13. Have you or your family experienced any difficulties related to your visa, citizenship, or refugee status here in _____ (HOST COUNTRY)?
14. Are there any (other) challenges or problems you or others in your family are facing related to your resettlement here?
15. Has coming to [HOST COUNTRY] resulted in something positive for you or your family? Can you tell me more about that?

Relationship with problem

16. Is there anything about your migration experience or current status in this country that has made a difference to your [PROBLEM]?
17. Is there anything about your migration experience or current status that might make it easier or harder to get help for your [PROBLEM]?

Future expectations

18. What hopes and plans do you have for you and your family in the coming years?

12. Caregivers

Related Core CFI Question: 6, 12, 14

GUIDE TO INTERVIEWER: This module is designed to be administered to individuals who provide caregiving for the individual being assessed with the CFI. This module aims to explore the nature and cultural context of caregiving, and the social support and stresses in the immediate environment of the individual receiving care, from the perspective of the caregiver.

INTRODUCTION FOR THE CAREGIVER: People like yourself who take care of the needs of patients are very important participants in the treatment process. I would like to understand your relationship with [INDIVIDUAL RECEIVING CARE] and how you help him/her with his/her problems and concerns. By *help*, I mean support in the home, community, or clinic. Knowing more about that will help us plan his/her care more effectively.

Nature of relationship

1. How long have you been taking care of [INDIVIDUAL RECEIVING CARE]? How did this role for you start?
2. How are you connected to [INDIVIDUAL RECEIVING CARE]?

Caregiving activities and cultural perceptions of caregiving

3. How do you help him/her with the [PROBLEM] or with day-to-day activities?
4. What is most rewarding about helping him/her?
5. What is most challenging about helping him/her?
6. How, if at all, has his/her [PROBLEM] changed your relationship?

Sometimes caregivers like yourself are influenced in doing what they do by cultural traditions of helping others, such as beliefs and practices in your family or community. By cultural traditions I mean, for example, what is done in the communities you belong to, where you or your family are from, or among people who speak your language or who share your race or ethnic background, your gender or sexual orientation, or your faith or religion.

7. Are there any cultural traditions that influence how you approach helping [INDIVIDUAL RECEIVING CARE]?
8. Is the amount or kind of help you are giving him/her different in any way from what would be expected in the community that you come from or the one he/she comes from? Is it different from what society in general would expect?

Social context of caregiving

9. [IF CAREGIVER IS A FAMILY MEMBER:] How do you, as a family, cope with this [PROBLEM]?
10. Are there others, such as family members, friends, or neighbors, who also help him/her with the [PROBLEM]? If so, what do they do?
11. How do you feel about how much or how little others are helping with his/her [PROBLEM]?

Clinical support for caregiving

12. How do you see yourself helping to provide care to [INDIVIDUAL RECEIVING CARE] now and in the future?
13. [IF UNCLEAR:] How do you see yourself helping with the care that he/she receives in this clinic?
14. How can we make it easier for you to be able to help [INDIVIDUAL RECEIVING CARE] with the [PROBLEM]?

Cultural Concepts of Distress

Cultural concepts of distress refers to ways that cultural groups experience, understand, and communicate suffering, behavioral problems, or troubling thoughts and emotions. Three main types of cultural concepts may be distinguished. *Cultural syndromes* are clusters of symptoms and attributions that tend to co-occur among individuals in specific cultural groups, communities, or contexts and that are recognized locally as coherent patterns of experience. *Cultural idioms of distress* are ways of expressing distress that may not involve specific symptoms or syndromes, but that provide collective, shared ways of experiencing and talking about personal or social concerns. For example, everyday talk about “nerves” or “depression” may refer to widely varying forms of suffering without mapping onto a discrete set of symptoms, syndrome, or disorder. *Cultural explanations* or *perceived causes* are labels, attributions, or features of an explanatory model that indicate culturally recognized meaning or etiology for symptoms, illness, or distress.

These three concepts—syndromes, idioms, and explanations—are more relevant to clinical practice than the older formulation *culture-bound syndrome*. Specifically, the term *culture-bound syndrome* ignores the fact that clinically important cultural differences often involve explanations or experience of distress rather than culturally distinctive configurations of symptoms. Furthermore, the term *culture-bound* overemphasizes the local particularity and limited distribution of cultural concepts of distress. The current formulation acknowledges that *all* forms of distress are locally shaped, including the DSM disorders. From this perspective, many DSM diagnoses can be understood as operationalized prototypes that started out as cultural syndromes, and became widely accepted as a result of their clinical and research utility. Across groups there remain culturally patterned differences in symptoms, ways of talking about distress, and locally perceived causes, which are in turn associated with coping strategies and patterns of help seeking.

Cultural concepts arise from local folk or professional diagnostic systems for mental and emotional distress, and they may also reflect the influence of biomedical concepts. Cultural concepts have four key features in relation to the DSM-5 nosology:

- There is seldom a one-to-one correspondence of any cultural concept with a DSM diagnostic entity; the correspondence is more likely to be one-to-many in either direction. Symptoms or behaviors that might be sorted by DSM-5 into several disorders may be included in a single folk concept, and diverse presentations that might be classified by DSM-5 as variants of a single disorder may be sorted into several distinct concepts by an indigenous diagnostic system.
- Cultural concepts may apply to a wide range of severity, including presentations that do not meet DSM criteria for any mental disorder. For example, an individual with acute grief or a social predicament may use the same idiom of distress or display the same cultural syndrome as another individual with more severe psychopathology.
- In common usage, the same cultural term frequently denotes more than one type of cultural concept. A familiar example may be the concept of “depression,” which may be used to describe a syndrome (e.g., major depressive disorder), an idiom of distress (e.g., as in the common expression “I feel depressed”), or a perceived cause (similar to “stress”).
- Like culture and DSM itself, cultural concepts may change over time in response to both local and global influences.

Cultural concepts are important to psychiatric diagnosis for several reasons:

- **To avoid misdiagnosis:** Cultural variation in symptoms and in explanatory models associated with these cultural concepts may lead clinicians to misjudge the severity of a

problem or assign the wrong diagnosis (e.g., unfamiliar spiritual explanations may be misunderstood as psychosis).

- **To obtain useful clinical information:** Cultural variations in symptoms and attributions may be associated with particular features of risk, resilience, and outcome.
- **To improve clinical rapport and engagement:** "Speaking the language of the patient," both linguistically and in terms of his or her dominant concepts and metaphors, can result in greater communication and satisfaction, facilitate treatment negotiation, and lead to higher retention and adherence.
- **To improve therapeutic efficacy:** Culture influences the psychological mechanisms of disorder, which need to be understood and addressed to improve clinical efficacy. For example, culturally specific catastrophic cognitions can contribute to symptom escalation into panic attacks.
- **To guide clinical research:** Locally perceived connections between cultural concepts may help identify patterns of comorbidity and underlying biological substrates.
- **To clarify the cultural epidemiology:** Cultural concepts of distress are not endorsed uniformly by everyone in a given culture. Distinguishing syndromes, idioms, and explanations provides an approach for studying the distribution of cultural features of illness across settings and regions, and over time. It also suggests questions about cultural determinants of risk, course, and outcome in clinical and community settings to enhance the evidence base of cultural research.

DSM-5 includes information on cultural concepts in order to improve the accuracy of diagnosis and the comprehensiveness of clinical assessment. Clinical assessment of individuals presenting with these cultural concepts should determine whether they meet DSM-5 criteria for a specified disorder or an *other specified or unspecified* diagnosis. Once the disorder is diagnosed, the cultural terms and explanations should be included in case formulations; they may help clarify symptoms and etiological attributions that could otherwise be confusing. Individuals whose symptoms do not meet DSM criteria for a specific mental disorder may still expect and require treatment; this should be assessed on a case-by-case basis. In addition to the CFI and its supplementary modules, DSM-5 contains the following information and tools that may be useful when integrating cultural information in clinical practice:

- **Data in DSM-5 criteria and text for specific disorders:** The text includes information on cultural variations in prevalence, symptomatology, associated cultural concepts, and other clinical aspects. It is important to emphasize that there is no one-to-one correspondence at the categorical level between DSM disorders and cultural concepts. Differential diagnosis for individuals must therefore incorporate information on cultural variation with information elicited by the CFI.
- **Other Conditions That May Be a Focus of Clinical Attention:** Some of the clinical concerns identified by the CFI may correspond to V codes or Z codes—for example, acculturation problems, parent-child relational problems, or religious or spiritual problems.
- **Glossary of Cultural Concepts of Distress:** Located in the Appendix, this glossary provides examples of well-studied cultural concepts of distress that illustrate the relevance of cultural information for clinical diagnosis and some of the interrelationships among cultural syndromes, idioms of distress, and causal explanations.

Glossary of Cultural Concepts of Distress

Ataque de nervios

Ataque de nervios ("attack of nerves") is a syndrome among individuals of Latino descent, characterized by symptoms of intense emotional upset, including acute anxiety, anger, or grief; screaming and shouting uncontrollably; attacks of crying; trembling; heat in the chest rising into the head; and becoming verbally and physically aggressive. Dissociative experiences (e.g., depersonalization, derealization, amnesia), seizure-like or fainting episodes, and suicidal gestures are prominent in some *ataques* but absent in others. A general feature of an *ataque de nervios* is a sense of being out of control. Attacks frequently occur as a direct result of a stressful event relating to the family, such as news of the death of a close relative, conflicts with a spouse or children, or witnessing an accident involving a family member. For a minority of individuals, no particular social event triggers their *ataques*; instead, their vulnerability to losing control comes from the accumulated experience of suffering.

No one-to-one relationship has been found between *ataque* and any specific psychiatric disorder, although several disorders, including panic disorder, other specified or unspecified dissociative disorder, and conversion disorder, have symptomatic overlap with *ataque*.

