Clinical Manual of Cultural Psychiatry

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

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The Assessment of Culturally Diverse Individuals

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The United States is becoming increasingly diverse. Although non-Hispanic whites represent 69% of the population, minority groups are rapidly growing. Figure 1–1 illustrates the percentage growth of various ethnic/racial groups over the past several decades.

Ethnic minorities have grown at rates far greater than those of non-Hispanic whites over the past 20 years. Currently, there are more than 35 mil-

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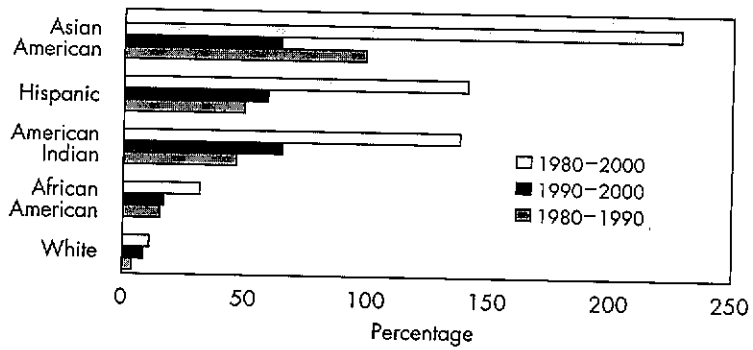

Figure 1–1. U.S. population growth by race, 1980–2000.

Source. U.S. Census Bureau 2000.

lion Hispanics and nearly the same number of African Americans. Asian Americans number about 10 million, and the Native American community is nearly 2 million in size. By the middle of the twenty-first century, it is estimated that the U.S. population will be 72.1% non-Hispanic white, 24.4% Hispanic (nonexclusive category, meaning that one can claim to be Hispanic *and* some other designation), 14.6% African American, 8% Asian, and 5.3% other ethnic groups (U.S. Census Bureau 2004). Ethnic variations reflect only a fraction of the diversity in our society, however. Tremendous diversity exists also in gender, sexual preference, age, occupational, and religious and spiritual affiliations. In addition, technological advances in communication and transportation have enabled the development of a global community comprising multitudes of languages, customs, and beliefs.

Our society will undoubtedly continue to be enriched by the ideas, perspectives, and contributions of the many groups of which it is composed. Mental health providers, however, face the particularly challenging task of providing culturally competent care to an increasingly diverse community. In 2001, the Office of the Surgeon General released a detailed supplement to its report on mental health entitled *Mental Health: Culture, Race, and Ethnicity* (U. S. Department of Health and Human Services 2001) about the growing crisis of inadequate mental health services for the country's ethnic minorities.

The report identifies several disparities in mental health care of racial and ethnic minorities compared with whites: 1) minorities have less access to, and availability of, mental health services; 2) they are less likely to receive needed mental health services; 3) those who are in treatment often receive poorer-quality mental health care; and 4) minorities are underrepresented as subjects in mental health research. However, the report also states that the recognition of these disparities brings hope that they can be addressed and remedied.

The purpose of this handbook is to help clinicians take steps to address these important issues. This chapter, specifically, will highlight the principles of cultural psychiatry used in the assessment and treatment of psychiatric conditions.

Historical Perspective

Work on cultural psychiatry dates back to more than 100 years ago, when unusual clinical syndromes seen in non-Western countries were examined using Western universalistic interpretations of the findings (Group for the Advancement of Psychiatry Committee on Cultural Psychiatry 2002). This ethnocentric approach tended to limit the focus of cultural inquiry to exotic or isolated locations and cultural groups, and thus it did little to incorporate cultural evaluation into mainstream psychiatry. By the latter half of the twentieth century, modern psychiatry came under criticism by sociologists and cultural anthropologists, who were concerned with the cultural relativity of mental disorders, believing that mental illness is socially defined (Kleinman 1988). This belief was in direct opposition to the perspective of scientific universalism held within mainstream psychiatry.

Psychiatry's initial response was to reaffirm its scientific foundations and to view culture as a set of confounding variables that distorted the ways in which the real psychiatric disorders manifested (Fabrega 2001). However, interest in investigating the interplay between psychiatric disorders and sociocultural factors continued to develop, culminating in the universal acceptance of Engel's biopsychosocial approach in the 1980s (Group for the Advancement of Psychiatry Committee on Cultural Psychiatry 2002). Subsequently there have been significant advances in our understanding of the impact of culture on psychopharmacology, psychotherapy, the application of treatment to ethnic minorities, and the development of mental health services. An example of this change can be seen in DSM-IV-TR, with its Outline for Cul-

Table 1–1. Essential components of culture

- Culture is learned.
- Culture refers to a system of meanings.
- Culture acts as a shaping template.
- Culture is taught and reproduced.
- Culture exists in a constant state of change.
- Culture includes patterns of both subjective and objective components of human behavior.

Source. Adapted from Gaw 2001.

tural Formulation and Glossary of Culture-bound Syndromes (American Psychiatric Association 2000). Consideration of cultural factors in the evaluation of patients with mental illness will result in improved access to care, an increased understanding of patients' illness experiences, more accurate diagnosis, and, ultimately, better treatment.

Critical Concepts

Culture has been defined in many different ways, an indication that even the most comprehensive definitions cannot encompass all of its attributed meanings. In this section we attempt to define culture in terms that are usable and relevant to the mental health clinician. Culture can be defined as a set of meanings, norms, beliefs, and values shared by a group of people. It is dynamic and evolves over time and with each generation (Matsumoto 1996). Gaw (2001) describes six essential components of culture (Table 1–1). Culture is learned, and therefore it can be taught and reproduced. The term *culture* refers to a system of meanings in which words, behaviors, events, and symbols have attached meanings that are agreed upon by the members within the cultural group. Hence, culture shapes how individuals make sense of the social and natural world. Culture also encompasses a body of learned behaviors and perspectives that serves as a template to shape and orient future behaviors and perspectives from generation to generation and as novel situations emerge. Finally, culture includes both the subjective components of human behavior (the shared ideas and meanings that exist within the minds of individuals within a group) and the objective components (the observable behaviors and interactions of these individuals).

