The DSM-5 Approach to Assessing Culturally Relevant Issues for Treatment & Diagnostic Decision Making

Presenters:
Tim Barksdale PsyD  Cheryll Rothery PsyD ABPP  Kee O’Toole M.S
OBJECTIVES

AT THE COMPLETION OF THIS COURSE, ATTENDEES WILL BE ABLE TO:

• Report the significance of culture in diagnoses and treatment

• Discuss the history of DSM related to cultural diversity

• Compare and contrast the DSM 5 cultural approach to other suggested methods

• Describe the Cultural Formulation Interview Tool (CFI).

• Explain the ethical considerations and supervisory implications for using the CFI

• Apply the experience of being an interviewer and interviewee in using the DSM-5 Cultural Formulation Interview in simulated conditions.
INTRODUCTIONS

- Pair with someone you do not know
- Two Interview questions for your new friend after exchanging names:
  1. For you, what are the most important aspects of your background or identity?
  2. Are there any parts or aspects of your identity that bring you to this class today?
WHY EXPLORE CULTURAL ISSUES?

The value, ethics and significance of recognizing cultural differences for diagnoses & treatment

Tim Barksdale PsyD, NADD-CC*
WHY

• To address the growing political and social presence of diverse cultural groups, both within APA and in the larger society

• New sets of values, beliefs, and cultural expectations have been introduced into educational, political, business, and healthcare systems by the physical presence of these groups. [macro systems]

• The issues of language and culture do impact on the provision of appropriate psychological services. (APA 1990)
COST OF CULTURAL INCOMPETENCE

- Miscommunication
  - (verbal and non-verbal language barriers)
- Refusal to participate in treatment
- Ineffective counseling relationship
- Risks of missing key issues
- Allegations of neglect or abuse more likely
BENEFITS CULTURAL COMPETENCE FOR PSYCHOLOGY PRACTICE

Business benefits

• Incorporates different perspectives, ideas and strategies into the decision-making process
• Improves efficiency of care services
• Increases the referral & client pool
• Increases office and community safety
• Increases cost savings from a reduction in hospital stays and legal costs
• Increased attendance/Decreased missed appointments
• Increased Client Retention
BENEFITS CULTURAL COMPETENCE

• **Social benefits**
  • Increases mutual respect and understanding between patient & the practice
  • Increases trust
  • Promotes inclusion of all community members
  • Increases community participation
  • Assists patients and families in their care
  • Promotes patient and family responsibilities for health
Health Benefits

- Improves patient data collection
- Increases preventive care by patients
- Reduces care disparities in the patient population
GUIDELINES FOR PROVIDERS OF PSYCHOLOGICAL SERVICES TO ETHNIC, LINGUISTIC, AND CULTURALLY DIVERSE POPULATIONS

Approved by the Council of Representatives in August of 1990 during the 98th Annual APA Convention in Boston, Massachusetts.

• (Hand-Out)
Psychological Service providers need a socio-cultural framework for multicultural assessment and intervention, including the ability to:

- recognize cultural diversity (not color blind)
- understand the role that culture and ethnicity/race play in the socio-psychological and economic development of ethnic and culturally diverse populations
- understand that socioeconomic and political factors significantly impact the psychosocial, political and economic development of ethnic and culturally diverse groups.
- help clients to understand/maintain/resolve their own socio-cultural identification; and understand the interaction of culture, gender, and sexual orientation on behavior and needs.  (APA, 1990)
THE DSM APPROACH TO DIVERSITY
A Historical Review

Kee O’Toole M.S.
DSM: DEFINITION OF MENTAL DISORDER

- Mental disorders occur “in an individual” rather than within a larger context.

- Adherence to western, American models of the self, restricts conceptualization of mental disorders, diagnostic constructs are themselves culture-bound (Kinghorn, 2013, p. 58).

- DSM definition of mental disorder & DSM did not develop in a historical vacuum (Kinghorn, 2013, p. 52).
HISTORY OF SEXUAL IDENTITY ISSUES AND DSM

• DSM-I (1952) Influence of psychoanalytic ego psychology, Homosexuality classified as mental illness (“Sociopathic Personality Disturbance”).

• DSM-II (1968) Homosexuality reclassified as Sexual Deviation.

