

**Cultural Issues in DSM-5:
Outline for Cultural Formulation (OCF) and
Cultural Formulation Interview (CFI)**

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Outline

- Definitions and rationale
- Overview of cultural issues in DSM-5
- DSM-5 Outline for Cultural Formulation (OCF)
- DSM-5 Cultural Formulation Interview (CFI)

Objectives - 1

- 1) Describe the five parts of the Outline for Cultural Formulation (OCF)
- 2) Use the 16 questions of the Cultural Formulation Interview (CFI) to conduct an interview to elicit cultural issues described by the OCF:
 - cultural identity
 - cultural concepts of distress
 - cultural stressors and supports
 - cultural features of the clinician-individual relationship

Objectives - 2

3) Be familiar with the use of the 12 supplementary modules when appropriate.

4) Be able to formulate a case using the DSM-5 Outline for Cultural Formulation (OCF).

“Cultural 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.
 - (Terry Cross, et al, 1989)
 - www.omhrc.gov/clas added “Linguistic Competence”

“Cultural Competence” (Joint Commission, 2010)

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

“Cultural Competence”: Essential Elements of the Journey

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

Improve Quality Indicators of Health Care:
Institute of Medicine, 2001
(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. [Culturally/linguistically competent]

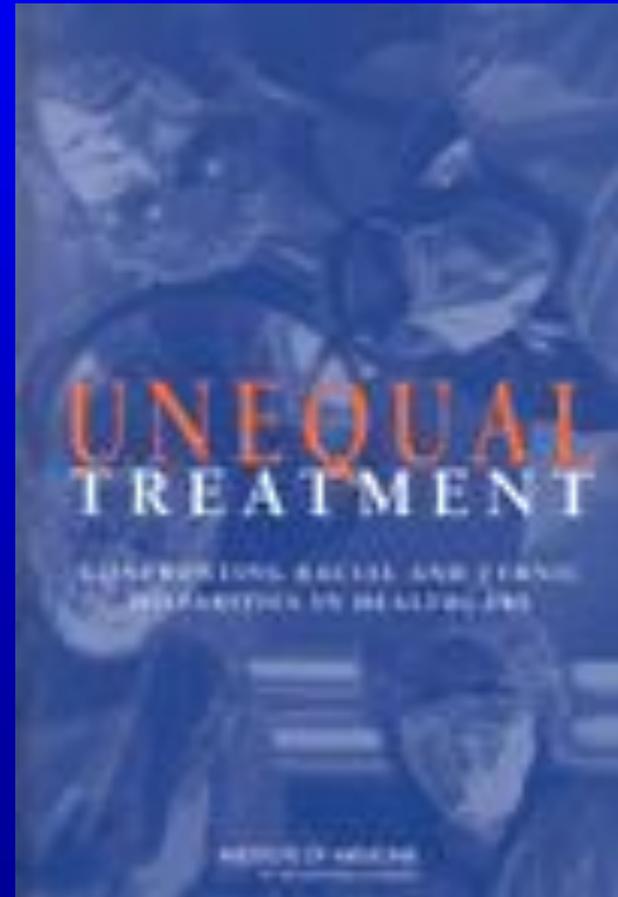
6 Quality outcomes as goals

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

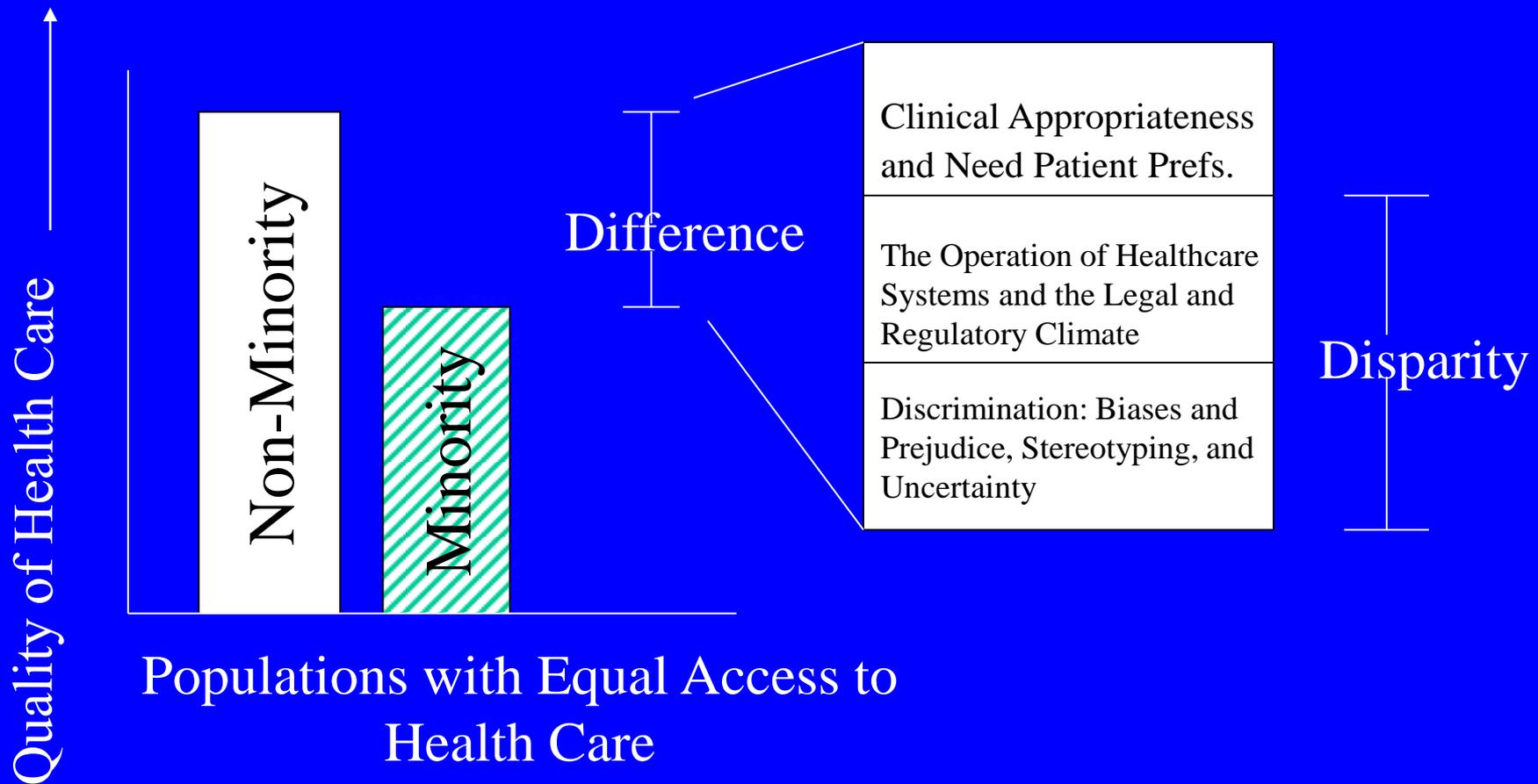
[Eliminating Disparities]

Unequal Treatment: Confronting Racial and Ethnic Disparities In Health Care

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



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 in care are associated with higher mortality among minorities (e.g., Bach et al., 1999; Peterson et al., 1997; Bennett et al., 1995).

Clinical Encounter Factors Contributing to Disparities

- **Bias (prejudice)** –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.’