In community samples, *ataque* is associated with suicidal ideation, disability, and outpatient psychiatric utilization, after adjustment for psychiatric diagnoses, traumatic exposure, and other covariates. However, some *ataques* represent normative expressions of acute distress (e.g., at a funeral) without clinical sequelae. The term *ataque de nervios* may also refer to an idiom of distress that includes any "fit"-like paroxysm of emotionality (e.g., hysterical laughing) and may be used to indicate an episode of loss of control in response to an intense stressor.

Related conditions in other cultural contexts: Indisposition in Haiti, blacking out in the Southern United States, and falling out in the West Indies.

Related conditions in DSM-5: Panic attack, panic disorder, other specified or unspecified dissociative disorder, conversion (functional neurologic symptom) disorder, intermittent explosive disorder, other specified or unspecified anxiety disorder, other specified or unspecified trauma and stressor-related disorder.

Dhat syndrome

Dhat syndrome is a term that was coined in South Asia little more than half a century ago to account for common clinical presentations of young male patients who attributed their various symptoms to semen loss. Despite the name, it is not a discrete syndrome but rather a cultural explanation of distress for patients who refer to diverse symptoms, such as anxiety, fatigue, weakness, weight loss, impotence, other multiple somatic complaints, and depressive mood. The cardinal feature is anxiety and distress about the loss of *dhat* in the absence of any identifiable physiological dysfunction. *Dhat* was identified by patients as a white discharge that was noted on defecation or urination. Ideas about this substance are related to the concept of *dhatu* (semen) described in the Hindu system of medicine, Ayurveda, as one of seven essential bodily fluids whose balance is necessary to maintain health.

Although *dhat syndrome* was formulated as a cultural guide to local clinical practice, related ideas about the harmful effects of semen loss have been shown to be widespread in the general population, suggesting a cultural disposition for explaining health problems and symptoms with reference to *dhat syndrome*. Research in health care settings has yielded diverse estimates of the syndrome's prevalence (e.g., 64% of men attending psychiatric clinics in India for sexual complaints; 30% of men attending general medical clinics in Pakistan). Although *dhat syndrome* is most commonly identified with young men from lower socioeconomic backgrounds, middle-aged men may also be affected. Comparable concerns about white vaginal discharge (leukorrhea) have been associated with a variant of the concept for women.

Related conditions in other cultural contexts: *koro* in Southeast Asia, particularly Singapore and *shen-k'uei* ("kidney deficiency") in China.

Related conditions in DSM-5: Major depressive disorder, persistent depressive disorder (dysthymia), generalized anxiety disorder, somatic symptom disorder, illness anxiety disorder, erectile disorder, early (premature) ejaculation, other specified or unspecified sexual dysfunction, academic problem.

Khyâl cap

"*Khyâl attacks*" (*khyâl cap*), or "wind attacks," is a syndrome found among Cambodians in the United States and Cambodia. Common symptoms include those of panic attacks, such as dizziness, palpitations, shortness of breath, and cold extremities, as well as other symptoms of anxiety and autonomic arousal (e.g., tinnitus and neck soreness). *Khyâl attacks* include catastrophic cognitions centered on the concern that *khyâl* (a windlike substance) may rise in the body—along with blood—and cause a range of serious effects (e.g., compressing the lungs to cause shortness of breath and asphyxia; entering the cranium to cause tinnitus, dizziness, blurry vision, and a fatal syncope). *Khyâl attacks* may occur without warning, but are frequently brought about by triggers such as worrisome thoughts, standing up (i.e., orthostasis), specific odors with negative associations, and agoraphobic-type cues like going to crowded spaces or riding in a car. *Khyâl attacks* usually meet panic attack criteria and may shape the experience of other anxiety and trauma- and stressor-related disorders. *Khyâl attacks* may be associated with considerable disability.

Related conditions in other cultural contexts: Laos (*pen lom*), Tibet (*srog rlung gi nad*), Sri Lanka (*vata*), and Korea (*hwa byung*).

Related conditions in DSM-5: Panic attack, panic disorder, generalized anxiety disorder, agoraphobia, posttraumatic stress disorder, illness anxiety disorder.

Kufungisisa

Kufungisisa ("thinking too much" in Shona) is an idiom of distress and a cultural explanation among the Shona of Zimbabwe. As an explanation, it is considered to be causative of anxiety, depression, and somatic problems (e.g., "my heart is painful because I think too much"). As an idiom of psychosocial distress, it is indicative of interpersonal and social difficulties (e.g., marital problems, having no money to take care of children). *Kufungisisa* involves ruminating on upsetting thoughts, particularly worries.

Kufungisisa is associated with a range of psychopathology, including anxiety symptoms, excessive worry, panic attacks, depressive symptoms, and irritability. In a study of a random community sample, two-thirds of the cases identified by a general psychopathology measure were of this complaint.

In many cultures, "thinking too much" is considered to be damaging to the mind and body and to cause specific symptoms like headache and dizziness. "Thinking too much" may also be a key component of cultural syndromes such as "brain fag" in Nigeria. In the case of brain fag, "thinking too much" is primarily attributed to excessive study, which is considered to damage the brain in particular, with symptoms including feelings of heat or crawling sensations in the head.

Related conditions in other cultural contexts: "Thinking too much" is a common idiom of distress and cultural explanation across many countries and ethnic groups. It has been described in Africa, the Caribbean and Latin America, and among East Asian and Native American groups.

Related conditions in DSM-5: Major depressive disorder, persistent depressive disorder (dysthymia), generalized anxiety disorder, posttraumatic stress disorder, obsessive-compulsive disorder, persistent complex bereavement disorder (see "Conditions for Further Study").

Maladi moun

Maladi moun (literally "humanly caused illness," also referred to as "sent sickness") is a cultural explanation in Haitian communities for diverse medical and psychiatric disorders. In this explanatory model, interpersonal envy and malice cause people to harm their enemies by sending illnesses such as psychosis, depression, social or academic failure, and inability to perform activities of daily living. The etiological model assumes that illness may be caused by others' envy and hatred, provoked by the victim's economic success as evidenced by a new job or expensive purchase. One person's gain is assumed to produce another person's loss, so visible success makes one vulnerable to attack. Assigning the label of sent sickness depends on mode of onset and social status more than presenting symptoms. The acute onset of new symptoms or an abrupt behavioral change raises suspicions of a spiritual attack. Someone who is attractive, intelligent, or wealthy is perceived as especially vulnerable, and even young healthy children are at risk.

Related conditions in other cultural contexts: Concerns about illness (typically, physical illness) caused by envy or social conflict are common across cultures and often expressed in the form of "evil eye" (e.g. in Spanish, *mal de ojo*, in Italian, *mal'occhiu*).

Related conditions in DSM-5: Delusional disorder, persecutory type; schizophrenia with paranoid features.

Nervios

Nervios ("nerves") is a common idiom of distress among Latinos in the United States and Latin America. *Nervios* refers to a general state of vulnerability to stressful life experiences and to difficult life circumstances. The term *nervios* includes a wide range of symptoms of emotional distress, somatic disturbance, and inability to function. The most common symptoms attributed to *nervios* include headaches and "brain aches" (occipital neck tension), irritability, stomach disturbances, sleep difficulties, nervousness, easy tearfulness, inability to concentrate, trembling, tingling sensations, and *mareos* (dizziness with occasional vertigo-like exacerbations). *Nervios* is a broad idiom of distress that spans the range of severity from cases with no mental disorder to presentations resembling adjustment, anxiety, depressive, dissociative, somatic symptom, or psychotic disorders. "Being nervous since childhood" appears to be more of a trait and may precede social anxiety disorder, while "being ill with nerves" is more related than other forms of *nervios* to psychiatric problems, especially dissociation and depression.

Related conditions in other cultural contexts: *Nevra* among Greeks in North America, *nierbi* among Sicilians in North America, and *nerves* among whites in Appalachia and Newfoundland.

Related conditions in DSM-5: Major depressive disorder, persistent depressive disorder (dysthymia), generalized anxiety disorder, social anxiety disorder, other specified or unspecified dissociative disorder, somatic symptom disorder, schizophrenia.

Shenjing shuairuo

Shenjing shuairuo ("weakness of the nervous system" in Mandarin Chinese) is a cultural syndrome that integrates conceptual categories of traditional Chinese medicine with the

Western diagnosis of neurasthenia. In the second, revised edition of the *Chinese Classification of Mental Disorders* (CCMD-2-R), *shenjing shuairuo* is defined as a syndrome composed of three out of five nonhierarchical symptom clusters: weakness (e.g., mental fatigue), emotions (e.g., feeling vexed), excitement (e.g., increased recollections), nervous pain (e.g., headache), and sleep (e.g., insomnia). *Fan nao* (feeling vexed) is a form of irritability mixed with worry and distress over conflicting thoughts and unfulfilled desires. The third edition of the CCMD retains *shenjing shuairuo* as a somatoform diagnosis of exclusion. Salient precipitants of *shenjing shuairuo* include work- or family-related stressors, loss of face (*mianzi, lianzi*), and an acute sense of failure (e.g., in academic performance). *Shenjing shuairuo* is related to traditional concepts of weakness (*xu*) and health imbalances related to deficiencies of a vital essence (e.g., the depletion of *qi* [vital energy] following overstraining or stagnation of *qi* due to excessive worry). In the traditional interpretation, *shenjing shuairuo* results when bodily channels (*jing*) conveying vital forces (*shen*) become dysregulated as a result of various social and interpersonal stressors, such as the inability to change a chronically frustrating and distressing situation. Various psychiatric disorders are associated with *shenjing shuairuo*, notably mood, anxiety, and somatic symptom disorders. In medical clinics in China, however, up to 45% of patients with *shenjing shuairuo* do not meet criteria for any DSM-IV disorder.

