Clinical Manual of Cultural Psychiatry

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To Francis Lu, who led the way, and Liz Kramer, who got us there.

Appendix A

A Resident's Guide to the Cultural Formulation

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Everyone brings his or her own personal and professional culture to an interaction; culture influences many aspects of psychiatric illness, including illness manifestation, coping, and help-seeking behavior. The DSM-IV-TR Outline for Cultural Formulation (American Psychiatric Association 2000b) is a critical framework for evaluation that belongs in the standard psychiatric evaluation. As noted in Chapter 1 of this volume, "Factual knowledge about cultural groups, while essential, can have limited utility without a framework to organize and to make sense of the information. Further, the clinician will encounter many patients who are affiliated with one or more cultural groups of which the clinician may have inadequate knowledge. In these instances, an organizing framework is helpful to guide the clinician to areas of potentially important inquiry."

This appendix was written by psychiatry residents for psychiatrists in training, and for others who may not be as familiar with cultural implications in mental health, in the hope that it will be helpful in the assessment and treatment of culturally diverse patients. The cultural formulation is a hypothesis-generating tool and is just one part of the overall assessment that can help the clinician sort out the patient's problems in cultural context. It is important to note that conclusions drawn at the first visit may be tentative and are subject to change as more information is obtained.

How does one apply the Outline practically to a clinical encounter? What factors does the clinician consider when thinking about how to apply the cultural formulation to a standard psychiatric evaluation? Here are some tips to consider in working with patients/clients from diverse cultural backgrounds.

- Building rapport is critical. Allow the patient to guide the process of getting to know him or her better. As a general rule, ask the least intrusive questions first.
- Explain the process of the interview and evaluation, and elicit questions and concerns along the way to help build trust. Normalize the line of questioning and respond appropriately to discomfort and doubt. Trust will be especially important when working with undocumented migrants and patients with long legacies of distrust of the medical profession.
- A critical part of the evaluation is respecting patients "where they are." Don't assume anything about patients' cultural identity; be curious and sensitive in determining their reference group, what terms they feel sensitive about or shamed by, and what types of experiences they have had with mental health professionals or others of your cultural background. Also, allow for curiosity that the patient may have about *your* cultural background.
- Clinicians should not be afraid to use interpreter/translator services, even if the clinician thinks the patients and their families understand English (or your language) well. Language is incredibly nuanced. If you do not have translators at your facility, use national translation phone services such as languagefon.com, certifiedlanguages.com, 1-800-translate.com, and languageline.com. All or most of these services will charge a fee.
- Family members should be used as interpreters only as a last resort. In addition to the issues surrounding patient confidentiality, a patient may withhold information when a family member is interpreting for a number of reasons: finding the problem too difficult or too traumatic to discuss in the presence of family members and not wanting to share it, fear of repercussions (e.g., in cases of domestic violence), or wanting to "save face." In addition, there may simply be a misunderstanding of what is reported, especially when children are used as the interpreters.
- Be very sensitive to the fact that for many people, there is great stigma attached to seeking help for mental illness. Be aware of discomfort, fear, and your reactions to what you might perceive as resistance (Lu 2005).

- It is important to get releases to speak to family, friends, community leaders, and others in your patient's life if the patient wants to have these people involved in care. Be aware that all may minimize reports of symptoms because of their fears of stigmatizing the patient and their fears of mental illness (Lu et al. 1995).
- Be aware of cultural dissonance and divergence in beliefs between the clinician, the patient, and friends and family (Henderson and Nguyen 2004). Remember, the clinician also brings his or her own cultural biases and belief systems to the interaction.
- Consider culturally and linguistically appropriate diagnostic screening questions, interviews, and schedules to help determine a differential diagnosis.
- Remember, there is not a 1:1 correspondence between culture-bound syndromes and DSM-IV-TR diagnostic criteria. Focus on symptoms that need to be addressed and collaborate on their alleviation (Guarnaccia and Rogler 1999).
- Do not overattribute or underattribute symptoms to culture. Check with others (such as family, reference group community members, and cultural consultants) to get a better sense of cultural norms.
- There may be situations in which you feel limited in your knowledge and skills in successfully performing and integrating a cultural formulation into your assessment. In such instances, consultation with an individual who is knowledgeable about the patient's culture may be helpful. One should never hesitate to use a culture broker or cultural consultant, someone who knows the culture well and can discuss it with the clinician.
- There are well-known mnemonics such as LEARN, ETHNIC, TRANSLATE, and BATHE that can help the clinician decide which questions to ask to obtain a quick, culturally appropriate evaluation regarding what aspects of the patient's presentation are cultural and what aspects are psychopathological. These mnemonics appear in Table A-1. (We have created other mnemonics to aid in an extended evaluation. These are listed throughout the appendix.)