Culture shapes what symptoms are expressed and how they are expressed (Mezzich et al. 2000; Rogler 1993). It influences the meaning that one attributes to symptoms. Culture also influences what a society regards as appropriate or inappropriate behavior. In other words, it influences the conceptualization and rationale of psychiatric diagnostic categories and groupings. In addition, culture provides the matrix for the clinician-patient exchange. It can operate as a pathogenic and pathoplastic agent (Alarcon et al. 1999). The association of war with posttraumatic stress disorder is one example of how historical events can cause or contribute to psychopathology (Du and Lu 1997; Kirmayer 2001). Likewise, culture exerts a protective influence on mental health. There is some evidence, for example, that the extended family systems in non-Western cultures mitigate the effects of schizophrenia (Kulhara and Chakrabarti 2001). Traditional healing approaches and spiritual/religious interventions can also provide meaningful benefits to patients (Kinzie 2000; Lee 1997a; Lukoff et al. 1995; Muskin 2000).

The terms *culture, ethnicity,* and *race* are often used interchangeably, but it is important to highlight the distinctions among the three concepts. Like culture, ethnicity and race have been defined in many ways. *Ethnicity* can be used to refer to an individual's sense of belonging to a group of people who have a common set of beliefs and customs (culture) and who share a common history and origin. It may imply nationality, geographic location, and religious beliefs. Examples of ethnicity include Vietnamese American, Russian Jewish, and Ethiopian. *Race* is often used to refer to a group of people who share biological similarities (Lu et al. 1995). Application of this concept has often meant grouping people according to physical appearance, such as skin color, with little attention to actual biological or genetic determinants. However, there is much disagreement about what the biological similarities attributed to a particular race are. In much of the history of the United States, the use of race has had the effect of furthering racial prejudices and inequalities. In psychiatry, race is a powerful influencing factor in the clinician-patient dyad. African Americans, for example, have often been misdiagnosed with schizophrenia (Adebimpe 1981), likely because of differences in interactional styles and values rather than any specific biological predisposition to psychosis (U.S. Department of Health and Human Services 2001). It is important to note, however, that although biological definitions of ethnicity and race may be problematic and difficult to validate, the concepts as they are

described here do not exclude biological similarities between members of an ethnic group. Each individual's culture may encompass a sense of ethnicity and perhaps race, but there are many other affiliations, such as occupation, age, gender, sexual orientation, spirituality, and religion, that contribute to his or her overall cultural identity.

The Outline for Cultural Formulation

The publication of DSM-IV (American Psychiatric Association 1994) and its text revision in 2000, DSM-IV-TR, represented a turning point in the application of cultural psychiatry principles by introducing the Outline for Cultural Formulation. This tool gives clinicians a framework for assessing the impact of culture on psychiatric illness.

Because culture plays such a crucial role in all aspects of mental health and illness, it is important to incorporate cultural assessment as part of intervention. The astute clinician strives to gain knowledge about the cultural groups to which his or her patients belong. The complexity of the interplay between culture and illness can make this process potentially overwhelming. 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.

Historical Background

In 1990, the DSM-IV Task Force, chaired by Juan Mezzich, M.D., convened for the planning of DSM-IV. For the first time, serious consideration was given to incorporating cultural factors into diagnosis and evaluation of mental disorders (Mezzich et al. 2001). The Task Force formed the Culture and Diagnosis Work Group, composed of many of the leading clinical and scholarly experts on culture in the mental health disciplines, to address culture in DSM-IV. The Outline for Cultural Formulation was one of the Work Group's later contributions. It is based on an extensive review of the literature that identified five major areas in which culture had major influences on mental health and illness (Table 1–2). This finding was further substantiated by

Table 1–2. DSM-IV-TR Outline for Cultural Formulation

A. Cultural identity of the individual
B. Cultural explanations of the individual's illness
C. Cultural factors related to psychosocial environment and levels of functioning
D. Cultural elements of the relationship between the individual and the clinician
E. Overall cultural assessment for diagnosis and care

Note. In this volume, the sections of the Outline have been lettered for ease of reference.
Source. American Psychiatric Association 2000.

field trials (Mezzich et al. 2001). Although a significant portion of the Work Group's recommendations was omitted in the final text, the Outline for Cultural Formulation was included in Appendix I to DSM-IV, along with a glossary of culture-bound syndromes. These guidelines quickly became regarded as a crucial innovation in cultural psychiatry.

In the following section, we discuss the five major areas of the DSM-IV-TR Outline for Cultural Formulation with reference to a case example. We first present the patient's history, followed by a discussion of each of these five major areas. Drawn from an actual cultural evaluation, this case is meant to illustrate the practical application of the cultural formulation in clinical practice.

> X.W. is a 30-year-old Mandarin/English-speaking woman from Hong Kong who was hospitalized after jumping off a multistory building. She had immigrated to the United States 6 months earlier with her husband to work at an industrial company. She had left her 7-year-old daughter in Hong Kong because she felt that she was unable to care for her while she worked. Ms. W. reports that since the move, she had felt depressed because of isolation and work stress. She also felt unhappy about her relationship with her husband, who remained distant despite numerous overtures on her part to become more intimate. Her husband reports that their relationship was "good" but that she was overly dependent on him. Ms. W. found work very competitive, which she attributed to downsizing and to discrimination against non-U.S. citizens. One month prior to her hospitalization, she had become increasingly worried about the safety of her daughter, although she recognized that the worries were unfounded. Several days before her hospitalization, Ms. W. lost her job. Her husband encouraged her to return to Hong Kong for a break and visit with family. During a layover to Hong Kong, she encountered ticketing difficulties. She reportedly became overwhelmed and jumped off a multistory building. She later reported that this was due to the shame and stress of losing her job. X.W. was interviewed with a Mandarin-speaking interpreter.