Related conditions in other cultural contexts: Neurasthenia-spectrum idioms and syndromes are present in India (*ashaktapanna*) and Japan (*shinkei-suijaku*), among other settings. Other conditions, such as brain fog syndrome, burnout syndrome, and chronic fatigue syndrome, are also closely related.

Related conditions in DSM-5: Major depressive disorder, persistent depressive disorder (dysthymia), generalized anxiety disorder, somatic symptom disorder, social anxiety disorder, specific phobia, posttraumatic stress disorder.

Susto

Susto ("fright") is a cultural explanation for distress and misfortune prevalent among some Latinos in the United States and among people in Mexico, Central America, and South America. It is not recognized as an illness category among Latinos from the Caribbean. *Susto* is an illness attributed to a frightening event that causes the soul to leave the body and results in unhappiness and sickness, as well as difficulties functioning in key social roles. Symptoms may appear any time from days to years after the fright is experienced. In extreme cases, *susto* may result in death. There are no specific defining symptoms for *susto*; however, symptoms that are often reported by people with *susto* include appetite disturbances, inadequate or excessive sleep, troubled sleep or dreams, feelings of sadness, low self-worth or dirtiness, interpersonal sensitivity, and lack of motivation to do anything. Somatic symptoms accompanying *susto* may include muscle aches and pains, cold in the extremities, pallor, headache, stomachache, and diarrhea. Precipitating events are diverse, and include natural phenomena, animals, interpersonal situations, and supernatural agents, among others.

Three syndromic types of *susto* (referred to as *cibih* in the local Zapotec language) have been identified, each having different relationships with psychiatric diagnoses. An interpersonal *susto* characterized by feelings of loss, abandonment, and not being loved by family, with accompanying symptoms of sadness, poor self-image, and suicidal ideation, seemed to be closely related to major depressive disorder. When *susto* resulted from a traumatic event that played a major role in shaping symptoms and in emotional processing of the experience, the diagnosis of posttraumatic stress disorder appeared more appropriate. *Susto* characterized by various recurrent somatic symptoms—for which the person sought health care from several practitioners—was thought to resemble a somatic symptom disorder.

Related conditions in other cultural contexts: Similar etiological concepts and symptom configurations are found globally. In the Andean region, *susto* is referred to as *espanto*.

Related conditions in DSM-5: Major depressive disorder, posttraumatic stress disorder, other specified or unspecified trauma and stressor-related disorder, somatic symptom disorders.

Taijin kyofusho

Taijin kyofusho ("interpersonal fear disorder" in Japanese) is a cultural syndrome characterized by anxiety about and avoidance of interpersonal situations due to the thought, feeling, or conviction that one's appearance and actions in social interactions are inadequate or offensive to others. In the United States, the variant involves having an offensive body odor and is termed *olfactory reference syndrome*. Individuals with *taijin kyofusho* tend to focus on the impact of their symptoms and behaviors on others. Variants include major concerns about facial blushing (erythrophobia), having an offensive body odor (olfactory reference syndrome), inappropriate gaze (too much or too little eye contact), stiff or awkward facial expression or bodily movements (e.g., stiffening, trembling), or body deformity.

Taijin kyofusho is a broader construct than social anxiety disorder in DSM-5. In addition to performance anxiety, *taijin kyofusho* includes two culture-related forms: a "sensitive type," with extreme social sensitivity and anxiety about interpersonal interactions, and an "offensive type," in which the major concern is offending others. As a category, *taijin kyofusho* thus includes syndromes with features of body dysmorphic disorder as well as delusional disorder. Concerns may have a delusional quality, responding poorly to simple reassurance or counterexample.

The distinctive symptoms of *taijin kyofusho* occur in specific cultural contexts and, to some extent, with more severe social anxiety across cultures. Similar syndromes are found in Korea and other societies that place a strong emphasis on the self-conscious maintenance of appropriate social behavior in hierarchical interpersonal relationships. *Taijin kyofusho*-like symptoms have also been described in other cultural contexts, including the United States, Australia, and New Zealand.

Related conditions in other cultural contexts: *Taein kong po* in Korea.

Related conditions in DSM-5: Social anxiety disorder, body dysmorphic disorder, delusional disorder, obsessive-compulsive disorder, olfactory reference syndrome (a type of other specified obsessive-compulsive and related disorder). Olfactory reference syndrome is related specifically to the *jikoshu-kyofu* variant of *taijin kyofusho*, whose core symptom is the concern that the person emits an offensive body odor. This presentation is seen in various cultures outside Japan.

An Introduction to the Cultural Formulation Interview

Neil Krishan Aggarwal, M.D., M.B.A., and Roberto Lewis-Fernández, M.D., M.T.S.

This article explains the origins, development, and applications of the DSM-5 Cultural Formulation Interview (CFI). This work first discusses the relevance of cultural factors to all aspects of mental health care, demonstrating the need for person-centered cultural formulations in diagnostic and treatment planning. The DSM-IV Outline for Cultural Formulation is then reviewed as a framework for conducting cultural formulations. Key revisions from *DSM-IV* to *DSM-5* are covered, including a consensus definition of culture relevant to mental health, guidelines for conducting cultural formulations in practice,

and explanations of various CFI questionnaires for providers. Finally, this article provides a detailed examination of the core, 16-item CFI, the content of which serves as the foundation for all questionnaires. The CFI can be used to promote culturally competent practice that clarifies the meanings and expectations of health, illness, and treatment from the patient's perspective.

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Culture shapes every aspect of patient care in psychiatry, influencing when, where, how, and to whom patients narrate their experiences of illness and distress, the patterning of symptoms, and the models clinicians use to interpret and understand symptoms in terms of psychiatric diagnoses. Culture also shapes patients' perceptions of care, including what types of treatment are acceptable and for how long. Even when patients and clinicians share similar ethnic or linguistic backgrounds, culture affects care through other influences on identity, such as those attributable to gender, age, class, race, occupation, sexual orientation, and religion/spirituality. Because cultural contexts and expectations frame the clinical encounter for every patient, and not just those from underserved minority groups, cultural formulation is an essential component of any comprehensive psychiatric assessment.

Acknowledging that illnesses occur in cultural and social contexts, *DSM-5* includes two questionnaires to aid clinicians with cultural formulation. The first questionnaire, known as the core Cultural Formulation Interview (CFI), contains instructions for clinicians in a left column and 16 questions with probes for direct patient interviewing in a right column, similar in format to other standardized questionnaires such as the Structured Clinical Interview for DSM-IV. In addition, there is an informant Cultural Formulation Interview (I-CFI) for clinicians to use with close associates of patients, such as family, friends, caregivers, and others who can provide collateral information. Finally, *DSM-5* includes 12 supplementary modules to the core CFI, which provide additional questions to investigate a topic in greater depth or include topics of additional concern (e.g., phase in the life cycle for certain populations, such as children and adolescents or older adults).

This set of interviews is known collectively as the CFIs, and they greatly expand the clinician's tool kit so that attention to cultural issues remains integral throughout the process of diagnostic and treatment planning. APA has made all of these interviews available online for free on its Web site (www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures) in recognition of the growing interest in clinician cultural formulation. This article reviews the development of the core CFI and discusses its contents in detail so that clinicians can develop a working understanding of the theoretical foundations common to all of the interviews.

Development of the CFI

Outline for cultural formulation. The core CFI, I-CFI, and all 12 supplementary modules were developed by the *DSM-5* Cross-Cultural Issues Subgroup (DCCIS) based on reviews of the scientific literature since the publication of the Outline for Cultural Formulation (OCF) in 1994. The development process is discussed elsewhere in greater depth (1) but is summarized here for background. The OCF was an early attempt at standardizing cultural formulation that first appeared in *DSM-IV*. The OCF was developed as a conceptual framework—a summary of the topics that could be included in a cultural formulation during a mental health evaluation to improve diagnostic accuracy and patient engagement in treatment planning. These topics were organized in four OCF domains: cultural identity of the individual, cultural explanations of the individual's illness, cultural factors related to psychosocial environment and levels of functioning, and cultural elements of the relationship between the individual and the clinician. Information from these domains influencing diagnosis and treatment was

summarized and synthesized in a fifth section to provide an overall formulation.

For the past 20 years, the OCF has been a widely taught cultural assessment tool in mental health care. Members of the DCCIS included clinicians and researchers from around the world who attempted to implement the OCF in diverse organizational and practice settings, attesting to the significant international interest in cross-cultural patient formulation (2). Although a substantial scholarship has emerged since the 1970s to propose different cultural interviews based on varying lengths that clinicians can use with patients, there have been few attempts to analyze their similarities and differences. The DCCIS therefore provided an institutional mechanism for international experts to come together regularly and advance a consensus approach that synthesized common topics covered under various interviews and proposed revisions to shortcomings discovered in the OCF. A revised version of the OCF was also included in *DSM-5* (1).

A definition of culture. A major advance of the DCCIS was the development of a single definition for culture that can be used for clinically relevant practice. This definition is found in *DSM-5*, and the CFI operationalizes this definition in the form of questions to patients as follows:

Culture refers to systems of knowledge, concepts, rules, and practices that are learned and transmitted across generations. Culture includes language, religion and spirituality, family structures, life-cycle stages, ceremonial rituals, and customs, as well as moral and legal systems. Cultures are open, dynamic systems that undergo continuous change over time; in the contemporary world, most individuals and groups are exposed to multiple cultures, which they use to fashion their own identities and make sense of experience.

This definition captures the multiple, vibrant sources of meaning that we all draw upon to comprehend our experiences throughout life, including those of illness and suffering. Such meanings can be inherited and acquired, derived through symbolic systems such as language and creed, inherent to patterns of social organization such as families and legal systems, and ever-changing as our priorities and identities shift according to our development along the lifespan. A fundamental tenet of this definition is that culture exists in the ties that bind people to social groups. Instead of reducing cultural identity to a single demographic trait such as language, race, or ethnicity without considering its effects on patients (3, 4), the CFI encourages clinicians to inquire about the various sources of meaning that affect how all stakeholders in health care make sense of illnesses and decisions about care.