A note: The questions presented in this appendix are only suggestions, not a formal checklist. They should not be construed as the definitive protocol for performing a cultural formulation. Additional questions may be important and relevant for any particular clinical encounter. Ultimately, the clinician

Table A–1. Useful general mnemonics for cultural formulation

LEARN	ETHNIC	TRANSLATE	BATHE
Listen with sympathy	Explanation (of symptoms)	Trust	Background
Explain your perceptions of the problem	Treatment	Roles (of interpreter)	Affect (feeling state of patient)
Acknowledge and discuss differences and similarities in explanation of illness	Healers (previous use)	Advocacy (how will this occur?)	Trouble (what situation troubles you most?)
Recommend treatment	Negotiation of treatment	Nonjudgmental attitude	Handling (how are you handling this?)
Negotiate treatment	Intervention	Setting	Empathy
	Collaboration	Language (what methods of communication will occur?)	
		Accuracy (of information collected)	
		Time (how will this be managed in the encounter?)	
		Ethical issues (such as confidentiality)	

Source. Chachkes 1999.

will tailor his or her use of the Outline according to the type and setting of the evaluation (one-time emergency department visit or ongoing therapy).

A. Cultural Identity of the Individual

Cultural identity is many-faceted (see Table 1–3 in Chapter 1). The role of the clinician is to encourage the patient to describe the cultural identity factors that are important to him or her (Lu 2005).

The way in which questions about cultural identity are asked is not trivial, but crucial; it will set the tone for the rest of the interview. For example, if the patient feels judged from the beginning of the interview, it will be very difficult to have him or her open up and cooperate during the rest of the interview.

Language

Language is an extremely important aspect of cultural identity.

- The patient's preferred language should be assessed first to facilitate communication between patient and therapist.
- Knowing how to speak a different language from that of the host country is a source of pride and acceptance for some, but it can be a source of embarrassment for others. Therefore, it is very important to assess the patient's level of comfort and to determine his or her preference regarding the language in which sessions are to be conducted.

Assessment of spoken language early in the interview is important for several reasons:

- It can give the clinician a rough approximation of level of acculturation and ensure that the diagnostic assessment is accurate. For example, psychotic symptoms may not be apparent until an assessment is done in the native language, in which the patient may be able to express the full complexity of his or her thought.
- It will also help the clinician determine whether an interpreter is needed for the session.

Questions to consider and how to ask them:

- *Primary questions:* What language(s) do you speak? Which language do you prefer? Do you know how to write or read in any language other than English?
- *Secondary questions:* What languages did you speak while growing up? Do you speak to your family in a language(s) other than English? What language(s) do you speak at work?

Chief Complaint

Having established the language of communication, the official interview should start with an assessment of the chief complaint. (Part B below discusses how to incorporate the Outline into the history of present illness.)

- *An appropriate question* would be: "What is the reason you are here today?"

Basic Information

For those patients who cannot formulate a chief complaint, you can start with three basic questions. This will allow the clinician to create rapport with the client and start the flow of the interview naturally:

- *Basics:* Where are you from? Who lives with you? How do you support yourself?

With these three questions, you can obtain information about socioeconomic status, relationships and sexual orientation, and place of origin and get a sense of severity of illness (for instance, the person might be socially isolated and living on psychiatric disability).

Questions to consider and how to ask them:

- *Place of origin:* Where were you born? If the patient's answer indicates he or she is from another country: How much contact do you have with family or friends who still live in that country? How often do you visit your country of origin?
- *Socioeconomic status:* How do you support yourself? To what extent do you have trouble affording the basics of life like housing and food? How does your current financial status affect your life? Has your lifestyle changed since you came to the United States (if the patient is an immigrant)?
- *Sexual orientation/relationship status:* Are you currently in a relationship?
  - If yes, is your partner a man or a woman? This area of inquiry may be very sensitive for persons from some cultures.
  - If the patient has *not* been involved in a relationship, you should inquire about sexual orientation gently and nondirectively.

Ethnicity and Race

The same principles that apply to language also apply to ethnicity and race, which are crucial components of an individual's cultural identity

Questions to consider and how to ask them:

- *Ethnicity:* Do you consider yourself part of any specific ethnic group? If so, which ethnic group do you identify with the most? Are you bicultural, "all American," or do you identify primarily with your culture of origin? It is important to keep in mind that identifying with a specific ethnic group does not imply that everyone is the same. For example, there are multiple subgroups included in the term *Latino* or *Hispanic*. Identification with subgroups can also have an impact on the way patients explain their illness. Inquiring about these other components will also facilitate the development of rapport because patients will feel that the clinician is interested in them as individuals and not just in their illnesses (Rohluf et al. 2001).
- *Race:* How do you identify yourself in terms of race?

