

Culture, context and psychiatric diagnosis

Interview Manual for the Outline for a Cultural Formulation in
DSM-IV

Sofie Bäärnhielm

Marco Scarpinati Rosso

Laszlo Pattyi

Transcultural Centre, Stockholm County Council



in co-operation with

Spånga Psychiatric Unit, North Stockholm's Psychiatric Service

English translation Steve Wicks and Sofie Bäärnhielm

Aim with the Cultural Formulation

The Outline for a Cultural Formulation in DSM-IV (APA, 2000) aims to support clinicians in systematically exploring the individual patient's perspective regarding her/his illness and problems with reference to her/his social and cultural context. The Cultural Formulation is an idiographic method intended to be used as a complement to the DSM-system's other axes when making diagnoses in multi-cultural care environments and when treatment staff and patients have different socio-cultural backgrounds.

Contents

Introduction

The Outline for a Cultural Formulation in DSM-IV

When can the Cultural Formulation be used?

Culture, context and psychopathology

Cultural perspectives in DSM-IV

How this manual has been constructed

The ethnographically-based interview

What the sections in the Cultural Formulation intend to explore

Cultural identity of the individual

Suggested questions for exploring the patient's cultural identity

Cultural explanations of the individual's illness

– expressions and meaning making

Suggested questions for exploring expressions and meaning making

Cultural factors in relation to psychosocial environment and levels of functioning

Suggested questions for exploring cultural factors related to psychosocial environment and levels of functioning

Migration and acculturation

Suggested questions for exploring the patient's migration background and acculturation situation

Cultural elements of the relationship between the individual and clinician

Suggested questions for exploring the importance of cultural elements of the relationship between the patient and clinician

Finally, the clinician evaluates how she/he thinks the interview went.

Suggested questions to reflect upon.

Overall assessment for diagnosis and care

Ideas and practical advice for the interviewer

Working alliance

Interviewing with an interpreter

For whom?

When and by whom?

Interview technique

Useful points of view

Planning the interview

Introductory phase

Interview phase

Concluding phase

References

Appendix 1.

Suggested questions for the clinical interview according to
the Cultural Formulation

Own notes

Introduction

Our intention with this Manual is to support clinicians making diagnoses in exploring the individual patient's illness perspective as well as social and cultural context. The Manual has been developed based on the Outline for a Cultural Formulation in the diagnostic system DSM-IV (APA, 2000). It is intended for physicians, psychologists and other care professionals who make assessments and establish diagnoses in the field of psychiatry and mental health in multicultural care environments. It can also be used in training.

The Manual has been developed through co-operation between the Transcultural Centre, Stockholm County Council and Spånga psychiatric outpatient unit, North Stockholm's Psychiatric Services. The Transcultural Centre is a knowledge centre for transcultural psychiatry and asylum and refugee health care. Spånga psychiatric outpatient unit provides care for the population of the multicultural suburbs of Rinkeby, Tensta and Hjulsta in Western Stockholm. Funding has been made available through the National Psychiatric Co-ordination 69/2005 as well as ALF medicine Dnr 0508-1391 and Dnr LS 0601-0082. The Project has been approved by the regional ethical committee in October 2004, Dnr 04-760/4.

The team at Spånga psychiatric outpatient unit has included the following members of staff: psychologists Ewa Harris, Marie Ljunggren and Ann-Marie Svedstedt as well as secretaries Werona Seitaneva and Camilla Löwengrip. The developmental work has been possible thanks to active support by the Director, Professor Anna Åberg Wistedt, North Stockholm's Psychiatric Services and Head of Unit Kersti Gabrielsson, Spånga psychiatric outpatient unit.

We would like say a warm thank you to all the patients at Spånga psychiatric outpatient unit who participated in the Project. Similarly we wish to thank Professor Laurence Kirmayer, McGill University in Montreal, Canada for extensive support in the development of the Manual and Professor Juan Mezzich, New York University, USA for support and views. In addition, we are grateful to Associate Professor Bo Runeson, Karolinska Institutet for methodological viewpoints regarding the evaluation and to Dr. Jörgen Herlofson for his work on the translation from English to Swedish of the Outline for a Cultural Formulation. Finally, we would like

to express our gratitude to Professor Nora Ahlberg, Nakmi (Norwegian Centre of Minority Health Research) Oslo; Dr. Per Borgå, Research, Development and Training Dept., Danderyd hospital; Dr. Leena Maria Johansson, Centre for Family and Community Medicine, and hospital chaplain Hans Gentzel, S:t Göran's hospital for valuable views on an earlier text.

*Sofie Bäärnhielm,
Marco Scarpinati Rosso,
Laszlo Pattyi
Stockholm May 2007*

Outline for a Cultural Formulation

(From DSM-IV Appendix I)

(The Cultural Formulation in Swedish - translation)

The Outline for a Cultural Formulation in DSM-IV comprises:

- Cultural identity of the person
- Cultural explanations of individual's illness
- Cultural factors related to psychosocial environment and levels of functioning
- Cultural elements of the relationship between the individual and the clinician
- Overall cultural assessment regarding diagnosis and care

The Outline for a Cultural Formulation in DSM-IV Appendix I (P.p 897-898)

The following outline for cultural formulation is meant to supplement the multi-axial diagnostic assessment and to address difficulties that may be encountered in applying DSM-IV criteria in a multicultural environment. The cultural formulation provides a systematic review of the individual's cultural background, the role of the cultural context in the expression and evaluation of symptoms and dysfunction, and the effect that cultural differences may have on the relationship between the individual and the clinician.

As indicated in the introduction to the manual, it is important that the clinician takes into account the individual's ethnic and cultural context in the evaluation of each of the DSM-IV axes. In addition, the cultural formulation suggested below provides an opportunity to describe systematically the individual's cultural and social reference group and ways in which the cultural context is relevant to clinical care. The clinician may provide a narrative summary for each of the following categories:

Cultural identity of the individual. Note the individual's ethnic or cultural reference groups. For immigrants and ethnic minorities, note separately the degree of involvement with both the culture of origin and the host culture (where applicable). Also note language abilities, use, and preference (including multilingualism).

Cultural explanations of the individual's illness. The following may be identified: the predominant idioms of distress through which symptoms or the need for social support are communicated (e.g., “nerves,” possessing spirits, somatic complaints, inexplicable misfortune), the meaning and perceived severity of the individual's symptoms in relation to norms of the cultural reference group, any local illness category used by the individual's family and community to identify the condition (see “Glossary of Culture-Bound Syndromes” below), the perceived causes or explanatory models that the individual and the reference group use to explain the illness, and current preferences for and past experiences with professional and popular sources of care.

Cultural factors related to psychosocial environment and levels of functioning. Note culturally relevant interpretations of social stressors, available social supports, and levels of functioning and disability. This would include stresses in the local social environment and the role of religion and kin networks in providing emotional, instrumental, and informational support.

Cultural elements of the relationship between the individual and the clinician. Indicate differences in culture and social status between the individual and the clinician and problems that these differences may cause in diagnosis and treatment (e.g., difficulty in communicating in the individual's first language, in eliciting symptoms or understanding their cultural significance, in negotiating an appropriate relationship or level of intimacy, in determining whether a behavior is normative or pathological).

Overall cultural assessment for diagnosis and care. The formulation concludes with a discussion of how cultural considerations specifically influence comprehensive diagnosis and care.

“The cultural formulation provides a systematic review of the individual's cultural background, the role of the cultural context in the expression and evaluation of symptoms and dysfunction” (p. 897).

When can the Cultural Formulation be used?

