The Cultural Formulation Interview:
A collaborative storytelling approach to Clinical Care

Session 1:

The Value of Person-Centered Cultural Assessment in Clinical Practice

April 7, 2022

South Southwest (HHS Region 6)

MHTTC Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Acknowledgement

Presented 2022

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INVITING TO INDIVIDUALS PARTICIPATING IN THEIR OWN JOURNEYS

STRENGTHS-BASED AND HOPEFUL

PERSON-FIRST AND FREE OF LABELS

INCLUSIVE AND ACCEPTING OF DIVERSE CULTURES, GENDERS, PERSPECTIVES, AND EXPERIENCES

NON-JUDGMENTAL AND AVOIDING ASSUMPTIONS

RESPECTFUL, CLEAR AND UNDERSTANDABLE

HEALING-CENTERED AND TRAUMA-RESPONSIVE

CONSISTENT WITH OUR ACTIONS, POLICIES, AND PRODUCTS

Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

South Southwest MHTTC Code of Conduct

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Thank you for your cooperation.
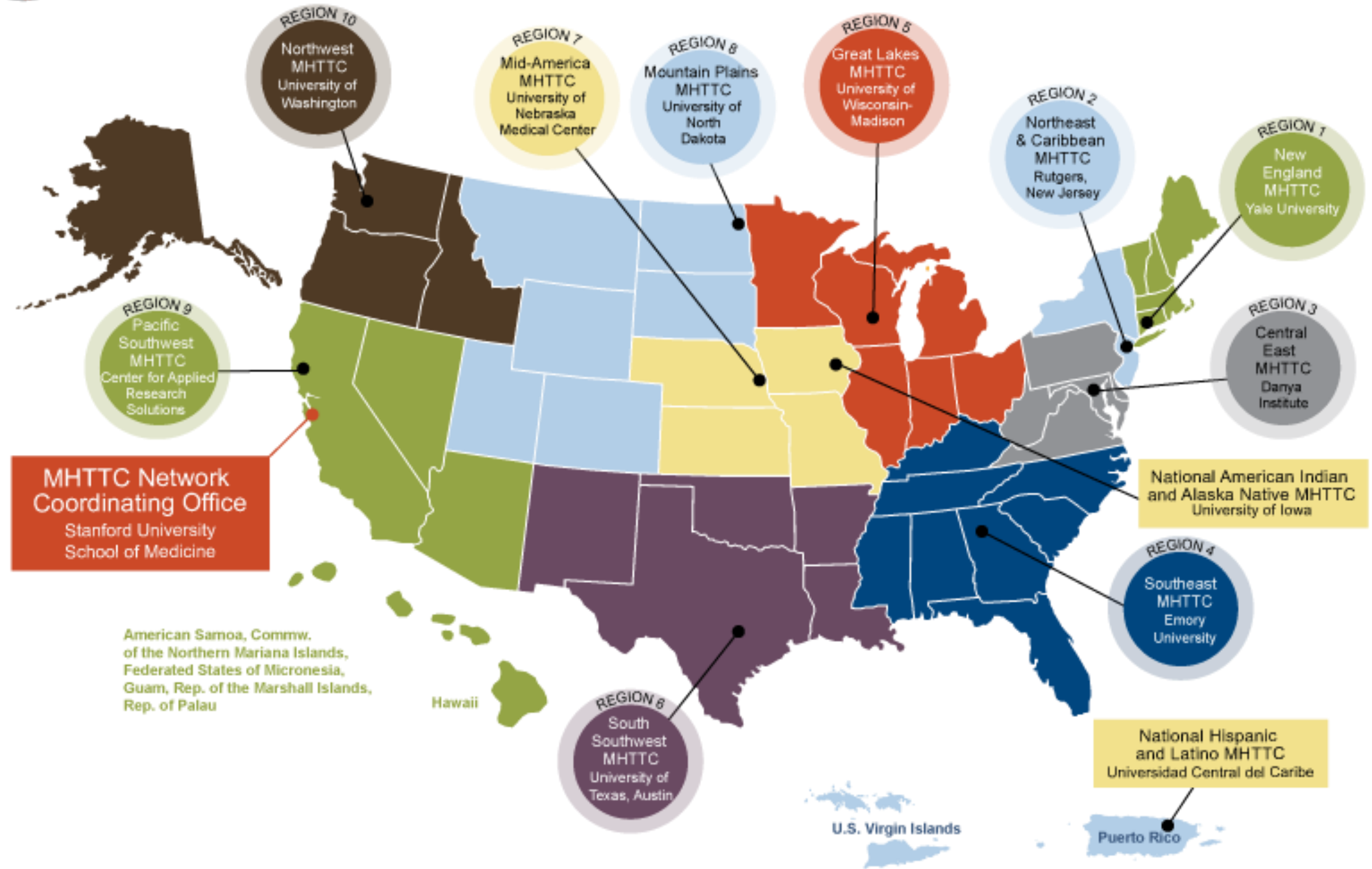
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The Value of Person-Centered Cultural Assessment in Clinical Practice

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Disclosure

We have no relevant disclosures

Take-away

Including person-centered cultural assessment in routine clinical care can contextualize clients' experience and enhance treatment planning and client engagement

Overview

- Goals of mental health assessment
- Definition of culture & cultural competence
- Cultural concepts of distress
- Social determinants of health, disparities & structural competence
- Individual cultural assessment
- Cultural Formulation Interview (CFI)
- Conclusions

GOALS OF MENTAL HEALTH ASSESSMENT

Goals of Assessment

- Witness patient's suffering
- Frame patient's account for managing treatment and course
- Establish a caring relationship
- Foster patient engagement

Medicalization–Contextualization

- Medicalization: focus on *disease*
  - ▫ E.g., diagnosis, technical aspects of treatment

- Contextualization: focus on *illness*
  - ▫ E.g., patient's cultural interpretations, life circumstances, structural risk factors, lifestyle

Consequences of De-contextualization

- Missing crucial information
- Poor patient satisfaction
- Mistrust/miscommunication
- Limited patient engagement
- Incomplete research
- Clinician burnout?
- Higher risk of lawsuits?

Potential Solutions

- Cultural competence/humility/safety
- Structural competence: SDOMH
- Attention to patient narratives
- Shared decision-making
- Person-centered care
- Inclusion of patient's social network
- Peer involvement
- Recovery orientation
- Addressing barriers to care

DEFINITION OF CULTURE & CULTURAL COMPETENCE

What is culture?