Other Aspects of Cultural Identity

Some of the other aspects of cultural identity are already incorporated into a general psychiatric evaluation. Examples include age, religion/spirituality, and country of origin. However, more detailed questions will help the clinician better understand the importance that these aspects play for patients and how they identify culturally.

In particular, education and religion/spirituality are very important aspects of one's cultural identity. These aspects will also play a major role in how a patient explains the stressors and the supports in his or her life.

Questions to consider and how to ask them:

- *Age:* How old are you? Age is very important for some people but not for others. What role does age play in your life?
- *Education:* How far did you go in school? How important is education for you and for your family members?
- *Religion/spirituality:* An excellent religious/spiritual screening tool is FICA (Puchalski and Romer 2000), which asks four questions:
  F—Is religious **F**aith an important part of your day-to-day life? This question could be followed by associated questions about formal religious identity and level of spirituality.
  I—How has faith **I**nfluenced your life, past and present? This question may uncover important spiritual experiences.
  C—Are you currently part of a religious or spiritual **C**ommunity? This question helps clarify the role a spiritual community might play in treatment interventions.

A—What are the spiritual needs that you would like me to Address? This question allows the clinician to identify spiritual areas that may become part of a treatment plan.

Immigration History

It is helpful to use the mnemonic "Who, What, Where, When, Why, How" (Cultural Consultation Service, Sir Mortimer Davis–Jewish General Hospital 2000).

WHO did you leave?

—It is common for families to be separated during migration, sometimes involuntarily.

- **How to ask:** Who came with you, and who are the important people in your life who weren't able to come? Do you have plans to be reunited?

WHAT did you leave?

—It is important to find out whether your patient wanted to immigrate or not. If the patient did not want to move, he or she will have a more difficult time adjusting.

- **How to ask:** What was the economic and political situation in your country when you left?

(Through) WHERE did you leave?

—This can be a sensitive question. Sometimes the immigration journey itself can be a traumatic experience. Be particularly attuned to this if your patient is a refugee or has an undocumented status. Entering the United States without legal paperwork can be both traumatizing and expensive (people may pay a "coyote" or "snakehead," a professional people smuggler, to transport them across the border or into this country).

- **How to ask:** The clinician may want to ask first, "What was your immigration journey like?" to find out if he or she is touching on a traumatizing topic, and then, "What was your immigration route?"

WHEN did you leave?

—Refugees, in particular, may have been displaced from their country of origin for years in refugee camps.

- **How to ask:** When did you leave home, and how long was your journey to this country?

WHY did you leave?

—Did the patient immigrate for economic reasons, or is he or she the fleeing the country of origin as a refugee? Immigrants who have no possibility of returning to their country of origin are more likely to find the process of acculturation more stressful, and hence to be more symptomatic. Immigrants who can frequently visit their home country or who are not planning to stay permanently in the United States are not faced with the full task of abruptly adjusting to a new culture and may have a less stressful experience (Tseng 2001).

- **How to ask:** Why did you leave your country? Was it your choice? Do you have a possibility of returning home?

HOW [legally] did you leave (immigration status)?

—This can be a sensitive question, especially if your patient has an undocumented status. It also can be a tremendous source of fear and point of vulnerability. People who do not have legal status may be afraid of deportation and afraid of accessing services, which greatly impedes their acculturation.

- **How to ask:** Is your legal status a source of stress for you? I know that many people are afraid to get the services they need because they do not have a documented legal status. This places them in a stressful situation that affects their health. This is why I ask. It is helpful for me to understand the obstacles you are facing.

Cultural Identity and Level of Acculturation

Cultural identity can be a source of distress or of support for an individual. For example, for some people, having to identify with a specific group can be a source of distress because this sets them apart from the majority, while others have a great fear of becoming acculturated with the majority. Further, people may have intrapsychic conflicts about their cultural identity. It is important to properly assess the level of acculturation of a patient.

Inquiring about cultural identity and level of acculturation will aid in establishing the proper diagnosis; the diagnosis may otherwise be influenced by erroneous assumptions and lead to the establishment of a treatment plan that is not well thought out.

Questions to consider and how to ask them:

- How do you feel about your culture of origin? How involved are you with your culture of origin? Which community organizations are you involved with and what role do you play in them? Do you belong to any group where there are people from your culture of origin (e.g., a religious organization or leisure setting) or groups with people mostly from the United States? Do you have any friends from your culture of origin or a culture other than yours? How do you relate to these people? How do you socialize with members of your extended family?
- How do you view the way you are treated by people from other cultures? What type of discrimination have you experienced? Have you ever experienced racism? Have any of these experiences transformed your life in any way?