The Cultural Formulation is an aid in psychiatric diagnosis when cultural and social factors are deemed to be of importance for the clinician's possibility to:

- make a correct nosological categorisation
- understand the patient's illness perception and socio-cultural context
- create a treatment alliance characterised by trust and
- formulate a joint treatment plan.

With this Manual we want to provide support and guidance in interviewing patients about culture, ethnicity, identity, social context, migration as well as experiences and perceptions concerning illness. The Manual is intended to be used in a flexible manner taking account of the patient's capacity and situation as well as the interviewer's knowledge.

Culture, context and psychopathology

“Culture has the same ubiquity and transparency as water except at the junction of cultures, where the world is refracted and reflected”

Kirmayer and Minas (2000, p. 438).

Illness is experienced in a cultural, social and historical context. Universal psychopathological phenomena are experienced and interpreted from culturally-coloured frames of reference and theoretical assumptions. Feelings and experiences can be attributed different meanings and clothed in various words and expressions.

When the anthropologist Hannerz (1983) analyses the concept of culture he places the focus upon the plane of ideas and defines the concept as ” a common consciousness that people make accessible by communicating with each other in various ways” (p.15).

Hannerz suggests that what makes it possible for us human beings to construct a common consciousness is our ability to create and use symbols. Hannerz (1992) relates culture to meaning, the meanings that people create and are influenced by, and to

something that is collectively shared. The ethnologist Spradley (1979) likens culture to an interactive cognitive map against which we interpret events in our surroundings.

Hylland Eriksen (2004) points to the difficulty in defining borders between cultures when our world teems with mixed cultural forms and transnational flows of cultural elements. Kleinman (1996) emphasizes that culture is created in interactions in everyday life and is shared by many, such as families, places of work, networks or larger communities. Kleinman (1988) is of the view that we express our distress through bodily idioms that are both specific with reference to distinct cultural worlds and constrained by our shared human condition. Culture is like a screen through which illness, problems, reduced levels of functioning and treatment are experienced and understood. The cultural screen influences in turn how psychopathology is formed, expressed and communicated. Culture becomes a dynamic concept that relates to the creation of meaning in everyday life. People experience illness and health in a context. Hylland Eriksen (2004) relates the concept of context to all phenomena having to be understood with a view to its dynamic relationship to other phenomena. Knowledge about the patient's situation and context provides a picture of the living world in which the illness and distress are experienced.

With this Manual we want to encourage the clinician to explore the patient's socio-cultural context from a dynamic cultural perspective and to counteract cultural and ethnic stereo-typing and "exotification". We also want to support the diagnosing clinician in constantly reflecting over her/his own traditions, theories, values and ways of working. Self-reflection is a source for understanding "the other".

Cultural perspectives in DSM-IV

The diagnostic system DSM -IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition) has the ambition of being usable in various cultural contexts. In the introduction to DSM –IV’s textbook (APA, 2000) it is pointed out that the symptoms and course of many psychiatric conditions are influenced by cultural and ethnic factors.

In the textbook there are three different types of information about the cultural aspects of diagnosis:

- cultural variations in the clinical presentation (see the chapters about disorders)
- a description of cultural-bound syndromes as well as
- an Outline for a Cultural Formulation.

The comments about cultural variations in the presentation of psychopathology are often linked to age and gender-related features. Some examples from the text in DSM-IV are given below. In the introductory text in the chapter on schizophrenia and other psychotic disorders it is pointed out that the clinician should take the patient’s cultural context into consideration. In certain cultures, visual and audio hallucinations with religious content, for example, can be considered to be normal religious experiences.

Further, it is stated in the text that it is necessary to be sensitive to differences in expressions of emotions, eye contact and body language when assessing affects (p.p. 306–308). Reference is made here to evidence from USA and Great Britain showing that clinicians can have a tendency to overdiagnose schizophrenia, at the cost of bipolar illness, in some minority groups (p. 385).

“.. in some cultures, depression may be experienced largely in somatic terms, rather than with sadness or guilt. ”

In the section about major depressive disorder it is stated that communication of depression is affected by cultural factors. In some cultural contexts depression is manifested largely in somatic terms and not as guilt and shame – e.g. as “nerves”, headaches, weakness, tiredness, “imbalance” or heart problems (p.p. 353-354).

The chapter on personality disorders emphasizes the importance of not confusing these with acculturation following immigration (p.p. 687-688). Pathology is not to be confused with unfamiliar habits, customs, or religious or political values. The importance of considering the individual's ethnic, cultural and social background is emphasized. The value of the clinician obtaining information from persons who are familiar with the patient's cultural context is highlighted.

There is criticism of the DSM-IV system. One critical view is that it is not meaningful to use a Western diagnostic system outside the West or for refugees and minority groups. Kleinman (1977) has coined the term "category fallacy" that refers to the problem of using psychiatric diagnoses for symptoms outside the cultural sphere in which the diagnoses were created. Systematic use of the Cultural Formulation in multicultural care environments can contribute to a clearer picture of the DSM system's limitations in transcultural diagnosis. In the development of the diagnostic system ICD10 to ICD11 a discussion is taking place about whether to supplement diagnostic categories with a multi-axes model that includes an individually-focused assessment (IGDA Workgroup, 2003; Mezzich and Salloum, 2007).

How this Manual has been developed

It has taken two and a half years to produce this Manual. We began by formulating questions for interviewing patients about their socio-cultural context and perceptions of illness. We based this initial work on the Outline for a Cultural Formulation in DSM-IV. Together with colleagues in the project group at Spånga psychiatric outpatient unit we tested the questions with new patients attending the unit. The patients were informed that their participation in the project was voluntary, that they could withdraw at any time and that it would not affect their treatment.

From the experiences gained during the interviews the questions have been continually scrutinised, edited and tested anew, firstly within the frame for a pilot study and then as a development and research project. Thirty patients have been interviewed, of whom twenty-three within the current project. The patients' countries of origin are: Iraq, Turkey, Bosnia-Herzegovina, Iran, Peru, Syria, Lebanon, Bangladesh and Ethiopia.

Several ethnic groups are represented. The Manual contains some quotes from the patient interviews.

The process of formulating questions which are comprehensible and meaningful for both patient and clinician has been characterized by making the questions all the more concrete. They have successively become focused upon the patients' current life-situation, everyday life and thoughts about the current illness episode. Combining open questions with questions of a more focused character has worked well. From the patients' narratives we have tried to formulate follow-up questions in order to explore the various areas in the Cultural Formulation and the patient's current distress and problems. The questions have often been adapted to the individual patient's language and narrative.

The ethnographically based interview

“ I want to understand the world from your point of view. I want to know what you know in the way you know it” Spradley (1997, p. 34)

The Cultural Formulation has been described as a form of "mini-ethnographic" narrative assessment (Lewis-Fernández, 1996). Ethnography is an anthropological method that aims to describe life in a local world at a specific place (Kleinman, 2006). Ethnography emphasizes the importance of acquainting oneself with how the other lives in her/his local world and the ambivalence that people can feel when they live between worlds (Kleinman, 2006). Ethnography emphasizes the importance of trying to understand the other's point of view (Geertz, 1983). The ethnographer Spradley (1997) emphasizes the difference between regarding people as actors or merely as informers. Traditionally anthropologists have often travelled to foreign countries, learnt new languages and systematically described local social patterns.

There are various forms of ethnographic work methods. All have a common interest in local social and cultural contexts and in regarding "the other" from her/his own

perspective. Ethnographic interviews are characterized by an interest in exploring how people themselves interpret their experiences (Sherman Heyl, 2001). Information about details in the patient's everyday life and her/his thoughts about illness are important.