Developing guidelines for implementing the CFI. Aside from this consensus definition of culture, members of the DCCIS also worked on developing guidelines for clinicians on how to implement the CFI. The first step was to prepare literature reviews on extant cultural assessments available to clinicians. The literature reviews followed certain assumptions

(1). First, the DCCIS recommended that clinicians responsible for diagnosis and treatment planning should complete the CFI. This stance differs from the notion that other members of a clinical team, such as interpreters or cultural brokers, should conduct cultural assessments because these staff members, who undoubtedly perform valuable functions, may not be called for each patient or may not be available in all settings. Moreover, the intent of the CFI is to elicit the patient's own perspective on his or her illness experience, which is very useful information for all clinicians to obtain.

Second, the DCCIS sought to harmonize the CFI with the OCF by identifying problems in either the OCF's content or its implementation in clinical settings. DCCIS members conducting the literature reviews assessed areas for possible revision in written drafts that were circulated and discussed in committee meetings. For the core CFI, the literature reviews culminated in an initial draft of the interview that was later tested among clinicians, patients, and (in some settings) members of the patient's social network as part of the *DSM-5* field trials. In this manner, the CFI revision process adhered to the general revision process for *DSM-5*, in which expert individuals conducted comprehensive literature reviews to pinpoint areas for revision, proposed recommendations in committee, and then field tested recommendations with human participants. The CFI field trial was conducted in mental health clinics in Canada, India, Kenya, the Netherlands, Peru, and the United States. Resource constraints prevented the DCCIS from field testing the I-CFI and the supplementary modules, and these interviews were developed in DCCIS subcommittees (2, 5).

An example of an area identified for revision since the OCF publication was the need for instructions for clinicians on the logistics of conducting a cultural formulation. The OCF included an outline of key topics that would be helpful to assess, but there were no actual questions that well-intentioned clinicians could use, no guidelines on when a cultural formulation would be useful, and no explanation for cultural concepts that may have been unfamiliar to clinicians (6). In response to this lack of implementation instructions, the core CFI now consists of 16 questions with instructions for clinicians. These instructions orient clinicians on the type of information that is sought for each question. The DCCIS also recommended that clinicians from any professional background (e.g., psychiatrists, psychologists, social workers, counselors, therapists, or nurses) begin every standard clinical assessment with the core CFI. Peer providers, employment counselors, and other recovery specialists are also encouraged to use the CFI to conduct a cultural formulation as part of their work. The interview has been designed for use with patients with any diagnosis and in all settings, including inpatient units, outpatient clinics, rehabilitation centers, emergency rooms, and transitional settings such as intensive outpatient programs. At the same time, the DCCIS also acknowledged that certain constraints may limit use of the full CFI and that providers can implement questions according to their needs. Experience in teaching

services suggests that the CFI can be used to bridge patient and provider understanding even in acute clinical settings, such as psychiatric emergency rooms, in which safety is the top priority. Clinicians may choose to use some CFI questions in the first encounter and other questions in subsequent encounters based on the patient's clinical stability. This comprehensive approach affirms that all patients and clinicians possess cultural backgrounds that affect clinical care; that cultural considerations are not restricted only to racial, ethnic, or linguistic minorities; and that the institutional context of service delivery influences the clinical encounter.

Furthermore, the DCCIS has recognized five specific situations in which cultural factors would be especially important for evaluation. First, there may be difficulty in diagnostic assessment owing to significant differences in the cultural, religious, or socioeconomic backgrounds of the clinician and the individual. The underlying principle describing this situation is to use the CFI when a clinician is unfamiliar with the patient's culture, regardless of similarities or differences in background or identity. Second, there may be uncertainty about the fit between culturally distinctive symptoms and diagnostic criteria. In this situation, there may be uncertainty between the diagnostic criteria and any of the patient's symptoms, not only those that either the clinician or the patient might consider culturally distinctive. Third, there may be difficulty in judging illness severity or impairment. Here, the clinician may not understand the level of severity indicated by the person's symptoms (e.g., whether the patient is describing a delusion or a strongly held view common in the person's culture) or how the patient's symptoms represent a clinically significant impairment in academic, occupational, or social functioning. Fourth, there may be disagreement between the individual and clinician on the course of care. Patients and clinicians may not agree on the length and types of treatments most needed for the patient's symptoms. Finally, there may be limited engagement in and adherence to treatment by the individual. Once treatment has started, patients may demonstrate variations in full adherence to recommended treatment modalities. The CFI responds to these situations by asking patients about their views of health, illness, and treatment through key questions.

The questions in the core CFI represented another topic of active deliberation within the DCCIS. The OCF has been criticized on the grounds that some topics in its four domains may overlap too much and lead to redundant information or replicate content elicited from the social history in routine clinical assessments (7, 8). *DSM-IV* also did not specify when the OCF should be used: Should clinicians obtain all information in each of the four domains or pick and choose as necessary? Is there a recommended order? Should the cultural formulation be completed in the same session as the diagnostic interview or later? These questions have remained an active area of research on the CFI. To provide clarity, the DCCIS reorganized the OCF domains so that the CFI questions can be used at the beginning of every clinical assessment. First, clinicians should obtain all

information in each of the four CFI sections when possible. Analyses of transcripts from the *DSM-5* CFI field trial indicate that clinicians in busy outpatient services could obtain all information in each of the CFI's four sections while completing the standard clinical assessment within 1 hour (2). Second, the CFI questions have been written in a particular order to maintain clinical rapport throughout the interview. For example, because the OCF lists cultural identity first, it implied that clinicians should assess this domain first. Some members of the DCCIS raised concerns that patients may not understand why clinicians are asking about their cultural identities without first inquiring into the problems being presented or establishing trust in a clinical environment. For this reason, the CFI includes questions on patient cultural identity after general questions on how patients define their problem and perceive its causes, context, and sources of support. Although the CFI questions are in the recommended order, the order in which clinicians ask them may vary depending on how the interview evolves in practice. Finally, circumstances will dictate whether the cultural formulation can be completed in the same session as the diagnostic interview. *DSM-5* states that the CFI can be used in a variety of situations. For new patients, the CFI can precede the standard diagnostic assessment. However, the five specific situations outlined in *DSM-5* indicate that a diagnostic assessment may have already occurred. In these situations, the CFI can help clinicians conduct an additional cultural formulation that may come later than the diagnostic assessment but nonetheless imparts critical and clarifying information.

All of the CFI interviews can be used to obtain cultural information in a patient-centered way. The introduction to the core CFI that clinicians can say to patients to frame the interview emphasizes that "there are no right or wrong answers." This acknowledgment underscores the patient's right to construct a narrative about the illness experience in recognition that this narrative may differ from the clinician's biomedical understanding of the disease process (9). Clinicians who are skilled in the CFI do not overlook or disregard patient-clinician differences; rather, they use cultural content to co-construct a narrative about illness with patients and negotiate a treatment plan that all parties can find feasible, acceptable, and useful (10).

Content of the Core CFI

Having discussed the development process of the CFI, this article now turns to its content. The core CFI comprises four sections. The first section, known as the "Cultural Definition of the Problem," includes the first three questions. Question 1 is "What brings you here today?" Although this question may not appear to have a specific cultural focus, its open-ended nature is intended to elicit the patient's view of core problems and concerns. The intent is to begin the clinical encounter with the issues that matter most to patients rather than to prioritize biomedical signs and symptoms (11). A prompt is included if the individual gives few details or only

mentions biomedical terms: “People often understand their problems in their own way, which may be similar to or different from how doctors describe the problem. How would you describe your problem?” This prompt empowers patients to share their experiences of distress in narrative form without concern for medical accuracy. Question 2 (“Sometimes people have different ways of describing their problem to their family, friends, or others in their community. How would you describe your problem to them?”) situates the patient’s description of the problem within the social network, recognizing that culture exists in the ties between people and shapes how information is processed and communicated differently based on audience, including patients and clinicians (12). Question 3 (“What troubles you most about your problem?”) obtains perceptions of illness severity in order to discuss impairments from the patient’s perspective.

Questions 4–10 compose the second section, “Cultural Perceptions of Cause, Context, and Support.” Question 4 (“Why do you think this is happening to you? What do you think are the causes of your [PROBLEM]?”) explores the patient’s meaning of illness. This information can be useful for treatment planning. For example, patients who perceive their illness to be caused by difficult interpersonal relationships may not want to try medication, whereas patients who believe that their illness is biologically inherited may be more receptive to pharmacotherapy (13). The “[PROBLEM]” placeholder is designed for clinicians to use the patient’s terms and phrases throughout the rest of the interview in order to build rapport and linguistically enter the patient’s life world (14). Language matching is one explicit communication strategy that the CFI promotes to reduce cultural misunderstandings between patients and clinicians. Patients may use biomedical vocabulary such as “depression” or common vernacular terms such as “the baby blues” in discussing their experiences, and clinicians can use such terms in the placeholder. A prompt can help patients consider a range of causes for more complete answers: “Some people may explain their problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes.” The prompt normalizes the possibility that differences may exist between patient and clinician perceptions of illness causes without prioritizing any single meaning. Question 5 (“What do others in your family, your friends, or others in your community think is causing your [PROBLEM]?”) asks the patient to consider what members of the social network understand as the cause of illness. Questions throughout the CFI that ask the patient to think about topics from the perspectives of close associates are concrete ways in which the CFI operationalizes the *DSM-5* definition of culture as transmitted among groups. The CFI assesses all four OCF domains. Questions 1–5 address many of the elements of a cultural assessment mentioned in OCF domain B, titled “Cultural Conceptualizations of Distress” in *DSM-5*, including “cultural constructs that influence how the individual experiences, understands, and communicates his or her symptoms

or problems to others” (p. 750). Other elements of OCF domain B are tapped in later CFI questions on coping (Question 11) and help seeking (Questions 12–15).

