DSM 5: Tools to Advance Cultural Competence

Margaret Faye, Ph.D.
Senior Associate, CiMH
Learning Objectives

• Overview of major structural changes in DSM 5

• Changes in DSM 5 related to the consideration of cultural factors

• The new Cultural Formulation Interview (CFI)

• Culturally based concepts of distress and illness
The first version of the Diagnostic and Statistical Manual published in 1952 by the American Psychiatric Association Committee on Nomenclature and Statistics.

Around that time, The World Health Organization (WHO) published the sixth edition of the International Classification of Diseases, (ICD)

- it included mental disorders for the first time.
- The DSM differed from the ICD,
  - ICD was developed as a tool for epidemiology and health management as well as clinical purposes,
o DSM focused primarily on clinical utility and relied heavily on psycho-dynamic concepts of diagnosing psychopathology.

o DSM I was 145 pages long and included a total of 106 disorders.
the diagnostic categories in ICD 6 and 7 were not widely accepted,

Because of this lack of acceptance, in 1968
  o both the DSM and the ICD were revised.
  o DSM II was only 136 pages long, but it now included 182 disorders. The manual could be ordered for $3.50. This edition of the DSM retained the overall approach used in the DSM I and continued to conceptualize psychopathology from a psychodynamic perspective. One of the most controversial issue with the DSM II was that it included a new section on Sexual deviations and homosexuality was listed as one of the disorders.
By 1970, there was a growing movement opposing the inclusion of homosexuality as a mental illness. The movement grew strong enough that protesters rallied at the 1970 APA conference.

By 1973, it became clear to the psychiatric community that homosexuality within itself did not meet the requirements needed to be considered a specific mental disorder. Finally, homosexuality was removed in the seventh printing of the DSM II.
• DSM III was published in 1980.
• It increased the number of disorders to 265 diagnostic categories and expanded to 494 pages.
• There was a major shift from its earlier editions. DSM III dropped the psychodynamic perspective in favor of empiricism.
• It had several methodological innovations
  o Explicit diagnostic criteria
  o the multi-axial system
  o neutrality regarding the etiology, or cause, of a disorder.
  o Diagnostic criteria were validated by empirical research.
• 7 years later by DSM III R. (Revised).
• DSM III R addressed
  o inconsistencies in the system of classification and
  o lack of clarity in diagnostic criteria.
  o removed ego-dystonic sexual orientation as a disorder, the term in DSM III that had replaced homosexuality.
In 1994 DSM-IV was published. We now have over 300 disorders and not much changed in terms of structure from DSM III to DSM IV.

It included changes to classifications and diagnostic criteria. In order for disorders to be included, they had to have more empirical research to substantiate the diagnosis.

In 2000, the DSM IV TR (text revision) was published. The disorders remained unchanged. Only the background information, such as prevalence and familial patterns was updated to reflect current research.
• In May 2013,
  • DSM-5 was released during the Annual Conference of the American Psychiatric Association in San Francisco.

• Prior to DSM 5, no culture workgroup was included in making proposals for modification of criteria to address culture in DSM psychiatric conditions.

1999
• **Planning for development of DSM 5 began**
  o American Psychiatric Association recognizes that DSM 5 will be used in many different settings and must recognize difference in
mental illness that may occur across gender, race and ethnic groups. Each stage of the DSM-5 development process has sought significant involvement of women, members of diverse racial and ethnic groups and international researchers and clinicians. There was a specific study group designated to review and research diversity issues. The gender and cross cultural study group revised introductory chapter on culture and used a number of methods to review and incorporate cultural considerations into the dsm5 proposed criteria. They reviewed epidemiological data sets from the US and other countries to determine if there were significant differences in incidence of mental illness among different subgroups that might indicate a bias in currently used diagnostic criteria. Group members also reviewed the literature from a broad range of international researchers who had explored issues of gender, ethnic and racial differences for specific diagnostic categories of mental illness.

- In this process, the gender and cross cultural study group has tried to determine whether the diagnostic categories of mental illness in dsm need changes in order to be sensitive to the
various ways in which gender, races and culture affect the expression of symptoms that may be found in some cultures, but not others.