Table 1–3. Aspects of cultural identity

- Ethnicity
- Race
- Country of origin
- Language
- Gender
- Age
- Marital status
- Sexual orientation
- Religious/spiritual beliefs
- Socioeconomic status
- Education
- Other identified groups
- Migration history
- Level of acculturation
- Degree of affiliation with above

Source. Adapted from Lu et al. 1995.

A. Cultural Identity of the Individual

Cultural identity can be understood as a multifaceted core set of identities that contributes to how an individual understands his or her environment. Ethnic identity is often a crucial facet of an individual's overall cultural identity, but many other facets may contribute to it as well. The greater the amount of detail a clinician is able to ascertain about the individual's cultural identity, the better understanding he or she will have of the individual's perspectives on health, illness, and the mental health system. Moreover, the clinician will more readily anticipate issues of cultural and identity conflict that may arise during the course of evaluation and treatment. Table 1–3 highlights the most common aspects of cultural identity.

Another important aspect of cultural and ethnic identity is the objective versus the subjective dimension of identity definition. In this respect, it is important to note the distinction between the terms *identity* and *identification;* the latter term refers to a subjective identification with a reference group, the former to a more solidly internalized individual core identity (Phinney 1995). Another relevant conceptual distinction, often obscured, is that between *culture* and *ethnicity.* These terms tend to be used interchangeably without much definitional clarity. *Ethnicity* typically refers to one's roots, ancestry, and heritage, whereas the concept of *culture* captures more active elements, such as values, understandings, behaviors, and practices. Based on this conceptual distinction, it would seem appropriate to claim a Latino *ethnic* identity based solely on Hispanic roots and heritage, but claiming a Latino *cultural* identity would necessitate participation in, for example, values and behaviors that have been shaped by Latino culture. In contrast to non-Western cultures, U.S. mainstream society is heavily influenced by Euro-American Protestant culture, which places a high value on independence, autonomy, and self-sufficiency, perhaps best reflected in the pioneer image of self-reliance and "rugged individualism" (Hsu 1983).

In considering cultural and ethnic identity it is important to remember that these identities emerge in particular social contexts and, as such, are fluid, multiple, and changing. Rather than viewing them as fixed traits of individuals or groups, it is best to regard them as "contextualized identities." New identities that did not formerly exist for a person may develop in response to migration. For example, a Latino immigrant may adopt a new "ethnic minority" identity after residing in the U.S. for several years, despite perhaps never having previously encountered that term in his or her country of origin. An immigrant woman from the Dominican Republic may have been familiar with the terms "Hispana" or "Latina" before migrating to the U.S. yet may come to experience these cultural descriptors as more relevant self-identifiers in the new sociocultural milieu. Similarly, old labels may lose salience, so that Mexican *chilangos* (natives of Mexico City) may gradually become more strongly identified as Mexican or Latino the longer they reside in the United States, only to find themselves readopting those previous identity labels upon traveling back to Mexico. In a sense, one may think of identities as having varying degrees of latency or manifest activation according to different situational and contextual factors. Of course, this process of contextual activation of identities is not unique to Latino cultures.

Ideally, the clinician should encourage the patients themselves to describe the aspects of identity that are important to them. In reviewing these aspects, the clinician should also note the degree of affiliation or involvement, negative or positive, that the patient has with each aspect, as this may highlight areas that strongly influence clinical care. The number of foreign-born residents in the United States is estimated to be over 30 million (U.S. Census

Table 1–4. Migration history

Pre-migration history
- Country of origin, family, education, socioeconomic status, community and family support, political issues, war, trauma

Experience of migration
- Migrant vs. refugee: Why did they leave? Who was left behind? Who paid for their trip?
- Means of escape, trauma

Degree of loss
- Loss of immediate family members, relatives, and friends
- Material losses: business, careers, properties
- Loss of cultural milieu, community, religious, and spiritual support

Traumatic experience
- Physical: torture, rape, starvation, imprisonment
- Psychological: rage, depression, guilt, grief, posttraumatic stress disorder

Work and financial history
- Original line of work, current occupation, socioeconomic status

Support systems
- Community support, religion, family

Medical history
- Beliefs in herbal medicine, somatic complaints

Family's concept of illness
- What do family members think the problem is? Its cause? What do they do for help?
- What result is expected?

Level of acculturation
- First or second generation

Impact on development
- Level of adjustment, assess developmental tasks

Source. Adapted from Lee 1990.

Bureau 2000). Therefore, it is important to ask ethnic minority patients where they were born. Ascertaining a migration history is often crucial (Lee 1990) (see Table 1–4). Elements of the migration history that should be obtained include reason for migration, time spent in transit, and losses and trauma associated with migration, as well as traumatic events before and after migration.

Table 1–5. Cultural identity: advantages of assessment

- Identifies potential areas of strengths and supports that may enhance treatment planning or vulnerabilities that may impede treatment success.
- Identifies areas of cultural conflict that may need to be addressed. These conflicts can be between the various aspects of identity (e.g., parent vs. worker), or between traditional and mainstream expectations for a particular aspect (e.g., traditional parenting role vs. mainstream parenting role).
- Clinician becomes more informed about the patient's perspective on his or her illness and treatment by trying to understand who the patient is.
- Assists in building rapport because clinician is attempting to understand the individual as a "whole person" rather than an ill person.