Domain C of the OCF, “Psychosocial Stressors and Cultural Features of Vulnerability and Resilience,” is addressed in CFI Questions 6 and 7 on supports and stressors. Question 6 asks “Are there any kinds of support that make your [PROBLEM] better, such as support from family, friends, or others?,” whereas Question 7 asks “Are there any kinds of stresses that make your [PROBLEM] worse, such as difficulties with money, or family problems?” Both of these questions can help patients and clinicians appreciate how other individuals and situations may improve or worsen the problem in expanding the focus of the interview to include the social contexts of illness (15).

Questions 8–10 tackle domain A of the OCF, “Cultural Identity of the Individual.” They serve as a transition to how the patient’s cultural identity relates to the problem being presented. Question 8 begins with an introduction to activate patients toward considering diverse sources of cultural identity: “Sometimes, aspects of people’s background or identity can make their [PROBLEM] better or worse. By background or identity, I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, or your faith or religion.” This introduction provides examples of identities that may be salient for the patient. Question 8 (“For you, what are the most important aspects of your background or identity?”) then poses a question directly to the patient to encourage a patient-centered approach of eliciting and understanding this important cultural information. This method releases clinicians from the burden of guessing the patient’s identity, which has sometimes characterized previous and now outmoded models of cultural competence (4). Instead, the CFI opts for a patient-centered approach to culturally competent care. Question 9 (“Are there any aspects of your background or identity that make a difference to your [PROBLEM]?”) asks patients to assess the relationship between cultural identity and the problem presented. This question can prevent clinicians from assuming that a particular form of care is needed for a certain social group (e.g., a racial or ethnic community) without first considering its relevance to individual patient care. Question 10 (“Are there any aspects of your background or identity that are causing other concerns or difficulties for you?”) moves from the clinical setting to the patient’s social context as another way of situating the illness within general life experiences. Problems with migration, immigration status, gender roles, or intergenerational conflict may be mentioned as possible answers and can provide valuable information on the extent to which resources (2) are available to patients as clinicians devise treatment plans.

Questions 11–13 compose the third CFI section, “Cultural Factors Affecting Self-Coping and Past Help-Seeking.” The objective of this section is to evaluate which interventions—at the individual, community, or clinical levels—have improved

or worsened the patient's condition. Question 11 ("Sometimes people have various ways of dealing with problems like [PROBLEM]. What have you done on your own to cope with your [PROBLEM]?") clarifies the individual's forms of self-coping. Question 12 moves beyond the individual to address help seeking at the community level, either with or without receipt of biomedical services: "Often, people look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing have you sought for your [PROBLEM]?" A prompt for this question illuminates which types of help may be mobilized for current treatment planning: "What types of help or treatment were most useful? Not useful?" Question 13 can elucidate barriers in accessing care: "Has anything prevented you from getting the help you need?" Another prompt follows to help clinicians consider the range of resources for the current illness episode: "For example, money, work or family commitments, stigma or discrimination, or lack of services that understand your language or background?"

The final three questions constitute the fourth and final CFI section, "Cultural Factors Affecting Current Help Seeking." Question 14 transitions from the past to the present illness episode: "Now let's talk some more about the help you need. What kinds of help do you think would be most useful to you at this time for your [PROBLEM]?" The goal of this question is to elicit the patient's perceived needs and expectations of help. Question 15 reviews treatment preferences according to members of the patient's social network: "Are there other kinds of help that your family, friends, or other people have suggested would be helpful for you now?" These questions complete the assessment of patients' cultural views of help seeking and self-care described in domain B of the OCF.

Question 16 begins with an open-ended statement before a direct question to the patient in contemplating perceived similarities and differences in the current patient-clinician relationship: "Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations. Have you been concerned about this and is there anything that we can do to provide you with the care you need?" The goal of this question is to anticipate concerns and resolve potential conflicts while putting domain D of the OCF into practice. Under this fourth domain, "Cultural Features of the Relationship Between the Individual and the Clinician," the CFI suggested:

Identify differences in culture, language, and social status between and individual and clinician that may cause difficulties in communication and may influence diagnosis and treatment. Experiences of racism and discrimination in the larger society may impede establishing trust and safety in the clinical diagnostic encounter. Effects may include problems eliciting symptoms, misunderstanding of the cultural and clinical significance of symptoms and behaviors, and difficulty establishing or maintaining the rapport needed for an effective clinical experience.

The goal of this question is to help patients identify differences that could cause difficulties in communicating with

providers. A strong therapeutic alliance is crucial to diagnostic accuracy and treatment engagement, and this question can signal to patients that providers are willing to establish trust and safety. After this question, clinicians can proceed to the standard assessment, having begun the encounter by prioritizing the patient's point of view.

Mission of the CFI

It is important to note that the CFI is designed to advance what is, in effect, a radical agenda: to change the way clinicians conduct a diagnostic interview so that the perspective of the patient becomes at least as important as the signs and symptoms of disease identified by the clinician. The mission of the CFI is in fact to expand what counts as data in a clinical encounter, encouraging the clinician—and the patient, who is empowered to recount his or her experience more fully—to attend to the experience of illness and the life world. The CFI helps to elaborate the patient's perspective within a specific local world, such as the views of the community (exemplified by the patient's social network) and the life context in which the problem presented emerges. The CFI can help clarify what the patient is looking for in the clinical encounter, the various possibilities for treatment and other forms of self-coping and help seeking that the patient can draw upon, and, very specifically, the ways in which treatment will be carried out. The greater understanding afforded to the clinician—paired with a fuller expression of the problem, preferences for care, and trust on the part of the patient—can facilitate a process of shared decision making, including negotiating and clarifying the subsequent concrete steps and decisions for both partners in the session.

Conclusions

The CFI is a state-of-the-art tool for clinicians to use in conducting cultural formulations with patients. Calls for patient-centered care and health equity have increasingly led to the development of standards for cultural and linguistic competence for clinicians and service organizations (16). The CFI fulfills these functions by ascertaining the cultural meanings of health, illness, and treatment from the patient's perspective. The CFI also restores the patient's voice to the clinical encounter, offering a complementary perspective to diagnostic interviews that may otherwise elevate symptom checklists over intimate experiences of suffering and care.

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Call for Papers

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An Online Training Module on the Cultural Formulation Interview: The Case of New York State

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Professional organizations and government guidelines recommend cultural competence training for providers, but the lack of a standardized cultural assessment has hindered research. Studies with the *DSM-5* Cultural Formulation Interview (CFI) suggest that active learning during training improves perceptions of the CFI's usefulness as a cultural competence tool. This column reports demographic

characteristics and evaluation scores among 423 providers who completed an online CFI training module developed through the New York State Office of Mental Health. Both the module, which uses the principle of active learning, and the CFI were associated with strong favorability ratings.

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Cultural factors affect all aspects of mental health care, from the patterning of patient symptoms to the illness classifications of clinicians and the language used to co-construct illness narratives (1). Nevertheless, generating scientific evidence to train clinicians in cultural competence has been a challenge. Studies of cultural competence training have not employed standardized cultural assessment tools, leading to differential appraisals of their effects on clinical outcomes (2). One promising tool is the *DSM-5* Cultural Formulation Interview (CFI), which is disseminated free of cost by the American Psychiatric Association (APA) (3). The CFI is a 16-item, semistructured questionnaire created through a literature review on clinically based cultural assessments, a field trial with 321 patients and 75 clinicians, and expert consensus. The clinicians in the field trial preferred active, case-based, behavioral simulations that allowed them to practice using the interview by taking turns as patients and clinicians rather than passive training methods, such as watching videos (4). This paradigm is known as “active learning,” an interactive process in which participants develop skills by reflecting upon the content rather than by passive attendance at didactic lectures (5).

Subsequent studies have examined whether the method of training affects whether the CFI can be used by psychiatric residents as a cultural competence tool. Investigators who distributed the CFI and a written summary of its contents from *DSM-5* as the training method found that residents without prior social science exposure felt that the CFI did not address cultural issues (6). However, active learning improved perceptions of the CFI and its training. In a study of 22 residents, a lecture on health

disparities was combined with a group activity in which participants shared personal reflections on cultural identity (7); scores on the cultural knowledge subscale of the cultural competence assessment tool improved. In another study, 16 residents reported increased comfort with the CFI after practicing with it and receiving feedback (8). These findings raise questions about how to create a training intervention that elicits active learning and can be applied to all providers, not just residents. This column discusses the creation of a CFI online training module developed with consumers in recovery, clinicians, providers, the New York State Office of Mental Health (OMH), and the APA. It also describes the profile of participants who completed this training. Notably, this study is the first to examine CFI training with providers other than psychiatric residents.

Description of the Module

The Center of Excellence for Cultural Competence (CECC) and the Center for Practice Innovations (CPI) at OMH's New York State Psychiatric Institute (NYSPI) developed the module after receiving copyright permission to use the CFI from the APA in 2013. The CECC contributed content expertise by identifying providers to model CFI use. The CPI recruited consumers in recovery who shared their experiences by responding to CFI questions. The CPI contracted with a vendor to create the module. Activities included using instructional design principles to organize content and create interactive experiences for learners, filming expert commentary and consumer CFI sessions, and creating

the Web interface. The CPI's learning management system stored deidentified demographic and evaluation data. The CECC and CPI completed an application for physicians, social workers, and substance use counselors to receive continuing education through OMH. The NYSPI Institutional Review Board approved the study.