- For example, it was found that there were different cultural expressions, how individuals experience and describe symptoms in panic disorder among some Hispanic and Asian cultures. The study group subsequently recommended some changes to diagnostic criteria for panic disorder being considered for DSM 5 based on these differences. Specifically, in the criteria section, there is a note highlighting that culture-specific symptoms such as tinnitus, neck soreness, headache, uncontrollable screaming or crying may be seen.

- The work group also worked on cultural formulation interview for field trials and added additional modules to elaborate CFI. CFI field trial sites included countries from North America, South America, Europe, and Africa and Asia.
Case of Michele B.
Born: 1882
Admitted to Willard: 1928
Died at Willard: 1960

- Michele was an Italian Immigrant, a laborer, he saved his money and bought his own home. He was hospitalized after the police were called to his home because he was screaming. He said that he had guns to protect himself. He understood little English, so it was very difficult for others to talk with him. He did not believe he was insane, but admitted he sang a lot.

- In his suitcase, among other things, there was a photo of him in an American military uniform of the WWI era and a prayer card.

- Diagnosis then: Dementia Praecox, now called schizophrenia.
- He was provided with safe confinement and steady work.

HOW WOULD WE ASSESS and possibly DIAGNOSE Michele NOW?
  - Now: It is not known whether Michele actually suffered from schizophrenia.
  - He would be interview in his native language,
  - using CFI,
  - include the impact of his emigration and war experience
  - put his experience in cultural context
Manual’s New Structure

- DSM-5 Classification and Preface
  - Classification includes diagnoses, subtypes and specifiers, codes (ICD-9 and ICD-10)
- Section I: DSM-5 Basics
  - Introduction to the Manual
  - How to use the manual
  - Cautionary Statement for Forensic Use
- Section II: Diagnostic Criteria and Codes
  - 22 chapters covering all the disorders
  - For each diagnosis there is (although not all diagnosis have each of these sections):
    - Overview of the chapter
    - Diagnostic criteria for each diagnosis
    - Diagnostic features
    - Associated features supporting diagnosis
    - Prevalence
    - Development and course of disorder
    - Risk and prognostic factors
    - Gender related diagnostic issues
- cultural related diagnostic issues
- gender related diagnostic issues
- suicide risk
- functional consequences of disorder
- differential diagnosis
- comorbidity

- Section III: Emerging Measures and
  - Assessment Measures
  - Cultural Formulation
  - Alternative DSM-5 Model for Personality Disorder
  - Conditions for further study
  - Appendix
  - Highlights of Changes from IV to 5
  - Glossary of Terms
  - Glossary of Cultural Concepts of Distress
  - Alphabetical Listing of DSM-5 Diagnosis and Codes (ICD-9)
  - Numerical Listing of DSM-5 Diagnosis and Codes (ICD-9)
  - Numerical Listing of DSM-5 Diagnosis and Codes (ICD-10)
  - DSM-5 Advisors and Other contributors
  - Index
In the DSM-4, diagnoses were conducted along five axes.
  o Axis I referred broadly to the principal condition that needed immediate therapeutic attention, such as a major depressive episode.
  o Axis II included personality disorders and mental retardation.
  o Axis III addressed any neurological or medical problem that might be relevant understanding the individual's mental disorder or managing the mental disorder. For example, someone might have obstructive sleep apnea, leading to inadequate rest, which in turn could worsen the depressive episode.
  o Axis IV covered recent psychosocial stressors; for example, a death in the family may have triggered the depressive episode.
  o Under Axis V, the individual's Global Assessment of Functioning, or "level of function" which was assessed on a 0-to-100 scale.
Diagnosis in DSM-5 without 5-Axis system

Where is the information in a DSM-5 diagnosis?

**Former Axis I**

- Clinical Disorder
  - This is the psychiatric diagnosis

**Former Axis II**

- Personality D/O
  - This is now a psychiatric diagnosis
- Mental Retardation
  - This is now under Intellectual Disabilities, a psychiatric diagnosis

**Former Axis III**

- General Medical Condition
  - This is a medical diagnosis, also charted
V-codes are used to indicated conditions and problems that impact the diagnosis, course of illness, prognosis, and treatment of a mental disorder. If these conditions are part of the focus of treatment, or explain the need for treatment or evaluation, they can be used along with the mental disorder code. These expanded codes can also be used in the patient’s record to provide information and circumstances that may affect care.

