Using the Cultural Formulation Interview to Build Culturally Sensitive Services

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As part of the development of *DSM-5,* the Cultural Formulation Interview (CFI) was administered to 30 monolingual Spanish-speaking adults at one site of a 2012 feasibility study of the CFI. The authors identified salient themes in data collected through use of the CFI, with a focus on interventions that could lead to more culturally responsive mental health services. Findings suggest that establishing trust and focusing on the restoration of social ties while attending to the impact of stigma and patients' pressing psychosocial needs are elements of culturally responsive services for Hispanic persons. Routine use of the CFI can help clinicians identify unique needs and preferences by understanding an individual within his or her cultural context.

Psychiatric Services 2017; 68:112–114; doi: 10.1176/appi.ps.201600440

Cultural sensitivity increases the probability of a therapeutic relationship by enhancing trust and improving communication between clinicians and patients (1). Culturally responsive services effectively address health care disparities and increase providers' knowledge of diverse cultures. Introducing culturally responsive care increases service utilization and reduces premature termination (2,3). However, few examples exist that illustrate culturally responsive care in routine practice beyond its positive effect on help seeking and service utilization.

The revision of the Outline for Cultural Formulation from the *DSM-IV* resulted in the Cultural Formulation Interview (CFI) to elicit information about perceived cultural influences of care with a set of 16 questions included in the *DSM-5* (4). This personalized interview facilitates individualized assessments by clinicians instead of their relying on preconceived or stereotypic notions about race-ethnicity or country of origin (5). The CFI captures the patient's voice systematically and documents what is "at stake" for the person (6). The CFI field trial provided an opportunity to observe this innovative way to elicit information and to clarify cultural versus idiosyncratic details. The CFI has a unique role, even in mental health services that are focused on racial-ethnic minority groups. In this column, we describe CFI-elicited information in one of the trial sites and discuss potential ways for the CFI to improve care.

CFI Field Trial

From February to September 2012, we recruited 30 participants for a CFI feasibility study that included an audio-recorded interview. The participants were monolingual Spanish-speaking adults ages 18–70 from several Latin American countries and were receiving outpatient services at the Hispanic Clinic of the Connecticut Mental Health Center, which serves individuals regardless of legal status and ability to pay. We obtained institutional review board approval and informed consent. Inclusion criteria were a stable *DSM-IV* disorder and the ability to understand the purpose, requirements, and voluntary nature of the study.

Data Analyses

After reading audio-recorded interview transcripts in Spanish without any preconceived categories, we identified salient themes, organized them into initial domains, and created codes. We compared and revised codes and themes until reaching agreement (7). Ultimately, the codes were condensed into categories, with three overarching themes: reasons for seeking treatment, understanding the problem and how to name it, and how the problem was resolved. Examples of codes were religion, somatic complaints, interpersonal issues, coping style, psychosocial needs, substance use, loss, and services. Some themes are described below and are illustrated with participant quotes.

Themes Elicited by the CFI

Disruption of relationships was a major theme. When participants could not get along with important people in their lives, such as family members or fellow churchgoers, they sought mental health care. "We do not treat each other like family anymore." "He cheated on me, he traumatized me." "I have problems with my children." Interpersonal harmony

was crucial for participants, and disruption of relationships was a powerful motivation to seek help.

The loss of trust—"confianza"—was a serious problem for some participants, requiring professional attention. "Confianza" is a Hispanic value related to feeling at ease about revealing personal experiences to others. "I do not trust." "I could not work, I felt nervous thinking that other people were talking about me." "I felt judged by people around me, especially from church." Restoration of trust was critical. Participants appreciated the benefits of talking with a therapist, and the issue of trust also emerged in this context. As participants gained trust in the therapeutic relationship, they reestablished social ties. In turn, restored relationships aided in healing.

Similarly, traumatic experiences emerged as a major source of stress, forcing some participants to seek help. Traumatic experiences sometimes caused strong and alarming emotional reactions. "I have raw memories. I hear my partner's voice." For Hispanics, auditory hallucinations can be trauma related without meeting criteria for a psychotic disorder (8). "I cannot find myself. I feel lost." "The memories made me nervous." "My mind is gone." "I want to stop remembering sad things. I want to stop thinking bad thoughts." These experiences reveal both the trauma and the resilience of participants. Despite their symptoms, participants were able to cross borders to start a new life. "I was a victim of domestic violence." "Many things came from my childhood. My parents hit me." These comments reveal the long wait of many participants to address past traumas and their hope for recovery with the help of a culturally sensitive provider.

Through the CFI questions, many participants presented the problem as a consequence of their actions. "This is a punishment." "I was called to preach and did not follow." "I did not live a life according to God." "I abandoned my children." "This is because I did not obey my mother." "This is a test. If God allowed it, there must be a reason." Resolutions were facilitated when the treatment valued their religious beliefs. Participants' perceptions that they were not in good standing as church members was also a compelling reason to seek help. When their concerns were addressed, they often perceived a restored relationship with God and reconnected with their church.