In a similar way to an anthropologist a clinician can become interested in how the patient understands, feels, and relates to her/his illness (Kleinman, 2006). A clinical interview according to the Cultural Formulation can be described as an "ethnographically based interview". Patients can seldom answer abstract questions about identity and culture. Questions about ethnicity are also seldom meaningful. Clinicians can gain knowledge about culture and identity by asking about the patient's everyday world, thoughts, and how illness, symptoms and problems are experienced and perceived. Open questions encourage the patient to provide information in a narrative form. Follow-up questions and focused questions give the opportunity to more deeply explore areas and situations of significance.

The clinician interprets the patient's illness narrative from her/his professional and personal frame of reference regarding understanding. In order to receive help with the interpretation of the narrative the clinician can turn to other sources of knowledge, for example, to the patient's relatives and friends, cultural brokers, but also to written sources – professional writing or literature. Cultural brokers must always be used with respect for professional confidentiality and anonymity. The clinician or someone in the team at a local unit may initiate contact within the frame of joint development work. These sources can provide valuable information/knowledge about the patient's local context.

Whilst the ethnographically-based interview is a source of knowledge about the patient's situation, the clinician is neither anthropologist nor ethnologist. The clinician is not merely openly curious but is also focused on assessing a possible illness and then providing treatment. The dual approach of wanting to understand both the patient and her/his illness is described in patient-centred community medicine (Levenstein et al., 1986). Here is emphasized how important it is for clinicians to become acquainted with the patient's world and to see the illness through her/his eyes. The desire to understand the patient from her/his perspective provides information and knowledge that makes it easier to reach a shared understanding and treatment plan.

The various sections of the Cultural Formulation explore specific areas. These are described in detail below. To these sections we have added one on migration and acculturation that includes questions about threats and violence. The term acculturation concerns the cultural change that takes place in the contact between two different cultural groups (Berry and Kim, 1988). The background to the supplementary section is that Sweden has many patients with an ethnic minority background that have migrated and find themselves in an acculturation situation. Many are refugees with experiences of threat and violence in the form of war experiences, torture or other forms of abuse.

What the section in the Cultural Formulation intends to explore

Cultural identity of the individual

Interviewer: "What is your cultural background?"

Patient: "What do you mean? Do you mean my family? We belong to the Syrian-Orthodox Church" 32-year old Syrian woman from Syria.

Current section in the Cultural Formulation:

Cultural identity of the individual. Note the individual's ethnic or cultural reference groups. For immigrants and ethnic minorities, note separately the degree of involvement with both the culture of origin and the host culture (where applicable). Also note language abilities, use, and preference (including multilingualism).

The first section of the Cultural Formulation illuminates the patient's experience of identity and cultural affiliation. In the case of migrants this also concerns participation in both the new host culture and the culture of origin. The section on "migration and acculturation" supplements this section.

The interest in the patient's identity is an active interest in the patient's experience of him/herself and how the surroundings relate to this self-image. Identity also concerns how we identify ourselves in relation to those around us. Identity is sometimes used to

categorize with reference to appearance, external qualities, language or geographical origin. This reflects the needs of the surroundings to categorize the “other” or the one who is different. A person’s experience of identity is not a permanent given quality but stands in relation to the surroundings; it changes over time and shifts with the surrounding context. What the person experiences as important can vary. In a certain situation ethnic affiliation can be important for some patients but not for others.

The term ethnicity has many definitions and meanings. Tseng (2001) assigns ethnicity to social groups that distinguish themselves from others by a common historical path, behaviour norms and their own group identities. Direct questions about ethnicity are not always meaningful for the patient. The term cultural identity emphasizes that relating to others and groups is more complex than merely focusing on ethnicity. For the person who belongs to a minority group the experiences of discrimination, feeling an outsider, special treatment and affiliation to a surrounding majority culture are important for identity, mental health and treatment strategies. Similarly, the patient’s experience of new opportunities is important.

Migration entails breaking up, moving, adapting and acculturation to a new community. Acculturation entails a change at group level but also a potential change in the individual’s identity (Berry and Kim, 1988). This can take place in various ways for different individuals, e.g. through the person relinquishing her/his previous identity in favour of that of the new host country (assimilation). It may also result in the old being integrated with the new or to a marginalised feeling of being an outsider. It is primarily marginalisation that involves a potentially stressing situation according to Berry and Kim (1988). Knowledge about the individual patient’s acculturation process and situation provides the clinician with a picture of the patient’s living conditions, cultural identity, stress factors and avenues of development.

In the section about cultural identity a reference is made to the patient’s reference group. The latter is the group of people that is important to the patient. The composition of this group can vary. It may be the family, friends or being included in a cultural, ethnic, religious, political or social community. It may also be a matter of loneliness. The clinician needs to find out about each individual patient’s situation. The reference group is important both as support for the patient and as a possible partner in co-operation in assessment and treatment. Persons from the reference group can, as long as the patient

accepts and with reference to secrecy legislation, contribute with important information about the patient and her/his world.

Language is also a part of the individual's cultural identity and can function as a marker for group affiliation and change of affiliation. An interest in languages and learning languages can stimulate the patient to talk about him/herself in relation to her/his surroundings and how the relationship changes over time and in connection with migration. Information about the patient's knowledge of languages and use of language can provide a picture of communication possibilities, limitations and potentials.

Knowledge about the patient's cultural identity is of importance in understanding who the patient is and the state of her/his self-image, as well as the relationship with the surroundings, world, illness and problems. Through this understanding the clinician and patient will find it easier to formulate a joint and realistic treatment plan. Questions about identity can sometimes be experienced as personal and sensitive and need to be posed with respect for the patient's integrity. Such questions often need to be raised at a later stage of an interview when contact has been created and the questions can then be related to what the patient has said and to the words she/he uses. The questions we have formulated are intended to be adapted to the patient and the interview situation.

” In certain situations ethnic affiliation can be important for some patients but not for others.”

Suggested questions for exploring the patient's cultural identity:

Is there any group, or groups, that are important to you? I am thinking of, for example, national, ethnic, cultural, religious, social or other groups (exemplify if needed).

Do you think of yourself as – exemplify with ethnic group, e.g. ”Kurdish” (Exemplify from the response given).

Do you think of yourself as Swedish?

How do you think that others see you? (Exemplify if needed using earlier responses.)

What does the group**** mean to you? (****Use the term for group affiliation that the patient uses; in the case of affiliation with several groups ask about all of them.)

What is it like to belong to several groups****? (If relevant.)

What problems does it create?

What opportunities does it create?

Has your experience of belonging to a particular group**** changed over time?

What has this meant for you? (If relevant.)

Is there anything you miss?

Is there anything that has given you new opportunities?

How is your group **** treated by those in your surroundings?

Have you experienced misunderstandings or been subjected to unfair treatment because of your group affiliation****?

Is there any group, or several groups, that are important to your family? I am thinking, for example, of national, ethnic, cultural, and social or other groups (exemplify if needed).

What does the group **** mean to your family? (****Use the term for group affiliation that the patient uses, in the case of affiliation with several groups ask about all of them.)

How does it work for your family belonging to several groups ****? (If relevant.)

Cultural explanations of the individual's illness – expression and meaning making

"I cannot read, I cannot concentrate, I cannot sleep. I am worried. The attacks come many times. Then I go directly to the balcony in order to breathe. I cannot work. I am always tired. I am constantly beset with worry in my thoughts, bad thoughts. I think too much." 32-year old man, Kurd from Turkey

Current section from the Cultural Formulation:

Cultural explanations of the individual's illness. The following may be identified: the predominant idioms of distress through which symptoms or the need for social support are communicated (e.g., "nerves," possessing spirits, somatic complaints, inexplicable misfortune), the meaning and perceived severity of the individual's symptoms in relation to norms of the cultural reference group, any local illness category used by the individual's family and community to identify the condition (see "Glossary of Culture-Bound Syndromes" below), the perceived causes or explanatory models that the individual and the reference group use to explain the illness, and current preferences for and past experiences with professional and popular sources of care.