V/Z codes include acculturation difficulty, targeted or perceived adverse discrimination or persecution, religious or spiritual problem, problem related to lifestyle.

World Health Organization Disability Assessment Schedule version 2.0—it was developed to assess a client’s ability to perform activities in six areas: understanding and communicating, getting around, self-care, getting along with people, life activities (household, work/school); and participation in society. Good measures for those who are applying for disability. Self-administered
• criteria have changed for many diagnosis and there are new diagnoses in DSM 5,
• the codes
  o (which are taken from the ICD-9)
  o have not changed and
  o can be used for medical records and billing purposes.
• Starting October 1, 2014, ICD-10 codes will be used for coding mental health diagnosis.
• You will notice that the ICD 9 codes are in the manual with the ICD-10 code, in parenthesis, next to it. (picture on slide)
• Note that some diagnosis have the same code as others, see photo – there are not ICD codes for all the new diagnosis.
• Use the codes in the book and write the specific diagnosis in the chart notes
Subtypes and Specifiers

- Provide increase specificity when diagnosing
- Found in Classification Section
- Most subtypes and specifiers cannot be coded using ICD-9 or ICD-10
- Some subtypes or codes are available in ICD-10, will be able to use that after October 2014.
- Write the subtype or specifier next to diagnosis, if no code available

Subtypes & Specifiers

- Provide increase specificity when diagnosing
- Found in Classification Section, very front of the manual & in each chapter
- Most subtypes and specifiers cannot be coded using ICD-9 or ICD-10
- Some subtypes or codes are available in ICD-10, will be able to use that after October 2014.
Write the subtype or specifier next to the diagnosis and code if no code available
Subtypes and Specifiers

The Difference

<table>
<thead>
<tr>
<th>Subtypes</th>
<th>Specifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Diagnostic subgroups</td>
<td>• More than one specifier may be given at a time.</td>
</tr>
<tr>
<td>• Can only fall into one subgroup at at time</td>
<td>• Allows for defining more homogeneous subgroupings</td>
</tr>
<tr>
<td>• All the possible subgroups are listed</td>
<td>• Individuals with the same disorder sharing features</td>
</tr>
<tr>
<td></td>
<td>• convey information relevant to management of the disorder</td>
</tr>
</tbody>
</table>

Subtypes:
• Diagnostic subgroups
• Can only fall into one subgroup at at time
• All the possible subgroups are listed

Specifiers:
• not mutually exclusive or jointly exhaustive
• more than one may be given at a time
• allow for defining more homogeneous subgroupings of a disorder with individuals with the same disorder sharing certain features
• convey information relevant to management of the disorder
### Subtypes and Specifiers

<table>
<thead>
<tr>
<th>Subtypes</th>
<th>Specifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specify Whether</td>
<td>Specify or Specify if</td>
</tr>
<tr>
<td>Examples:</td>
<td>Examples:</td>
</tr>
<tr>
<td>Specify whether:</td>
<td>Specify symptom type</td>
</tr>
<tr>
<td>With depressed mood</td>
<td>Specify current severity</td>
</tr>
<tr>
<td>With anxiety</td>
<td></td>
</tr>
<tr>
<td>With mixed anxiety and</td>
<td></td>
</tr>
<tr>
<td>depressed mood</td>
<td></td>
</tr>
<tr>
<td>With disturbance of</td>
<td></td>
</tr>
<tr>
<td>conduct</td>
<td></td>
</tr>
<tr>
<td>With mixed disturbance</td>
<td></td>
</tr>
<tr>
<td>of emotions and conduct</td>
<td></td>
</tr>
<tr>
<td>Unspecified</td>
<td></td>
</tr>
</tbody>
</table>

**Specify Whether**
- When it states Specify Whether, a subtype is selects.
- This example is the subtypes for Adjustment Disorder
- When it says Specify or Specify if,
- select one of the subtypes
- It might be a symptom type or it could be a severity rating.
A dimensional approach

Mental illnesses, like most human problems, have many and varied causes and symptoms.

DSM-5’s Diagnostic Spectra Study Group had a goal to develop a dimensional approach to diagnosing.