B. Cultural Explanations of the Individual's Illness

Remember the mnemonic SPESial TEsT. (Symptoms, Precipitators and Explanation, Severity, Treatment history, Experiences with help-seeking, what patient Thinks about course of illness and treatment options). Most of the information in this section can be incorporated into the standard history of present illness or review of systems.

SPESial TEsT

Symptoms? What are your worst symptoms or most distressing experiences? (Elicit idioms of distress and culture-bound syndromes; see Table A–2 for examples of the latter.)

- **How to ask:** What kinds of things are you experiencing? How has this affected your life? What are your worst symptoms? What do you call these?
  — *Point to note:* Some of these experiences are self-limited and may not require treatment.

Precipitators and Explanation for symptoms and distress? Course of illness, symptoms, or distressing experiences?

- **How to ask:** How do you explain what is happening? When did it start, and what started it? How do your friends, family, and community, or those who know you best and/or are most like you (reference group such as specific ethnic or cultural affiliation, race, religious affiliation, sex, age, or acculturative stage) explain what is happening?
  — *Points to note:*
  · These explanations can include religious beliefs, magical explanations, exhaustion, perceived discrimination, disabilities, character weakness and moral judgment, and biological explanations.
  · Explanations can also include beliefs related to specific subcultures, witchcraft/voodoo, spirits/demons, family legacy, migration histories, humoral explanations, and others.

It will be important to remember how the patient self-identifies and with which cultural group(s) he or she identifies. For example, level of acculturation may be very important, because a second-generation Chinese American male might have more Western belief influences in his or her explanations than a recent immigrant.

Severity? What are the level of dysfunction and the meaning of the symptoms and distressing experiences in reference to the host culture or culture of origin?

- **How to ask:** What does it mean that you are experiencing these symptoms? How serious are these symptoms for you, and does that have any meaning? Do you worry about what your symptoms might mean (Kleinman et al. 1978)?
  — *Points to note:*
  · The clinician should inquire about level of function, as is done in a typical psychiatric evaluation, because this will help guide the treatment decisions.
  · The clinician will be able to derive an implicit sense of how these symptoms interface with the culture of origin and the host culture, but one can ask additional questions to elicit how these symptoms are perceived in the host culture, such as: Are these symptoms affecting your work? Has your boss [if the boss is of the host or majority culture] made any comments or complaints?

The following questions can be asked as part of the past psychiatric history or past medical history portion of the assessment.

Treatment history? This is a question of actual treatments that have been tried in the past.

- **How to ask:** What kinds of treatments have you received up until now? How would someone from your [reference group such as friends, family, geographic location, and religion] be treated, or what advice have you gotten on how to deal with the symptoms?
  — *Point to note:* Treatments can come in any form, such as prayer, decreasing stress by stress-reduction exercises, having family and friends leave the person alone, or using doctors, faith healers, shamans, alternative and traditional medicines, homeopathy, Ayurveda, cupping/coining, diet, meditation, or supplements.

Experiences with help-seeking? This is a question of the patient's emotional and overall experience with trying to get help for his or her problems. These experiences will greatly influence how the patient will perceive future (and current) help-seeking attempts and treatment options.

- **How to ask:** What kinds of experience have you had with previous types of treatment? What types of experiences have others that you know had (for example, did anyone in your family or friends see a psychiatrist)? What has helped the most? In your culture, is there shame associated with seeking psychiatric help? Who experiences the shame?
  — *Point to note:* EVERYONE has some emotional response to help-seeking attempts. Additional questions can include, What did it feel like for you when you previously sought help? How would you have wanted it to be different? People will refer to the experiences of their family and friends as well as to their own experiences, so it is important to ask about both.

What do you ***Think*** the course of your presentation is, and what type of ***Treatment*** would you like now? What do you fear most about your symptoms?

- **How to ask:** What do you think will happen now? What do you fear or worry about most regarding your symptoms and your treatment? What do you think will be most helpful at this point? (Choices can include discussing past and present experiences, receiving advice, exercise, medications, alternative treatments, psychoeducation, etc.)
  — *Points to note:*
  · It is important to remember that many treatment options can coexist at the same time. Thought must be given to what makes the most sense and what is the most helpful for the patient.
  · The relationship between the patient and clinician is important to consider: it will be important to elicit expectations about you and your role in treatment, such as authoritarian figure or cooperative figure.
  · Remember to be aware of the differences between the clinician and the patient regarding illness beliefs and treatment beliefs. It will be important to recognize when the clinician's specific beliefs are influencing patient care.
  · It is important to remember that many people regard mental illness as greatly stigmatized. Stress that seeking help does not mean that they are "crazy" (Lewis-Fernandez et al. 2000).

