

# Bringing Culture into the Clinical Encounter: DSM-IV-TR Outline for Cultural Formulation

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# Agenda

- Definitions
- Rationales
  - Reduce disparities in mental health and health care
  - Provide culturally competent care
    - APA Practice Guideline for the Psychiatric Evaluation of Adults, 2<sup>nd</sup> ed.
- Cultural issues in DSM-IV-TR (2000)
- DSM-IV-TR Outline for Cultural Formulation



# Cultural and Linguistic Competence

- A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enable them to work effectively in cross-cultural situations.
  - (T. Cross, et al, 1989)
  - [www.omhrc.gov/clas](http://www.omhrc.gov/clas)



# Culture

- Refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups.
  - (T. Cross, et al, 1989)



# Competence

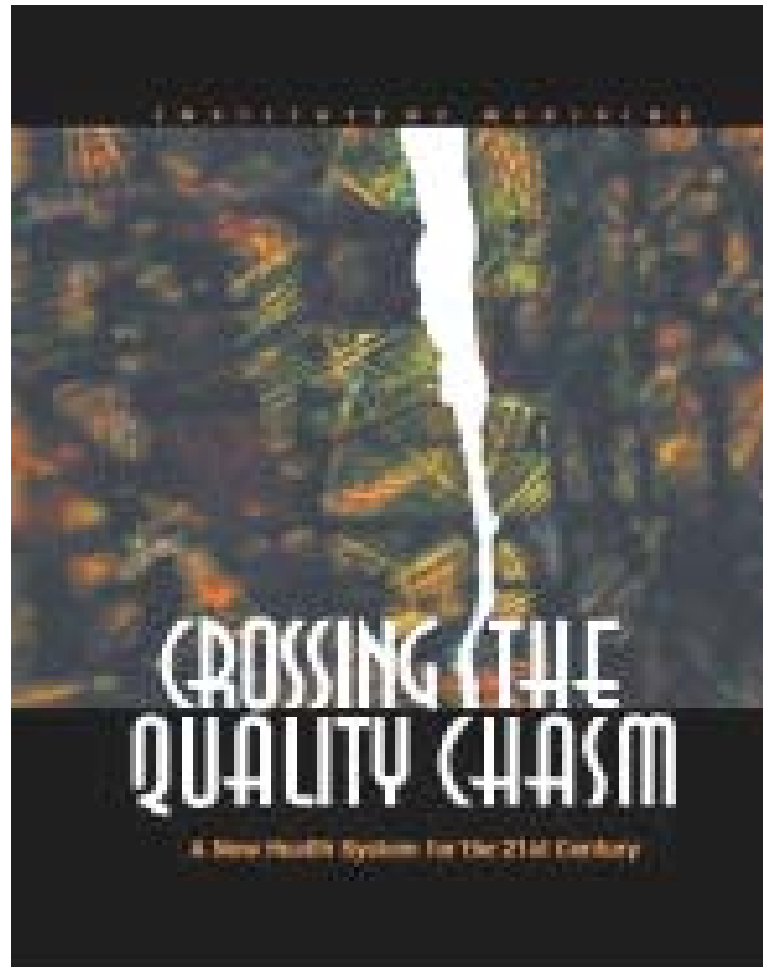
- Implies the capacity to function effectively as an individual and as an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.
  - (T. Cross, et al, 1989)



# Disparities and Cultural Competence in Mental Health

- Disparities in mental health care for ethnic minorities and other underserved populations exist and should be eliminated.
- Cultural and linguistic competence will reduce disparities.
  - Systems—at the organization level
  - Clinical—at the individual provider level
- Workforce recruitment and training will reduce disparities.