- Culture as <u>process</u> of meaning making and social practice
- Linked to participation in multiple social groups
- Culture has <u>always</u> been mixed or creolized
- Risks of thinking of culture as static group characteristics
- Must engage person to elicit cultural views and practices

Fish don't know they are in water

DSM-5-TR Definition of Culture

Processes through which people **assign meaning to experience,** drawing from **values, orientations, knowledge, and practices** of the diverse social groups in which they participate

Aspects of a person's background, experience, and social context and position that may affect their perspective

The influence of family, friends, and other community members (the individual's *social network*) on the individual's illness experience

Cultural background of healthcare providers and **values and assumptions** embedded in the organization and practices of **health care systems and institutions** that may affect the clinical interaction

Cultural Competence

▶ A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations
                                                    US Department of Health and Human Services

▶ The multi-pronged ability of a health care system to engage and provide high-quality care to clients with diverse values, beliefs and behaviors
  ▶ Creating organizational policies and procedures
  ▶ Tailoring service delivery to meet client social, cultural, and linguistic needs
  ▶ Training staff to appropriately respond to clients from diverse cultural groups
  ▶ Close monitoring of compliance with cultural competence
  ▶ Reducing disparities in service delivery and outcomes

US Office of Minority Health

CULTURAL CONCEPTS OF DISTRESS

Cultural Concepts of Distress
DSM-5-TR

- "Ways that individuals experience, understand, and communicate suffering, behavioral problems, or troubling thoughts and emotions"

  DSM-5-TR, 2021

- Local forms of distress that depend on specific culturally-based attributions, behavioral responses, and interpersonal interaction patterns

  Kaplan & Sadock Comprehensive Textbook, in press

- Occur in all geographic regions

- Replaces "culture-bound syndromes" in psychiatry
  - Not "bound"
  - Not necessarily syndromal
  - Not always psychopathology

Lewis-Fernández & Kirmayer, 2019; Lewis-Fernández, Kirmayer, Kohrt, in press

Key Elements of Cultural Concepts of Distress

Cultural Idioms of Distress	Cultural Explanations	Cultural Syndromes
Linguistic or nonverbal mode of communication: local "languages" for expressing distress	Reference etiologies rooted in local systems of knowledge	Collections of co-occurring signs and symptoms
Not necessarily linked to specific signs and symptoms		Distinctive courses, precipitants, causal attributions, and treatment responses
Do not presuppose psychopathology		
Suggest tension with idioms of resilience		
Can guide help seeking		

Lewis-Fernández & Kirmayer, 2019; Lewis-Fernández, Kirmayer, Kohrt, in press

Body-Mind Holism: Khyâl cap

A *Khyâl* Attack (an upsurge of *khyâl* and blood in the body): Associated symptoms, ethnophysiology, and catastrophic cognitions

Head
• headache from *khyâl* entering the cranium (*khyâl* may cause syncope)
  dizziness from *khyâl* entering the cranium (*khyâl* may cause syncope)

• tinnitus from *khyâl* exiting through the ears (*khyâl* may cause deafness and syncope)
• blurry vision from *khyâl* exiting through the eyes (*khyâl* may cause blindness and syncope)

Neck
• neck soreness from *khyâl* distending the neck vessels (*khyâl* may cause neck vessel rupture)

Heart and Lungs
• palpitations from *khyâl* hitting the heart (*khyâl* may cause heart arrest)
• chest discomfort from *khyâl* entering the chest cavity (*khyâl* may cause asphyxia)
• shortness of breath from *khyâl* compressing the lungs (*khyâl* may cause asphyxia)

Stomach
• stomach discomfort and bloating from excessive *khyâl* (*khyâl* may move up from the stomach into the trunk of the body to cause the disasters listed above)

Hands and Arms
• cold hands from a lack of flow of *khyâl* and blood to the hands (this lack of flow may cause "death of the hands," i.e., stroke, and an upsurge of *khyâl* and blood in the body)
• sore arms from blockage of blood and *khyâl* flow owing to coagulation-like plugs (this lack of flow may cause "death of the hands," i.e., stroke, and an upsurge of *khyâl* and blood in the body)

Feet and Legs
• cold feet from a lack of flow of *khyâl* and blood to the feet (this lack of flow may cause "death of the legs," i.e., stroke, and an upsurge of *khyâl* and blood in the body)
• sore legs from blockage of blood and *khyâl* flow owing to coagulation-like plugs (this lack of flow may cause "death of the legs," i.e., stroke, and an upsurge of *khyâl* and blood in the body)

Hinton 2001; 2010; 2012

Cultural Concepts of Distress and Psychiatric Disorders

DSM-5

Latinx Caribbean Cultural Concepts

DSM-5	Latinx Caribbean Cultural Concepts
Major Depression	*Ataques de nervios*
GAD	Altered perceptions
PTSD	Suffer from nerves
Panic Disorder	Be sick with nerves
Schizophrenia	Be *loco*
Other Specified Dissociative D/o	Have *facultades*
Conversion Disorder	Suffer from a demon
Borderline Personality D/o	Be nervous since childhood
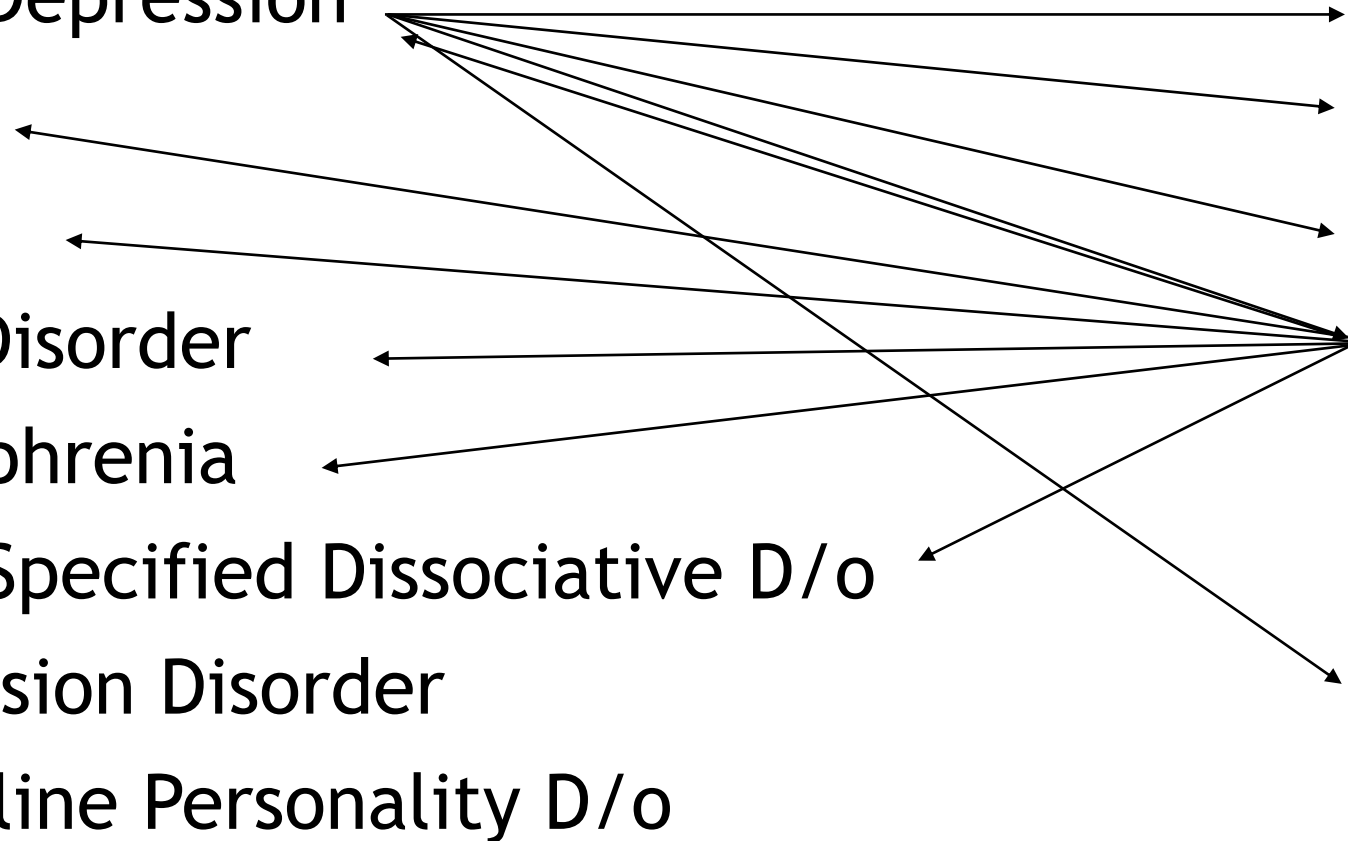
Cultural Concepts of Distress and Psychiatric Disorders