The training module's learning objectives are to understand the *DSM-5* definition of culture and how the CFI puts this into practice, understand the theory and content behind the four domains and 16 questions of the CFI, and identity barriers and possible solutions for implementing the CFI in the trainees' setting. The module consists of brief presentations delivered by the senior author on the importance of cultural assessments in psychiatry, professional recommendations for clinicians to demonstrate cultural competence, and the CFI's four domains. Afterward, participants complete a demographic survey. When learners click on each domain, videos appear of clinicians interviewing consumers. CFI questions also appear onscreen simultaneously to optimize multimodal audiovisual learning (4). Segments from five video interviews with different clinicians and consumers demonstrate the range of information that the CFI can elicit. At intervals, participants complete surveys to reflect on the CFI questions they like most, barriers to using the CFI in their practice, and strategies for overcoming such barriers, in line with research on implementing the CFI in real-world settings (9). Participants can save their responses for personal reference. This strategy introduces aspects of active learning, given that participants must complete content-based questions to proceed throughout the module rather than only consume videos passively. The module can be completed in an hour.

The module went live in March 2017. It is available without cost to providers in New York and on a low-cost, sliding scale worldwide by contacting CECCinfo@nyculturalcompetence.org. Thus far, participants have been recruited through the CPI listserv, which reaches approximately 20,000 people.

Participants' Characteristics and Responses

As of January 2, 2018, 423 providers completed the module, including eight (2%) psychiatrists, 27 (6%) psychologists, 18 (4%) nurses, 194 (46%) social workers, and 176 (42%) other providers (such as counselors, peer providers, case managers, and therapists). Of these, 320 (76%) had a master's degree; 44 (10%), a bachelor's degree; and 36 (9%), a doctorate. Of 423 providers, 339 (80%) worked in outpatient settings, with an equal number ($N=23$, 5%) in inpatient and assertive community treatment settings. Participants estimated the amount of cross-cultural training they had received over the past five years, with 79 (19%) reporting less than five hours; 134 (32%), five to 10 hours; 98 (23%), 11 to 25 hours; 70 (17%), 26 to 50 hours, and 42 (10%), 50 or more hours. Three hundred (71%) took the training for continuing education credit. Fifty-eight participants (14%) identified their ethnicity as Latino; in terms of race, 296 identified as

white (70%), 63 as black (15%), 17 (4%) as Asian, 10 (2%) as Native American, and 35 (9%) as mixed or other. Ninety percent were born in the United States.

Participants evaluated the module on a 5-point Likert scale, from 1, strongly disagree, to 5, strongly agree. The module received an overall mean \pm SD evaluation score of $4.13\pm.80$ from the 423 learners. The lowest mean score was for wanting further CFI training ($3.82\pm.92$). Two items tied for the highest mean score—training that met stated objectives ($4.26\pm.77$) and better understanding of the type of information obtained through the CFI ($4.26\pm.76$). The training appeared to elicit agreement on the item that participants could provide *DSM-5* definitions for culture and cultural assessment, which received a mean score of 4.17. [A table providing the scoring breakdown and mean score per item is available in an online supplement to the column.]

One learner's optional response typified other answers about how the training helped emphasize culture, "It comes down to finding out who the person really is and not simply making unqualified judgments or stereotypes." Another learner wrote, "The questions focusing on how the [clients perceive] themselves and how they think that their support network perceives them [were helpful in cultural assessment]."

Finally, participants completed a closed-ended questionnaire on whether the training would influence their implementation of the CFI. Of 423 participants, 247 (58%) indicated that this module would result in practice changes, 164 (39%) responded that the module would "change the management and/or treatment of my patients/clients," and 83 (20%) responded that the module would help "create/revise protocols, policies, and/or procedures." Many ($N=174$, 41%) responded that the module "validated my current practice and that no changes will be made," and three people (1%) were unsure about changing their practice because of systemic barriers, such as needing more time.

Discussion and Future Directions

This column contributes to scholarship on cultural competence by presenting data on the largest sample of mental health providers trained in a standardized format through the CFI. A training module requiring participants to demonstrate active engagement with content elicited agreement about the CFI's usefulness as a cultural competence tool. Possible caveats include the following: more than 85% of participants were social workers, mental health counselors, or other providers besides physicians (6–8) and may have been biased toward valuing cultural assessments. Over a quarter had more than 25 hours of cross-cultural training over the past five years, exceeding the typical training for general psychiatric residents, the only population studied since the CFI's release in *DSM-5*. Our participants worked in public mental health settings and chose this module for continuing education rather than being mandated to use it. Social desirability bias may partly be responsible for the training's

positive responses. It is possible that psychiatrists chose not to participate because they see their roles as limited to medication management. Future work could examine whether training and evaluation outcomes differ for providers with less cultural competence training and experience. The APA and the American Association of Directors of Psychiatric Residency Training could consider publicizing the module to reach more attending psychiatrists and trainees, respectively.

Our work partly responded to prior critiques. Cultural competence initiatives across medicine suffer from a lack of standardization, in both content and evaluation (2). The CFI offers one standardized tool for training in cultural competence—which we believe is a lifelong process—and the evaluation questions listed in the online supplement can be used for posttraining assessment. Almost 60% of participants indicated that the CFI could change their practice or policies, and over 41% responded that the module validated their practice. However, these are self-reported scores, and studies on CFI implementation are needed. Such studies could explore how trainees incorporate information from the module into their practice, either through ethnographies of patient-clinician interactions or independent ratings of taped patient-clinician interviews. The CFI fidelity instrument can help researchers and administrators determine whether certain training packages affect the quality of implementation (3). For example, is the online training module sufficient to ensure fidelity? Does it need supplementation with more active types of learning, such as behavioral simulations or expert feedback? How can programs sustain long-term fidelity while minimizing costs? Do training and fidelity change on the basis of practice setting, patient cohort, provider experience, or type of health care organization? The standardization of a CFI training module and fidelity instrument enables clinical trials to test the CFI's mechanisms of action by examining its relationships to patient satisfaction, symptoms, and quality of life (10). In recognition that cultural competence is in the public interest, we encourage others to use the module and share their experiences.

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Update on the Cultural Formulation Interview

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This article reviews the clinical and research literature on the Cultural Formulation Interview (CFI) since its publication in *DSM-5*. The CFI is an interview protocol designed to be used by clinicians in any setting to gather essential data to produce a cultural formulation. The CFI aims to improve culturally sensitive diagnosis and treatment by focusing clinical attention on the patient's perspective and social context. Preliminary evidence indicates that the CFI can improve clinical communication by enhancing clinician-patient rapport, allowing the clinician to obtain new, cultural data in a relatively short period, eliciting patients' perspectives on what caused their symptoms, and helping patients to become aware of their problems in more insightful ways. With practice, the CFI takes approximately 20 minutes to complete. The CFI has been evaluated

internationally in the United States, Canada, Kenya, Peru, the Netherlands, India, and Mexico and generally has been found to be clinically acceptable and useful in these varied settings. Clinicians receiving as little as one hour of training on the CFI improved their ability to work with culturally diverse patients. The CFI may be more difficult to conduct with patients who have severe symptoms, including acute psychosis, suicidal behavior, aggression, and cognitive impairment. The CFI provides a simple way to begin the process of cultural assessment, and its systematic use can foster a reflective stance and promote systemic thinking in routine clinical practice about the patient's life and experience.

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Changing demography and new waves of migration have highlighted the importance of providing effective mental health care to culturally diverse populations. Against this backdrop, the need to obtain narratives of illness experience and help seeking from every patient, regardless of background, has been widely recognized as crucial to person-centered care. Understanding this narrative depends on situating it in social and cultural context, and this may be particularly challenging when patient and clinician come from different backgrounds (1).

The Outline for Cultural Formulation (OCF), a list of topics needed to develop a cultural formulation, was introduced in *DSM-IV* (2). However, the OCF received limited application by psychiatrists and mental health practitioners, perhaps in part because it did not guide clinicians in how to elicit cross-cultural information (3, 4), especially clinicians who were not already experienced in cultural assessment (5). To address this concern, the *DSM-5* Cross-Cultural Issues Subgroup developed the Cultural Formulation Interview (CFI), a semistructured 16-item interview protocol designed to be used by clinicians in any setting to gather essential data to produce a cultural formulation that improves culturally sensitive diagnosis and treatment (6). The CFI was designed to focus attention on the patient's

perspective and social context during diagnostic evaluation and to provide a way for patients to describe their experiences colloquially, not necessarily through biomedical terms or concepts. This can provide clinicians with information that may not be accessible by standard psychiatric evaluation while facilitating patient engagement, treatment negotiation, and collaboration. This article reviews published findings regarding the CFI over the 6 years since its publication, summarizes its implementation in international settings, and discusses clinical applications and challenges.

IMPLEMENTATION OF THE CFI

The CFI field trials conducted for *DSM-5* launched several ongoing research efforts. The field trial aimed to recruit 30 patients from each of several sites in the United States, Canada, the Netherlands, India, Kenya, and Peru and to apply a standard methodology to assess implementation (7). An initial, 14-item version of the CFI was tested; based on field trial results, it was then revised to produce the final 16-item version included in *DSM-5*.

In the United States, Aggarwal and his team (8) analyzed the content of 32 CFI interviews with patients and 32 debriefing interviews with clinicians at the New York site

of the field trial. Common themes included how the CFI benefited medical communication by enhancing clinician-patient rapport, allowing the clinician to obtain new data in a relatively short period of time, eliciting the patients' perspectives on what caused their symptoms, and collecting data that helped patients to become aware of their problems in more insightful ways.

Another U.S.-based study developed and pilot-tested a fidelity instrument to determine how reliably clinicians implemented the CFI and documented their perception of challenges during its use (9). The instrument was designed to capture adherence to method (i.e., whether clinicians adhered to the CFI topics) and clinical competence items (i.e., ratings of qualities such as empathy and patient centeredness). The CFI-Fidelity Instrument represents a first step toward quantifying fidelity in implementation of the CFI.