Institute of Medicine, 2001  
([www.iom.edu](http://www.iom.edu))





## 6 Quality outcomes as goals

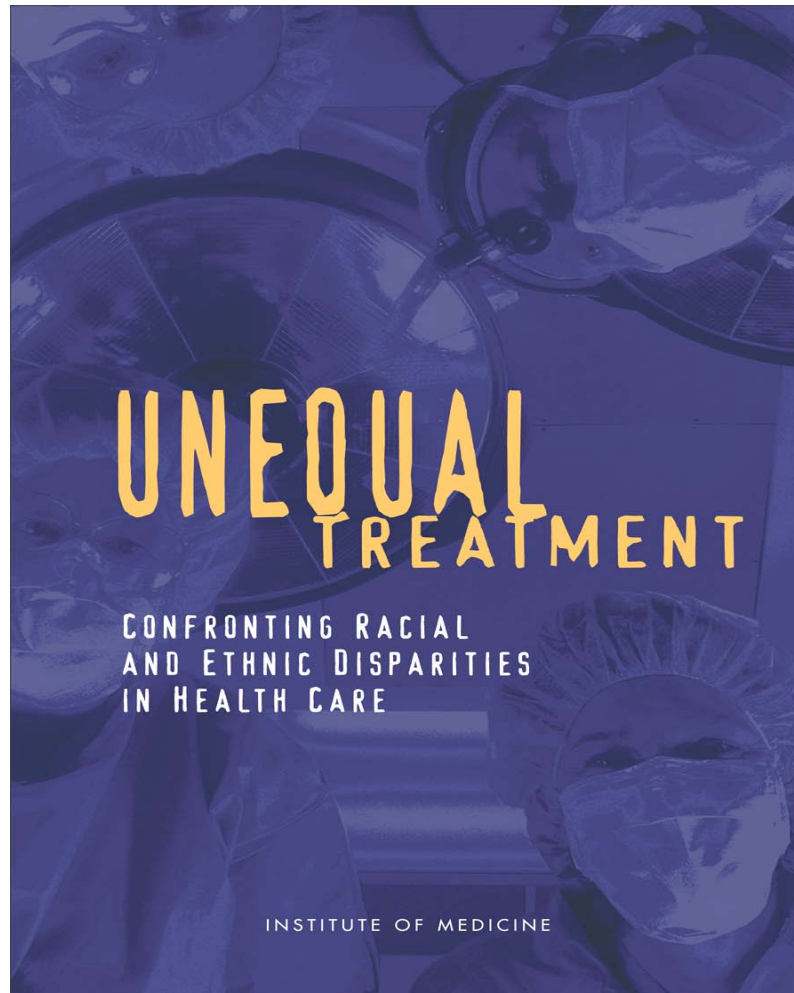
- *Safe*: avoiding injuries to patients from the care that is intended to help them.
- *Effective*: providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit.
- ***Patient-centered***: providing care that is respectful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