Source: Peter Guarnaccia, PhD
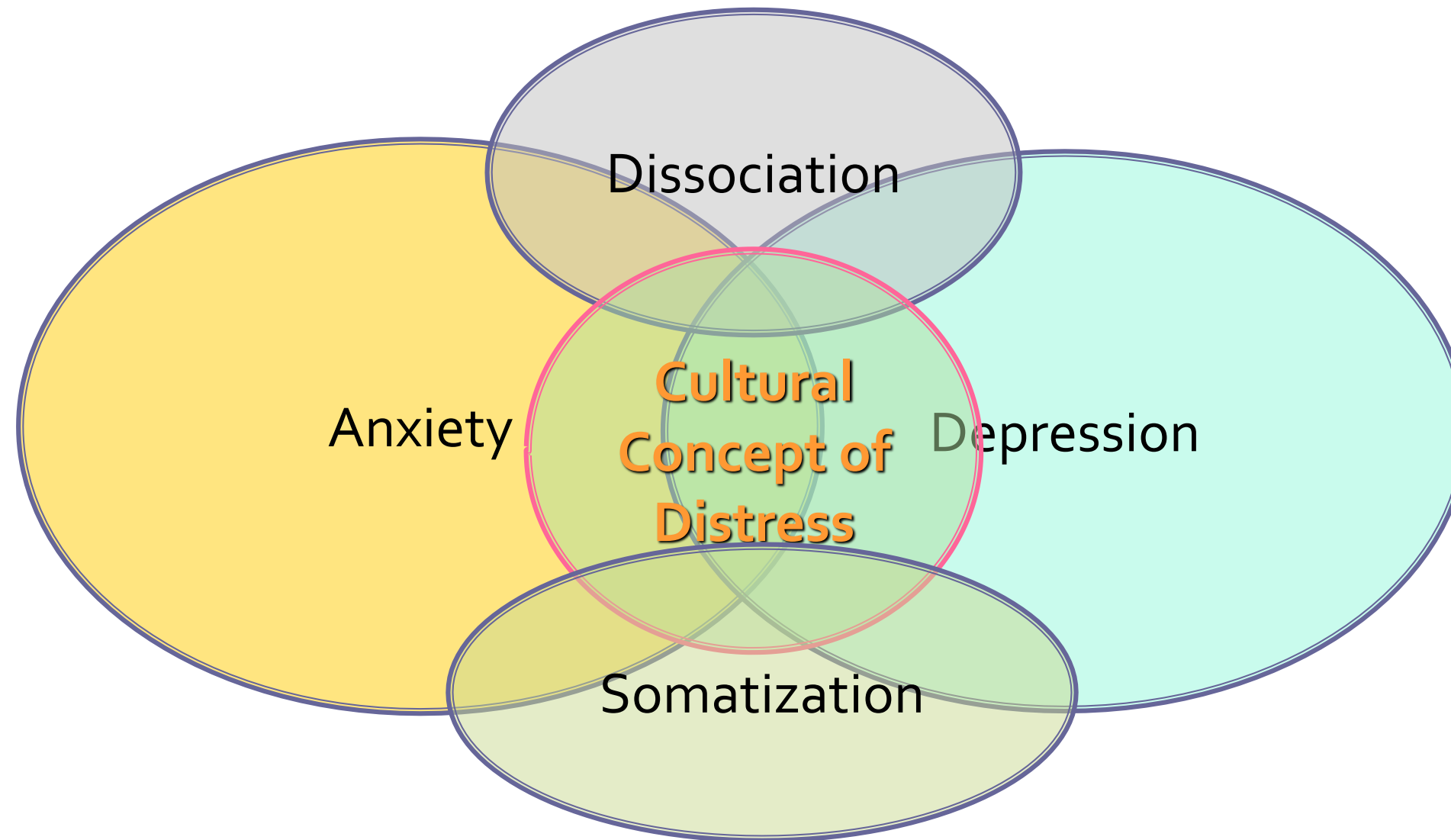
Uses of Cultural Concepts of Distress

Conceptually

- Clarify social construction of psychopathology
  - Recursive interaction of personal and collective interpretation within social contexts

- Reduce over-medicalization

- Help trace a path from distress to resilience

- Guide research on mechanisms & markers of morbidity

- Suggest missing diagnostic categories

- Guide cultural epidemiology - identify most at risk

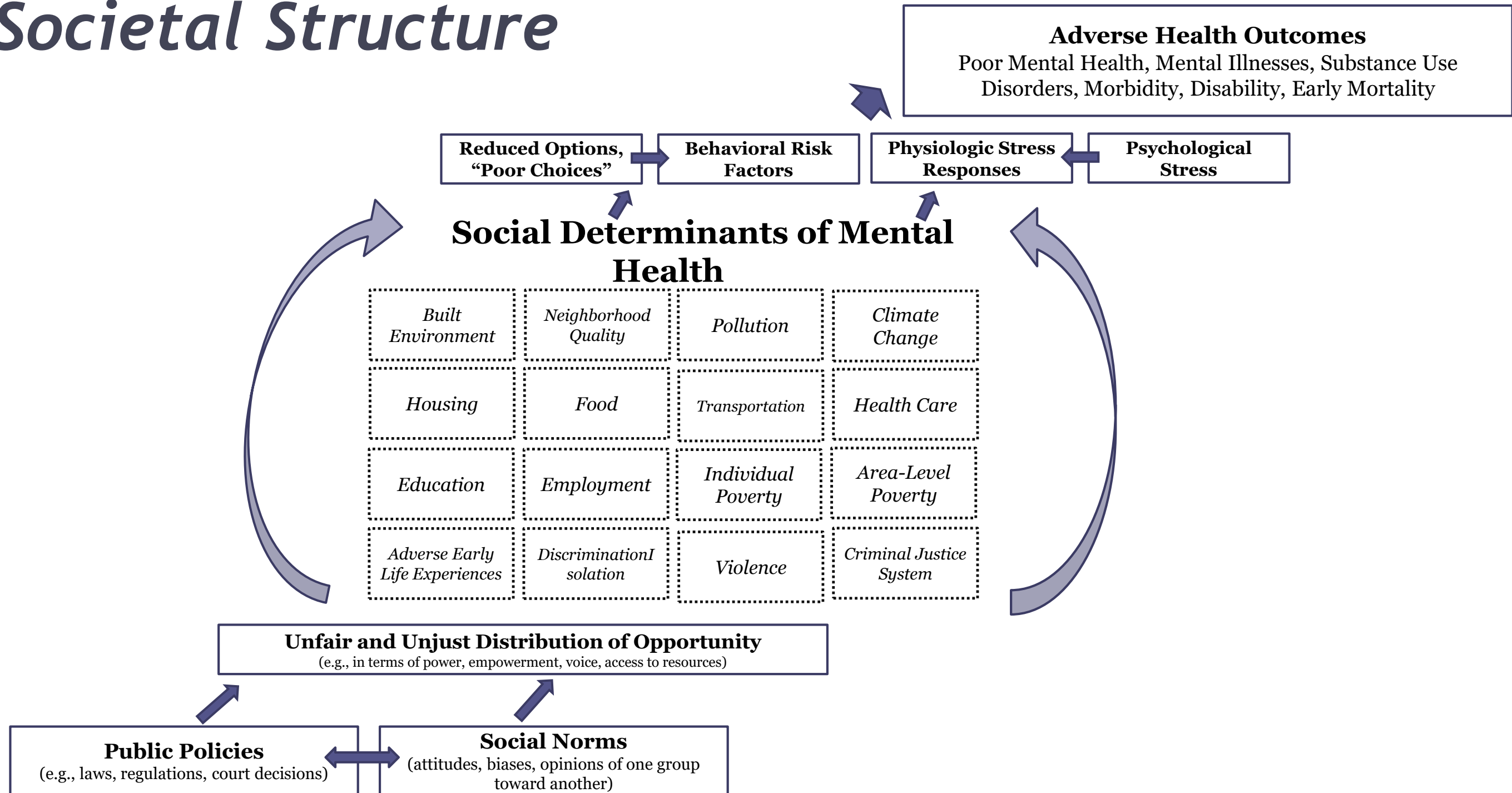- Clarify cultural conflicts feeding social inequities