• DSM-III (1973) Removal of Homosexuality (Spitzer brokered compromise), replaced with Sexual Orientation Disorder.
  • In response to scientific research supporting a non-pathological view, gay activism, and younger membership urging APA to greater social consciousness. (Drescher, 2010; Gittings, B, 2008)
HISTORY OF SEXUAL IDENTITY ISSUES AND DSM

• DSM-III (1980) Sexual Orientation Disorder changed to Ego Dystonic Homosexuality.

• DSM-III-R (1987) Ego Dystonic Homosexuality removed, APA accepted a normal variant view of homosexuality. Classification of Sexual Disorder, NOS.

• DSM-IV (1994) and DSM-IV-TR (2000) Gender Identity Disorder, Gender Identity Disorder, NOS, and Sexual Disorder, NOS.

(Drescher, 2010)
HISTORY OF SEXUAL IDENTITY ISSUES AND DSM

• Gender Identity Disorder

  Criterion A: “evidence of a strong and persistent cross-gender identification, which is a desire to be, or the insistence that one is, of the other sex”

  Criterion B: “evidence of persistent discomfort about one’s assigned sex or a sense of one’s assigned sex or a sense of inappropriateness in the gender role of that sex”

(APA, 2000, p. 576)
HISTORY OF SEXUAL IDENTITY
ISSUES AND DSM

• Many trans activists with LGB support and straight allies are calling for removal of GID diagnosis (like 1973 removal of Homosexuality from DSM-II).

• Also activists and supporters who want to retain psychiatric diagnosis as a needed step for medical treatment.

• While others want to remove mental health professionals from maintaining a gatekeeping role of determining psychological fitness for transition (medical vs. psychiatric disorder).

Drescher, 2010
HISTORY OF RELIGIOUS & SPIRITUAL ISSUES IN THE DSM
HISTORY OF RELIGIOUS & SPIRITUAL ISSUES AND DSM

- Religion and spiritual in DSM: from pathology to cultural consideration (Allomon, 2013).

- 1/6 clients presents issues involving religion/spirituality (Shafranske & Malony, 1990)

- Common appearance of religion/spirituality in client issues, a multicultural concept needing incorporation in assessment and diagnosis (Good, 1996).
HISTORY OF RELIGIOUS & SPIRITUAL ISSUES AND DSM

• DSM-III-R added as “afterthought” (Good, 1996).

• Pathologizing of religion in DSM-III-R (Post, 1992)
  • Over-inclusion of religion and spirituality in Glossary of Technical Terms (22%) more than in psychiatric literature (1%).

• 30% of all clinical caveats about diagnosis involved religion, more than other diversity factors (e.g., gender, race, ethnicity, culture).
HISTORY OF RELIGIOUS & SPIRITUAL ISSUES AND DSM

• DSM-IV provided more balanced and respectful interpretation of religion (Post, 1992).
  • Five Main Changes (Turner, 1995)
    • Included in Outline for Cultural Formulation (psychosocial environmental factor).
    • Glossary of Culture-Bound Syndromes, many diagnoses with religious/spiritual aspects.
    • Axis I & II include religious & spiritual considerations as cultural factor.
    • Language shifted from extremely pathological to more neutral (e.g., delusion definition)
    • Addition of Religious or Spiritual Problem V Code (V62.89).
Purpose of V Code:

1) Improved diagnostic assessment when religious/spiritual issues involved.

2) Reduction of harm from misdiagnosis of religious/spiritual problems.

3) Stimulate clinical research to improve treatment in such problems.

4) Encourage clinical training in addressing religious/spiritual dimensions of human experience.

(Lukoff et al, 1992)
• Examples of Religious or Spiritual Problem (V62.89):

  “distressing experiences that involve loss or questioning of faith”

  “problems associated with conversion to a new faith”

  “questioning of spiritual values that may not necessarily be related to an organized church or religious institution”

  (APA, 1994, p.741)
HISTORY OF RELIGIOUS & SPIRITUAL ISSUES AND DSM

• DSM-IV diagnoses with religious implications:

  Obsessive Compulsive Disorder
  Dissociative Trance Disorder
  Bipolar Disorder
  Substance Abuse
  Other Conditions That May Be Of Focus of Clinical Concern
HISTORY OF CULTURAL ISSUES AND DSM

• “Prior to DSM-IV, clinical diagnostic process was culturally biased, invariance in symptoms and disorders across cultures was assumed (Dana, 2008, p. 107).