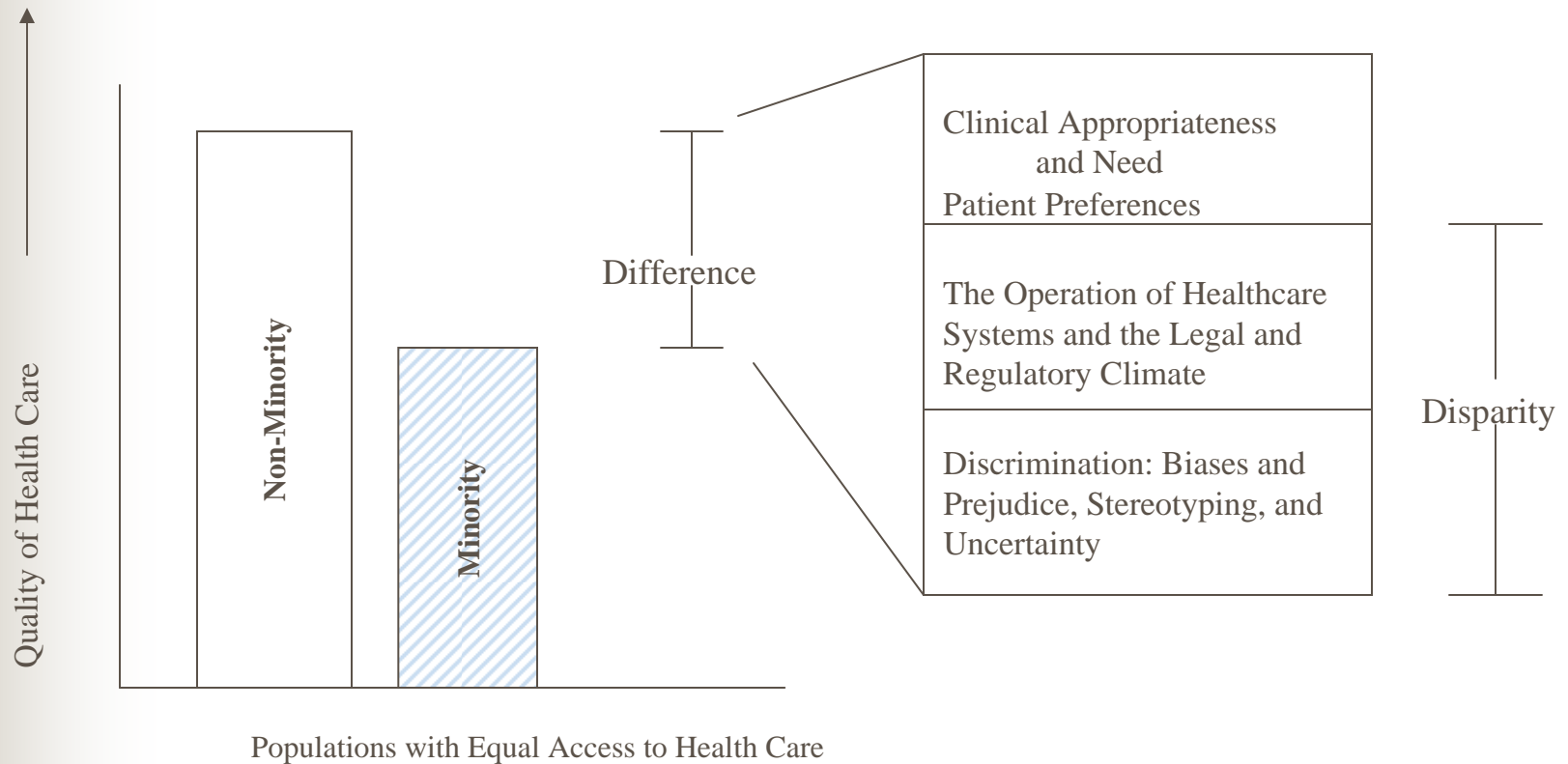
## 6 Quality outcomes as goals

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

Institute of Medicine, 2002  
([www.iom.edu](http://www.iom.edu))



# Figure 1: Differences, Disparities, and Discrimination: Populations with Equal Access to Health Care





# Evidence of Racial and Ethnic Disparities in Healthcare

- Disparities are consistently found across a wide range of disease areas and clinical services.
- Disparities are found even when clinical factors, such as stage of disease presentation, co-morbidities, age, and severity of disease are taken into account.
- Disparities are found across a range of clinical settings, including public and private hospitals, teaching and non-teaching hospitals, etc.
- Disparities in care are associated with higher mortality among minorities (e.g., Bach et al., 1999; Peterson et al., 1997; Bennett et al., 1995).



# What are potential sources of disparities in care?

- **Health systems-level factors** – financing, structure of care; cultural and linguistic barriers
- **Patient-level factors** – including patient preferences, refusal of treatment, poor adherence, biological differences
- **Clinical-encounter related factors**



## Disparities in the Clinical Encounter: The Core Paradox

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Possibilities examined:

- **Bias (prejudice)** – no evidence suggests that providers are more likely than the general public to express biases, but some evidence suggests that unconscious biases may exist.
- **Clinical uncertainty** – a plausible hypothesis, particularly when providers treat patients that are dissimilar in cultural or linguistic background.
- **Stereotyping** – evidence suggests that physicians, like everyone else, use these ‘cognitive shortcuts.’