Uses of Cultural Concepts of Distress

Clinically

- Suggest presence of psychopathology

- Avoid misdiagnosis

- Obtain information to personalize care

- Guide communication

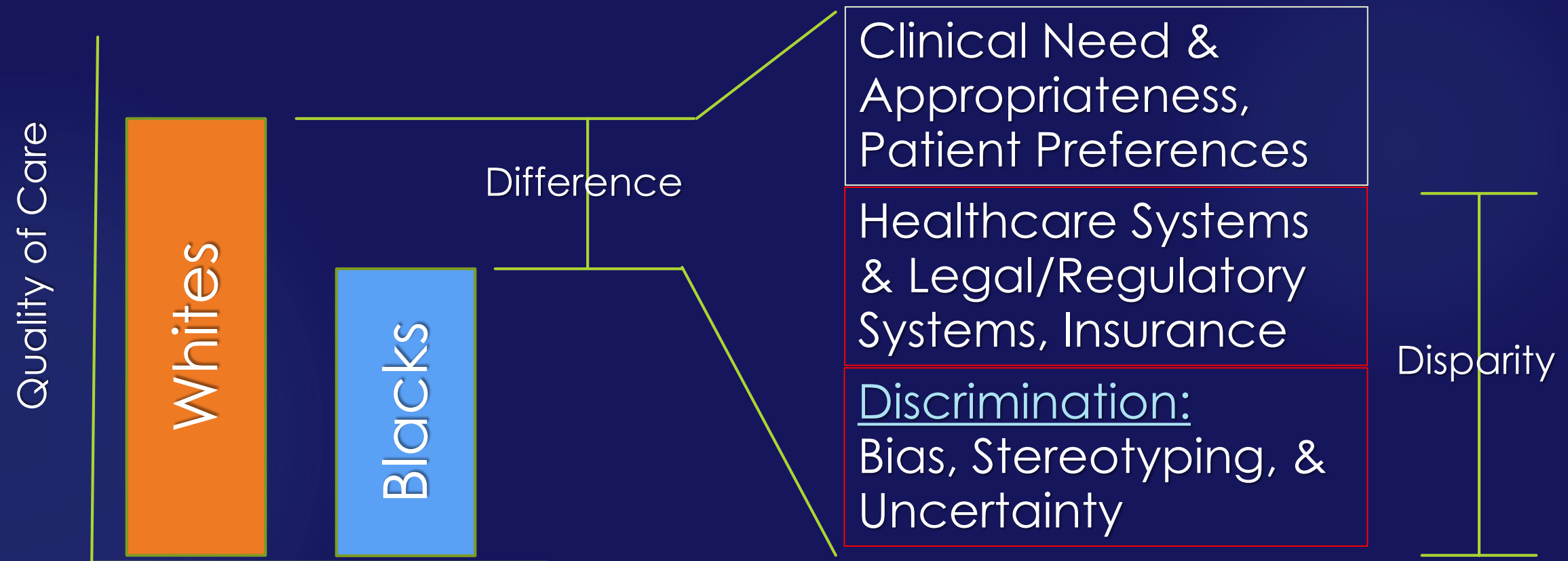- Improve clinical rapport and engagement