They looked for:
- new associations within diagnostic categories
- sharing of symptoms across disorders
- sharing of causality of symptoms between diagnostic categories

Assess severity

- Allows assessment of the severity of a condition
- It implies that there is not a solid line between what is considered normal and what is considered disordered, instead, we can assess the level of severity on a spectrum from few or no symptoms (no diagnosis) to mild, moderate and severe symptoms.
- It is being used with several diagnoses
- Disorders on a Spectrum
- This allows for measuring the degree of acuteness

EXAMPLE:
- Most well known and controversial is the Autism Spectrum Disorder
- The change from separate disorders to one disorder on a spectrum was determined by research
  - stated that these disorders were related conditions along a single continuum of behavior with symptoms ranging from mild to severe.
- The spectrum allows clinicians to account for variations from person to person.

EXAMPLE:
- substance use disorder
  - Abuse and Dependence are combined into a single spectrum and a severity measure is given based on the number of symptoms
Not Otherwise Specified

- In order to maintain greater concordance with the official International Classification of Diseases (ICD) coding system, NOS is replaced by:
  - Other Specified
  - Unspecified Disorders
- This is not a new specific mental disorder.
- The APA concluded NOS was being overused as a shortcut, substituting for more-careful diagnosis.
  - Research showed that more than half of all people diagnosed with eating disorders had NOS diagnoses.

Unspecified

- The term "unspecified" is an option for most categories of disorders.
- Can be used if the clinician chooses not to specify the reason that the criteria are not met for a specific disorder.
- Example:
  - "Unspecified Eating Disorder"
  - "Unspecified Alcohol-Related Disorder."

Other Specified

- The term "other specified" is an option for most categories of disorders.
- It allows clinicians to communicate the specific reason that the presentation does not meet the criteria for any specific category within a diagnostic class.
- Example: name of the dx followed by the specific reason.
  - "Other specified depressive d/o, depressive episode with insufficient symptoms."

- It’s a clinical decision
Medical Condition

“General Medical Condition” is replaced by “Another Medical Condition”

Where ever it is relevant
• the phrase “general medical condition” is replaced in DSM-5 with
  • “another medical condition”
Section 2 of the book includes 22 chapters with all of the disorders. The in the last version, diagnoses were divided up into 17 chapters

- 1 chapter kept the same name
  - Personality Disorders
6 chapters have new names but the same or similar diagnosis within the chapter, they are

- Schizophrenia Spectrum and Other Psychotic Disorders
  - Schizophrenia and Other Psychotic Disorders
- Somatic Symptom and Related Disorders
  - Somatoform Disorders
- Eating Disorders
  - Feeding and Eating Disorders
- Sleep Disorders
  - Sleep-Wake Disorders
- Substance-Related and Addictive Disorders
  - Substance-Related Disorders
- Delirium, Dementia, and Amnestic and Other Cognitive Disorders
  - Neurocognitive Disorders
15 chapters had significant changes

- Neurodevelopmental Disorders
- Bipolar and Related Disorders
- Depressive Chapters
- Anxiety Disorders
- Obsessive-Compulsive and Related Disorders
- Trauma- and Stressor-Related Disorders
- Dissociative Disorders
- Elimination Disorders
- Sexual Dysfunctions
- Gender Dysphoria

- Disruptive, Impulse-Control and Conduct Disorders
- Paraphilic Disorders
- Other Mental Disorders
- Medication-Induced Movement Disorders and Other Adverse Effects of Medication
- Other Conditions that may be a Focus of Clinical Attention
New and Eliminated Disorders

**New Disorders**

1. Social (Pragmatic) Communication Disorder
2. Disruptive Mood Dysregulation Disorder
3. Premenstrual Dysphoric Disorder (DSM IV appendix)
4. Hoarding Disorder
5. Excoriation (Skin Picking) Disorder
6. Disinhibited Social Engagement Disorder (split from Reactive Attachment Disorder)
7. Binge Eating Disorder (DSM IV appendix)
8. Central Sleep Apnea (split from Breathing Related Sleep Disorder)
9. Sleep Related Hypoventilation (split from Breathing Related Sleep Disorder)
10. Rapid Eye Movement Sleep Behavior Disorder (Parasomnia NOS)
New and Eliminated Disorders

New Disorders
11. Restless Legs Syndrome (Dyssomnia NOS)
12. Caffeine Withdrawal (DSM IV Appendix)
13. Cannabis Withdrawal
14. Major Neurocognitive Disorder with Lewy Body Disease
   (Dementia Due to Other Medical Conditions)
15. Mild Neurocognitive Disorder (DSM IV Appendix)

Eliminated Disorders
1. Sexual Aversion Disorder
2. Polysubstance Related Disorder

New and Eliminated Disorders
• 2 DSM IV disorders were eliminated
The increasing proportion of ethnic and cultural minorities in the US population represents one of the most fundamental demographic changes in the history of the US. The importance of studying and researching culture-related diagnostic issues is now widely recognized by mental health professionals.