# MENTAL HEALTH: CULTURE, RACE, AND ETHNICITY

(Office of the Surgeon General, 2001)

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




# Cultural Issues in the DSM-IV-TR


- Introduction to DSM-IV-TR
- Specific Culture, Age, and Gender Features
- Other Conditions That May Be a Focus of Clinical Attention: V Code section
  - Outline for Cultural Formulation
  - Glossary of Culture-Bound Syndromes




## INTRODUCTION: ETHNIC AND CULTURAL CONSIDERATIONS

“Diagnostic assessment can be especially challenging when a clinician from one ethnic or cultural group uses the DSM-IV classification to evaluate an individual from a different ethnic or cultural group. A clinician who is unfamiliar with the nuances of an individual's cultural frame of reference may incorrectly judge as psychopathology those normal variations in behavior, belief, or experience that are particular to the individual's culture.

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- For example, certain religious practices or beliefs (e.g., hearing or seeing a deceased relative during bereavement) may be misdiagnosed as manifestations of a Psychotic Disorder.


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- Applying Personality Disorder criteria across cultural settings may be especially difficult because of the wide cultural variations in concepts of self, styles of communication, and coping mechanisms...

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- It is hoped that these new features will increase sensitivity to variations in how mental disorders may be expressed in different cultures and will reduce the possible effect of *unintended bias stemming from the clinician's own cultural background.*” (*italics added*)




# Biases: Intended/Conscious or Unintended/Unconscious

- Racism
- Bias against immigrants/refugees
- Sexism
- Classism
- Ageism
- Homophobia
- Bias against religion/spirituality or certain beliefs/practices
- Other biases



“We just can’t know all about 100 cultures!  
This is hopeless, so why bother?”

- The antidote to the above requires both the attitude of humility and the skill of self-reflection. Appreciating the complexities of cultural assessment and formulation requires:
  - Knowing that we don't know rather than making assumptions.
  - Knowing about our biases and prejudices, either intentional or unintentional.




“We just can’t know all about 100 cultures, this is hopeless, so why bother?”

- Knowing the limits of our knowledge and skills.
- Knowing when to get a cultural consultation.
- Despite gaps in our knowledge and skills, we can learn a structured process like the Outline for Cultural Formulation, which can help us frame the cultural issues that impact on diagnosis and treatment.



# Specific Culture, Age, and Gender Features

- In the narrative sections of 79 diagnostic categories
- “***Symptoms and course*** of a number of DSM-IV disorders are influenced by cultural and ethnic factors...
- ***Symptom*** presentation (e.g., depressive disorders characterized by a preponderance of somatic symptoms rather than sadness in certain cultures),

- 
- Preferred *idioms for describing distress*
  - And information on *prevalence* when it is available.”
  - *Course and outcome*



## Example: Major Depressive Episode

- “Culture can influence the experience and communication of symptoms of depression.
- Underdiagnosis or misdiagnosis can be reduced by being alert to ethnic and cultural specificity in the presenting complaints of a Major Depressive Episode.



## Example: Major Depressive Disorders

- ...Depression may be experienced largely in somatic terms, rather than sadness or guilt.
- Complaints of weakness, tiredness or ‘imbalance’ (in Chinese and Asian cultures)...may express the depressive experience.”



## Other Conditions That May be a Focus of Clinical Attention: V Code section

1. The problem is the focus of diagnosis or treatment and the individual has no mental disorder.
2. The individual has a mental disorder but it is unrelated to the problem.
3. The individual has a mental disorder that is related to the problem, but the problem is sufficiently severe to warrant independent clinical attention.
4. The conditions and problems in this section are coded on Axis I.



## Religious or Spiritual Problem

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



## Acculturation Problem

- This category can be used when the focus of clinical attention is a problem involving adjustments to a different culture (e.g., following migration).



## Identity Problem

- This category can be used when the focus of clinical attention is uncertainty about multiple issues relating to identity such as long-term goals, career choice, friendship patterns, sexual orientation and behavior, moral values, and group loyalties.