- Improve therapeutic efficacy

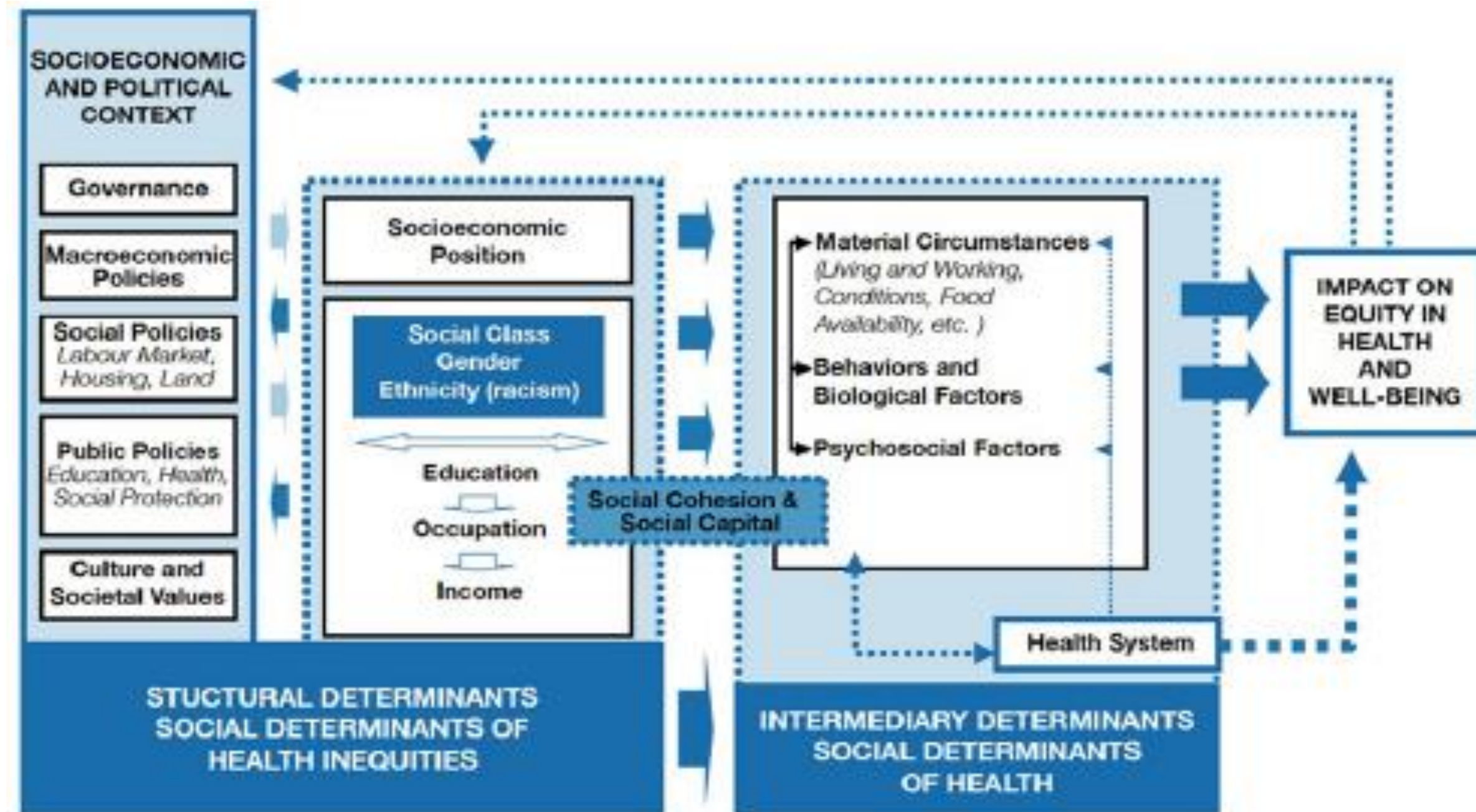# SOCIAL DETERMINANTS OF HEALTH, DISPARITIES, & STRUCTURAL COMPETENCE

Societal Structure

Adverse Health Outcomes
Poor Mental Health, Mental Illnesses, Substance Use
Disorders, Morbidity, Disability, Early Mortality

| Reduced Options, "Poor Choices" | → | Behavioral Risk Factors | | Physiologic Stress Responses | ← | Psychological Stress |

Social Determinants of Mental Health

Built Environment	*Neighborhood Quality*	*Pollution*	*Climate Change*
Housing	*Food*	*Transportation*	*Health Care*
Education	*Employment*	*Individual Poverty*	*Area-Level Poverty*
Adverse Early Life Experiences	*DiscriminationI solation*	*Violence*	*Criminal Justice System*

Unfair and Unjust Distribution of Opportunity
(e.g., in terms of power, empowerment, voice, access to resources)

Public Policies
(e.g., laws, regulations, court decisions)

Social Norms
(attitudes, biases, opinions of one group toward another)

Compton & Shim, 2015

IOM definition of disparities

Differences except due to clinical need & appropriateness & patient preferences

Quality of Care

Whites

Blacks

Difference

Clinical Need & Appropriateness, Patient Preferences

Healthcare Systems & Legal/Regulatory Systems, Insurance

Discrimination: Bias, Stereotyping, & Uncertainty

Disparity

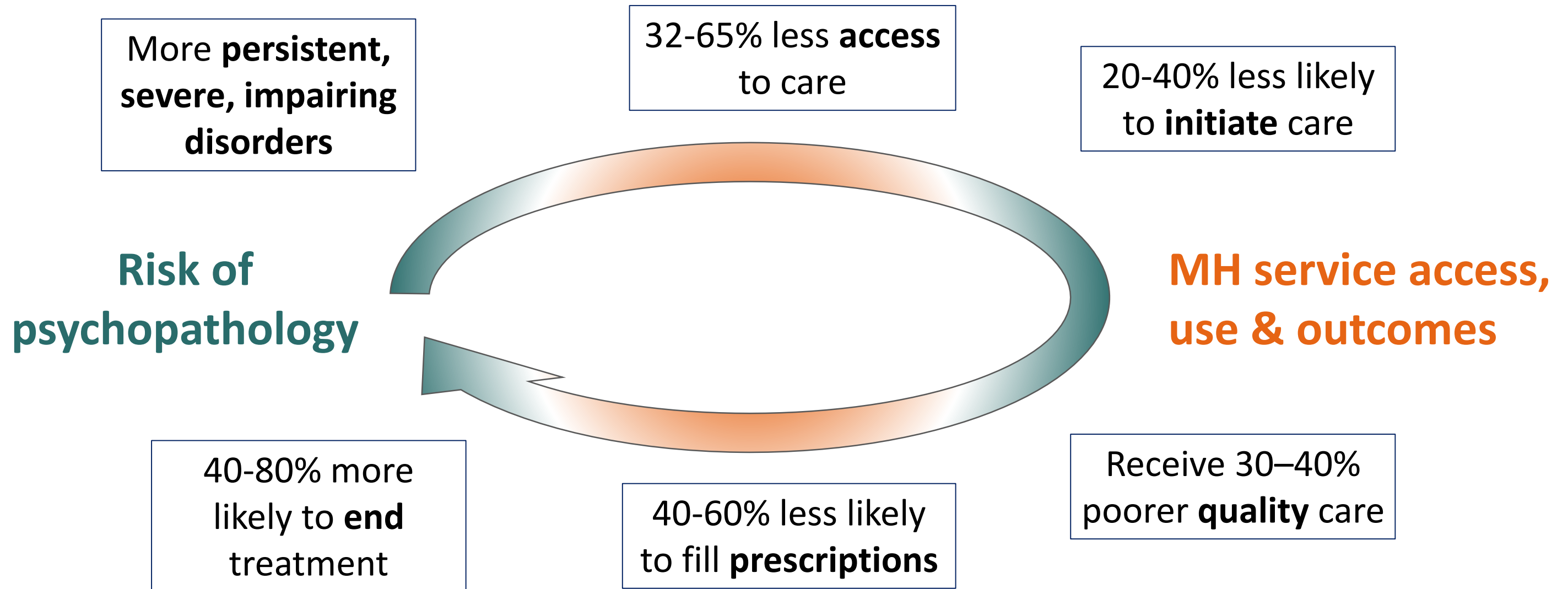*Institute of Medicine, Unequal Treatment, 2002*

Multi-Level Causes & Pathways of Disparities

WHO 2010

Disparities in MH & MH Care Continuum

Black, Indigenous and People of Color (BIPOC) individuals...

More **persistent, severe, impairing disorders**

32-65% less **access** to care

20-40% less likely to **initiate** care

Risk of psychopathology

MH service access, use & outcomes

40-80% more likely to **end** treatment

40-60% less likely to fill **prescriptions**

Receive 30–40% poorer **quality** care

AHRQ 2019; Aggarwal et al., 2016; SAMHSA, 2018; US Office of Minority Health 2018; Vilsaint et al. 2019

Structural Competence

- *Cultural competence* often interpreted incorrectly as focused exclusively on individual views and behaviors to the exclusion of the larger societal/political context

- New term – *structure* – shifts focus above the level of the individual – to communities, institutions, policies that determine health

- Focus on systematic practices of exclusion, discrimination, privilege, oppression, and other forms of *structural violence* at the societal level

- *Competence* to indicate expanded scope of clinical intervention and responsibility: providers can bring symbolic, social and cultural capital to bear (in partnerships)

INDIVIDUAL CULTURAL ASSESSMENT

What is a Cultural Assessment for Clinical Care?