The section about cultural explanations of illness is central and refers to how important it is to try to understand the individual patient's way of expressing and perception of illness. People's ways of expressing illness, suffering and distress are affected by traditions, education and surrounding socio-cultural frames of reference. The way of communicating the need of support and help can change.

How one judges limits for normality and degree of severity can change between both individuals and groups. Illness can be ascribed various explanations and meanings. Expectations of help and cure can also vary. A patient should never be ascribed a notion due to her/his culture or ethnicity. The care professional needs to actively try to find out what the individual patient is trying to communicate and what significance, what meaning, she/he gives her/his problems and situation. The significance of words and metaphors cannot always be taken for granted but needs to be examined.

The text of the Cultural Formulation in DSM-IV emphasizes the importance of exploring how the patient explains her/his symptoms. In this Manual we start out from a broader perspective than explanatory models. Causes and explanatory models regarding problems and illness are important for some patients but not for all. Patients' perceptions of illness can be fragmented and contain various and sometimes, on the face of it, contradictory aspects. The process of creating meaning from illness can be carried out in a varied and multifaceted way (Bäärnhielm, 2003, 2004, 2006; Bäärnhielm and

Ekblad 2008). Meanings shape expression and experience (Kleinman, 1991). This in turn affects meaning making communication, help-seeking, expectations and co-operation in the care provided.

Patients can sometimes give their problems very different significance and explanations than those of the care staff. They can, for example, explain problems with reference to fate, punishment, supernatural phenomena, the evil eye or jinns. Jinns are a type of spirit in the universe of the Koran (Esposito, 1998). The anthropologist Good (1997) describes how people and jinns, in large parts of the Muslim world, interact in everyday life and how jinns are ubiquitous as a cause of illness and are of importance in treatment. Many patients are keen to talk about how they see their illness whereas others may not be clear about how they perceive their problems. Some patients may hesitate before talking about their perceptions due to worry that these thoughts will be received patronizingly or be regarded as unacceptable, or alternatively as pure ignorance. The care professional needs to approach the patient's perspective with interest and to respect that it is the patient that chooses when to talk. Questions about the patient's perspective often need to start out from the patient's current problems and situation. Abstract and general questions may be difficult to answer.

Direct questions about cause and explanations of problems can sometimes yield a great deal of information but for some patients may be difficult to answer. Make a note of the words the patient uses as this can increase the understanding of her/his experiences and thoughts. The descriptions can vary from presentations of specific expressions, physical symptoms, and social conditions to the patient having difficulty in finding words to describe the problems. For those patients who do not have Swedish as their mother tongue it may be important to be able to refer to their own language. Another clue can be to ask if the patient knows others in their surroundings with similar problems. It is sometimes easier to begin talking about others than about oneself. Questions about how the patient and their relatives sought help as well as expectation of care can open the way for information about the patient's thoughts about illness and care. Interest in the patient's perspective often needs to be followed-up later during the session with follow-up questions related to specific situations and events.

Patients can use, or may wish to use, other forms of care than mainstream health services. This may be a question of alternative care or various forms of "traditional

medicine” care according to other medical traditions (Bäärnhielm et al. 2007). The meaning of traditional medicine can vary from other medical systems, like Ayurveda, to certain traditions such as amulets with healing powers, special rites, medication or attending a traditional healer (Bäärnhielm and Ekblad, 2000). Information about what care the patient prefers provides an insight into how she/he creates meaning and means a great deal in being able to formulate a joint treatment plan.

Suggested questions for exploring expressions and meaning making:

What sort of problems¹ (besvär in Swedish) do you have?

How serious do you think your problems are?

What words do you usually use when you talk with your family, relatives or friends about your problems? By all means use your mother tongue.

Do you know anyone who has had similar problems?

What do you believe can be the cause of your problems?

What sort of help and treatment do you want?

What sort of help and treatment have you sought?

It you had stayed in your country of origin, what sort of help and treatment would you have asked for then?

What does your family, relatives and those around you* say about your problems?

¹The Swedish concept “besvär” is translated into the English concept problems. There is no English concept clearly corresponding to “besvär” which includes a meaning of suffering and distress that can be bodily, mental or social.

How serious do they think your problems are? (*Refer to those persons that the patient mentions.)

What words do they * use when talking about your problems? By all means tell me in the language they use.

What do they* believe can be the cause of your problems?

What sort of help and treatment do they* think you should seek?

One can seek help for problems in various ways. Have you tried other ways than the healthcare services in Sweden? (Give examples of traditional medicine, alternative medicine and healthcare in the home country that can be relevant for the patient).

Cultural factors in relation to psychosocial surroundings and levels of functioning

Interviewer: "What problems do you have?"

Patient: "I am tired. I am tired almost all the time. I have been tired for a long time, but it got worse after the divorce. Then I began to feel anxious, tired and couldn't sleep or eat.... I do what I have to at home. I do it ploddingly and slowly and have to force myself the whole time." 30-year old woman from Iraq

Section from the Cultural Formulation:

Cultural factors related to psychosocial environment and levels of functioning. Note culturally relevant interpretations of social stressors, available social supports, and levels of functioning and disability. This would include stresses in the local social environment and the role of religion and kin networks in providing emotional, instrumental, and informational support.

The section focuses upon the patient's problems related to the psychosocial environment and level of functioning seen from the patient's point of view. The patient's description

of how she/he experiences illness and problems in everyday life can provide the care professional with a picture of the level of functioning and possible reductions in functioning. The description of everyday life gives the care professional the opportunity to pose follow-up questions about stress, strains in the local environment and about the patient's possibility to obtain advice, support and help. Neither stressful nor supportive factors can be taken for granted. What is experienced as burdensome and stressful can be individually, socially and culturally shaped.

In certain cultural traditions mental illness is interpreted primarily in social terms and as disturbed relations. Disturbances of mood, affects and anxiety may be interpreted in social and moral terms and not as mental health problems (Kirmayer, 2001). The social surroundings affect the experience of feelings (Leff, 1973). From experience of East Africa, Borgå (1996) describes how mental illness is interpreted as a disturbance in relations and that the treatment aims to restore relations. In a discussion about depression from an anthropological perspective Kleinman (1991) suggests that the same physiological phenomenon can be experienced differently as the psychological interpretation process interacts with meaning systems and social relationships.

When patients are not used to psychological and psychiatric terms or use emotional words that are unfamiliar to the clinician, everyday descriptions of problems and consequences of problems can make it easier for the clinician to evaluate possible psychopathology and severity. To listen to and take in the patient's narrative is a multi-dimensional process. The reception of the narrative entails the care professional "translating" and interpreting the patient's description of the problems from her/his own theoretical frame of reference. To translate between two different meaning systems is an important aid in evaluating possible occurrence of psychopathology and severity.

The patient's description of everyday life provides important information about actual conditions and from this the clinician is able to formulate follow-up questions aimed at assessing possible symptoms. Narratives from everyday life also give information about the significance of the symptoms for the patient both culturally and as a part of social relations and communication. Information from family and relatives can provide important knowledge about the patient's situation, problems, level of functioning and possibility to receive help, whilst at the same time giving a picture of how people in the patient's surroundings assess normality and deviant behaviour.