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

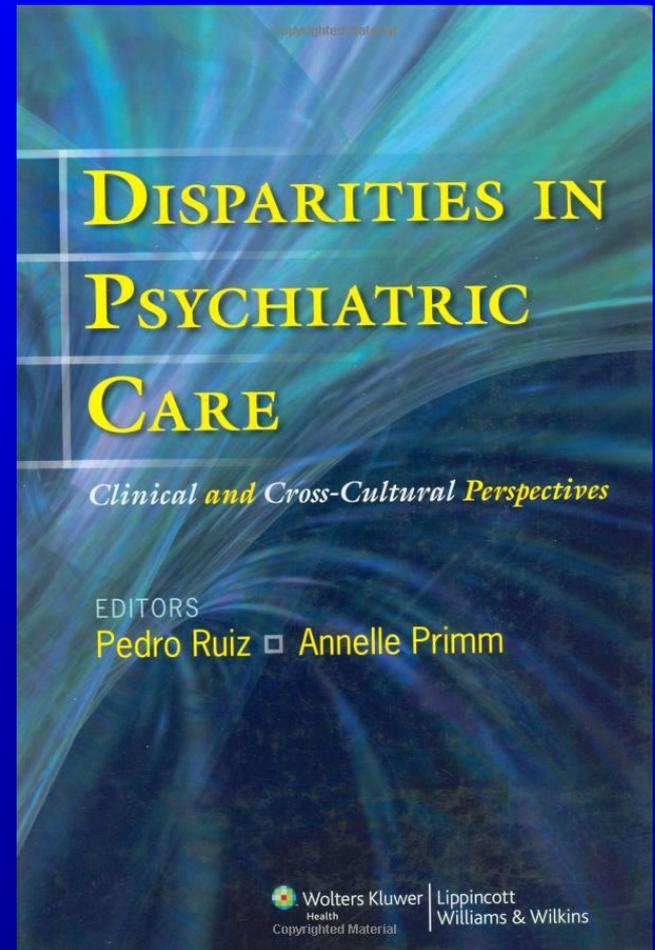
MENTAL HEALTH: CULTURE, RACE, AND ETHNICITY

(USDHHS-Office of the Surgeon General, 2001)

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

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

- Racial/ethnic minorities
- Women
- LGBT
- Incarcerated
- Chronically mentally ill
- Dual diagnosed
- Rural areas
- Disabled
- More



Summary: 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

Cultural Issues in DSM-5

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

Cultural Issues in DSM-5

Section 3

- Outline for Cultural Formulation (OCF) revised from DSM-IV/-IV-TR
- Cultural Formulation Interview (CFI)

Appendix

- Glossary of Cultural Concepts of Distress replacing Glossary of Culture-Bound Syndromes

Introduction: DSM-5 definition of culture

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

Culture in mental health

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

Schizophrenia - 1

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

Schizophrenia - 2

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

Panic Disorder

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

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

“The conditions and problems listed in this chapter are not mental disorders.”
(p. 715)

- Relational Problems
- Abuse and Neglect
- Educational and Occupational Problems
- Housing and Economic Problems
- 5 additional areas

V62.89 Religious or Spiritual Problem

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

V62.4 Acculturation Difficulty

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

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

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

The DSM-5 Outline for Cultural Formulation - 2

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

Revision of the Outline for Cultural Formulation (OCF)

DSM-IV Limitation	DSM-5 Solution
Lack of operationalization	<ul style="list-style-type: none">• Cultural Formulation Interview (CFI)• 16 standardized questions in 4 sections
Limited guidance	<ul style="list-style-type: none">• Use at beginning of initial evaluation• Apply with all patients
Risk of stereotyping	<ul style="list-style-type: none">• Person-centered approach• Collaborative, shared decision-making

Applying the OCF: The CFI

- **Patient version:** 16 questions (p. 750-754)
- **Informant version** (p. 755-757)
- **12 supplemental modules:** Explanatory Model, Level of Functioning, Social Network, Caregivers, Psychosocial Stressors, Religion, Spirituality, and Moral Traditions, Immigrants and Refugees, Cultural Identity, Older Adults, School-Age Children and Adolescents, Coping and Help-Seeking, Patient–Clinician Relationship (online only)

Cultural Formulation Interview (CFI)

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

GUIDE TO INTERVIEWER**INSTRUCTIONS TO THE INTERVIEWER ARE *ITALICIZED*.**

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

INTRODUCTION FOR THE PATIENT:

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

CULTURAL DEFINITION OF THE PROBLEM**CULTURAL DEFINITION OF THE PROBLEM****Explanatory Model, Level of Functioning**

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

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

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

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

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

1. What brings you here today?

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

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

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

Cultural Formulation Interview – 1

Cultural definition of the problem

Explanatory Model, Level of Functioning

1. What brings you here today?

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 Formulation Interview – 2

Causes

Explanatory Model, Social Network, Older Adults

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.

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

OCF B: Cultural conceptualizations of distress

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

Cultural Concepts of Distress (p. 758-759)

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

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

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

Examples

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

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

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Example: Shenjing Shuairou (p. 835-836) (Neurasthenia)

- “weakness of the nervous system in Mandarin Chinese.” Three of five nonhierarchical symptom clusters: weakness, emotion, excitement, nervous pain, and sleep.
- Weakness related to the depletion of qi (vital energy) following excessive worry.