The latter factors are particularly important to assess in refugee groups such as Southeast Asians and Eastern Europeans, whose migration history is often in the context of violence and war. Care must also be taken to explore the patient's level of acculturation. This includes the patient's prior experience with racism, and the degree to which he or she uses mainstream sociocultural resources (mainstream supermarkets, social networks, etc.). The evaluation of cultural identity helps to clarify a number of clinical issues. Table 1–5 lists some of the advantages of assessing cultural identity.

The prevailing view of acculturation encourages examination of the process on several levels (Escobar and Vega 2000). Is the process one in which the individual is actively or passively involved? Does the push for acculturation come from external sources or from within the individual? Is it a solitary endeavor, or do others participate with the individual? Is the process constant or intermittent? Is it subtle, dramatic, or somewhere in between? What are the individual's attitudes about acculturation in general, and specifically about an episode of acculturation? What vision does the individual hold about where the new mix of cultural elements will take him or her? A useful way of describing one's relationship to one's acquired culture (as opposed to one's inherited culture) was described by Berry (1997). The individuals who do not adopt the host country customs are described as "separated," while those who fully accept them are known as "assimilated." Individuals who successfully incorporate both acquired and inherited cultures are "integrated" or "bicultural," and those who reject both are "marginalized" or "deculturalized."

The following discussion of the case example illustrates how inquiry into cultural identity can enhance clinician understanding of the patient's problems:

When asked what she wanted most, Ms. W. responded, "All I want is to be with my daughter and husband, and to have a good job." Note that she clearly struggles between conflicting roles. Her identity as a working woman is clearly important to her. This may originate partly from China's post–Cultural Revolution expectations that women contribute equally with men economically. It also coincides with the values of more industrialized societies like Hong Kong. However, this priority conflicts with Ms. W.'s identity as a mother and a wife, which are roles that are traditionally considered important to women in Chinese culture. The patient has difficulty integrating these different identities. She seems unable to assume these roles simultaneously at important times, as shown when she immigrated to the U.S. to work but left her child behind. Although her extended family's role helps to lessen the conflict, X.W. nonetheless becomes anxious and depressed about it. This conflict will be further addressed in the section on treatment planning.

B. Cultural Explanations of the Individual's Illness

Patients' and providers' explanations of the illness represent an important part of clinical care. An explanatory model can have a number of components. It is an attempt to understand how and why one becomes ill. In addition, explanatory models define the culturally acceptable symptoms of the illness. These "idioms of distress" are strongly influenced by cultural values. In many Asian cultures, emotional symptoms of depression (such as depressed mood) are not as well accepted as somatic symptoms (such as poor energy and insomnia). The cultural explanations of illness also help define the behavior or role the sick individual is expected to assume. Finally, explanatory models contain elements of prognosis, which include ideas of the treatment options in addition to the general course of the illness.

Some patients' explanatory models are ill defined, whereas others are quite fixed. Many patients entertain multiple explanatory models for a particular illness as well. For example, many patients will seek spiritual/religious assistance or alternative treatments, such as acupuncture or herbal medicine, in addition to medical treatment for their condition.

Providers' explanatory models also have a varying degree of heterogeneity for any given illness. It is essential that the clinician elicit the patient's understanding of the cause of the illness while also explaining his or her own perspectives of illness to the patient. The following paragraphs illustrate the use of clinical methods and knowledge of the patient's cultural explanations of the illness to improve rapport with the patient.

Table 1–6. Consequences of conflicting explanatory models

Type of conflict	Consequences
Patient–provider	Diminished rapport, treatment nonadherence, treatment dropout
Patient–family	Lack of support, shame, family discord
Patient–community	Social isolation, stigmatization

Westermeyer (1989) discusses the usefulness of demonstrating interest, clarifying the patient's explanatory models, facilitating the patient's story, and ensuring that the patient understands the interviewer's questions by having him or her restate the question. Rapport with the patient is created by assessing the symptoms that the patient is most comfortable expressing. In many cases, these are the somatic symptoms; treating these idioms of distress with respect and appropriate concern often facilitates rapport with the patient and lays the groundwork necessary to address more difficult, yet clinically relevant issues. Patients who present with somatic complaints, for example, should be evaluated as if they were presenting for medical evaluation, with an exploration of precipitating, ameliorating, and aggravating factors. Next, the clinician should carefully review their complaints (review of symptoms), looking for the somatic symptoms of depression and anxiety such as sleep or appetite disturbances, decrease in energy level, weight change, tachycardia, shortness of breath, and tremors. As the patient is engaged, other, more sensitive topics can be broached, such as the psychological symptoms of irritability, fears, thoughts of a gloomy future, crying spells, nightmares, and then personal or family problems, as well as a history of trauma. Other psychological symptoms that also need to be assessed directly include problems with concentration and memory, hallucinations, feelings of mistrust, intrusive thoughts, and suicidal or homicidal ideas (Cheung 1987).

Successful treatment also requires the formation of a collaborative model that is acceptable to both provider and patient. This includes arriving at an agreed-upon set of symptoms to treat, treatment expectations, and general course of illness. It may also be helpful to involve members of the patient's primary support group as well. Difficulties arise when there are conflicts between explanatory models. Table 1–6 illustrates some potential consequences of these conflicts.

Although a full discussion of the types of explanatory models is beyond the scope of this chapter (see Ton 1996), a number of the more common

types, including moral, spiritual, religious, magical, medical, and psychosocial stress, are described below. Clinicians should keep in mind that these are general descriptions. A patient's particular model may incorporate elements of one or more of these common types. Some patients have poorly defined explanatory models, whereas others may have very detailed explanations. Moreover, patients may use more than one explanatory model, and the different models may operate independently or even in conflict with each other. Efforts should therefore be taken to clarify the patient's models through cultural assessment.