Process of eliciting, organizing, and interpreting information on the impact of culture and social context on the person's and social network's views, practices, and resources pertinent to clinical evaluation and treatment planning

Can be systematic or ad hoc

Aggarwal & Lewis-Fernández, 2015; Edwards et al. 2017; Kirmayer et al. 2014; Lewis-Fernández & Aggarwal, 2015; Lewis-Fernández et al. 2016

A Systematic Cultural Assessment Method Should Be:

Comprehensive	*Thorough*	*Standardized*
Skills-based	*Person-centered*	*Educational*

Why Do Cultural Assessments in Routine Care?

- ## Guide diagnostic translation
  - Culture affects experience and expression of mental illness
  - Difficulty translating into criteria-based categorical classification systems (e.g., DSM)

- ## Re-contextualize psychiatric evaluation
  - Avoid diagnostic reification
    = symptoms AS diagnosis, not SIGNS of diagnosis

Hyman, 2010; Kendler, 2017; Lewis-Fernández & Aggarwal, 2015

Ceci n'est pas une pipe.

René Magritte, Treachery of Images, 1929
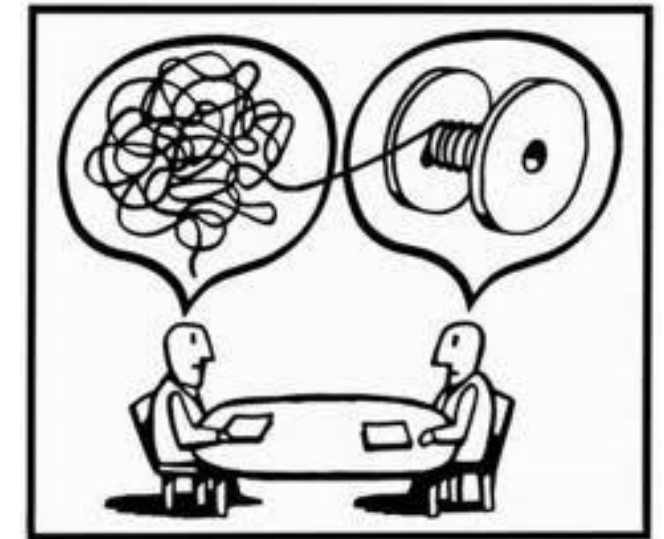
Why Do Cultural Assessments in Routine Care?

- Obtain person-centered information
  - Elicit person's and family's views of illness and care
    - Patient's "story": meaning of illness or predicament
    - Impact on person of the social/structural context
- Increase rapport and trust, enhance alliance
- Align treatment with patient's expectations
- Evidence caring
- Help empower patient

Aggarwal & Lewis-Fernández, 2015; Kirmayer et al. 2014; Lewis-Fernández et al. 2016, 2020

Complements Usual Assessment Formats

Generic	Person-centered
Intersectionality • Demographic indicators	**Intersectionality** • Most relevant aspects of own identity
Subjective Appraisal • Symptom experience	**Subjective Appraisal** • Most troubling aspects of problem • Own experiences of discrimination
Structure • Living arrangements • Food insecurity	**Structure** • Perceived barriers to care • Scared to walk in neighborhood

Aggarwal et al. 2020; Bourgois et al. 2017; Lewis-Fernández et al. 2016; NIH PhenX Toolkit

CULTURAL FORMULATION INTERVIEW

DSM-5 Cultural Formulation Interview

- Set of interview protocols that can guide cultural assessment during evaluation and treatment planning with any consumer by any provider in any care setting
- CECC NYSPI led its development and inclusion in DSM-5
- Three components:
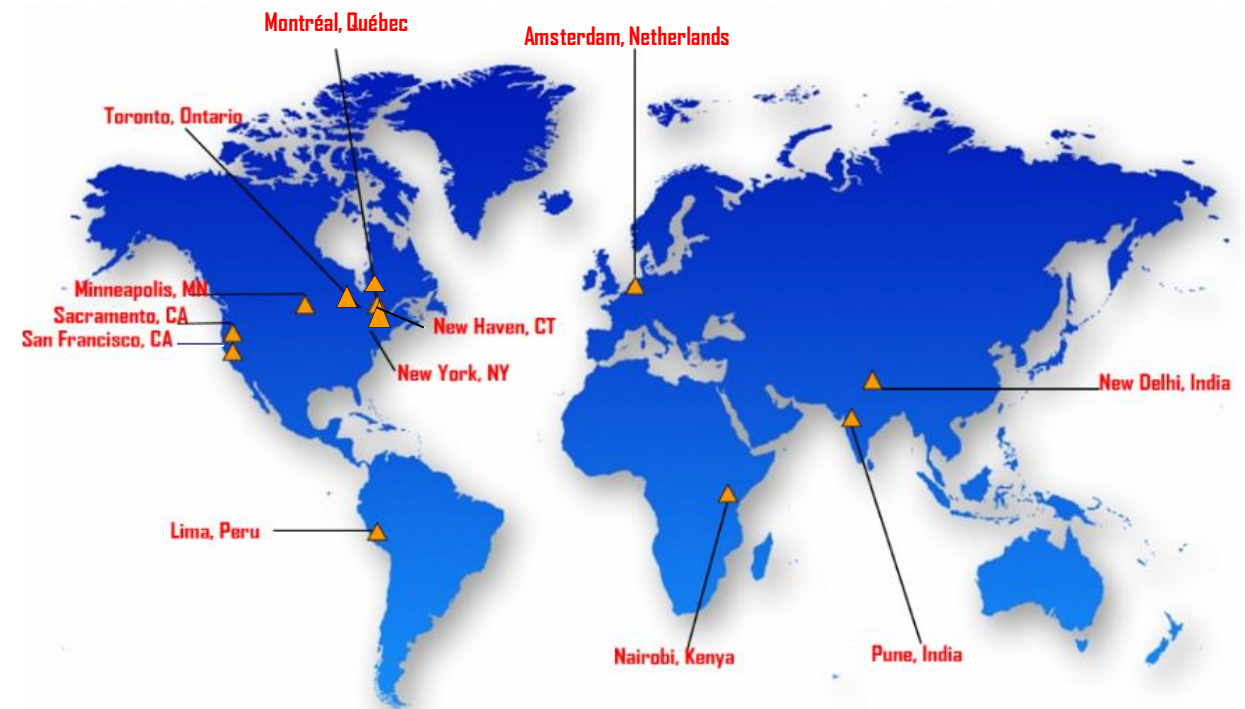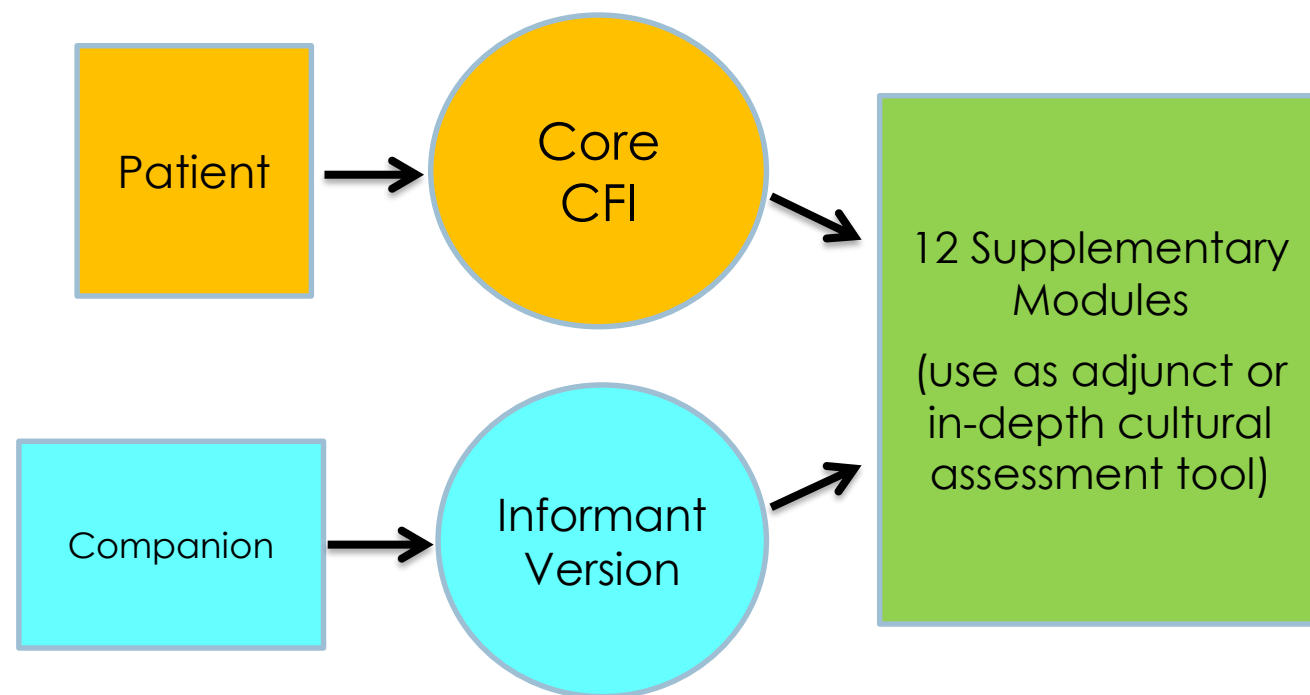
Aggarwal et al. 2013, 2014, 2015, 2016, 2017, 2020; Hinton et al. 2015; Lewis-Fernández et al. 2014, 2016, 2017; Paralikar et al. 2015