Possibilities of help and problem solving may vary. The solution to the problems are often to be found in the patient's local context and life situation. It is important to explore the social network around the patient and its significance. Even a small network can be a significant resource. Knowledge about supportive factors and possible strategies for change can contribute to creating an individually-tailored treatment plan.

Suggested questions for exploring cultural factors related to psychosocial environment and levels of functioning:

How do your problems affect your everyday life? (Exemplify if needed with everyday activities.)

How do your problems affect your contacts with others? (For example, family, friends, work colleagues, etc.)

How do your problems affect your ability to be active?

How do your problems affect your ability to cope at home?

How do your problems affect your ability to work?

Is there anything in your everyday life that contributes to, or has contributed to, you having problems?

What affects, or has affected you? (If relevant.)

How have you been affected?

Is there anyone, or any persons, that you trust and can talk with about your problems and your situation?

Are you able to talk with your family and your relatives about your problems?

Are there any difficulties in doing so?

How do you let others know that you need help?

What sort of help do you need in your everyday life?

From whom can you receive advice, support and help in your everyday life?

What sort of advice, support and help can you receive in your everyday life?

Do you have a faith or belong to a religious community that is a support and help for you?

What sort of advice, support and help do you receive? (If relevant.)

Migration and acculturation

"Certainly, I have a head-ache and back problems. But that's nothing compared to my loneliness. You cannot comprehend what it means to lose all your friends and all contact with one's history". 46-year old man, Kurd from Iraq

We have added a section on migration and acculturation to the original one in the Cultural Formulation. This section is a tangent to the chapter on cultural identity. Migration is a major process of change for the individual and a stress factor (Roth, 2006). Migration is also a known risk factor for schizophrenia (Cantor-Grae et al., 2003; Cantor Grae and Selten, 2005). There are several hypotheses about possible mechanisms. One hypothesis is that a long-term "social defeat" can increase the risk for schizophrenia. Social defeat and stress can also be significant for patients with a migration background falling ill with a psychosis (Zolkowska, 2003).

Migration is not only an abrupt change but consists of a series of events and adaptation to various stressors (Westermeyer, 1989; Watters, 2001; Bhurgra, 2004, Achotegui, 2005). The course of the acculturation process depends upon a number of factors such as, motivation, ethnicity, age, gender etc. (Comas-Diaz and Greene, 1994; Canino and Spurlock, 1994; Sakauye, 1992). Whilst migration can induce stress it is a very heterogeneous process. Not everyone has the same experiences prior to migration

and accordingly do not meet the same ones after. The care professional therefore also needs to pay attention to the patient's coping strategies and strengths (Bhurga, 2004).

Many refugees have experiences of trauma and war from their home countries or their flight. Traumatized refugees do not always spontaneously talk about what they have experienced, not even with care staff (Norström, 2004). It is sometimes difficult for a clinician to listen to and interpret a patient's narrative about trauma, loss and migration. Patients can describe violence, evil, social chaos and oppression – sometimes beyond the care professional's world of experience. The degree of fantasy and capacity for imagination can limit the care professional's ability to fully appreciate the patient's experiences and suffering (Kirmayer, 2003).

The significance of the psychosocial context for traumatised patients living in exile has been shown by Sveaas (2000). Regular activities and proximity to the family is important for the level of symptoms in traumatised refugees. Al-Saffar (2003) highlights the central importance of culture in how the individual copes with potentially traumatic experiences by the context in which social support is experienced. She emphasizes also the significance of the interaction between the individual and the community for the individual's possibility to cope with potentially traumatizing experiences with risk of developing posttraumatic stress disorder (PTSD). Al-Saffar describes how the culture also suffers in conflict-ridden areas and in this way is reduced as a protective factor. Al Saffar compares this with the function of exile.

A psychiatric assessment of a patient who has migrated needs to include a narrative of the individual's migration history (Lee, 1990). This is necessary in order to understand the patient's situation in the country of origin, the family of origin's social status and social network, the reason for flight and possible traumatic experiences. The significance of having lost important relationships with relatives and friends needs to be highlighted. Concrete questions, such as asking about journeys to the home region can provide information about the acculturation process. The patient's narrative about migration and acculturation can provide the clinician with information that is needed if the latter is to be able to individualize treatment and planning.

Suggested questions for exploring the patient's migration history and acculturation situation:

Where ** do you come from?

Why did you leave your neighbourhood**? (**Use the reference that the patient gives.)

How did you come to Sweden?

Pose follow-up questions about the migration and possible flight (respect boundaries regarding what the patient is prepared to talk about).

What made you move to Sweden in particular?

How has your life been affected by the move to Sweden? (Pose follow-up questions about life in the home country, e.g. work, housing, socio-economic status.)

What did you leave behind when you moved to Sweden?

Which important people did you leave?

What contact do you have with your old neighbourhood**?

What contact do you have with family and friends who still live there?

Do you visit your old neighbourhood?

What new relationships have you made in Sweden?

What new opportunities have you had in Sweden?

Pose follow-up questions about work, education, housing and other current conditions.

How has your family been affected by the move?

Has the move to Sweden affected your health? (Pose follow-up questions about how the patient perceives the situation.)

In what way?

Were you subjected to threats or violence in your neighbourhood**?

How has this affected you? (If relevant.)

Were you subjected to threats or violence on the way to Sweden?

How has this affected you? (If relevant.)

Were your relatives subjected to threats or violence in your neighbourhood **?

Were your relatives subjected to threats or violence on the way to Sweden?

How has this affected your relatives? (If relevant.)

How has this affected you? (If relevant.)

Do you often think of your neighbourhood ** and the past?

What are your expectations and hopes regarding the future?

Cultural factors in the relationship between individual and clinician

"I'm sorry doctor but I don't understand. I met the GP and told him about my back-ache. He didn't believe me and sent me to a psychiatrist. Now I am talking with a psychiatrist you ask me about my back-ache." 52-year old Turkish woman, from Turkey

Section from the Cultural Formulation text:

Cultural elements of the relationship between the individual and the clinician. Indicate differences in culture and social status between the individual and the clinician and problems that these differences may cause in diagnosis and treatment (e.g., difficulty in communicating in the individual's first language, in eliciting symptoms or understanding their cultural significance, in negotiating an appropriate relationship or level of intimacy, in determining whether a behaviour is normative or pathological).

The section aims to evaluate and reflect upon the significance of socio-cultural factors for the relationship between patient and clinician in the actual diagnostic situation. The care professional needs to give him/herself time to think and reflect over the relationship and how it affects the assessment. Language is central to communication. Language, understanding of language and how interpreting functions are of importance for both communication and the relationship. Opinions about what is an appropriate level of intimacy can vary and affect how comfortable the care professional and patient feel, and what it is possible to talk about.

The cognitive understanding of the diagnostic assessment situation is of significance to the relationship. The patient's understanding is affected by how familiar she/he is with the health care system and with the information that is given in connection with the assessment and interview. If the patient does not understand the situation it is difficult to conduct a meaningful interview. The relationship is also affected by feelings and reactions that are awoken in both the patient and the care professional.

Comas-Diaz and Jacobsen (1991) describe how cultural and ethnic factors affect emotional reactions in both the therapist and patient in psychotherapy. The reactions can, for example, swing between overcompensation and exaggerated friendliness and suspicion with more or less concealed hostility. The reactions can put their stamp on the relationship. Comas-Diaz and Jacobsen suggest that an exaggerated suspicion, but also an exaggerated focus on differences in ethnicity, can hinder a functioning working alliance. The patient and the care professional can hide behind the attitude of "How can this person understand me?".