The *moral model* asserts that the patient's condition is caused by a moral defect such as laziness, selfishness, or weak will. Family members can be seen operating with this model, although patients themselves may use this as well. Typical statements include "you just have to work harder and get over this," or "I was able to overcome this on my own, so why can't you?" Patients working under this model typically attempt to change their character flaws.

The *spiritual/religious model* maintains that illness is caused by spiritual or religious transgressions. As a result, the patient is punished by angered spirits or the patient's higher power(s). Typical interventions include atonement, ritual appeasement of the angered spirits, or efforts to more closely follow prescribed spiritual/religious practices. Often, a spiritual leader is enlisted to treat the affliction.

The *magical explanatory model* suggests that sorcery or witchcraft causes illness. Magic-based treatments vary from culture to culture and may include finding the person who has caused the illness or involving a sorcerer or shaman to counteract the spell.

Patients who attribute a biological etiology to the illness learn to use a *medical model.* This is not limited to traditional Western allopathic medicine, which is only one type of medical model. Others include traditional Chinese medicine, ayurvedic medicine, homeopathy, osteopathy, and various herbal medicine traditions. In a national survey, Eisenberg and colleagues (1993) estimated that one of every three Americans used non-Western allopathic medicine remedies. Given the growing number of patients who are using alternative medical therapies and the drug interactions that can result, it is important for the clinician to adequately assess for usage.

Individuals who use the *psychosocial stress* model may maintain that illness is caused by overwhelming psychosocial stressors. Treatment includes addressing the psychosocial stressors.

The case of X.W. illustrates how an evaluation of a patient's explanatory model can provide significant insights into the clinical situation.

> On further evaluation, X.W.'s clinicians found that emotional and psychological expressions of distress were not as much supported as were physical expressions within Ms. W.'s family system. The patient felt distressed and saddened about her marriage. She also stated that her husband did not take her seriously and that he responded to her concerns with promises on which he did not follow through. This is in contrast to how the patient's husband has behaved since she sustained her multiple physical injuries. He goes to great lengths to make sure she is comfortable. He feeds her and protects her from intrusions from doctors and potential interviewers. He is, in essence, sacrificing time at work to be with her—something that she had tried to get him to do but was unable to prior to her injuries. However, the patient and her husband did not acknowledge the significance of her social isolation and psychological distress in prompting her jump. Later, with psychoeducation, Ms. W.'s husband expressed interest in psychological follow-up for her depressive and anxious symptoms and asked how he could become better involved. The patient and husband developed greater comfort with the *psychosocial explanatory model.* X.W.'s jump indicated the seriousness of her distress and, along with her physical injuries, sent a clear message to her husband of the need for psychological intervention.

A discussion of cultural explanations of illness is incomplete without attention to culture-bound syndromes. These can be understood as a cluster of symptoms and behaviors that are considered by a cultural group to be an illness, and that typically afflict only members of the given cultural group. Some examples of culture-bound syndromes are *amok, ataques de nervios, taijin kyofusho,* and *brain fag* (American Psychiatric Association 2000). A further discussion of various culture-bound syndromes, as they apply to the four major racial/ethnic groups, will be addressed in the chapters that follow.

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

The assessment of sociocultural stressors and supports is an essential part of any evaluation. In the case of a cultural formulation, attention needs to be given to the political history and current political situation between the patient's cultural group(s) and the mainstream culture. This factor includes history of racial/ethnic discrimination and relations between the individual's

country of origin and the host country in the case of immigrants and refugees. In addition, patients may identify sources of support commonly used by his or her cultural group in Western cultures, such as extended families, surrogate family networks (e.g., gangs), and religious organizations. Individuals may also experience stressors that are specific to their cultural group, such as conflicts caused by familial role reversals in immigrant families. The patient's symptoms may vary with environment, indicating varying levels of sociocultural distress. Hence, his or her level of functioning and disability should be assessed across various relevant settings, including home, extended family, community of origin, and mainstream community.

> X.W. has experienced a number of recent stressors. As a result of her immigration to the United States, she has few family supports. This stressor is further exacerbated by the lack of intimacy and support that she feels from her husband. She is further distressed about the discrimination she feels in her workplace, which has further frustrated her efforts to become productive and exacerbated feelings of isolation. Since she sustained the injuries, her stressors are compounded by her inability to work; she remains away from her daughter and must now cope with disabilities. However, her husband has become quite involved and now serves as a significant source of support.

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

The provider's cultural identity and the culture of mental health treatment can have a significant impact on a patient's care. The Surgeon General (U.S. Department of Health and Human Services 2001) states that "the culture of the clinician and the larger health care system govern the societal response to a patient with mental illness. They influence many aspects of the delivery of care, including diagnosis, treatments, and the organization and reimbursement of services" (p. 8). In this section, we discuss 1) key issues that arise from cultural conflicts between the provider and patient; 2) pitfalls of using the traditional psychiatric mental status exam; and 3) guidelines for appropriate use of interpreters and cultural informants to mitigate potential cultural conflicts and misunderstandings between providers and their patients.