Example: Ataque de Nervios (p. 833)

- “a syndrome [seen] among individuals of Latino descent, characterized by symptoms of intense emotional upset, including acute anxiety, anger or grief: screaming and shouting uncontrollably: attacks of crying trembling: heat in the chest rising into the head, and becoming verbally and physically aggressive. ...as a direct result of a stressful event relating to the family.”

Examples of Idioms of Distress

- Dizziness
- Fatigue
- Pain- Headaches, Backaches, Stomach aches
- Nerves

Examples of Explanatory Models

- Magic- Evil Eye
- Religious- Punishment
- Moral- Laziness, selfishness, weak will
- Medical- Ayurveda, CTM, Homeopathy, osteopathy, herbal treatments, etc.
- Psychological Stress

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

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



INSIDE A SWEAT LODGE CEREMONY

HLN

▶ WHAT IS A SWEAT LODGE CEREMONY?
CEREMONY INVOLVES PRAYERS AND CHANTING

MORNING EXPRESS



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

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

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

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

Cultural Formulation Interview - 3

Stressors and supports

Social Network, Caregivers, Psychosocial Stressors, Religion, Spirituality, and Moral Traditions, Immigrants and Refugees, Cultural Identity, Older Adults, Coping & Help Seeking

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?

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

- Stressors and supports
- Role of religion, family, and other social networks in providing support
- Levels of functioning, disability, and resilience related to the individual's cultural reference groups

Cultural Formulation Interview - 4

Role of cultural identity

Cultural Identity, Psychosocial Stressors, Religion, Spirituality, and Moral Traditions, Immigrants and Refugees, Older Adults, Children and Adolescents

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

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

Cultural Formulation Interview - 5

Role of cultural identity (cont.)

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?

OCF A: Cultural identity of the individual in DSM-IV

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

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

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

“Addressing” Framework

- Age and generational influences
- Developmental and acquired
- Disabilities
- Religion and spiritual orientation
- Ethnicity
- Socioeconomic status Language
- Sexual orientation
- Indigenous heritage
- National origin
- Gender

Source: Hays, 2007

Cultural identity: Inquire, don't assume!

- “Asian” encompasses 30 Asian subgroups and 21 Pacific Islander groups.
- National origin does not define a homogeneous ethnic group.
Example: 54 distinct ethnic groups in Vietnam.

Immigration History

- Who did you leave?
- What did you leave?
- Where did you leave?
- When did you leave?
- Why did you leave?
- How did you leave?

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

- Cultural identity can impact on cultural concepts of distress, stressors and supports in the person's life, and the cultural features 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.

Cultural Formulation Interview - 6

Self-coping

Coping and Help Seeking, Religion, Spirituality, and Moral Traditions, Older Adults, Caregivers, Psychosocial Stressors

11. Sometimes people have various ways of dealing with problems like your problem. What have you done on your own to cope with your problems? *What types of help or treatment were most useful? Not useful?*

Past help-seeking *Coping and Help Seeking, Religion, Spirituality, and Moral Traditions, Older Adults, Caregivers, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship*

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?

Cultural Formulation Interview - 7

Barriers *Coping and Help Seeking, Religion, Spirituality, and Moral Traditions, Older Adults, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship*

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

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

Stigma

The stigmatization of mental illness prevents many individuals and families from seeking help. Clinicians need to be sensitive and responsive to the cultural shame associated with mental illness, respect the family's face-saving needs, and be particularly careful to maintain confidentiality.

Cultural Formulation Interview - 8

Help-seeking preferences

Social Network, Caregivers, Religion, Spirituality, and Moral Traditions, Older Adults, Coping and Help Seeking

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

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

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

Cultural Formulation Interview - 9

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

Clinician-patient relationship

Clinician-Patient Relationship, Older Adults

16. Have you been concerned about this [the patient and the clinician having different backgrounds] and is there anything that we can do to provide you with the care you need?