For the relationship in psychotherapy with traumatized female Kurdish refugees, Ahlberg (2000) describes the importance of factors such as gender, hierarchies and social etiquette. The clinician and patient are also affected by these factors in diagnostic assessment interviews. Reflecting upon one's own feelings and reactions can facilitate understanding of one's own role. An objective exploration of the patient's perspective, culture and context can contribute to creating a good relationship.

In conclusion, the care professional needs to reflect upon and evaluate how she/he can understand the patient and how possible it is to become acquainted with the patient's perspective and situation. The care professional also needs to think about how this affects the possibility of formulating a correct diagnosis and assessing the line between

normality and pathology. The clinician also needs to consider whether the assessment is comprehensible and meaningful for the patient and how they can jointly formulate a treatment plan. An active reflecting approach in the clinician can bring knowledge to the diagnostic process and contribute to a good relationship. Below are suggested questions to pose to the patient in order to find out how she/he regards the interview and suggestions regarding questions for the clinician to think about for her/his own part. The interview and the summarizing assessment is not the end of the journey but a beginning of interest in the patient's illness perspective and social and cultural context.

Suggested questions for exploring the importance of cultural factors in the relationship between patient and clinician:

What has it been like to describe and explain your problems and your situation for me?

What has it meant for you to be able/not be able to use your mother tongue with me?

What has it been like using an interpreter during our conversation? (If relevant.)

Did you need an interpreter? (If relevant.)

What do you think about the questions I have asked?

Is there anything important that you would like to tell me that we have not talked about?

What has been easy to explain?

What has been difficult to explain?

How well do you think that I have understood your problems and your situation?

How well do you think that others at this unit have understood your problems and your situation?

Finally the clinician evaluates how she/ he thinks the interview has been.

Suggested questions on which to reflect:

What was the relationship with the patient like?

What has made it difficult/easy to form a good relationship?

What was the communication like?

What has made it difficult/easy to create good communication?

How has the language worked during the session?

What has it meant that you do not have the same mother tongue? (If relevant.)

What has it meant that you have used an interpreter?

Did you need an interpreter?

What was the level of intimacy?

What has made it difficult/easy to attain an adequate level of intimacy?

How do you assess your possibility of understanding the patient's problems?

What has made understanding more difficult/easy?

How do you assess your possibility of understanding the patient's life situation and social context?

What has made understanding more difficult/easy?

How do you assess your possibility of understanding the patient's self-image and expectations of

the healthcare services?

What has made understanding more difficult/easy?

What feelings and reactions has the patient awoken in you?

How have you managed your feelings and reactions?

How do you assess your possibility to decide what is normal and pathological with regard to the patient's problems?

How reliable do you think your diagnostics are? Regarding categorisation (Axes I and II)?

Regarding other DSM-IV Axes?

How do you assess your possibility of suggesting an adequate treatment?

How do you assess your possibility of making your diagnostic assessment comprehensible for the patient?

What is the importance of your and the patient's ethnic, social and cultural affiliations in your encounter? (Reflect upon what you believe that these factors have had for significance in your encounter).

Other reflections?

Overall assessment for diagnosis and care

Current section in the Cultural Formulation:

Overall cultural assessment for diagnosis and care. The formulation concludes with a discussion of how cultural considerations specifically influence comprehensive diagnosis and care.

In conclusion a summary is made with an overall assessment of how cultural considerations influence diagnosis and care. This can also be described as the clinician translating the patient's narrative to her/his professional language from her/his theoretical frame of reference. The summary is based on the interview with the patient and from other relevant information that has been gathered.

The summary is written in a narrative form and can be a supplementary document to the other documentation. How the assessment is written needs to be adapted to local documentation guide-lines. The summary should include those various areas that are explored in the Cultural Formulation and other important areas that have arisen during the interview. From the various sections in the Cultural Formulation the clinician is able to evaluate what cultural factors and social context mean for the patient's illness and life situation, as well as for nosological categorisation and treatment. The patient's perspective should be included in order to facilitate treatment planning.

Let the summarizing assessment contain information about details (ethnographic information) from the patient's illness narrative. Ethnographic data make it easier for the reader to create an understanding and a picture of the patient's situation. A parallel is how the richly detailed descriptions in literature create pictures within us. In the summary comments should be made about current difficulties but also the patient's strengths, resources and possibilities for support. Be open about uncertainties, assessment difficulties and deliberations. By all means discuss the summarizing assessment with the patient. For an example of how a summary can be written see Bäärnhielm and Scarpinati Rosso (in press).

Ideas and practical advice for the interviewer

Working alliance

A prerequisite for a good interview is that the patient understands the aim of the interview situation, develops confidence in the clinician and is able to feel secure and respected. The quality of the interview is influenced by the working alliance between the clinician and patient. Psychotherapy research shows how important relational factors

are in order to attain a good therapeutic result (Lambert and Barley, 2002). Norcross (2002) describes a number of important variables that potentially contribute to a positive relationship and effectiveness for both therapy sessions and pharmacological treatment: alliance, context, empathy, consensus about treatment goals, co-operations, agreement, feedback and counter-transference (the care professional's emotional reactions). Even if there are problems with translating results from psychotherapy research to psychiatric diagnosis, research does show how important it is to create a good working alliance and a positive relationship. Johansson (2006) identifies the importance of the therapeutic alliance as the most decisive factor for patients' experience of good psychiatric care.

The interpersonal process in the interview situation can be divided roughly into two dimensions, the cognitive and the emotional. The cognitive dimension concerns what data are explored, the aim of the interview and what needs to be done in order to achieve the goal. The other dimension concerns the relationship and the emotional contact. This includes the experience of being "inside" or "outside" with regard to the relationship with the clinician. The patient needs to find a suitable degree of involvement and commitment in the interview so that she/he is able to participate in a free manner. The patient should not feel dominated by the clinician in such a way as to restrict her/his freedom to respond freely. The patient's responses are influenced by the underlying feeling of acceptance. Non-verbal communication such as body posture, tone of voice etc. can provide clues as to how the patient experiences the interview situation.

Interview with an interpreter

The interviews frequently need to be conducted with an interpreter. The clinician is responsible for both the patient and the interpreter being informed of the interview's purpose, form and how interpreting is to proceed. The patient needs to be informed of the interpreter's professional confidentiality. In cognitive psychology Grabos and Hagström (2006) point to the importance of continuity regarding the interpreter and that the interpreters are familiar with the method, i.e. that the situation's rules and frames are clarified. Both patient and clinician need to feel secure with the interpreter and understand how she/he works. This is of particular importance when the interpreter translates words for feelings, for example, anxiety and fear.

Kale (2006) points to how important it is that the patient receives information about interpreting rules and how the interpreter strives to make sure that the patient knows what to expect. To use an interpreter is sometimes experienced as time-consuming – but also gives scope for reflection.

For whom?

In clinical work it is appropriate to use the Manual in cases when, from the referral/own referral and from the first contact, it appears that socio-cultural aspects are of importance for diagnosis and treatment.

When and by whom?

Conduct the Cultural Formulation interview as early as possible in the diagnosis assessment process, preferably on one of the first visits after the initial contact. The interview can be conducted by the clinician carrying out the diagnostic assessment. It can also be used as a component of the team work when several persons are included in the diagnostic work. Never use the interview as the only basis for diagnosis – but rather as a complement to the rest of the diagnostic work.

Interview technique

The interview technique we suggest is semi-structured, i.e. there is a basic structure whilst at the same time permitting flexibility. Many questions are open and give the patient scope to answer freely and make associations. The interviewer is able to reframe the questions and alter their order as well as to follow-up interesting areas. In doing so one avoids unnecessary rigidity, whilst at the same time the Manual helps the interviewer maintain the interview's structure and maintain focus. The semi-structured form makes it possible to collect data in a systematic and flexible manner.