Culture-related assessment and consideration is not only a pull out as we’ll see in later in Cultural Formulation Interview, they are also integrated and embedded in all the major diagnoses.
Questions?
Intro to Cultural Issues
Disclaimer: more than just race and ethnicity, it includes class/employment, sexual identity, religion, age, gender, geographic area of origin, views and experiences on health, illness and disability

More importantly, we are going to look at cultural dimensions of health and illness including how it shape our experience, culture-specific symptoms and idioms of distress, explanations and attributions of symptoms, modes of coping, stigma, and treatment
Changes to the Outline

DSM-IV
- cultural identity of the person
- cultural explanations of individual’s illness
- cultural factors related to psychosocial environment and levels of functioning
- cultural elements of the relationship between the individual and the clinician
- overall cultural assessment regarding diagnosis and care

DSM-5
- cultural identity of the individual
- cultural conceptualization of distress
- psychosocial stressors and cultural features of vulnerability and resilience
- cultural features of the relationship between the individual and the provider
- overall cultural assessment
DSM 5 is divided into 3 sections. Section 1, it highlights mental disorders are defined in relation to cultural, social and familial norms and values. Culture provides interpretive frameworks that shape the experience and expression of the symptoms, signs and behaviors that are criteria for diagnosis. Section II – diagnostic criteria and codes has specific comments and recommendations for different disorders. Section iii: emerging measures and models includes a chapter on cultural formulation and cultural formulation interview questions and guidelines. And an appendix which includes a glossary of cultural concepts of distress.
Specific comments recommendations for disorders: for example, Major Depressive Disorder, under culture-related diagnostic issues it indicated that research findings suggest substantial cultural differences in the expression of major depressive disorder, they do not permit simple linkages between particular cultures and the likelihood of specific symptoms. Rather, clinicians should be aware that in most countries the majority of cases of depression go unrecognized in primary care settings and that in many cultures, somatic symptoms are very likely to constitute the presenting complaint. Among the Criterion A symptoms (depressed mood, lost of interest, weight loss, insomnia, feelings of worthlessness), insomnia and loss of energy are the most uniformly reported.

Another example: Separation Anxiety Disorder, under culture-related diagnostic issues: it discusses there are cultural
variations in the degree to which it is considered desirable to tolerate separation, so that demands and opportunities for separation between parents and children are avoided in some cultures. In addition, it is important to differentiate separation anxiety disorder from the high value some cultures place on strong interdependence among family members.

Lastly, in schizophrenia spectrum disorder chapter, it cautions that cultural and socioeconomic factors must be considered, particularly when the individual and the clinician do not share the same cultural and socioeconomic background. Ideas that appear to be delusional in one culture (i.e., seeing the spirits of love ones who died) may be commonly held in another. In some cultures, visual or auditory hallucinations with a religious content are a normal part of religious experience. Moreover, the assessment of disorganized speech may be made difficult by linguistic variation in narrative styles across cultures. Likewise with emotional expression (some culture may be less expressive than others), eye contact and body language, which vary across cultures.
In DSM IV appendix section, there was a list of 25 culture bound syndromes. The use of the term culture bound made these conditions appear highly localized and confiend. DSM 5 replaced them with 3 concepts:

1. Cultural explanations of distress or perceived causes: “labels, attributions, or features of an explanatory model that indicate culturally recognized meaning or etiology for symptoms, illness or distress.
2. cultural syndromes: cluster of symptoms and attributions that tend to co-occur among individuals in specific cultural groups, communities.
3. Cultural idioms of distress: ways of expressing distress that may not involved specific symptoms or syndromes, but that provide collective, shared way of experiencing and talking about personal or social concerns
Using depression as an example of a cultural concept. For western clinicians, major depressive disorder can be considered a “syndrome,” or cluster of symptoms that appear to hang together. But depression can also be considered an “idiom of distress” in the sense that westerners commonly talk of feeling depressed in everyday life. Finally the label depression can include a set of behaviors with a particular meaning.