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



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

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

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

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

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

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

Cultural Identity Exercise

- Reflect on your cultural identity - 1 minute
- Write down for yourself - 1 minute
- Form pairs and share to the extent you feel comfortable - 1 minute each
- General group discussion

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

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

Step 3: Assess the cultural features of the relationship - 1

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

Step 3: Assess the cultural features of the relationship - 2

- Transference
 - Related to cultural identity variable differences and/ or similarities
- Countertransference
 - Related to cultural identity variable differences and/or similarities

Biases: Intended/Conscious or Unintended/Unconscious

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

OCF E: Overall cultural assessment

“Summarize the implications of the components of the cultural formulation...for diagnosis...as well as appropriate management and treatment intervention.”

Differential diagnosis: Issues

- Misdiagnosis due to:
 - Misunderstanding cultural idioms of distress/syndromes
 - Not eliciting and understanding explanatory models
 - 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 - 1

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

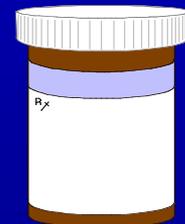
Treatment planning - 2

Biological

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

Clinical Strategies - Prescribing

- Small doses- slow metabolizers
- Use as few pills as possible- “too much medicine”
- Bring pill bottles- “Western medicine is too strong,” poor adherence
- Check blood levels
- Home visit, bubble pack
- Frequent follow-up



Treatment planning - 3

Psychotherapy

Respect patient/family expectations

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

Treatment planning - 4

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

Applying the OCF - The CFI

- 16 questions
- Informant version
- **12 modules:** Explanatory Model, Level of Functioning, Social Network, Caregivers, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Cultural Identity, Older Adults, School-Age Children and Adolescents, Coping and Help-Seeking, Patient–Clinician Relationship

Comprehensive assessment

- Informant CFI and supplementary modules expand on core CFI
- May use in two ways:
 - As adjuncts to core CFI for additional information on specific aspects of illness
 - As tools for in-depth cultural assessment independent of core CFI
- May use individual questions, subdomains, domains, modules or entire set of modules
- May use at intake or any time over course of care

Comprehensive assessment

- Especially useful in cases of:
 - Cultural differences that complicate diagnostic assessment
 - Uncertainty of fit between symptoms and DSM categories
 - Difficulty in judging severity or impairment
 - Disagreement between patient and clinician on course of care
 - Limited treatment engagement or adherence
- Helpful to identify area of concern to select approach

Informant version

- **Collects information from informant**
 - To supplement patient information
 - When patient unable to provide information
- **Follows same format as patient CFI**
- **Clarifies informant's relationship with patient**
- **Obtains informant's views about illness and care in addition to social network's**
 - (e.g., *Why do you think this is happening to [INDIVIDUAL]?*)

Modules that expand sections of CFI

1. Explanatory model (14 items)

Clarifies patient's understanding of the problem based on his/her ideas about cause and mechanism (explanatory models) and past experiences of, or knowing someone with, a similar problem (illness prototypes). The patient may identify the problem as a symptom, a specific term or expression (e.g., "nerves," "being on edge"), a situation (e.g., loss of a job), or a relationship (e.g., conflict with others). In the examples below, the patient's own words should be used to replace "[PROBLEM]". If there are multiple problems, each relevant problem can be explored.

- General understanding of the problem
- Illness prototypes
- Causal explanations *
- Course of illness *
- Help seeking and treatment expectations *

2. Level of functioning (8 items) *

Aims to clarify patient's level of functioning in relation to his/her own priorities and those of the cultural reference group. The interview begins with a general question about everyday activities that are important for the patient. Questions follow about domains important for positive health (social relations, work/school, economic viability, and resilience).

- * Includes perspective of social network

Modules that expand sections of CFI

3. Social network (15 items)

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

- Composition of the patient's social network
- Social network understanding of the problem *
- Social network response to problem *
- Social network as a stress/buffer *
- Social network in treatment *

4. Psychosocial stressors (7 items) *

Clarifies the stressors that have aggravated the problem or otherwise affected the health of the patient. (Stressors that initially caused the problem are covered in the module on Explanatory Models.) In the examples below, the patient's own words should be used to replace "[STRESSORS]". If there are multiple stressors, each relevant stressor can be explored.