• DSM-IV, unprecedented recognition of cultural diversity.
  • Approximately 15 of 849 pages contain caveats regarding culture, age, and gender intersection with mental illness (Dana, 2001, p. 116)
HISTORY OF CULTURAL ISSUES AND DSM

• Cultural Considerations in DSM-IV

  • Information on intersection of cultural factors with diagnoses in the “Specific Culture, Age, and Gender Features” section.

  • 3 V Codes focus on cultural factors (e.g., acculturation, religious or spiritual problems, and identity problem).

  • Axis IV allows incorporation of psychosocial and environmental influences on the presence of mental illness (e.g., overt racism, sexism, and other forms of systemic oppression) (Hays, 2008)
HISTORY OF CULTURAL ISSUES AND DSM

• Cultural Considerations of DSM-IV and DSM-IV-TR

  Inclusion of **Culture-Bound Syndromes** (25 in Glossary)

  “denotes recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to particular DSM-IV diagnostic category.

  Many of these patterns are indigenously considered to be “illnesses” or at least afflictions, and most have local names.” (APA, 2000, p.898)
HISTORY OF CULTURAL ISSUES AND DSM

- DSM-IV and DSM-IV-TR: Cultural Formulation
  
  Most important addition.
  Outline presented as Appendix.

  Designed for systematic review of patient’s cultural history (e.g., cultural identity, cultural explanations of illness, cultural factors of social environment, levels of functioning or disability, cultural factors in patient’s relationship with clinician) and written as narrative.

  (Dana, 2001, p. 116)
THE CULTURAL FORMULATION INTERVIEW

An Introduction
Cheryll Rothery PsyD, ABPP
COMPONENTS OF THE CFI

• Relationship with the Client

• Cultural Definition of the Problem

• Cultural Perceptions of Cause, Context, and Support
  • Causes
  • Stressors and Supports
COMPONENTS OF THE CFI

• Cultural Factors Affecting Self-Coping and Past Help Seeking
  • Self-Coping
  • Past Help Seeking
  • Barriers

• Cultural Factors Affecting Current Help Seeking
  • Preferences
  • Clinician-Client Relationship
CFI OF THE “JONES” FAMILY

• Relationship with the Client

• Cultural Definition of the Problem

• Cultural Perceptions of Cause, Context, and Support
  • Causes
  • Stressors and Supports
  • Role of Cultural Identity
CFI OF THE “JONES” FAMILY

• Cultural Factors Affecting Self-Coping and Past Help Seeking
  • Self-Coping
  • Past Help Seeking
  • Barriers

• Cultural Factors Affecting Current Help Seeking
  • Preferences
  • Clinician-Client Relationship
USE OF THE CFI

An Experiential Exercise
DEBRIEF
THE DSM-5 APPROACH, STRENGTHS AND LIMITATIONS

Tim Barksdale PsyD
PERCEIVED BARRIERS
QUALITATIVE STUDY(2013)

• Patient Threats: (N=32)
  • Lack of differentiation from Other treatments
  • Lack of Buy-in
  • Ambiguity of design
  • Over-standardization of the CFI
  • Severity of illness
IMPLEMENTATION BARRIERS
QUALITATIVE STUDY (2013)

Clinician Threats: (N=7)

- Lack of conceptual relevance between intervention and the problem
- Drift from Format
- Repetition
- Severity of Patient
- Lack of Clinician Buy-in
CFI GOOD POINTS

• Asks about culturally variables on a person centered basis
• Identifies cultural variables that we did not know exists
  • Military gay, Jewish Africans, Native American Bricklayers in unions
• Potential for scientific evidence of relevance of culture on treatment
  • based on practice of clinicians and outcomes of participants.
• Provides clinically rich information that would not be anticipated otherwise
• Participants perceive that clinician really listens and has genuine interest
• Participants like open ended questions that are not right or wrong giving more control in providing their own narratives.
REFERENCES


REFERENCES


THANK YOU

• Please complete and turn-in your evaluations

• Don’t Forget to Stop by The Committee of Multiculturalism (CoM) table in the Vendors Area

• Sign up and become a member of CoM, (at the resource table)
Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations

These guidelines were approved by the Council of Representatives in August of 1990 during the 98th Annual APA Convention in Boston, Massachusetts.