Outline for Cultural Formulation
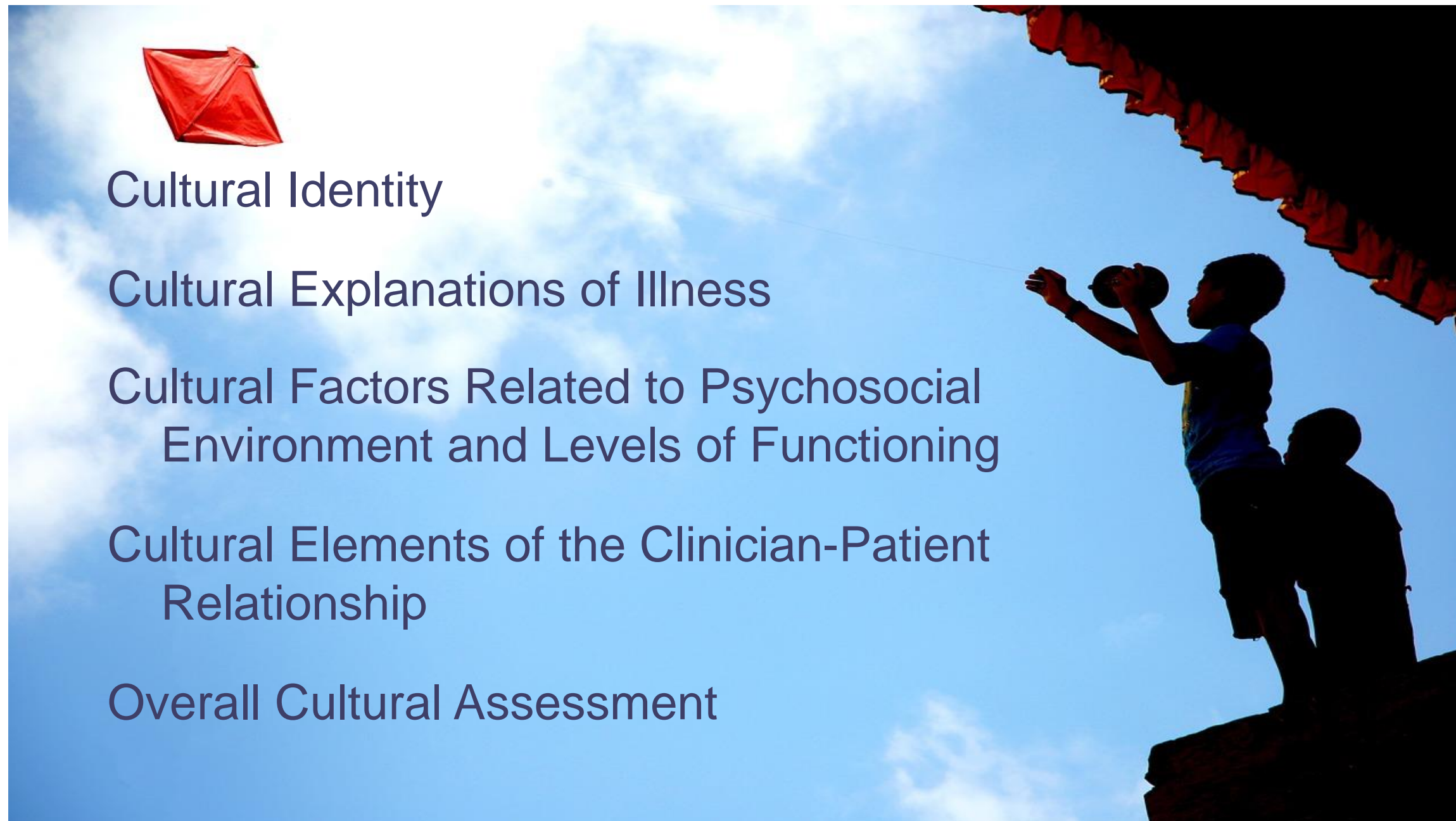
Cultural Identity

Cultural Explanations of Illness

Cultural Factors Related to Psychosocial Environment and Levels of Functioning

Cultural Elements of the Clinician-Patient Relationship

Overall Cultural Assessment

Development of the CFI

- Review of DSM-IV Outline for Cultural Formulation (OCF) literature
- Existing interviews, questionnaires, and protocols
- Drafting of 14-item Beta version of CFI
- Development of training approach
- Testing in international field trial

- 6 countries, 11 sites, 321 patients, 75 clinicians, 86 family members
- Preliminary data analysis of field trial results
- Revision to 16-item final version of CFI
- Reports of field trial findings
- Implementation: fidelity instrument, training