An international group of researchers led by Lewis-Fernández (10) reported data from the *DSM-5* international field trials on feasibility, acceptability, and clinical utility of the CFI. A total of 75 clinicians from participating outpatient clinics received 2 hours of training prior to conducting an initial mental health evaluation of 318 patients at their clinics. Depending on the site, new or existing patients were enrolled, and each clinician assessed at least three patients over the course of the trial. Mixed-methods evaluation found the CFI to be feasible, acceptable, and useful. Clinicians' initial concerns about feasibility were significantly reduced after the second time they used the CFI, suggesting a rapid learning curve. Results demonstrated the value of investing about 20 minutes of an initial evaluation on a cultural assessment in terms of possible effects on communication, engagement, diagnostic accuracy, and treatment participation. However, direct assessment of these potential effects is only now under way (11).

Bäärnhielm and colleagues (12) discussed experience with the CFI field trials in India, Kenya, and the Netherlands and reviewed work in Nordic countries with the OCF and CFI. The experience of the CFI field trial at the Indian site was noteworthy for how patients appreciated the extra time doctors devoted to them and to the cultural aspects of their problems. However, given the high volume of patients seen at the Indian sites (200–250 outpatients treated per day and 10,000 new patients per year at the New Delhi site alone) and the severe shortage of mental health professionals in India, the CFI may need to be shortened for routine use. Details of the CFI field trial in Kenya indicated that the CFI provided sufficient context, on at least one occasion, for the interviewer to reassess apparent psychosis as depressive disorder rather than schizophrenia. Experience with the CFI field trial at the Dutch site revealed that some respondents of Dutch origin appreciated the opportunity to discuss aspects of their cultural identity beyond simply being from the Netherlands, such as being a veteran or being born in the Dutch East Indies. Bäärnhielm and colleagues (12) emphasized the need to translate the CFI into other languages and

to produce local training materials. They also noted that the CFI requires a flexible approach rather than simply repeating the standard questions to patients of diverse backgrounds. They suggested that initial CFI training needs to be augmented by careful support and follow-up to maintain what has been learned and to reinforce how to appropriately implement the interview. Modifications to the CFI itself, such as condensing it for use in busy clinical practices, are important issues and are being considered; ongoing research with the current version of the CFI is needed to establish a firm basis for amending it.

A team in Pune, India, administered semistructured debriefing interviews following audio-recorded CFIs with eight clinicians, 36 patients, and 12 relatives in a psychiatric clinic of a general hospital (13). The authors found that the CFI was acceptable to family members accompanying patients but that patients and clinicians rated the CFI lower when relatives were present. The role of families is important everywhere, but in India this is even more the case because family members often accompany patients to the doctor and expect to be included in the process of evaluation and treatment. However, the authors suggested that the presence of families might have limited how much patients could discuss family issues related to their mental health problems. In addition, relatives tended to raise additional aspects of the presenting problem, which tended to make the clinical assessment more complicated. Nevertheless, the study concluded that the CFI needed to be adapted to include families in the evaluation process. The study also raised important questions about respecting patient confidentiality and negotiating cultural norms in settings in which the focus of clinical attention is relatively more on families than on the individual.

Ramírez Stege and Yarris (14) translated the CFI into Spanish and used it routinely during outpatient follow-up in a regional psychiatric hospital in central Mexico. Participating clinicians did not receive training on how to use the CFI, beyond reading the written CFI guidelines in *DSM-5*. Furthermore, the interviews were regular follow-up appointments rather than intake evaluations. The authors found that the CFI was clinically useful for diagnosis and treatment planning, decreased mistrust during the session, and helped to elicit information about patients' social networks and support. Another clinical benefit was the contribution of cultural identity to the person's understanding of the illness and options of care that came from using the CFI; for example, information about a person's age, gender, educational background, sexual orientation, religion, occupation, and language became part of the clinical discussion. However, patients and clinicians frequently misunderstood question 8, which is intended to elicit clinically relevant aspects of the patient's cultural identity. Only two clinicians with social science training appreciated the intent of the question as written, which is to assess for broad aspects of cultural background and identity, not just national or ethnic origin. Clinicians without social science training tended to

conflate “culture” with “indigeneity,” rejecting answers that did not relate to this narrow understanding of cultural identity. This misunderstanding demonstrates the need to train clinicians adequately before they use the CFI, including ensuring that local views of culture and identity are considered in framing the interview questions. More research is needed to address the impact of training and the need for local adaptation. More broadly, the CFI could eventually be revised to add assessments of specific social determinants of mental health; however, to ground changes in evidence, further research on the current version of the CFI is needed to establish which aspects are most important for clinical care.

In a study at a U.S. Department of Veterans Affairs clinic, Muralidharan and colleagues (15) conducted the core CFI with 14 patients with chronic psychosis, most of whom were male and African American, to assess the extent to which their diagnoses interfered with CFI implementation. They found that the CFI validated and deepened patients’ realization of their clinical experience and their process of recovery. The authors concluded that the CFI usefully enhances rapport and yields meaningful clinical information when used with individuals with chronic psychosis. However, this finding may not apply to individuals with acute psychoses.

Yet another research team found that the CFI elicited data that augmented culturally responsive care by bringing to attention what mattered most to Hispanic patients in an ethnic-focused clinic in New Haven, Connecticut: establishing relationships of trust with caregivers, addressing the stigma of mental illness, and paying attention to family- and church-related matters (16). The authors judged that some of this material would not have been uncovered without the CFI, which would have undermined the care of patients. Importantly, the New Haven experience suggested that use of the CFI not only sensitizes clinicians to the cultural issues of individual patients but can also contribute to the evaluation of clinical programs by highlighting problem areas and adapting the delivery of interventions to the cultural needs of patients and their families.

CHALLENGES

In addition to local cultural issues that complicate implementation of the CFI, general barriers to implementation have also been described. Aggarwal and colleagues (17) evaluated data from the New York site of the CFI field trial, which used the 14-item version of the CFI. Results were based on the responses of 32 patients and seven clinicians. The authors conducted a qualitative study evaluating barriers to CFI implementation based on debriefing interviews with patients and clinicians after administration of the CFI. For patients, the most common concerns were lack of differentiation from other interviews they had received, discomfort with discussing the past or talking about religion, and difficulty understanding some CFI questions.

For clinicians, the most common concerns included lack of clarity about the relevance of the CFI to the presenting problem, diagnostic assessment, and intervention planning; doubts about using the full CFI at the beginning of an evaluation; repetitiveness; difficulty engaging patients with severe illness; and lack of clinician buy-in, which may mostly reflect lack of familiarity with the CFI. Patients with severe symptoms, including acute psychosis, suicidal behavior, and aggression, and those with acute disabilities, such as cognitive impairment, may not be able to complete the CFI (7).

INSIGHTS FROM A SPECIALIZED CULTURAL CONSULTATION SERVICE

The Cultural Consultation Service at the Jewish General Hospital in Montreal has been using a cultural formulation approach to evaluate patients from diverse backgrounds since 1999. This experience suggests strategies to address some of the challenges reported by practitioners implementing the CFI, especially when patients are recent migrants, acutely psychotic, suicidal, uncooperative, or otherwise difficult to engage. First, the quality of information obtained by the CFI and its ability to increase clinical rapport depend on good clinical communication. An adequate linguistic assessment is necessary for all migrant patients to determine the need for an interpreter. Even patients who strive to speak the mainstream language during the evaluation may have limited capacity to discuss intimate matters in their second (or third) language. Routinely offering the help of an interpreter, even to those without obvious language barriers, greatly increases the quantity and quality of the information obtained. An interview with an interpreter present can suggest diagnostic changes or can bring relief to patients who have been unable to communicate for prolonged periods. Patients who have been deemed mute, intellectually impaired, or unresponsive may brighten considerably and have much to say that bears directly on the diagnosis and treatment, such as details of the trauma they have experienced, family they hope to contact, and their history of migration.

Second, when facing communication difficulties, an educational assessment can help clarify the context of clinical findings. Patients with little formal schooling may have limited literacy and find it difficult to answer overly broad, abstract, or open-ended questions. An educational assessment need not be time consuming but should establish the number of years of schooling and whether the patient learned to read and write in the mother tongue and in the language(s) of the new country.

Third, although many patients appreciate the CFI’s focus on their personal experience, some patients may feel uncertain about the purpose of the interview. They may find some questions difficult because of shame, stigma or loss of face, or family honor. Careful explanation of the purpose of the evaluation and the fact that it is confidential, that the patient is in control of its duration and content, and that the

aim is to clarify what is important for patient care is essential. The CFI may need to be used with caution in some kinds of evaluations, such as those conducted for forensic or insurance determination purposes, or in some delicate refugee evaluations, when the patient is forced to participate and is not in full control of the interview and its products. Use of the CFI in these situations will need to be carefully considered.

Fourth, for most patients, information from other family or community members is needed to clarify the social context and to assess family and community networks. The CFI has a key informant version that can be used with others in the patient's entourage. This can identify sources of stress and resilience factors as well as caregiver issues that need to be addressed. Clinicians should check with managers in the organizations where they practice as well as local laws to ensure that collateral information from others is balanced with maintaining the patient's confidentiality.

CLINICAL APPLICATIONS OF THE CFI AND ITS DOMAINS

The core CFI is framed in a way that allows it to be applied to assessments in any clinical setting by mental health practitioners (18). Studies of the CFI in diverse training and clinical settings are starting to appear. For example, Alarcón and his team (19) discussed how the CFI improved communication in several clinical settings: the emergency department, consultation-liaison psychiatry, community health centers, and outpatient settings. Drawing from the CFI field trial data from Lima, Peru, the authors noted that the main positive outcomes had to do with improved clinical communication: patients felt listened to and better understood by their doctors; the CFI enabled honest discussions about prejudice among ethnic groups and about religious beliefs, such as bewitchment, as a cause of illness; and the CFI gave permission to patients to frankly express their views about illness and treatment. Other researchers reported how the CFI contributed to sensitively communicating a psychiatric diagnosis to a patient for whom mental health problems carried a heavy burden of stigma (20). These examples make it clear that the CFI can improve intercultural clinical communication. Improving how patients and clinicians speak to one another by bridging cultural divides is a fundamental building block of developing culturally appropriate services.