Introduction

There is increasing motivation among psychologists to understand culture and ethnicity factors in order to provide appropriate psychological services. This increased motivation for improving quality of psychological services to ethnic and culturally diverse populations is attributable, in part, to the growing political and social presence of diverse cultural groups, both within APA and in the larger society. New sets of values, beliefs, and cultural expectations have been introduced into educational, political, business, and healthcare systems by the physical presence of these groups. The issues of language and culture do impact on the provision of appropriate psychological services.

Psychological service providers need a sociocultural framework to consider diversity of values, interactional styles, and cultural expectations in a systematic fashion. They need knowledge and skills for multicultural assessment and intervention, including abilities to:

1. recognize cultural diversity;
2. understand the role that culture and ethnicity/race play in the sociopsychological and economic development of ethnic and culturally diverse populations;
3. understand that socioeconomic and political factors significantly impact the psychosocial, political and economic development of ethnic and culturally diverse groups;
4. help clients to understand/maintain/resolve their own sociocultural identification; and understand the interaction of culture, gender, and sexual orientation on behavior and needs.

Likewise, there is a need to develop a conceptual framework that would enable psychologists to organize, access, and accurately assess the value and utility of existing and future research involving ethnic and culturally diverse populations.

Research has addressed issues regarding responsiveness of psychological services to the needs of ethnic minority populations. The focus of mental health research issues has included:

1. The impact of ethnic/racial similarity in the counseling process (Acosta & Sheenan, 1976; Atkinson, 1983; Parham & Helms, 1981);
2. Minority utilization of mental health services (Cheung & Snowden, 1990; Everett, Proctor, & Cartmell, 1983; Rosado, 1986; Snowden & Cheung, 1990);
3. Relative effectiveness of directed versus nondirected styles of therapy (Acosta, Yamamomoto, & Evans, 1982; Dauphinais, Dauphinais, & Rowe, 1981; Lorion, 1974);
4. The role of cultural values in treatment (Juarez, 1985; Padilla & Ruiz, 1973; Padilla, Ruiz, & Alvarez, 1975; Sue & Sue, 1987);
5. Appropriate counseling and therapy models (Comas-Diaz & Griffith, 1988; McGoldrick, Pearce, & Giordino, 1982; Nishio & Blimes, 1987);
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6. Competency in skills for working with specific ethnic populations (Malgady, Rogler, & Constantino, 1987; Root, 1985; Zuniga, 1988).

The APA's Board of Ethnic Minority Affairs (BEMA) established a Task Force on the Delivery of Services to Ethnic Minority Populations in 1988 in response to the increased awareness about psychological service needs associated with ethnic and cultural diversity. The populations of concern include, but are not limited to the following groups: American Indians/Alaska Natives, Asian Americans, and Hispanics/Latinos. For example, the populations also include recently arrived refugee and immigrant groups and established U.S. subcultures such as Amish, Hasidic Jewish, and rural Appalachian people.

The Task Force established as its first priority development of the Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations. The guidelines that follow are intended to enlighten all areas of service delivery, not simply clinical or counseling endeavors. The clients referred to may be clients, organizations, government and/or community agencies.

Guidelines

Preamble: The Guidelines represent general principles that are intended to be aspirational in nature and are designed to provide suggestions to psychologists in working with ethnic, linguistic, and culturally diverse populations.

1. Psychologists educate their clients to the processes of psychological intervention, such as goals and expectations; the scope and, where appropriate, legal limits of confidentiality; and the psychologists' orientations.
   a. Whenever possible, psychologists provide information in writing along with oral explanations.
   b. Whenever possible, the written information is provided in the language understandable to the client.