Conflicting explanatory models can result in poor adherence, poor rapport, and early termination from treatment. Cultural conflicts between provider and patient can cause more difficulties to arise in treatment. Clinicians

Table 1–7. Cultural influences on transference and countertransference

	Interethnic effects	Intraethnic effects
Transference	Overcompliance Denial of ethnocultural factors Mistrust Hostility Ambivalence	Omniscient-omnipotent therapist The traitor Autoracism Ambivalence
Countertransference	Denial of ethnocultural factors Clinical anthropologist syndrome Guilt or pity Aggression Ambivalence	Overidentification Distancing Cultural myopia Ambivalence Anger Survivor's guilt

Source. Adapted from Comas-Diaz and Jacobsen 1991.

who have clarity about their own cultural identity and their own role in mental health treatment are in a better position to anticipate these cultural dynamics and subsequently diminish the negative outcomes and enhance the positive outcomes of the clinical exchange. Part of this process involves maintaining an awareness of the clinician's own biases, attitudes, and stereotypes. It also is important to consider the cultural influences on transference and countertransference in the clinical exchange (Table 1–7). Comas-Diaz and Jacobsen (1991) discuss these potential influences.

Interethnic transference involves the patient's response to an ethnoculturally different clinician. *Overcompliance,* for example, may occur when there is a sociocultural power differential between patient and clinician, resulting in superficial agreement on treatment in the clinical setting but nonadherence to treatment at home. *Denial of culture and ethnicity* is shown when the patient avoids discussing issues related to ethnicity and culture with the culturally different clinician, making cultural assessment more difficult. *Mistrust and hostility* may also occur in the context of the sociopolitical history between the patient's and clinician's respective cultural groups. Unacknowledged cultural differences may exacerbate the suspicion. *Ambivalence* describes the patient's struggle with negative feelings about the culturally dif-

ferent clinician while he or she is also developing attachment to the clinician. Likewise, ethnoculturally different clinicians may respond in a nontherapeutic manner, what Comas-Diaz and Jacobsen refer to as *interethnic* countertransference. Examples of this include a *denial* of ethnocultural differences in which the clinician maintains that the clinical encounter is not influenced by the cultural and social factors. Conversely, the *clinical anthropologist syndrome* occurs when the therapeutic process is derailed by an inordinate devotion to inquiring about the patient's cultural background to the exclusion of other interventions. The clinician may also have unresolved *guilt* about his or her cultural or social privilege in society, or pity the patient's position in society. This may manifest in either *pity* or *aggression* toward the patient.

Although ethnocultural matching between patient and clinician can have significant therapeutic benefits (Takeuchi et al. 1995), there is also potential for destructive transference and countertransference. Comas-Diaz and Jacobsen describe the potential negative transferences associated with this dyad. One such involves the *omniscient-omnipotent therapist* phenomenon, in which the patient overidealizes the clinician because of their shared cultural background. Alternatively, the patient may perceive the clinician as a traitor because he or she has sold out to their shared culture. *Autoracism* can occur in transference as well, manifesting as the patient's belief that he or she is getting inferior treatment because the clinician is of the same ethnic group. The patient may also have ambivalent feelings about the therapist, at once appreciating the shared cultural background and being apprehensive about too much psychological closeness.

The clinician must also be aware of his or her negative countertransferences when treating patients from a similar ethnocultural background. Without this awareness, the clinician risks *overidentifying* with the patient by choosing an activist approach when other approaches would be more beneficial. The clinician may also become judgmental of the patient. "If I've been able to overcome these cultural barriers, my patient should do the same." This "us versus them" mentality is an extreme form of overidentification. In contrast, *distancing* can occur when the clinician has fears of overidentifying with the patient. *Cultural myopia* occurs when the clinician frames the therapy in cultural terms to the exclusion of other clinical perspectives. Further, the patient's experiences, shared from an ethnocultural perspective, may bring up painful memories for the clinician, which may result in *anger* or *guilt* toward the patient. Finally, the clinician's own

experience with unresolved cultural conflicts may emerge as *ambivalence* when addressing similar experiences of the patient.

The case of X.W. illustrates some of the potential cultural conflicts that can arise between patients and clinicians from differing backgrounds, as well as the therapeutic potential of further cultural inquiry.

> X.W.'s treating clinicians were troubled by her husband's seemingly paternalistic attitude. On further inquiry, this was found to be consistent with the traditional role of the husband in Chinese culture as the protector of and spokesman for his family. As the treatment team became more accepting of the husband's traditional role, he became more interested in understanding more about the patient's emotional state and in learning about possible follow-up. This process was facilitated by one of the clinicians, who was Chinese American and Mandarin-speaking.

The Mental Status Examination and Psychological Assessment

The cognitive and descriptive aspects of the mental status examination were developed in Western European, British, and American settings to describe the various cognitive, linguistic, perceptual, and affective domains of brain function. The result is that the exam is culturally biased. Accordingly, mental status measures must be elicited, described, and integrated in ways sensitive to the patient's cultural identity and milieu. Patients' responses are shaped by their culture of origin, educational level, and level of acculturation. For example, asking patients to state today's date checks for the patient's level of orientation. The patient may use a different calendar, such as the lunar calendar, and may not feel that dates are important information to recall. Some cultures do not use clocks, and seasons vary around the world, depending on latitude (Westermeyer 1993). For some societies with strong oral history traditions, the patient's date of birth is irrelevant information. The interpretation of tests of abstraction, commonly tested by proverb interpretation, is difficult to assess because the meaning and wording of proverbs varies widely among different societies and language groups. Using serial 7s to assess patients from illiterate cultures may be meaningless if their education has been limited to arithmetic with single digits. Differences in educational background may further limit the general usefulness of questions that assess fund of information. It is often an incorrect assumption that most people know much geography (Escobar et al. 1986). The patient's ability to name objects or remember items

in short-term memory tests is affected by his or her familiarity with the items chosen. Similarly, three-step commands should be adapted to be very simple (Hughes 1993). Escobar and others (1986) concluded that the Mini-Mental State Examination (MMSE) was influenced by age, educational level, ethnicity, and the language of the interview and recommended that it be revised to remove educational, social, and cultural artifacts if it is to be used in a Hispanic population.