Other examples of the CFI in action include case studies of patients from specific origins, such as Ethiopians in Israel and immigrants to Italy from Morocco and Sierra Leone, and applications of the CFI with children and families. Clinicians from Israel evaluated two young Ethiopian women with apparent eating disorders (21). The CFI led the clinical team to appreciate cultural and familial meanings of stomachache in one case and led to active involvement of the mother in the second—both of these applications led to breakthroughs in the treatment, drew appropriate attention to potential

predicaments of Ethiopians in Israeli society, brought to awareness clinical information that was previously neglected, and caused the treating team to question diagnoses of eating disorders given new cultural information. The authors considered that these factors facilitated recovery in these patients who had previously been difficult to help. Italian clinicians found that the CFI was helpful for clarifying the diagnosis, strengthening the therapeutic relationship, facilitating patient communication, and fostering adherence to treatment in their cases of immigrants to Italy from Morocco and Sierra Leone (22).

Although the CFI has a Supplementary Module for School-Age Children and Adolescents (SACA) (23), little research has been published on this module to date. In a case study, La Roche and Bloom (24) found that the components of the CFI were too dependent on adult communication capabilities to be used with children. In their research, the authors found that the CFI raised issues of mistrust of whites in the interview of a Somali-American child and enabled the development of a more nuanced treatment plan that incorporated religious practice and family involvement. However, the authors found that the CFI and SACA depended on verbal questions and cognitive capacity at the formal operations level and thus were not well suited to interviewing children younger than 11 years. They proposed a supplementary module for young children that would focus on drawing, building or sculpting, and acting through puppets or role playing as ways to access their perspectives, rather than relying on verbal questioning.

The role of families in cultural assessment is another area in need of further work. Investigators found that of the 321 patient interviews in the *DSM-5* field trial, 86 at four of the 12 sites included family members, who generally found the CFI acceptable, although some found the questions too time consuming, intrusive, or personal (25). Of interest was the pattern of family involvement by site. Family members accompanied all patients in Kenya, whereas no relatives went to interviews in Canada and the United States, perhaps reflecting differences in family- versus individual-oriented care and support in these settings. Adapting the CFI for use with families may require changing the order of questions and remaining alert and responsive to diverse perspectives within the family.

TRAINING

Given the significant challenges working in cross-cultural mental health, training clinicians to use the CFI is of critical importance. Aggarwal and collaborators (26) used mixed methods to analyze field trial interviews with 75 clinicians from five continents about their training preferences for the CFI. Most of the clinicians preferred active behavioral simulations, such as role-play mock interviews. Respondents felt that mock interviews helped them to learn how to ask the CFI questions and resolve their doubts about the interview. Video presentations were deemed to be less helpful

because they did not demonstrate how to work with uncooperative patients. The authors concluded that CFI training might best be accomplished through a combination of written guideline review, video demonstration, and behavioral simulations but that older, more experienced clinicians tended to prefer active rather than passive learning techniques. The New York State Center of Excellence for Cultural Competence developed an online training module (<https://nyculturalcompetence.org/cfionlinemodule/>) on how to use the CFI and reported its use by 423 service providers in the state, mostly social workers and other nonmedical counselors (27). Feedback was favorable, with an overall mean evaluation score of 4.13 (range 1–5, with 1=strongly disagree and 5=strongly agree that the module was helpful in various ways) and with most participants expressing the belief that the module would change their clinical practice.

In other work, researchers developed a novel curriculum for training psychiatry residents to be culturally sensitive (28). Four 90-minute training sessions were delivered in the second residency year, with CFI-related segments inserted into the second and fourth sessions. Generally, the residents appreciated the opportunity to practice the CFI questions, and the investigators found that the CFI questions acted as scaffolds for the residents to build better understanding of health disparities, biases in clinical work, and culture-related attitudes that may affect patient outcomes. These educational achievements resulted from residents practicing how to deliver the CFI questions in light of information they had previously received about disparities, bias, and other culture-related issues.

Yet other research found that 1-hour education sessions on the CFI improved resident cultural competence scores throughout six residency programs in the United States and Canada (29). Importantly, the amount of previous training in cultural competence did not influence the outcome. In another study, psychiatry residents who were given a 1-hour training session on the CFI showed significant pre- and posttest changes in overall scores on an adapted version of the Cultural Competence Assessment Tool, as reflected on the nonverbal communications and cultural knowledge subscales (30). These findings suggested that residents receiving even brief training on the CFI improve their understanding of how members of various ethnic groups differ in their use of space and physical contact as well as in health beliefs and practices and use of health services.

Another team described the use of small-group objective structured clinical examinations for teaching use of the CFI and found that this approach enhanced trainees' comfort in using the CFI, improved their knowledge of cultural syndromes, and refined their diagnostic skills by helping them differentiate between acceptable religious practices and religious behaviors associated with psychosis (31).

An important question concerns whether and how training with the CFI can contribute to broader cultural competence. Lim and colleagues (32) discussed the use of

the CFI in training medical students and psychiatry residents and in providing continuing medical education. The authors found that medical students might benefit from learning to conduct a CFI-enhanced medical interview that embeds core CFI questions into standard medical interviews. For psychiatry residents, the CFI can be used to foster the development of skills in clinical interviewing and patient-centered care. The CFI–Informant Version and supplementary modules, which could be introduced in core training sessions or in elective cultural psychiatry rotations, can provide residents with tools to elicit cultural material throughout their clinical practice. The CFI focus on individual experience in context may counteract the tendency to present cultural information in terms of stereotypes and may help students develop a systemic perspective on patients' circumstances. Ideally, the CFI and related materials should be introduced early in residency training, and trainees should be encouraged to adapt the CFI according to clinical needs in different settings throughout their training. Developing a flexible, culturally informed approach to assessment is an important component of cultural competence and person-centered medical practice. University-based training on the CFI is just the beginning. Future efforts should also address the educational needs of practicing clinicians.

ALTERNATE APPROACHES TO CULTURAL FORMULATION

The CFI was designed to provide a simple and systematic way to collect the kind of information listed in the OCF and thus to provide a basis for clinically relevant case formulation. Other approaches have been developed to assess key dimensions and domains of illness experience (33). A Dutch team piloted the Brief Cultural Interview with the aim of reducing the time required to conduct a culturally competent evaluation while incorporating the basic components of the OCF (34). The CFI may not always stand alone but may be used as one component of a broader approach to cultural formulation. Multicultural assessment (35), an approach developed specifically for clinical psychologists, includes the CFI along with other instruments and procedures.

Some researchers have called for caution and warned of the risk of stereotyping and simplifying cultural material when using the CFI (36). They proposed the use of interdisciplinary case discussions (ICDs) as a way to guard against cultural formulations that draw overly general conclusions from idiosyncratic cultural and personal data. More specifically, ICDs broadened the scope of clinical data collection, eschewed simplistic assignments of cultural identity, and brought to the discussion structural issues that may perpetuate stigma, inequity, and “othering” of immigrants and refugees. ICDs represent a check on possible misuse of the CFI by those who lack experience or training. However, conducting an ICD requires staff members with high levels of cultural and clinical experience, as well as the time to hold an intensive case discussion. The number of staff and clinical

hours needed for such an approach may not be feasible or acceptable in most practice contexts. This suggests the need for studies that test various components of a cultural formulation assessment to balance comprehensive information gathering with the aim of making cultural evaluation systematic yet practical in clinical practice.

CONCLUSIONS

Since the publication of the CFI as part of *DSM-5* in 2013, the literature on its use in training and clinical work has grown. The instrument is widely available and relatively easy to use. Most investigators report favorable evaluations of its clinical utility, feasibility, and acceptability to patients and clinicians alike. Training is straightforward, and even one hour of training conveys measurable benefits to students. The time required for its completion shrinks to about 20 minutes after one administration. However, studies on the effectiveness of the CFI to improve clinical outcomes are lacking, and this paucity of data points to an urgent research priority. To date, most studies of the CFI have been authored by a small group of researchers and academics, mostly from North America, who were involved in the *DSM-5* field trials.

Research on the CFI is needed to guide its further refinement and implementation in diverse settings. Given that the current version of the CFI needs further testing and evaluation, it may be more efficient at this time to adapt the CFI guidelines to address specific issues while retaining core elements. Areas requiring attention include translation of the CFI to other languages; cultural adaptation to non-academic settings worldwide; and best training practices for optimal clinical implementation, including its use with interpreters, culture brokers, and allied health professionals.

Growing attention to structural competency (37) raises questions about the extent to which the CFI sufficiently addresses this important aspect of culturally competent assessment and care. Structural competency refers to focusing attention not just on the local cultures of the patient and clinician but also on the social structures, institutions, inequities, dynamics of power, and exclusion experienced in the societies in which we live and work (38). This includes the historical legacies of oppression and racism that persist as part of the social fabric of everyday life as well as within professional education and clinical practice. Addressing the health needs of marginalized people is crucial for health equity. Responding to issues of structural violence and marginalization is essential to achieve health equity (39). Research should examine how best to ensure that the CFI elicits these aspects of patients' lives and experience.

Use of the CFI is an important step toward person-centered care. Future research may suggest additional refinements, but in its current form it provides a simple way to begin the process of cultural assessment, and its systematic use can foster a reflective stance and promote systemic thinking about the patient's life world, which otherwise may be hard to establish in routine clinical practice. Widespread

use of the CFI can contribute to more respectful clinical interaction and more inclusive care for all—in psychiatry and the mental health professions, as well as in general health care and social services.

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