2. Psychologists are cognizant of relevant research and practice issues as related to the population being served.
   a. Psychologists acknowledge that ethnicity and culture impacts on behavior and take those factors into account when working with various ethnic/racial groups.
   b. Psychologists seek out educational and training experiences to enhance their understanding to address the needs of these populations more appropriately and effectively. These experiences include cultural, social, psychological, political, economic, and historical material specific to the particular ethnic group being served.
   c. Psychologists recognize the limits of their competencies and expertise. Psychologists who do not possess
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- Knowledge and training about an ethnic group seek consultation with, and/or make referrals to, appropriate experts as necessary.

  d. Psychologists consider the validity of a given instrument or procedure and interpret resulting data, keeping in mind the cultural and linguistic characteristics of the person being assessed. Psychologists are aware of the test's reference population and possible limitations of such instruments with other populations.

3. Psychologists recognize ethnicity and culture as significant parameters in understanding psychological processes.

  a. Psychologists, regardless of ethnic/racial background, are aware of how their own cultural background/experiences, attitudes, values, and biases influence psychological processes. They make efforts to correct any prejudices and biases.

  Illustrative Statement: Psychologists might routinely ask themselves, 'Is it appropriate for me to view this client or organization any differently than I would if they were from my own ethnic or cultural group?'

  b. Psychologists’ practice incorporates an understanding of the client's ethnic and cultural background. This includes the client's familiarity and comfort with the majority culture as well as ways in which the client's culture may add to or improve various aspects of the majority culture and/or of society at large.

  Illustrative Statement: The kinds of mainstream social activities in which families participate may offer information about the level and quality of acculturation to American society. It is important to distinguish acculturation from length of stay in the United States, and not to assume that these issues are relevant only for new immigrants and refugees.

  c. Psychologists help clients increase their awareness of their own cultural values and norms, and they facilitate discovery of ways clients can apply this awareness to their own lives and to society at large.

  Illustrative Statement: Psychologists may be able to help parents distinguish between generational conflict and culture gaps when problems arise between them and their children. In the process, psychologists could help both parents and children to appreciate their own distinguishing cultural values.

  d. Psychologists seek to help a client determine whether a 'problem' stems from racism or bias in others so that the client does not inappropriately personalize problems.

  Illustrative Statement: The concept of 'healthy paranoia,' whereby ethnic minorities may develop defensive behaviors in response to discrimination, illustrates this principle.

  e. Psychologists consider not only differential diagnostic issues but also cultural beliefs and values of the clients and his/her community in providing intervention.

  Illustrative Statement: There is a disorder among the traditional Navajo called 'Moth Madness.' Symptoms include seizure-like behaviors. The disorder is believed by the Navajo to be the supernatural result of
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incestuous thoughts or behaviors. Both differential diagnosis and intervention should take into consideration the traditional values of Moth Madness.

4. Psychologists respect the roles of family members and community structures, hierarchies, values, and beliefs within the client's culture.

a. Psychologists identify resources in the family and the larger community.

b. Clarification of the role of the psychologist and the expectations of the client precede intervention. Psychologists seek to ensure that both the psychologist and client have a clear understanding of what services and roles are reasonable.

Illustrative Statement: It is not uncommon for an entire American Indian family to come into the clinic to provide support to the person in distress. Many of the healing practices found in American Indian communities are centered in the family and the whole community.

5. Psychologists respect clients' religious and/or spiritual beliefs and values, including attributions and taboos, since they affect world view, psychosocial functioning, and expressions of distress.

a. Part of working in minority communities is to become familiar with indigenous beliefs and practices and to respect them.

Illustrative Statement: Traditional healers (e.g., shamans, curanderos, espiritistas) have an important place in minority communities.

b. Effective psychological intervention may be aided by consultation with and/or inclusion of religious/spiritual leaders/practitioners relevant to the client's cultural and belief systems.

6. Psychologists interact in the language requested by the client and, if this is not feasible, make an appropriate referral.

a. Problems may arise when the linguistic skills of the psychologist do not match the language of the client. In such a case, psychologists refer the client to a mental health professional who is competent to interact in the language of the client. If this is not possible, psychologists offer the client a translator with cultural knowledge and an appropriate professional background. When no translator is available, then a trained paraprofessional from the client's culture is used as a translator/culture broker.

b. If translation is necessary, psychologists do not retain the services of translators/paraprofessionals that may have a dual role with the client to avoid jeopardizing the validity of evaluation or the effectiveness of intervention.

c. Psychologists interpret and relate test data in terms understandable and relevant to the needs of those assessed.
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7. Psychologists consider the impact of adverse social, environmental, and political factors in assessing problems and designing interventions.

   a. Types of intervention strategies to be used match to the client's level of need (e.g., Maslow's hierarchy of needs).