# 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



## DSM-IV-TR Outline for Cultural Formulation

- Included in the text of the *APA Practice Guideline for the Psychiatric Evaluation of Adults, 2<sup>nd</sup> Edition*, American Journal of Psychiatry, June 2006 supplement
- Subject of the *Clinical Manual of Cultural Psychiatry* edited by Russell F. Lim, MD, APPI , May 2006



## DSM-IV-TR Outline for Cultural Formulation

- Subject of the 2002 DVD “*The Culture of Emotions*,” which is a 58-minute program with 23 multicultural experts commenting on the five sections of the Outline.  
[www.fanlight.com](http://www.fanlight.com)
- 3 cases Illustrate use in the 2008 DVD  
“Saving Face: Recognizing and Managing the Stigma of Mental Illness in Asian Americans”  
[www.mhac.org/barriers/antistigma.cfm](http://www.mhac.org/barriers/antistigma.cfm)



## A. Cultural identity of the individual

- “Note the individuals’ ethnic or cultural reference groups. For immigrants and ethnic minorities, note separately the degree of involvement with both the culture of origin and the host culture (where applicable). Also note language abilities, use, and preference (including multilingualism).”



# Cultural identity: Think widely 1

- Ethnicity
- Race
- National origin/Indigenous culture
- Migration/acculturation/bi-culturality
- Language(s)
- Age
- Gender
- Sexual orientation



## Cultural identity: Think widely 2

- Religious/spiritual beliefs & practices
- Socioeconomic status
- Political orientation
- Geographic location
- Disabilities
- Other aspects of identity, such as vocation




## Cultural identity: Think deeply


- “Asian” encompasses 30 Asian subgroups and 21 Pacific Islander groups.
- National origin does not define a homogeneous ethnic group. Example: 54 distinct ethnic groups in Vietnam.
- Differences between ethnic subgroups as well as regional differences within countries.



# Cultural identity: Connect the dots— the case of Mr. M. (Weinreich, et.al., 2003)

- M. lives in a large city in the north of Israel.
- He defines himself as a Palestinian Christian Arab with Israeli citizenship.
- As a Palestinian, he shares the fate of his people in Israel, in the West Bank, and in the Palestinian Diaspora, striving for some type of national self-determination.

- 
- As a Christian, M. is historically and theologically connected to Christians all over the world.
  - On the other hand, M. speaks Arabic and considers himself part of the Arab culture, particularly of the local Arab culture, shared by the Muslim and Christian Arabs.
  - M. also holds Israeli citizenship; he has many Israeli Jewish neighbors; is quite fluent in the Hebrew language, and is attracted to many aspects of Israeli Western lifestyle.



## What are the possibilities for Mr. M's cultural identity?

- Identity conflicts between parts
- Identity rooted in just one part: Defensive high self-regard
- Identity diffusion: Indeterminate identity
- Integrated identity of all the parts




## Cultural identity --Inquire, don't assume!

“A person’s identity is defined as the totality of one’s self-construal, in which how one construes oneself in the present expresses the **continuity** between how one construes oneself as one was in the past and how one construes oneself as one aspires to be in the future.” (Weinreich, 2003).




## Cultural identity— From a fixed, singular category to many aspects in flux/process

- Time--past-present-future
- Place—International and national migration
- Situation—At home with family vs. with friends vs. at work vs. with the healthcare provider
- Identity as I see myself vs. how others see me
- Conscious vs. unconscious aspects



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

- Cultural identity can impact on idioms of distress/explanations of illness, stressors and supports in the person's life, and the cultural elements of the relationship with the healthcare provider.
- Cultural identity can be a source of support or distress (when conflicted or diffuse) both intrapsychically, interpersonally and in the community and society.

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- Clinicians can prematurely close on and make assumptions about the person's cultural identity, then make erroneous assessments, diagnosis and treatment plans. This could contribute to poorer outcomes, less cost-effectiveness and healthcare disparities. VS.
  - Clinicians will enhance rapport and the therapeutic relationship by being respectful to the whole person including his/her cultural identity.