No single concept maps onto a specific psychiatric disorder and conversely, no single psychiatric disorder maps onto a cultural concept.
In the glossary section, there is a list of nine best studied concepts of distress around the world. For example, One of the common cultural concept of distress in the Chinese culture, shenjing shuairuo: in Mandarin, it literally means weakness of the nervous system; it’s an idiom for feeling depressed.” ataque de nervios (attack of the nerves in many Latino cultures), taijin kyofusho (interperonal fear disorder among Japanese culture) and so on.

Briefly, ataque is a syndrome characterized by intense emotional upset, including acute anxiety, anger, or grief. Screaming and shouting uncontrollably, attacks of crying; trembling, heat in the chest rising into the head and becoming verbally and physically aggressive. The entry in the glossary cross-references related conditions in other cultural context and in the main text of DSM-5 under Panic disorder. Conversely, a section in the entry under
panic disorder in section II of DSM-5 describes attaque and refers the reader to the glossary. In this way, clinicians are alerted to culture-related features of DSM prototypes in the main text and in more detail in the glossary.

Similarly, Khyal attack is a syndrome found among Cambodians, sx incl palpitation, dizziness, shortness of breath and neck soreness. Khyal also has cross reference in both Panic disorder and the glossary. Again, having more detailed description in the glossary section is to increase the effectiveness of assessment by encouraging greater consideration of cultural concepts of distress and their role in understanding how something akin to panic disorder might be expressed, understood and treated in particular setting.
Cultural issues in therapeutic relationship

• Clinicians and clients may differ:
  – Framing of the problem
  – Language
  – Background knowledge
  – Styles of verbal and non-verbal communication
  – Worldview, value system
Each illness has to be assessed in its own right and both the clinician’s expertise and individual’s understanding of the illness should apply. Clinicians must not only draw from diagnostic experience, available categories of illness, and the various dimensions along which aspects of the illness may range, but also recognize and try to understand client’s individual, familial and cultural experiences.

This goes back to our video of how if we paid too much attention to certain detail, we may miss the forest for the trees.

To help clinicians in gathering culturally relevant information to formulate an appropriate diagnosis and treatment planning, in section iii of the DSM 5, there is a semi-structured interview: cultural formulation interview.
The Cultural Formulation Interview (CFI)
• It is found in the third section of the manual, there is also an online version.
• It consists of sixteen questions that focuses on individual experience and social context (the objective is to assess cultural factors using a person-centered approach).
• The text is divided into two columns, with questions on the right and instructions on the left. Two versions are available, one for the individual, one for an informant, such as a family member or caregiver.
• It can be used as part of the psychosocial assessment
• The purpose of the instrument is to Assess the effect of culture on important parts of patient care. CFI helps clinicians avoid misdiagnosis, obtain clinically useful information, improve clinical rapport and therapeutic efficacy.
The CFI provides an opportunity to explore
- The view the patient has of their difficulties,
- The influence on the difficulties of other’s in the patient’s life;
- How cultural background influences the patient and their difficulties
- The experiences the patient has had of pursuing help
- Treatment and Care expectations

The dominant themes in CFI are family systems, cultural identity, therapeutic relationship, understanding of illness and healing and social environment.
When to use the CFI

1. Start of assessment
2. If diagnostic process is hindered
3. Lack of match between symptoms and criteria
4. Difficulty judging severity of symptoms
5. Disagreement about treatment course
6. Limited engagement and adherence

At the start of the first assessment interview with adults in just about any clinical setting, the background of the patient or the clinician is irrelevant to whether the CFI should be used. (Individual questions may be used at any point in the interview, as necessary)

Later stages in working with patients, the CFI can help there are major cultural differences between the patient and the clinician which is impeding the diagnostic process.