   Illustrative Statement: Low income may be associated with such stressors as malnutrition, substandard housing, and poor medical care; and rural residency may mean inaccessibility of services. Clients may resist treatment at government agencies because of previous experience (e.g., refugees' status may be associated with violent treatments by government officials and agencies).

   b. Psychologists work within the cultural setting to improve the welfare of all persons concerned, if there is a conflict between cultural values and human rights.

8. Psychologists attend to as well as work to eliminate biases, prejudices, and discriminatory practices.

   a. Psychologists acknowledge relevant discriminatory practices at the social and community level that may be affecting the psychological welfare of the population being served.

   Illustrated Statement: Depression may be associated with frustrated attempts to climb the corporate ladder in an organization that is dominated by a top echelon of White males.

   b. Psychologists are cognizant of sociopolitical contexts in conducting evaluations and providing interventions; they develop sensitivity to issues of oppression, sexism, elitism, and racism.

   Illustrated Statement: An upsurge in the public expression of rancor or even violence between two ethnic or cultural groups may increase anxiety baselines in any member of these groups. This baseline of anxiety would interact with prevailing symptomatology. At the organizational level, the community conflict may interfere with open communication among staff.

9. Psychologists working with culturally diverse populations should document culturally and sociopolitically relevant factors in the records.

   a. number of generations in the country
   b. number of years in the country
   c. fluency in English
   d. extent of family support (or disintegration of family)
   e. community resources
   f. level of education
   g. change in social status as a result of coming to this country (for immigrant or refugee)
   h. intimate relationship with people of different backgrounds
   i. level of stress related to acculturation
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The APA is offering the Cultural Formulation Interview (including the Informant Version) and the Supplementary Modules to the Core Cultural Formulation Interview for further research and clinical evaluation. They should be used in research and clinical settings as potentially useful tools to enhance clinical understanding and decision-making and not as the sole basis for making a clinical diagnosis. Additional information can be found in DSM-5 in the Section III chapter “Cultural Formulation.” The APA requests that clinicians and researchers provide further data on the usefulness of these cultural formulation interviews at http://www.dsm5.org/Pages/Feedback-Form.aspx.

Measure: Cultural Formulation Interview (CFI)—Informant Version

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Cultural Formulation Interview (CFI)—Informant Version

**GUIDE TO INTERVIEWER**

The following questions aim to clarify key aspects of the presenting clinical problem from the informant’s point of view. This includes the problem’s meaning, potential sources of help, and expectations for services.

**INSTRUCTIONS TO THE INTERVIEWER ARE ITALICIZED.**

INTRODUCTION FOR THE INFORMANT:
I would like to understand the problems that bring your family member/friend here so that I can help you and him/her more effectively. I want to know about your experience and ideas. I will ask some questions about what is going on and how you and your family member/friend are dealing with it. There are no right or wrong answers.

### RELATIONSHIP WITH THE PATIENT

Clarify the informant’s relationship with the individual and/or the individual’s family.

| 1. | How would you describe your relationship to [INDIVIDUAL OR TO FAMILY]? |
| PROBE IF NOT CLEAR: |
| How often do you see [INDIVIDUAL]? |

### CULTURAL DEFINITION OF THE PROBLEM

Elicit the informant’s view of core problems and key concerns.
Focus on the informant’s way of understanding the individual’s problem.
Use the term, expression, or brief description elicited in question 1 to identify the problem in subsequent questions (e.g., “her conflict with her son”).

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

| 2. | What brings your family member/friend here today? |
| IF INFORMANT GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE: |
| People often understand problems in their own way, which may be similar or different from how doctors describe the problem. |
| How would you describe [INDIVIDUAL’S] problem? |

| 3. | Sometimes people have different ways of describing the problem to family, friends, or others in their community. How would you describe [INDIVIDUAL’S] problem to them? |

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

| 4. | What troubles you most about [INDIVIDUAL’S] problem? |

### CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT

**CAUSES**

This question indicates the meaning of the condition for the informant, which may be relevant for clinical care. Note that informants may identify multiple causes depending on the facet of the problem they are considering.