Marsella and Kameoka (1989) observed that many of the tests and self-assessment questionnaires used in research have been developed on Western subjects and are not appropriate for use among ethnic minority patients because they lack cultural equivalence. Merely translating the items was stated to be insufficient and to result in linguistic inequivalence, because meanings and connotations changed and idioms of expression differed between languages. Rating scales for symptoms can be used if the scales are translated, back-translated, and validated (Marin and Marin 1991). Excellent examples of culturally appropriate tests include the Hopkins Symptom Checklist-25 translated into Vietnamese, Laotian, and Cambodian (Mollica et al. 1987) and the Harvard Trauma Questionnaire translated into the same three languages (Mollica et al. 1992). Finally, the interpretation of the results can be affected by using improper norms. Often, translated tests are not standardized for the testing group and must be properly normed on a representative patient group for meaningful results. Other sources of error have included biased analysis, inaccurate assumptions and translation, and inappropriate instruments (Rogler 1989). The use of translated editions of existing rating scales must be viewed with extreme caution unless these concerns are addressed.

Language Barrier and Use of Interpreters

Effective communication is essential for a successful therapeutic interaction. In a mental health setting, communication has both verbal and nonverbal components and is highly influenced by cultural nuances. For patients with English as a second language, mental health encounters are even more difficult than standard medical interviews, since communicating emotional and social distress essential to a psychiatric interview requires more than Basic English proficiency. Hence, interpretation is critical for providing adequate care to patients who are monolingual or have only Basic English proficiency. The *therapeutic triad* incorporates the interpreter as an essential team member (Lee 1997b).

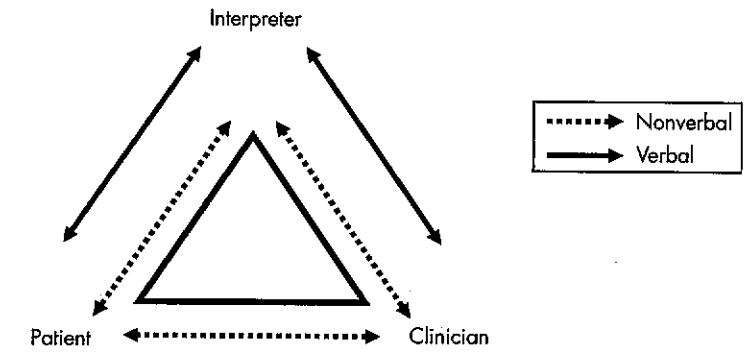

Figure 1–2. The therapeutic triad model.

Source. Adapted from Lee 1997.

Figure 1–2 illustrates the importance of the positioning of individuals in the clinical triad. Each individual should have a clear view of the others in order to effectively communicate and receive *nonverbal* communication. The interpreter provides the critical verbal communication link between clinician and patients, in addition to helping to contextualize nonverbal communication when appropriate (see section below on cultural informants).

Interpreters should be trained in a set of competencies (Table 1–8) that clearly extend beyond simply speaking the patient's language. There are significant problems in using an untrained interpreter, such as a family member, a stranger in the vicinity, or an untrained staff member, because they likely lack the necessary technical vocabulary or dual fluency. Problems may arise with confidentiality as well. Accuracy may also be affected if the ad hoc translator avoids communicating potentially embarrassing information. This can be particularly problematic when using family members, such as young children or spouses.

In addition to including an appropriately trained and matched interpreter, the clinician should be aware of the three phases of the interpreted interview: preinterview, interview, and postinterview (Lee 1997b). Prior to the clinical interview, the clinician should take time to prepare the interpreter by discussing issues such as the objectives of the interview, topics to be covered, the patient's background and current difficulties, interpreter's cultural knowl-

Table 1–8. Competency criteria for interpreters

Technical
- Good command of spoken and written English and language of the patient, including dialectical nuances
- Ability to translate fine shades of meaning and nonverbal communication
- Familiarity with psychiatric terminology and procedures

Cultural
- Intimate knowledge of his or her ethnic community, including illness models, social/power structures, cultural values
- Familiarity with culture of mainstream society and mental health service
- Ability to act as a cultural broker

Interpersonal
- Ability to get along with peers/staff and deal with conflicts arising from unrealistic expectations from clinician or patient
- Understanding of own communication style and awareness of personal values, attitudes, and bias
- Ability to assess areas of incompatibility with clinician or patient and react accordingly

Ethical
- Ability to maintain a code of ethics that includes confidentiality, impartiality, and professional conduct

Other
- Ability to effectively advocate for patient
- Fine attention to detail and good memory
- Flexibility in handling diverse situations

Source. Adapted from Lee 1997b.

edge about these issues, and the desired length of the interview. This preinterview phase allows for rapport building in addition to helping the participants use the interview time more effectively. During the actual interview, as noted above, it may be helpful for the clinician, interpreter, and patient to sit in a triangular formation so that each can have face-to-face contact with the others. The clinician-interpreter team can use a number of translating formats depending on the situation (Lee 1997b).

Verbatim translation involves minimal participation by the translator and can be useful when attempting to translate factual or technical information.

This can be done softly while the patient is speaking (which saves time but increases the chance of miscommunication) or after the patient speaks (which can potentially double the interview time).

Summary interpretations emphasize the main points that the patient is attempting to communicate. This method can save time, but it increases the margin of error. This method is particularly helpful when the patient requires a length of uninterrupted time to speak, as during an emotionally charged topic.

Cultural interpretation involves conveying the patient's statements as well as his or her cultural contexts so as to more accurately reflect the patient's experience. After the interview is finished (during the postinterview phase), the clinician and the interpreter should review the interview to clarify potential areas of confusion. Clinician and interpreter should also discuss their experience of working with each other in order to help build rapport and lay groundwork for future sessions utilizing the interpreter. After the interview, or during key moments in the interview, the interpreter may be able to act as a *cultural informant* to help the clinician gain a better sense of the norms and values of the patient's ethnic or cultural group.