## B. Cultural expressions and explanations of illness

- Idioms of distress (what is distressing from the individual's POV?)
- Meaning and perceived severity of symptoms in relation to the norms of the cultural reference group
- Culture-Bound Syndromes
- Explanatory model(s)
- Treatment pathway(s)—history and expectations (professional and popular sources of care)



# Culture-Bound Syndromes

- Recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category.
- Many of these patterns are indigenously considered to be “illnesses,” or at least afflictions, and most have local names.
- The particular symptoms, course, and social response are often influenced by local cultural factors.
- All industrialized societies include distinctive subcultures and widely diverse immigrant groups who may present with culture-bound syndromes.



## Example: Neurasthenia

- “In China, a condition characterized by physical and mental fatigue, dizziness, headaches, other pains, concentration difficulties, sleep disturbance, and memory loss... gastrointestinal problems, sexual dysfunction, irritability, excitability...”



## Examples: Explanatory models of traditionally acculturated Asian and Pacific Islanders

- Humoral beliefs
- Medical illness beliefs
- Physical and emotional strain and exhaustion
- Character weakness
- Supernatural beliefs (e.g., karma)
- Spiritual beliefs




# Treatment pathways: Past history and current expectations

- None
- Mental health
- Primary care
- CAM or indigenous healing practices
- Religious/spiritual healer



## Examples of treatment pathways involving CAM or indigenous healing practices

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

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



## Recommended

- Fadiman, Anne. *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors and the Collision of Two Cultures*. New York: Farrar Straus & Giroux, 1998



## C. Cultural factors related to psychosocial environment and levels of functioning

- “Note culturally relevant interpretations of social stressors, available social supports, and levels of functioning and disability. This would include stresses in the local social environment and the role of religion and kin networks in providing emotional, instrumental, and informational support.”



## Axis IV: Psychosocial and environmental problems

- Negative life event
- Environmental difficulty or problem
- Familial or other interpersonal stress
- Inadequacy of social support or personal resources
- Other problem relating to the context in which a person's difficulties have developed



## Axis IV categories

- Problems with primary support group
- Problems related to the social environment
  - Difficulty with acculturation; discrimination
- Educational problems
- Occupational problems
- Housing problems



## Axis IV categories

- Economic problems
- Problems with access to health care services
- Problems related to interaction with the legal system/crime
- Other psychosocial and environmental problems
  - War; discord with nonfamily caregivers such as counselor, social worker, or physician



## **Culturally related strengths and supports: *Personal strengths***

(Pamela Hays, 2007)

- 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 beliefs that help one cope
- Respectful attitude toward the natural environment
- Commitment to helping one's own group
- Wisdom from experience



## **Culturally related strengths and supports: *Interpersonal supports***

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



## **Culturally related strengths and supports: *Environmental conditions***

- An altar in one's home or room to honor deceased family members and ancestors
- A space for prayer and meditation
- Foods related to cultural preferences (cooking and eating)
- Pets
- A gardening area
- Access to outdoors for subsistence or recreation



## Recommended

Hays P. Addressing Cultural Complexities in Practice, 2<sup>nd</sup> ed. Washington, DC: American Psychological Assoc Press, 2007

Josephson A and Peteet J (eds.). Handbook of Spirituality and World Views in Clinical Practice. Washington, DC: APPI, 2004

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



## D. Cultural elements of the relationship between the individual and the clinician

- “Indicate differences in culture and social status between the individual and the clinician and problems that these differences may cause in diagnosis and treatment (e.g., difficulty in communicating in the individual's first language, in eliciting symptoms or understanding their cultural significance, in negotiating an appropriate relationship or level of intimacy, in determining whether a behavior is normative or pathological).”



# 1. Understand the cultural identity of the clinician through self-reflection.

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



## 2. Compare the cultural identity of the patient to the that of the clinician.

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



### 3. Assess the cultural elements of the relationship in an ongoing way.

- Rapport and respect
- Dealing with stigma and shame
- Empathy
- Communication, verbal and non-verbal
- Transference and counter-transference
- Involvement with significant others, community organizations



## E. Overall cultural assessment for diagnosis and care

- “The formulation concludes with a discussion of how cultural considerations specifically influence comprehensive diagnosis and care.”