Focus on the views of members of the individual’s social network. These may be diverse and vary from the informant’s.

| 5. | Why do you think this is happening to [INDIVIDUAL]? What do you think are the causes of his/her [PROBLEM]? |
| PROMPT FURTHER IF REQUIRED: |
| Some people may explain the 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. |

| 6. | What do others in [INDIVIDUAL’S] family, his/her friends, or others in the community think is causing [INDIVIDUAL’S] [PROBLEM]? |
### Stressors and Supports

Elicit information on the individual’s life context, focusing on resources, social supports, and resilience. May also probe other supports (e.g., from co-workers, from participation in religion or spirituality).

Focus on stressful aspects of the individual’s environment. Can also probe, e.g., relationship problems, difficulties at work or school, or discrimination.

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<td>Are there any kinds of supports that make his/her [PROBLEM] better, such as from family, friends, or others?</td>
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<td>8.</td>
<td>Are there any kinds of stresses that make his/her [PROBLEM] worse, such as difficulties with money, or family problems?</td>
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### Role of Cultural Identity

Sometimes, aspects of people’s background or identity can make the [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, and your faith or religion.

Ask the informant to reflect on the most salient elements of the individual’s cultural identity. Use this information to tailor questions 10–11 as needed.

Elicit aspects of identity that make the problem better or worse.

Probe as needed (e.g., clinical worsening as a result of discrimination due to migration status, race/ethnicity, or sexual orientation).

Probe as needed (e.g., migration-related problems; conflict across generations or due to gender roles).

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<td>9.</td>
<td>For you, what are the most important aspects of [INDIVIDUAL’S] background or identity?</td>
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| 10. | Are there any aspects of [INDIVIDUAL’S] background or identity that make a difference to his/her [PROBLEM]?
| 11. | Are there any aspects of [INDIVIDUAL’S] background or identity that are causing other concerns or difficulties for him/her? |

### Cultural Factors Affecting Self-Coping and Past Help Seeking

#### Self-Coping

Clarify individual’s self-coping for the -problem.

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<td>Sometimes people have various ways of dealing with problems like [PROBLEM]. What has [INDIVIDUAL] done on his/her own to cope with his/her [-PROBLEM]?</td>
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#### Past Help Seeking

Elicit various sources of help (e.g., medical care, mental health treatment, support groups, work-based counseling, folk healing, religious or spiritual counseling, other alternative healing).

Probe as needed (e.g., “What other sources of help has he/she used?”).

Clarify the individual’s experience and regard for previous help.

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</table>
| 13. | Often, people also 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 has [INDIVIDUAL] sought for his/her [PROBLEM]?
|   | PROBE IF DOES NOT DESCRIBE USEFULNESS OF HELP RECEIVED:
|   | What types of help or treatment were most useful? Not useful? |
**BARRIERS**

Clarify the role of social barriers to help-seeking, access to care, and problems engaging in previous treatment.

14. Has anything prevented [INDIVIDUAL] from getting the help he/she needs?

_PROBE AS NEEDED:_

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

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**CULTURAL FACTORS AFFECTING CURRENT HELP SEEKING**

**PREFERENCES**

Clarify individual’s current perceived needs and expectations of help, broadly defined, from the point of view of the informant.

Probe if informant lists only one source of help (e.g., “What other kinds of help would be useful to [INDIVIDUAL] at this time?”).

Focus on the views of the social network regarding help seeking.

15. What kinds of help would be most useful to him/her at this time for his/her [PROBLEM]?

Now let’s talk about the help [INDIVIDUAL] needs.

16. Are there other kinds of help that [INDIVIDUAL’S] family, friends, or other people have suggested would be helpful for him/her now?

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**CLINICIAN-PATIENT RELATIONSHIP**

Elicit possible concerns about the clinic or the clinician-patient relationship, including perceived racism, language barriers, or cultural differences that may undermine goodwill, communication, or care delivery.

 Probe details as needed (e.g., “In what way?”).

Address possible barriers to care or concerns about the clinic and the clinician-patient relationship raised previously.

17. Have you been concerned about this, and is there anything that we can do to provide [INDIVIDUAL] with the care he/she needs?

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