Culture-Bound Syndromes and Idioms of Distress

Some specific culture-bound syndromes are listed in Table A–2. Many of these syndromes and idioms exist across and within cultural distinctions, and some cross-utilization of terms is indicated here. See Appendix C for definitions of these terms.

C. Cultural Factors Related to Psychosocial Environment and Levels of Functioning

When assessing the psychosocial environment, direct your inquiry in widening social circles. Begin with the individual, then move out to the partner, the family (including extended family), and the community. It is particularly important to move beyond the nuclear family for patients from communal cultures. With each social sphere, assess for supports as well as stressors.

Stressors and Supports

When considering this section, it is useful to begin thinking about the types of stressors that are commonly included in Axis IV, the Psychosocial and Environmental Problems axis in the standard DSM-IV-TR multiaxial diagnostic

Table A–2. Culture-bound syndromes

Cultural groups (by locale)	Syndrome
Asian	
China	Qi-gong psychotic reaction
	Shenjing shuairuo ("neurasthenia")
	Shenkui
Japan	Taijin kyofusho
	Shinkeishitsu
Korea	Hwa-byung
	Shin-byung
India	Dhat (similar to sukra prameha in Sri Lanka and shenkuei in China)
Malaysia	Amok (similar experiences found in Laos, Papua New Guinea, the Philippines, Polynesia, and Puerto Rico, and among the Navajo)
	Koro (similar phenomenon found in parts of South Asia and East Asia)
	Latah (also found in other parts of Asia)
Latin American	
General	Locura (also found among Latinos in the United States)
	Susto (also found among Latino groups in the United States, Mexico, Central America, and South America)
	Nervios (also found among Latinos in the United States)
	Cólera (bilis, muina)
Puerto Rico	Ataque de nervios (also found in Latin and Mediterranean areas)
	Empacho (also found in Cuba)
Nicaragua	Gris siknis (noted in the Miskito group)

Table A–2. Culture-bound syndromes *(continued)*

Cultural groups (by locale)	Syndrome
Industrialized countries	
General	Anorexia nervosa and other eating disorders (found particularly in North America)
	Dissociative identity disorder
Germany	Involutional paraphrenia (also found in Spain)
United States	Spells (found in the southern United States)
Mediterranean cultures	Mal de ojo (also found in some Latin countries)
African and Caribbean	
General (Caribbean)	Falling out or blacking out (also found in the southern United States)
	Rootwork (also found in the southern United States in both African American and European American populations)
Haiti	Boufée delirante (also found in West Africa and France)
	Fright illness, among Native West Indians (also found in Africa and Brazil)
Trinidad	Tabanka
North Africa	Zar (also found in the Middle East)
West Africa	Brain fag
Sub-Saharan Africa	Amafufanyane (sleep paralysis), found among Zulu in southern Africa)
Native American	
General	Ghost sickness
Mohave	Hi-wa itck
Algonquian	Wihtigo (windigo)
Eskimo (Arctic and Subarctic)	Pibloktoq
Inuit	Uqamairineq

Note. See Appendix C for definitions of the syndromes except where otherwise noted.
Source. American Psychiatric Association 2000b; Henderson and Nguyen 2004; Kaplan and Sadock 1998.

system (American Psychiatric Association 2000a). These would typically include stressors such as interpersonal, familial, economic, occupational, educational, and legal difficulties. To be able to assess how distressed an individual might be by the stressors that he or she faces, it is also important to examine his or her psychological context. The patient's context can either mitigate or exacerbate the impact of stressors (Harvey 1996). Aspects of context that may exacerbate problems include difficulties with acculturation and discrimination. Difficulty with systems (educational, health care, legal) as well as discord with representatives from these systems (teachers, counselors, social workers, physicians, lawyers) can be exacerbating factors. The context may also be one of poor resources and insufficient buffering, as when there is a sparse network of social supports or a lack of community resources.

Strength and support may come from several culturally related sources:

- **Individual**-based culturally related strengths and supports include pride in one's culture, religious faith or spirituality, artistic abilities, bilingual and multilingual skills, group-specific social skills, sense of humor, culturally related knowledge and practical skills, culture-specific social skills, culture-specific beliefs that help one cope, respectful attitude toward the natural environment, commitment to helping one's own group, and wisdom based on experience.

- **Family/community**-based culturally related strengths and supports include 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 the history of the group, and involvement in political or social action groups.

- **Environment**-based culturally related strengths and supports include an altar in one's home or room to honor deceased family members and ancestors, a space for prayer and meditation, foods related to cultural preferences (cooking and eating), pets, a gardening area, and access to outdoors for subsistence or recreation (Hayes 2001).