If diagnostic criteria does not match up with how a patient's culture influences how they express symptoms;

If the clinician find themselves challenged to judge the severity of symptoms;

If there is a disagreement about the treatment course between the patient and the clinician;

If the patient shows limits in how much they will engage in the treatment or adhere to the treatment plan.
4 Domains

- Cultural definition of the problem
- Cultural perceptions of the cause context and support
- Cultural factors affecting self-coping and past help-seeking
- Cultural factors affecting current help seeking
aim to clarify key aspects of the presenting clinical problem from the point of view of the individual and other members of the individual’s social network

- family, friends, or others involved in current problem

this includes

- the problem’s meaning
- potential sources of help
- expectations for services
Introduction for the Individual

I would like to understand the problems that bring you here so that I can help you more effectively.

I want to know about your experience and ideas. I will ask some questions about what is going on and how you are dealing with it.

Please remember there are no right or wrong answers.

Now let’s go over the CFI interview questions which are the next 10 slides
Cultural Definition of the Problem

1. What brings you here today?
   - if individual gives few details or only mentions symptoms or a medical diagnosis, PROBE:
     - people often understand their problems in their own way, which may be similar to or different from how doctors describe the problem: how would you describe your problem?

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

3. What troubles you most about your problem?
Cultural Perceptions Of Cause, Context, And Support

CAUSES

4. Why do you think this is happening to you? What do you think are the causes of your [PROBLEM]?
   - Prompt further if required
     - Some people may explain their problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes

5. What do others in your family, your friends, or others in your community think is causing your [PROBLEM]?
Cultural Perceptions Of Cause, Context, And Support

STRESSORS AND SUPPORTS

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

7. Are there any kinds of stresses that make your [PROBLEM] worse, such as difficulties with money, or family problems?
Cultural Perceptions Of Cause, Context, And Support

ROLE OF CULTURAL IDENTITY

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

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

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

10. Are there any aspects of your background or identity that are causing other concerns or difficulties for you?
Cultural Factors Affecting Self-Coping And Past Help Seeking

SELF-COPING

11. Sometimes people have various ways of dealing with problems like [PROBLEM]. What have you done on your own to cope with your [PROBLEM]?
Cultural Factors Affecting Self-Coping And Past Help Seeking

PAST HELP SEEKING

12. Often, people look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing have you sought for your [PROBLEM]?
   - Probe if does not describe usefulness of help received
   - What types of help or treatment were most useful? Not useful?
Cultural Factors Affecting Self-Coping And Past Help Seeking

BARRIERS

13. Has anything prevented you from getting the help you need?
   • Probe as needed
   • For example, money, work or family commitments, stigma or discrimination, or lack of services that understand your language or background?
Cultural Factors Affecting Current Help Seeking

PREFERENCES

Now let’s talk some more about the help you need

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

15. Are there other kinds of help that your family, friends, or other people have suggested would be helpful for you now?
Cultural Factors Affecting Self-Coping And Past Help Seeking

CLINICAN-PATIENT RELATIONSHIP

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

16. Have you been concerned about this and is there anything that we can do to provide you with the care you need?
Using Sue and Zane (1987): quadrant approach:

- **Quadrant I**: Client and clinician shares similar cultural backgrounds, match in language and clinician shows competency in using CFI – Desired outcome
- **Quadrant II**: Client and clinician shares similar cultural backgrounds, match in language, but clinician doesn’t demonstrate competency in CFI – client is likely to drop out from treatment prematurely
- **Quadrant III**: Client and clinician do not share similar culture and/or language, but clinicians shows competency in using CFI – client is likely to stay in treatment
- **Quadrant IV**: Client and clinician do not share similar culture and/or language, and clinician is not competency in CFI – client is not likely to attend the first session or return after the first session

- Knowledge of the degree of enculturation and competence in CFI are important - An ethnic match may produce ascribed credibility, but this is secondary to achieved credibility.
Instruct participant to get in group of three

Interviewer
  Use the CFI
Observer
  Note feedback, questions, your experience
Interviewee (some who is willing to be self-revealing or creative)
  Make up a story – from your life or fictional, about a stressful situation, following the questions in the Vignette Handout
    NOTE: not the most stress or upsetting experience in your life.
Report back
Observer:
How was it for you to observe the interview?

Interviewer:
How was it for you to use the CFI?
What questions might you have?
How did it change your perspective of assessing a client?

Interviewee:
How was the experience of being interviewed?
How did it change your perspective about doing an assessment?