Practical views

Planning of the interview

Prepare the interview, plan the time, and remember that sessions with an interpreter take longer than ones without. Be friendly and correct when you describe the purpose of the interview. It is important that the patient is informed about the aim of the interview. Try to create a working alliance in which the patient feels free to reflect upon the questions. Respect the boundaries for what she/he wants to talk about and be prepared to revisit sensitive areas at a later date. Inform the patient about professional confidentiality.

A good working alliance is created more easily if the interviewer shows commitment, interest and respect. A basic tone of respectful professional curiosity can contribute to the interview flowing with ease. Remember the whole time that the goal of the session is to understand and improve the patient's mental health. Mezzich et al (in press) divide the interview in three phases; opening phase, body of the interview and closure. We have here used the terms; initial phase, interview phase, and termination phase.

Initial phase

Begin by explaining the purpose of the interview and how it will be conducted for both patient and possible interpreter. Try to create a relaxed interview atmosphere and highlight the problems that the patient is seeking help for and is concerned by. Pay attention to social and cultural formalities and customs regarding dress, how you greet each other, distance and possible physical touch (Mezzich et al., in press). Notice limitations in communication that are connected with language. Be generous with the use of an interpreter.

Interview phase

The suggested questions in the Manual are meant as support and points of departure. Reframe the questions as needed. Examine with special care the questions that are relevant for clinical understanding. Pose follow-up questions that stem from the patient's description of her/his distress and problems; by all means use her/his own

terminology. Go through the various parts of the Cultural Formulation Manual in a sensitive manner. With a gentle touch try to conduct the interview in a spontaneous manner by "following" the patient through the questions. Pay attention to how the patient formulates symptoms and anxiety. Let the patient express her/himself openly and contribute to the understanding of her/his distress and problems to as great an extent as possible (Mezzich et al., in press).

Termination phase

Finally complete the gaps and loose threads from the interview and check how you interpret and assess the situation, by all means together with the patient. Summarise each section of the Manual. In this way you will receive corroboration that you have understood her/him correctly. Also ask the patient if she/he has more information or unanswered questions. When the interview is terminated you need to explain, and try to attain a mutual agreement about, the next step in the assessment and treatment. Convey thanks to the patient for having given you information that you previously did not have.

In order to develop and improve this Manual we are very grateful for your and your patients' views!

You are welcome to send comments to:

Sofie Bäärnhielm, sofie.baarnhielm@sll.se, sofie.baarnhielm@ki.se

Marco Scarpinati Rosso, marco.scarpinati.rosso@ki.se

Laszlo Pattyi, laszlo.pattyi@ptj.se

References

Achotegui, J. (2005). Emigration in hard conditions: the immigrant syndrome with chronic and multiple stress.

Vertex, 16, 105-13.

Ahlberg, N. (2000). "No five fingers are alike". What Exiled Kurdish Women in Therapy told me. Oslo: Solum förlag.

Al Saffar, S.

Group for the Advancement in Psychiatry.

(2003). "Trauma, ethnicity and posttraumatic stress disorder in outpatient psychiatry." Ph.D. Thesis. Department of NEUROTEC, Section of Psychiatry, Karolinska University Press, Stockholm.

American Psychiatric Association. (2000). Diagnostic and Statistical Manual of Mental Disorder, Fourth Edition, Text Revision. Washington, DC: American Psychiatric Association.

Group for the Advancement in Psychiatry. (2002). Cultural assessment in clinical psychiatry Washington, DC: American Psychiatric Publishing.

Berry J.W., & Kim U. (1988). Acculturation and mental health. In J. Dasen, J.W. Berry, & N. Sartorius, (eds.), Health and Cross-Cultural Psychology towards Application (p.p. 207-235). London: Sage Publication.

Bhugra, D. (2004). Migration and mental health. Acta Psychiatrica Scandinavica, 109, 243–258.

Borgå, P. (1996). Psykopatologi utifrån ett kulturellt perspektiv. In P. Borgå, S. Bäärnhielm, & S. Ekblad, (eds.),

Kulturell psykiatri. Föredrag från en konferens. Stockholm: CPFU, 63-72.

Bäärnhelm, S. (2003). Clinical encounters with different illness realities. Qualitative studies of illness meaning and restructuring of illness meaning among two cultural groups of female patients in a multicultural area of Stockholm. Doktorsavhandling. Division of Psychiatry, Neurotec Department, Karolinska Institutet, Stockholm, Sweden.

Bäärnhelm, S. (2004). Restructuring illness meaning through the clinical encounter: a process of disruption and coherence. *Culture, Medicine and Psychiatry*, 28, 4 1-65.

Bäärnhelm, S. (2006). När det händer sådana saker, blir man förvirrad ... *Tidskrift for Forskning I Sygdom og Samfund*, 5, 67-80.

Bäärnhelm, S. (2007). Att möta den man möter i den mångkulturella vården. I B. Fossum. (eds.). *Kommunikation i vården*, Lund: Studentlitteratur.

Bäärnhelm, S., Löfvander, M & Håkansson, B. (2007). *Transkulturell medicin* (p.p. 942–952) Sundbyberg: Apoteket AB, Läke-medelsboken.

Bäärnhelm, S., & Ekblad, S. (2000). Turkish Migrant Women Encountering Health Care in Stockholm. A Qualitative Study of Somatization and Illness Meaning. *Culture, Medicine and Psychiatry*, 24(4), 431-52.

Bäärnhelm, S., & Ekblad, S. (2008). Introducing a Psychological Agenda for Understanding Somatic Symptoms- An Area of Conflict for Clinicians in Relation to Patients in a Multicultural Community. *Culture, Medicine and Psychiatry*, 32; 386-405.

Bäärnhelm, S., & Scarpinati Rosso, M. (in press). The Cultural Formulation – a Model to Combine Nosology and Patients' Life Context in Psychiatric Diagnosing. *Transcultural Psychiatry*.

Canino, I., & Spurlock, J. (1994). *Culturally Diverse Children and Adolescents*. Guildford: New York.

Cantor-Grae, E., Pedersen, C.B., McNeil, T.F., & Mortensen, B. (2003). Migration as a risk factor for schizophrenia: a Danish population-based cohort study. *British Journal of Psychiatry*, 182, 117-22.

Cantor-Grae, E., & Selten, J.P. (2005). Schizophrenia and Migration: a meta-analysis and review. *American Journal of Psychiatry*, 162, 12-24.

Comas-Diaz, L., & Greene, B. (1994). *Women of Color*. Guildford: New York.

Comas-Diaz, L., & Jacobsen F. (1991). Ethnocultural transference and countertransference in the therapeutic dyad. *Am J Orthopsychiatry*, 61 (3), 392-402.

Esposito, L.J. (1998). *Islam. Den raka vägen*. Lund: Studentlitteratur.

Geertz, C. (1983). *Local Knowledge: Further Essays in Interpretative Anthropology*. New York: Basic Books.

Good, B. J. (1997). *The meanings of symptoms: A cultural*

hermeneutic model for clinical practice. In L.Eisenberg, & A. Kleinman, (eds.), *The Relevance of Social Science for Medicine*. Dordrecht: Reidel Publishing Company.

Grabos, M., & Hagström, M. (2006). *Psykoterapi med tolk: möjligheter – svårigheter. Legitimationsgrundande utbildning i Kognitiv Psykoterapi*. Svenska Institutet för Kognitiv Psykoterapi.

Hannerz, U. (1983). *Över gränser. Studier i dagens socialantropologi*. Lund: Liber förlag.

