The DSM-5 Cultural Formulation Interview and the Evolution of Cultural Assessment in Psychiatry

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The US is rapidly becoming a “majority minority nation,” since US census data predict that by 2044 non-Latino whites will account for less than 50% of the country’s population. These demographic shifts create a unique set of circumstances for health care institutions charged with providing high-quality services to diverse cultural groups and eliminating disparities in health care delivery. Meeting this challenge has become a major priority and policy focus for many local, state, and national organizations.

The American Psychiatric Association (APA) and the DSM-5 Cross-Cultural Issues Subgroup (DCCIS) came together to produce and disseminate a tool at the vanguard of cultural psychiatric practice: the Cultural Formulation Interview (CFI). This evidence-based tool is composed of a series of questionnaires that assist clinicians in making person-centered cultural assessments to inform diagnosis and treatment planning.

What is culture?
At the core of the CFI is the definition of culture included in DSM-5:
Culture refers to systems of knowledge, concepts, rules, and practices that are learned and transmitted across generations. Culture includes language, religion and spirituality, family structures, life-cycle stages, ceremonial rituals, and customs, as well as moral and legal systems. Cultures are open, dynamic systems that undergo continuous change over time; in the contemporary world, most individuals and groups are exposed to multiple cultures, which they use to fashion their own identities and make sense of experience.

Culture is therefore a multifactorial set of overlapping systems made up of many components beyond race and ethnicity, including not only the characteristics mentioned above but also gender identity, sexual orientation, and even generational cohort and occupational group. The views and practices associated with the confluence of these cultural characteristics affect how all participants in the health care process—patients and their relatives, as well as clinicians, administrators, and policy makers—understand illness and engage in care.

Evolution of the CFI
The CFI culminates decades of work by cultural psychiatrists and medical anthropologists who have sought to develop guidance for providers on the domains of assessment that would clarify the contribution of culture to the clinical encounter. The first iteration of this guidance came in DSM-IV (1994) as the Outline for Cultural Formulation (OCF) that described in narrative form the components of a cultural assessment—including, for example, the need to assess a patient’s cultural identity and cultural explanations of the illness. For the past 20 years, the OCF has been the most widely taught cultural assessment tool in mental health care. Semi-structured interviews, protocols, and questionnaires based on the OCF were developed, largely in Europe and North America, to facilitate its implementation by busy clinicians. Yet adoption of the OCF in routine clinical care remained limited.

The DCCIS sought to develop a consensus CFI—based on previous work operationalizing the OCF—that was feasible, acceptable, and clinically useful in daily practice. With the publication of DSM-5, the CFI is fast becoming the most widely used operationalized method for implementing the kind of cultural assessment described by the OCF. To achieve broad dissemination of the CFI, the APA provides it free.

In collaboration with institutions from around the world, our team at Columbia University and the New York State Psychiatric Institute led a multidisciplinary consortium that developed and tested the CFI for DSM-5. More than 300 patients and 75 clinicians in 6 countries found the CFI to be feasible,
The value of this line of questioning may be illustrated by the situation of a homeless woman who appears to be responding to internal stimuli. Brought into an emergency department, she describes her problem as being “overwhelmed and unsure” and “unable to relax,” adding that the most troubling component is that she is always awake, looking around with worry, because of “sounds” that only she seems to notice. In sum, the main focus of her concern is that she cannot sleep because she is afraid.

This formulation of the problem comes much closer to the woman’s experience of her illness than a more technical focus on auditory hallucinations and paranoia. Her answers to the CFI evoke the reality of a person who lives on the streets without stable shelter and her consequent struggle for...
rest. These initial questions provide a framework for clinical humility regarding patients’ lived experience, helping to bridge the divide between concepts of “disease” used by medical experts and terms for “illness” that are closer to the experience of the person. Left unbridged, this divide can interfere with truly collaborative care.

**Domain 2: cultural perceptions of cause, context, and support.** The first set of questions in this domain aims to clarify what a person and his social network consider to be the origin of “the problem,” a key element of what Kleinman and colleagues called the “explanatory model.” For example, when a father responds to the informant CFI about the cause of his adolescent son’s crying spells and frequent school absences, he states that his son “has become trapped in the desires of the flesh and isn’t relying on God to shepherd him through the shadows of life. If he were only to pray and fast, he may find the comfort and redemption that only comes through faith and the cleansing power of sacrifice.”

This explanatory model is likely to be entirely different from that of the pediatric psychiatrist who diagnoses a biologically based major depression. The father’s narrative contributes critical information about the family’s dynamics and their views of sickness and identifies potential challenges to treatment that may have been missed if his viewpoint remained unexplored. Other questions in Domain 2 guide an interviewer in assessing what improves or worsens the problem, how the main aspects of the person’s cultural identity relate to the problem at hand, and whether the person’s background or identity is causing difficulties that may or may not be associated with this problem (eg, discrimination due to race/ethnicity or gender identity).

**Domain 3: cultural factors that affect self-coping and past help seeking.** This domain builds on Domain 2 to explore what the person has done in the past to cope by himself with the situation and to seek treatment or other forms of help (eg, advice), in light of the answers provided about stressors, supports, and cultural identity. An example is an African American man in his 20s who seeks treatment for substance abuse. His primary self-identification is as a gay man—more than any other marker of culture—but this places him in a quandary.

His family and neighbors support his desire for sobriety but see homosexuality as unacceptable, whereas his friends are supportive of his sexual orientation but use drugs as a way of establishing intimacy and having fun. Drugs, for him, remain an important vehicle to social acceptance and away from personal isolation, despite his growing concern about his drug use. He has tried to reconcile these issues in the past by seeking an LGBT drug counseling program, but so far he has been unsuccessful.

**Domain 4: cultural factors that affect current help seeking.** This domain explores the person’s preferences for future care as well as those of his social network; it also addresses any concerns about the clinician-patient relationship. A useful scenario is that of an airline pilot who is a member of the Air National Guard and who has experienced anxiety attacks since the sudden death of her husband 1 year earlier. Initially, she thought she was coping well; now finds financial pressures and raising her 2 teenage sons to be highly challenging. She prefers cognitive-behavioral therapy because she worries that medications may disqualify her from flying. She is also concerned about revealing her thoughts to mental health professionals for fear that her squadron leaders may obtain a report of her treatment and may demand more details about her private life.

**Conclusion**

As these examples illustrate, the CFI ultimately seeks to help the clinician explore human suffering more fully. With each passing day, our world becomes more layered and complex. We are increasingly challenged to relate to one another across many languages, identities, practices, and traditions. These concerns take on even greater importance in health care and illness, when we are most vulnerable and in greatest need of being heard and understood. As we seek personalized and patient-centered medicine, the CFI is a powerful and evidence-based tool to ensure that clinical encounters remain focused on alleviation of suffering and, above all, remain human.

Figure. Flow of Cultural Formulation Interview domains for cultural as...
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References:


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