Assessing Psychosocial Environment and Functioning

The following is a basic schema for assessing psychosocial environment and functioning. The schema can be further elaborated based on the particular circumstances of your patient.

Stressors and supports: The basic questions are: What are the major sources of support in your life? What are the major stressors in your life?

Partner support

- **How to ask:** Is your partner a source of support for you?

Partner stressors (domestic violence)

- **How to ask:** Does your partner make you feel bad about yourself? Have you been hit, kicked, punched, or otherwise physically hurt by someone in the past year? If so, by whom? (Questions are from Feldhaus et al. 1997.)
  — *Points to note:* When exploring the relationship with the partner, it is important to screen for domestic violence, because one out of eight cohabiting relationships are violent (American Medical Association Council of Scientific Affairs 1992). Because many women do not self-identify as abused, it is better to describe the specific behaviors that would constitute abuse. The above questions concerning physical abuse will detect 64% to 71% of abuse, including abuse by previous partners or other family members.

Family support

- **How to ask:** Which family members are major sources of support for you? Are there family members you are close to who are still in your home country?

Family stressors

- **How to ask:** What are some of the family problems that affect you? What are some of the family conflicts you've been having since moving to the United States?
  — *Point to note:* Particularly in immigrant families, each family member may be at a different level of acculturation, with correspondingly different values, expectations, and behaviors; this can be a significant source of stress for the family.

Community support

- **How to ask:** Is it important to you to find a community that fits with your cultural background (Barrett 2005)? If so, have you been able to find it? Is it a major source of support? Does it meet your needs?
  — *Point to note:* The clinician may also have developed a sense of whether or not the patient is part of a cultural community from the acculturation assessment earlier.

Community stressors

- **How to ask:**
  · Have you and your family felt accepted in this country? Why or why not?
  · How respected are your values and traditions by mainstream society (Barrett 2005)? Do you feel that you are discriminated against in the community or at work?
  · Are you having other problems at work or in the community?
  — *Point to note:* The above questions are purposely broad enough to include racial as well as religious, gender-based, and sexual identity–based discrimination. The patient's awareness of racism is tied to the level of racial identity development and may be related to the level of acculturation. Also, the ability to cope with the stress of discrimination is improved if the patient has found a community that is supportive of his or her cultural identity.

Religion/spirituality: Screen for whether religion is important in your patient's life (see Section A above). If screening reveals that religion is important to the patient, perform the remainder of the spiritual assessment (Kehoe 1997; Richards and Bergin 1997). A helpful mnemonic for conducting the following assessment is **A HOLY** (are you **A**ctive in religion now, has religion **H**urt you, could it help you **O**vercome your problems, could a spiritual **L**eader be helpful, what were your beliefs when **Y**oung).

- Are you **A**ctively involved in your religion, currently?
  — *Point to note:* Understanding how and why the patient is involved in his or her religion will help the clinician distinguish if their patient has an *intrinsic orientation* (internalized and lived beliefs regardless of consequences), which is associated with improved mental health, or an *extrinsic orientation* (using religion as a means of obtaining status, security, self-justification or sociability), which is associated with increased anxiety and difficulties with social and emotional adjustment.
- Do you believe that religious or spiritual influences have **H**urt you or contributed to your problem?
  — *Points to note:*
  · Incongruence between spiritual values and lifestyle can be a source of guilt and anxiety.
  · Patients may believe that their problems have a spiritual source. Although they may not feel comfortable divulging this to the clinician, a representative of the Western scientific model, one may be able to get a sense of their beliefs and practices by speaking to the family.
- Are there religious or spiritual resources that could help you **O**vercome your problem?
  — *Point to note:* Patients may have a *self-directing*, a *deferring*, or a *collaborative problem-solving* relationship with God or with their faith. This pattern may affect how they interact with the person who is treating them.
- Would it be helpful if we consulted a religious **L**eader or a traditional healer?
  — *Points to note:*
  · Religious patients who have lost a sense of a *positive spiritual identity* and no longer feel that they have a divine worth or potential may benefit from interventions such as counsel from a spiritual leader to help them reconnect with their spiritual identity and worth.
  · At times, religion can have a negative impact because patients may have a misunderstanding of the doctrines of their religion (i.e., may not have critically examined understandings they developed as children).
- What were your religious beliefs when you were **Y**oung?
  — *Point to note:* Often the patient's core spiritual belief system was formed during childhood.

Functioning: It can be difficult to assess functioning when the clinician does not know the norm for functioning in the patient's culture. The following questions can be helpful because they harness the community's values and norms to judge functioning. It can also be helpful to consult with a cultural broker such as the interpreter.