Differential diagnosis: The goal is a more accurate diagnosis.

- Step 1: Phenomenology
  - Cultural phenomena
  - Cultural idiom of distress
  - Culture-Bound Syndrome
  - Sign or symptom of a V code diagnosis
  - Sign or symptom of psychopathology
  - Any combination of the above



# Differential diagnosis

- Step 2: Categories
  - Cultural phenomena
  - Culture-Bound Syndrome
  - V code
  - Axis I and II psychopathology
    - Age, gender, cultural considerations
  - Any combination of the above
- Step 3:
  - Axis I vs. Axis II vs. both
  - Within Axis I and Axis II



# Differential diagnosis: Issues

- Misdiagnosis due to:
  - Cultural idioms of distress, explanatory models, treatment pathways
  - Inadequate relationship to gather history
  - Clinician bias, stereotyping, clinical uncertainty
- Prevalence may vary by culture/gender.
- Course and outcome may vary by culture/gender.
- Misdiagnosis can lead to mis-treatment.



# Treatment planning

- Process

- Negotiate and manage a treatment plan to maximize adherence/compliance

- Content

- Biological
- Psychological
- Sociocultural



# LEARN

(Berlin, et al., 1983)

- **L**isten with sympathy to the patient's perception of the problem
- **E**xplain your perception of the problem
- **A**cknowledge and discuss the differences and similarities
- **R**ecommend treatment
- **N**egotiate agreement



# ADHERE

(<http://erc.msh.org/quality&culture>)

- **A cknowledge** the need for treatment with the pt. Ask about previous treatments utilized. Together determine mutual goals and desired outcomes.
- **D iscuss** potential treatment strategies and options.
- **H andle** any questions or concerns the pt. might have about treatment



# ADHERE

(<http://erc.msh.org/quality&culture>)

- **E valuate** the patient's functional health literacy and understanding of the purpose/rationale for treatment and assess barriers and facilitators to adherence.
- **R ecommend** treatment and review plan
- **E mpower** by eliciting the pt's commitment to follow-through with the treatment plan



# Treatment planning

## ■ Biological

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



# Treatment planning

## ■ Psychotherapy

- Patient/family expectations and goals
  - “Be the Tiger Balm oil at the first interview.”  
-Evelyn Lee, Ed D
- Family vs. Individual vs. Group
- Supportive vs. Cognitive-Behavioral vs. Insight-oriented
- What cultural modifications in therapy would help?
- What therapist characteristics would facilitate/hinder treatment?



# Treatment planning

- Sociocultural Approaches
  - Utilize cultural strengths when possible such as:
    - Family
    - Spiritual/religious beliefs/practices
  - Work with other systems of care such as:
    - Primary care
    - Faith organizations and leaders



## Web-based resources

- 1) American Medical Association Commission to End Health Disparities  
[www.ama-assn.org/ama/pub/category/14629.html](http://www.ama-assn.org/ama/pub/category/14629.html)
- 2) EthnoMed (University of Washington Harborview Medical Center) [www.ethnomed.org](http://www.ethnomed.org)
- 3) The Provider's Guide to Quality and Culture- Outstanding web-based training on clinical cultural competence. <http://erc.msh.org>
- 4) CLAS Standards-Web-based training on systems cultural competence. [www.thinkculturalhealth.org](http://www.thinkculturalhealth.org)



## Web-based resources

- 4) Resources for Cross Cultural Health Care  
[www.diversityrx.org](http://www.diversityrx.org)
- 5) Health Resources and Services Administration  
[www.hrsa.gov/culturalcompetence](http://www.hrsa.gov/culturalcompetence)
- 6) National Health Law Program on language access.  
[www.healthlaw.org](http://www.healthlaw.org)
- 7) The California Endowment [www.calendow.org](http://www.calendow.org)
- 8) Fanlight Productions [www.fanlight.com](http://www.fanlight.com) Search for “The Culture of Emotions”