Losses had a great impact on participants' lives, causing a sense of helplessness. "When my brother died, the sadness overcame me. I could not go back to his funeral. I could not say good-bye." "The depression arrived when my father died." Some immigrants are able to return to their countries of origin. The experiences described here are those of immigrants who could not easily go back. "When I get this urge to see my dead daughter, I cannot stop crying." "I left my children. I cannot eat. I just want to cry and cry thinking how could I eat when my children might be hungry." Losses through immigration had profound effects. Nostalgia and guilt for being far away from the family were common. Inability to go back can make it difficult for an immigrant to accept and adapt to the new culture. Ambivalence about leaving one's country is part of any acculturation process. "Sometimes I feel sad without the family and speculate that perhaps none of this would have happened if I had not left." Psychotherapy can address the losses (for example, family, language, and food), and mourning these losses can help an immigrant go through a third separation-individuation process to help the person become established in the new country with a new identity, while respecting the old one (9).

Addressing the stigma related to mental illness was also an important component for participants. "Now, I can speak about my problems without shame." "I do not feel ashamed to say what I have." Patients who initially expressed grave concern about their social networks' perception of them but who were able to change their perspective reported feeling tremendous relief. As they participated with others who had similar difficulties, the stigma associated with mental health care decreased (10).

Psychosocial needs also drove participants to seek services. "I lost my papers and my wallet, all is gone." "I am homeless. Waiting for a place is too much stress." "My finances are bad. I do not have money." "I do not come out from the hole." Resolution of their psychosocial needs was part of their recovery. Participants identified obtaining employment and providing for their families as the most satisfactory treatment outcome. Participants appreciated attention to their psychosocial needs as care was facilitated and bureaucratic barriers were overcome.

Advantages of Using the CFI

Traditionally, mental health services for minority groups have not been organized to increase trust, address stigma, mend relationships with church and family, and address psychosocial needs. The data elicited through the CFI support framing the core treatment functions to include these issues and enhance the cultural responsiveness of care (11,12). These findings suggest that trust should be considered as a key facilitator of treatment engagement. Moreover, clinicians should explore patients' social ties, perceived as broken, to address their restoration during the treatment. Restored trust and restored social ties then become treatment outcomes.

The CFI facilitated listening to patients' perceptions to consider evidence not traditionally sought in administrative program evaluations. The CFI uncovered their subjective experience and provided reasons to trust. Outcomes could then be measured not only in terms of symptom reduction or improved functioning but also in improved ability to pursue culturally relevant goals and effects on the larger social circle.

Culturally sensitive care for Hispanics includes bilingual and bicultural staff; Hispanic values such as trust, familism, and personalism; an understanding of immigration stressors; attention to psychosocial stressors; shared decision making; and other components (13,14). Although some of these

characteristics were revealed in our data, others were new and were described with a personal perspective. The wish to repair disrupted relationships was an urgent reason to seek help, as was the wish to restore social ties. Both can introduce a new approach to setting treatment goals. The wish to restore trust as a motivator of treatment was surprising. Immigrants' profound suffering, elicited in the voices of these patients, underscores the need to prioritize their mourning and calls attention to the fact that many have waited a long time to address their past traumatic experiences. In addition, attention to psychosocial needs becomes a priority for treatment.

Potential uses of information from this field trial are related to building shared decision-making services and a more sustained focus on building "confianza." Services for Hispanics should explore church membership and spirituality and their role in helping individuals cope and regain social ties. Efforts to engage local churches to collaborate in providing services are important, especially because some churches do not endorse the use of traditional mental health services (15).

Aiming for restoration of social ties and supportive social networks as immediate treatment outcomes and using approaches that will build trust with the local community should be included in revised program strategies. To formulate a useful care plan, clinicians should consider the importance of the social networks available to a person. Reducing stigma related to mental illness was also an important component of patients' stories. Priorities for revising services should include interventions to promote stigma reduction, coping, and grief resolution; to address the multiple difficulties involved in immigration; and to support the creation of social networks.

Clinical and Policy Implications

When used routinely, the CFI can help clinicians identify unique needs and preferences by providing a better understanding of an individual within the context of his or her culture. Use of the CFI domains as part of a routine program evaluation opens new perspectives about services. The CFI can help identify what works for a specific group and uncover new evidence of cultural responsiveness. The descriptions presented here illuminate important aspects to include in clinical and system interventions and could be considered practice-based evidence that offer lessons for development of culturally sensitive services.

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The study was supported by a grant from the American Psychiatric Association. The authors thank Roberto Lewis-Fernandez, M.D., for helpful comments on the manuscript.

The authors report no financial relationships with commercial interests.

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