- **How to ask:** Each community has certain images of a successful person. Would your community judge you to be successful or unsuccessful (Berg-Cross and Chinen 1995)? Before you came to this country, would your community have judged you to be successful or unsuccessful?

D. Cultural Elements of the Relationship Between the Individual and the Clinician

Taking the time to examine the interactions between the cultural identities of the clinician and the patient is essential for the conduct of the clinical interview. The following are some suggestions for gathering this information.

1. **Consider your own cultural background.**

- Self-reflection, awareness, and understanding of one's own personal and professional identity development is essential for maintaining objectivity with the patient.
- Be aware of their own biases and limitations of knowledge and skills that might affect the clinical encounter.

2. **Consider the patient's cultural identity** compared with the clinician's, and compare similarities and differences.

3. **Move from a categorical approach** to an understanding of the patient's self-construal of identity. Factor in the context of the clinical encounter, assessment, and treatment that might arise from similarities and differences.

4. **Maintain ongoing assessment** of the cultural elements of the relationship.

- Factors to consider include rapport and respect, dealing with stigma and shame, empathy, verbal and nonverbal communication, and involvement with significant others and community organizations. What is the history of the relationships between the patient's culture of origin and the clinician's (e.g., colonization, sociopolitical conflict, local history and conflict, racism)? What is the relationship of the patient's culture of origin and the host/adopted country? Are there any value conflicts between the clinician and the patient?

5. **Be aware of transference and countertransference issues,** which may be interethnic (when patient and client are from different ethnic backgrounds) and intraethnic (when therapist and client share the same ethnicity).

- Common interethnic transference themes include patients distrusting the authority figure (whether it be therapist or institution), being overcompliant or friendly to please the authority figure, denial of cultural factors, and ambivalence. Interethnic countertransference may include the "clinical anthropologist" syndrome of pursuing cultural differences that are not necessarily clinically relevant. Therapists may have feelings of guilt or pity toward clients of differing ethnicities, resulting in a more timid approach when interviewing the patient.
- Examples of intraethnic transference: The patient may overidentify with the therapist, which may result in idealizing the therapist. Conversely, minority patients, for instance, may assume that an "ethnic" therapist is less competent than the therapist from the dominant culture. Patients who have different levels of acculturation from their therapists may also feel the therapist has "sold out" to the dominant culture. Examples of intraethnic countertransference include overidentification, guilt arising from the therapist's sociocultural and economic circumstances, anger because of increased demands from the patient, and defensive distancing due to feeling too close to the patient (Comas-Diaz and Jacobsen 1991).

6. **Consider the need for cultural consultation.** Do you have any specific knowledge about the patient's culture or ethnic group? If not, you may need to ask a person familiar with the patient's culture, known as a cultural broker or cultural consultant.

—*Tip:* The U.S. Department of State Web site (http://www.state.gov) has "Country Background Notes" for independent states and regions of special sovereignty. These notes include information on the history, politics, religion, and minority populations, and are useful for a quick review before you see a patient from another country or culture.

7. **Consider the patient's motivation for seeking treatment.** Is the patient coming to see the clinician of his or her own accord? Is the patient being forced to see the clinician by family? A school? A community? The law? What does the clinician expect the patient's attitude will be when they meet? The assessment

of attitudes toward medical personnel may be most helpful in a psychotherapy assessment. Working with a cultural consultant can be beneficial in this regard.

Questions to consider and how to ask them:

- What are your expectations of your doctors? How is mental illness viewed in your country of origin? Is there stigma against mentally ill people? How are they treated (institutionalized, ignored, supported by the community)? How are psychiatrists portrayed in the media in your country? Do you think those portrayals are accurate? In your country, have psychiatrists ever been used to persecute people? Have psychiatrists ever taken part in human rights abuses? Do you have fears about your treatment? Can you talk about them?
- Do you feel that you can speak freely with doctors? Are you comfortable telling them when you don't agree with something they say? If not, would you be able to express these feelings to an intermediary, such as a translator or social worker?
- When medical staff advises something or prescribe medicines, do you feel that you must take the advice or use the medicines? Have you ever told a doctor you would do something you didn't want to, simply because you didn't want to openly disagree with him or her? Do you feel free to ask questions about alternatives to medications?
- Before you came here, did you have any expectations about what your psychiatrist would be like (young, old, male, female)? How do I fit or not fit with those expectations? How do you think these differences will affect our work together?
- Do you have a preference for male or female psychiatrist/therapist? If so, why [possible choices to offer: trust, shame, greater likelihood that they will understand, easier to express yourself....]?
- Do you have a preference for a psychiatrist/therapist with a cultural background that is similar to yours, or of a different background, or don't you think this matters? Why [see choices above]?
- Would you like sessions to be conducted in your own language? Would it help you feel that you were being understood properly?
- Do you ever have difficulty understanding what your therapist is saying?
- Do you feel comfortable with your therapist?