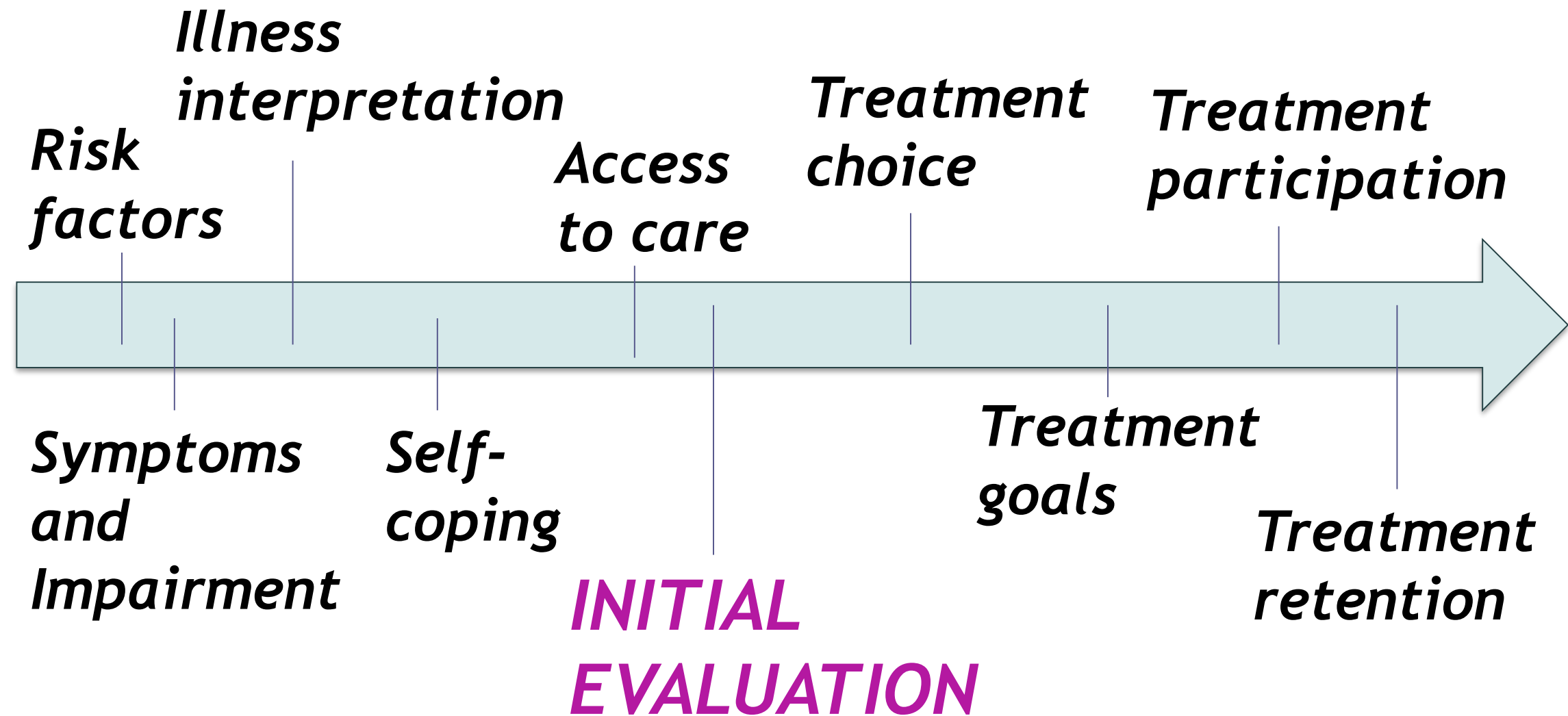# Inclusion of OCF Domains in Assessment Instruments

Lewis-Fernández et al. 2014

Cultural Identity	Canada[a]	Netherlands[b]	Sweden[c]	USA[d]	UK[e]	Denmark[f]
Language	√	√	√	√	√	√
Language use by developmental period and setting (e.g., at home)	√	√	√	√		√
Language(s) in which patient is literate	√			√		
Perceived fluency in language of host culture		√				
Cultural factors in development	√					
Involvement with culture of origin (e.g., other migrants)	√	√	√	√		√
Importance/frequency of involvement to patient		√	√	√		√
Perceptions of culture of origin	√	√*		√		√
Elements of culture of origin that are missed/relieved to have left		√*	√	√		√

[a]Kirmayer et al., 2001 (available in English); [b]Rohlof et al., 2002/Rohlof, 2008 (items included in abbreviated version by Groen, 2009b are noted with *) (Dutch and English); [c]Bäärnhielm et al., 2007, 2010a, 2010b (Swedish, English, and Norwegian); [d]Mezzich et al., 2009 (English); [e]Jadhav et al., 2010a, 2010b (English); [f]Østerskov, 2011 (Danish)

CFI Administration

- Used with any patient by any provider in any setting
- Can kick off evaluation to gather patient's views first
- Or at any point in care
- Indicated particularly in cases of:
  - Cultural differences that complicate diagnostic assessment
  - Uncertainty of fit between symptoms and DSM/ICD categories
  - Difficulty in judging severity or impairment
  - Disagreement between patient and clinician on course of care
  - Limited treatment engagement or adherence
  - Divergent views/expectations due to previous care experiences
  - Mistrust of services/institutions from past trauma/oppression

DSM-5, 2013; DSM-5-TR, 2022

Initial Evaluation is Central to Care-Seeking Pathway

Risk factors

Illness interpretation

Access to care

Treatment choice

Treatment participation

Symptoms and Impairment

Self-coping

INITIAL EVALUATION

Treatment goals

Treatment retention

Structure of Core CFI

Cultural Formulation Interview (CFI)

Supplementary modules used to expand each CFI subtopic are noted with <u>underline.</u>

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

<u>Explanatory Model, Level of Functioning</u>

Elicit the patient's view of core problems and key concerns.	1. What brings you here today? *IF PATIENT GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE:*
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").	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?
Ask how patient frames the problem for members of the social network.	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?
Focus on the aspects of the problem that matter most to the patient.	3. What troubles you most about your problem?

Cultural Formulation Interview Domains

1. CULTURAL DEFINITION OF PROBLEM

A. Person's definition of problem

2. CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT

B. Causes
C. Stressors and supports
D. Role of cultural identity

3. CULTURAL FACTORS AFFECTING COPING AND HELP SEEKING

E. Self-coping
F. Past help-seeking
G. Barriers to help-seeking

4. CURRENT HELP SEEKING

H. Preferences
I. Clinician-patient relationship

APA 2013; Lewis-Fernández et al. 2016

CONCLUSIONS

Conclusions

- Goals of clinical assessment are enhanced by person-centered cultural assessment
- Cultural concepts of distress
  - Focus clinicians on cultural experience of distress
  - Link illness, coping, and healing
- Social determinants of health are important components of cultural assessment
- Cultural Formulation Interview
  - Standardized approach for conducting individual cultural assessment

The Cultural Formulation Interview:
A collaborative storytelling approach to Clinical Care

Thank you for attending today's webinar!

Coming up on April 14th

Session 2: The Core Cultural Formulation Interview: Development, Research, and Implementation.

Next Sessions:
- Session 3: Using the Cultural Formulation Interview with Children and Adolescents. April 20th, 2022.
- Session 4: Working with families with the Cultural Formulation Interview. April 29th, 2022.

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