- * Includes perspective of social network

Modules that expand sections of CFI

5. Spirituality, religion & moral traditions (16 items)

Clarifies the influence of spirituality, religion, and other moral or philosophical traditions on the patient's problems and related stresses. People may have multiple spiritual, moral, and religious affiliations or practices. If the person reports having specific beliefs or practices, inquire about the level of involvement in that tradition and its impact on coping with the clinical problem. In the examples below, the patient's own words should be used to replace "[NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)]". If the patient identifies more than one tradition, each can be explored. If the patient does not describe a specific tradition, use the phrase "spirituality, religion or other moral traditions" instead of the specific name of a tradition.

- Spiritual, religious, and moral identity *
- Role of spirituality, religion, and moral traditions *
- Relationship to the [PROBLEM]
- Potential stressors or conflicts related to spirituality, religion, and moral traditions

* Includes perspective of social network

Modules that expand sections of CFI

6. Cultural identity (34 items)

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

- National, ethnic, racial background *
- Language
- Migration
- Spirituality, religion, and moral traditions *
- Gender identity
- Sexual orientation identity
- Summary

* Includes perspective of social network

Modules that expand sections of CFI

7. Coping and help seeking (13 items)

Clarifies the patient's ways of coping with the current problem. The patient may have identified the problem as a symptom or mentioned a term or expression (e.g., "nerves," "being on edge," spirit possession), or a situation (e.g., loss of a job), or a relationship (e.g., conflict with others).

-Self-coping

-Social network *

-Help- and treatment-seeking beyond social network

-Current treatment episode *

8. Patient-clinician relationship (12 items) *

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

The 1st set of questions evaluates 4 domains in the clinician-patient relationship from the point of view of the patient: experiences, expectations, communication, and possibility of collaboration with the clinician. The second set of questions is directed to the clinician to guide reflection on the role of cultural factors in the clinical relationship, the assessment, and treatment planning.

* Includes perspective of social network

Modules for special populations

9. School-age children and adolescents (28 items)

Identifies, from the perspective of the child/youth, the role of age-related cultural expectations, the possible cultural divergences between school, home, and the peer group, and whether these issues impact on the situation or problem that brought the youth for care. The questions indirectly explore cultural challenges, stressors and resilience, and issues of cultural hybridity, mixed ethnicity or multiple ethnic identifications. Peer group belonging is important to children and adolescents, and questions exploring ethnicity, religious identity, racism or gender difference should be included following the child's lead. Some children may not be able to answer all questions; clinicians should select and adapt questions to ensure they are developmentally appropriate for the patient. Children should not be used as informants to provide socio-demographic information on the family or an explicit analysis of the cultural dimensions of their problems. An Addendum lists cultural aspects of development and parenting that can be evaluated during parents' interviews.

-Feelings of appropriateness in different settings

-Age-related stressors and supports

-Age-related expectations *

-Transition to adulthood/maturity (for adolescents only) *

-Addendum for parents' interview *

* Includes perspective of social network

Modules for special populations

10. Older adults (17 items)

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

- Conceptions of aging and cultural identity *
- Conceptions of aging in relationship to illness attributions and coping
- Influence of comorbid medical problems and treatments on illness
- Quality and nature of social supports and caregiving *
- Additional age-related transitions
- Positive and negative attitudes towards aging and clinician-patient relationship

* Includes perspective of social network

Modules for special populations

11. Immigrants and refugees (18 items)

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

-Background information

-Pre-migration difficulties *

-Migration-related losses and challenges *

-Ongoing relationship with country of origin *

-Resettlement and new life *

-Relationship with problem

-Future expectations

* Includes perspective of social network

Modules for special populations

12. Caregivers (14 items)

This module is designed to be administered to individuals who provide caregiving for the patient being assessed with the CFI. This module aims to explore the nature and cultural context of caregiving, and the social support and stresses in the patients' immediate environment from the perspective of the caregiver.

-Nature of relationship

-Caregiving activities and cultural perceptions of caregiving *

-Social context of caregiving *

-Clinical support for caregiving *

* Includes perspective of social network

Supplementary modules



An Example: Cultural Identity Module

- National, Ethnic, Racial Background
 - 7 questions
- Language <http://psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
 - 6 questions
- Migration [measures](http://psychiatry.org/practice/dsm/dsm5/online-assessment-measures)
 - 9 questions
- Spirituality, Religion, and Moral Traditions
 - 3 questions
- Gender Identity
 - 3 questions
- Sexual Orientation Identity
 - 4 questions