E. Overall Cultural Assessment for Diagnosis and Care

Part E of the cultural formulation entails integrating the previous four sections to inform a culturally competent differential diagnosis and a culturally congruent treatment plan. Therefore we must have an adequate description of the patient's cultural identity, his or her cultural explanations of the illness, his or her stressors and supports, and the relationship between the clinician and the patient. Factors such as the role of family members and ethnic community, cultural, and religious institutions should be integrated into the formulation. The experiences of immigration, acculturation, and discrimination may be relevant. Understanding the patient's expectations regarding outcome of treatment is often helpful in negotiating a treatment plan.

1. **Make the differential diagnosis:** What is psychopathological and what is cultural? Does the clinician feel comfortable with his or her knowledge of the normative practices and values of the patient's culture?

Many psychiatric disorder, such as conduct, adjustment, anxiety, mood, somatoform, dissociative, personality, and dysthymic disorders are most likely to present differently across cultures (Kleinman 1988), whereas psychotic, bipolar, and substance abuse disorders vary less across cultures (Johnson 1988). For instance, some cultures believe that hearing the voice of a lost loved one is a natural rite of the mourning process. Be aware that a delusion, by definition, must be incongruent with culturally held values.

During this part of the cultural formulation, using a cultural consultant is critical (Lu et al. 1995). The clinician is advised to read the narrative introductions to each section of DSM-IV-TR, specifically the paragraphs on age, gender, and cultural features, and see if any of them apply to the patient. Also, consider Other Conditions That May be a Focus of Clinical Attention as a source of other, more appropriate diagnoses, such as an acculturation problem, a religious or spiritual problem, or an identity problem.

2. **Formulate a narrative of the patient's case incorporating the cultural factors.** When putting together the patient's story, bring in his or her cultural perspective, explanatory model, and mental health concept. The clinical narrative should reflect the patient's worldview, model of causality and illness,

and expectations. The degree to which historical, political, and environmental factors affecting the patient are understood by the clinician may reflect the degree to which the clinician can empathize with the patient.

3. Consider how the cultural formulation will affect management. The type of treatment recommended for the patient should be congruent with the patient's cultural experience. A large percentage of patients are nonadherent to their medications. Possible explanations for nonadherence may include a nonbiologically based explanatory model for symptoms, mistrust of medical institutions and authorities, fear of side effects, and resistance to addressing interpsychic conflicts.

Psychotherapeutic approaches should also be selected to fit the patient's needs. People who come from collectivist cultures may not be as amenable to individual psychotherapy and may be more receptive to family therapy and to involvement of individuals outside their immediate family. Conversely, people who come from societies that value individualism and autonomy may benefit more from more expressive psychodynamic psychotherapy.

Culture affects our choice of medications as well (Gaw 2001). We may choose a medication that has a combination of effects to avoid giving patients "too many" pills. The physician also has to prepare the patient for side effects and for the duration of therapy. Many patients believe that the medications work immediately and that they are very powerful. Therefore they will take only half the prescribed dose. Checking drug levels and having the patient bring in his or her pill bottles are useful strategies. Finally, the adage of "start low, go slow" warns clinicians that patients may inherit different forms of the CYP450 enzymes that metabolize medications, resulting in medication side effects or nonrespose.

Culture also affects the patient's social system, which often includes extended family and religious groups and their leaders. Part of the treatment plan should involve the family and religious groups if relevant. Appropriate interventions include family meetings, gathering collateral history, and asking patients to seek support from their church. Not involving all parts of the patient's social system can derail the treatment plan by giving the patient mixed messages about his or her treatment. For instance, an individual who plays a central role in the patient's decisionmaking process may discourage the patient from adhering to the treatment. Addressing the concerns of all parties involved may increase the likelihood of adherence.

To ensure that the clinician has provided comprehensive and culturally competent care, he or she may consider the useful mnemonic **LEARN**: Listen with sympathy, Explain your perceptions of the problem, Acknowledge and discuss differences and similarities in explanation of illness, Recommend treatment, and Negotiate treatment. The first guideline is good for developing the therapeutic alliance, and the other four pertain to Part E of the Outline for Cultural Formulation. We have to tell the patient that we understand his or her situation, note the cultural differences, and then act as a bridge between the differing belief systems to negotiate an acceptable treatment plan. Only then can we be satisfied that we have used the Outline to its fullest advantage. Of course, the formulation will evolve over time as we see the patient more often, but it offers a helpful framework for beginning to understand patients from culturally diverse backgrounds that might differ from that of the clinician.

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