Pitfalls in the Use of Interpreters

The common practice of relying on young members of the family, who are more likely to be proficient in English, as interpreters for the older members tends to create confusing roles and responsibilities within the family system's dynamics. Obviously, in situations in which an interpreter is not available on staff, the disadvantages of using a family member may be outweighed by the benefits of ensuring effective communication.

Another common practice in clinical settings is using bilingual staff members who are not professional interpreters and who are temporarily used in this role as needed because of their bilingual skills. This practice also presents several limitations, such as the inability to check for accuracy of translation, as well as ethical concerns about using employees to provide services for which they are not being adequately compensated.

There are numerous challenges even in the use of professional interpreters. Particularly relevant to mental health, concerns about confidentiality may inhibit some of the personal information that a patient may provide with a third party present. It is not uncommon, especially in some neighborhood

health clinics, that patients and interpreters are members of the same community, which may present serious confidentiality issues. Further, despite the assumed neutrality of the interpreter, he or she creates a triad that challenges some of the basic elements and assumptions of the more conventional therapeutic dyad. For example, differences and similarities between the interpreter and the patient in terms of nationality and socioeconomic, educational, or geographic (urban versus rural) background may create particular interpersonal dynamics that become part of the clinical encounter. Such dynamics need to be adequately identified and analyzed because they may influence the information provided by the patient, as well as his or her behavior.

Cultural Informants

Cultural informants, also referred to as cultural brokers or cultural consultants, are not limited to interpreters. They can be members of a cultural group with various other roles, including religious or community leaders, primary care or mental health providers, or peers. Their function is to provide information and clarification about attitudes and perspectives of the patient's cultural group(s). Their expertise is derived from their level of participation within the cultural group. Cultural informants may not necessarily have specific knowledge of or training in mental health. Hence, clinical questions about the broker's assessment of the patient's mental illness may be inappropriate. However, inquiries about the cultural group's general attitudes toward mental illness, explanatory models, and treatment pathways can be invaluable in helping the clinician understand and contextualize the cultural information that is obtained during an evaluation.

E. Overall Cultural Assessment for Diagnosis and Care

The overall assessment should highlight the key issues illustrated in the previous sections of the cultural formulation. Treatment planning should provide options that address these key issues without further exacerbating cultural conflicts or creating new ones. The treatment plan may involve culturally specific treatment pathways (such as traditional healers or religious interventions); appropriate application of ethnopharmacological principles, as discussed in Chapter 6; the use of cultural consultants; and the use of culturally appropriate services. Often, interventions that are focused on a family or social level can be very helpful for patients as well. The formulation of overall

assessment and treatment plans is illustrated below with reference to the case example.

> X.W. struggles with balancing three important roles in her life: worker, mother, and wife. She demonstrates an all-or-nothing strategy to cope with this struggle, which ultimately proves to be maladaptive for her, leading to further social isolation and distancing from her daughter. After her injuries, Ms. W. is under significant stress because she is now unable to work and remains far from her daughter. She will likely continue to experience alienation from the mainstream society. To some degree, she remains "a stranger in a strange land." Because of this, she is at significant risk for worsening depression. However, her husband has become more available to her with her physical injuries, and presently he is her most important source of support. A cultural assessment reveals several areas in which interventions will likely be helpful:
>
> 1. Although Ms. W. reports feeling disappointed in her relationship with her husband, she would benefit from the treatment team's efforts to bolster what is currently working in their relationship rather than to destabilize the relationship in this time of crisis. Such efforts will involve validating and encouraging the husband's role in her care as a protector and a caregiver. It is important for both the patient and the husband to have a positive and validating experience with the mental health system. If the husband feels alienated or "to blame" for the patient's injuries and distress, he may disengage from the treatment, resulting in destabilization of the family system and ultimately in a failure to follow through with mental health services. At a later point, when the family system is more stable and the patient has other sources of support, they would benefit from marital therapy.
> 2. The patient might benefit from exploring how she defines being a mother, a wife, and a worker, since she is presently experiencing role conflict. Eventually she might be encouraged to redefine her expectations of herself to facilitate a more balanced integration, hence mitigating the cultural conflicts arising from these different identities.
> 3. The patient should be reunited with her family. They will become an even more important source of validation now that she will be unable to work for some time. Consideration should be given to helping facilitate her return to Hong Kong. The patient has experienced significant migration stress in her transition to the United States and will likely continue to experience this stress if she remains here.

Conclusion

Culture has an influence at every level of the mental health system. Its effects mediate access, service delivery, evaluation, treatment, and follow-up. Moreover, mental illness affects an individual's role in his or her cultural system. In the best-case scenario, the cultural system can respond with a bolstering of sociocultural supports, but too often, the individual risks becoming stigmatized by his or her community. By understanding the individual's culture, the clinician will gain insight into the complex interplay between culture and mental illness, which will ultimately improve his or her ability to care for the individual. Although the ongoing pursuit of learning about the major cultural groups to which one's patients belong is important, that knowledge is often incomplete. The DSM-IV-TR Outline for Cultural Formulation discussed in this chapter provides a framework that helps guide and organize the clinician's exploration of an individual's multifaceted culture. The case example of X.W. illustrates the practical application of the Outline for Cultural Formulation, and the sections on working with interpreters and cultural informants are intended to help clinicians make optimal use of the available resources. These tools and guidelines, when used with an attitude of openness to learn from the patient and his or her community, will significantly improve the clinician's ability to assess and treat the increasingly heterogeneous and multicultural patient community.

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