Hannerz, U. (1992). *Cultural Complexity. Studies in the Social Organization of Meaning*. New York: Columbia University Press.

Hylland Eriksen, T. (2004). *What is Anthropology?* England: Pluto Press.

Johansson, H. (2006). *Therapeutic alliance in general psychiatric care*. Dissertation. Department of Psychology, Lund University and Division of Psychiatry, Lund University Hospital.

International Guidelines for Diagnosis Assessment Workgroup, WPA. (2003). IGDA. Introduction. *British Journal of Psychiatry*, 182 (suppl. 45), 37-39.

Kale, E. (2006). "Vi tar det vi har". Om bruk av tolk i helsevesendet i Oslo. En spørreskjemaundersøkelse. NAKMI:s skriftserie om minoriteter og helse 2/2006.

Kirmayer, L. J. (2001). Cultural variations in the clinical presentation of depression and anxiety: implications for diagnosis and treatment. *Journal of Clinical Psychiatry*, 62 (suppl. 13), 22–30.

Kirmayer, L. J. (2003). Failures of imagination: the refugee's narrative. *Psychiatry, Anthropology & Medicine*, 10 (2), 167–85.

Kirmayer, L. J., & Minas, H. (2000). The future of Cultural Psychiatry: an international perspective. *Canadian Journal of Psychiatry*, 45, 438–46.

Kleinman, A. (1977). Depression, somatization, and the “new cross-cultural psychiatry”. *Social Science and Medicine*, 11, 3–10.

Kleinman, A. (1988). *Illness narratives. Suffering, healing and the human condition.* USA: Basic Books.

Kleinman, A. (1991). “Preface, part II: What is depression”, (sid. vii-xvii). In J. Becker & A. Kleinman, (eds.), *Psychosocial aspects of depression.* London: Lawrence Erlbaum Associates, Publishers.

Kleinman, A. (1996). “How is Culture important for DSM-IV?” In J. Mezzich, A. Kleinman, H. Fabrega, & D. Parron (eds.), *Culture & Psychiatric Diagnosis. A DSM-IV Perspective* (p.p. 15-25). Washington: American Psychiatric Press.

Kleinman, A., & Benson, P. (2006). Anthropology in the clinic: the problem of cultural competency and how to fix it. *Public Library of Science-Medicine*, 3 (10), 1673–1676.

Lambert, M. J., & Barley, D. E. (2002). Research summary on the therapeutic relationship and psychotherapy outcome. In J.C. Norcross, (eds.). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (p.p. 17-32) New York: Oxford University Press.

Lee, E. (1990). Assessment and treatment of Chinese-American immigrant families. In G. Saba, B. Karrere, K. Hardy, (eds.), *Minorities and Family Therapy* (p.p. 191-209). New York: Haworth.

Leff, J. (1973). Culture and the differentiation of emotional states. *British Journal of Psychiatry*, 123, 299–306.

Levenstein, J.H., McCracken, E.C., McWhinney, I.R., Stewart, M.A., & Brown, J.B. (1986). The Patient centred clinical method. A model for the doctor-patient interaction. *Family Practice*, 13 (1), 24–30.

Lewis-Fernández, R. (1996). Cultural formulation of psychiatric diagnosis. *Culture, Medicine and Psychiatry*, 20, (2), 132–144.

Mezzich, J. E., Caracci, G., Fabrega, H., Jr., & Kirmayer, L. J. (in press).

Cultural formulation guidelines. *Transcultural Psychiatry*.

Mezzich, J.E., & Salloum, I.M. (2007). Towards innovative international classification and diagnostic systems: ICD-11 and person-centred integrative diagnosis. *Acta Psychiatrica Scandinavica*, 116, (1), 1-5

Norcross, J.C. (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (p.p. 3–16) New York: Oxford University Press.

Norström, E. (2004). *I väntan på asyl. Retorik och praktik i svensk flyktingpolitik*. Umeå: Boréa förlag.

Roth, G. (2006). *A perspective study of mental health among mass-evacuated Kosovo Albanians*. Ph. D. Thesis. Karolinska Institute, Department of Clinical Neuroscience, Stockholm.

Sherman Heyl, B. (2001). *Ethnographic Interviewing*. In P. Atkinson., A. Coffey., S. Delamont, J. Lofland., & L. Lofland (eds.), *Handbook of Ethnography* (p.p. 369–383). London: Sage Publication.

Spradley, J.P. (1997). *The ethnographic interview*. Florida: Harcourt Brace Jovaovich College Publishers.

Sakauye, K. (1992). The elderly Asian patient. *American Journal of Geriatric Psychiatry*, 25, 85–104.

Sveaas, N. (2000). Restructuring meaning after uprooting and violence. *Psychosocial interventions in refugee*

receiving and in post-conflict societies. Institute of Psychology, Faculty of Social Sciences, University of Oslo.

Tseng, W-S. (2001). *Handbook of Cultural Psychiatry*. San Diego: Academic Press.

Watters, C. (2001). Emerging paradigm in the mental health care of refugees. *Social Science & Medicine*, 52, 709–1718.

Westermeyer, J. (1989). Orientation to migration and migrants. In J. Westermeyer, (eds.), *Psychiatric Care of Migrants: a Clinical Guide*. Washington, DC: American Psychiatric Publishing.

Zolkowska, K., Cantor-Grae, E., & McNeil, T. (2003). Increased rates of psychosis among immigrants to Sweden: is migration a risk factor for psychosis? *Psychological Medicine*, 31, 669–678.

Appendix 1

Below is a summary of suggested interview questions according to the Cultural Formulation.

Suggested questions for the clinical interview according to the Cultural Formulation

Adapt vocabulary and formulations to the person you are interviewing. The order in which the questions are posed can be varied. Be sensitive to and respect the patient's boundaries for what she/he wishes to talk about. Check with the patient that you have understood correctly. Be prepared to repeat questions when necessary.

Cultural explanations of the individual's illness – expression and meaning

Firstly a few questions about your problems (“besvär”- in Swedish): (The Swedish concept “besvär” is translated into the English concept problems. There is no English concept clearly corresponding to “besvär” which includes a meaning of suffering and discomfort that can be bodily, mental or social).

What sort of problems do you have?

How serious do you think your problems are?

What words do you usually use when you talk with your family, relatives or friends about your problems? By all means use your mother tongue.

Do you know anyone who has had similar problems?

What do you believe can be the cause of your problems?

What sort of help and treatment do you want?

What sort of help and treatment have you sought?

If you had stayed in your country of origin, what sort of help and treatment would you have asked for then?

What does your family, relatives and those around you* say about your problems?

How serious do they think your problems are? (*Refer to those persons that the patient mentions.)

What words do they * use when talking about your problems? By all means tell me in the language they use.

What do they* believe can be the cause of your problems?

What sort of help and treatment do they* think you should seek?

One can seek help for problems in various ways. Have you tried other ways than the healthcare services in Sweden? (Give examples of traditional medicine, alternative medicine and healthcare in the home country that can be relevant for the patient).

Migration and acculturation

I shall now ask some questions about your move to Sweden (if relevant).

Where ** do you come from?

Why did you leave your neighbourhood**? (**Use the reference that the patient gives.)

How did you come to Sweden?

Pose follow-up questions about the migration and possible flight (respect boundaries regarding what the patient is prepared to talk about).

What made you move to Sweden in particular?

How has your life been affected by the move to Sweden? (Pose follow-up questions about life in the home country, e.g. work, housing, socio-economic status.)

What did you leave behind when you moved to Sweden?

Which important people did you leave?

What contact do you have with your old neighbourhood**?

What contact do you have with family and friends who still live there?

Do you visit your old neighbourhood?

What new relationships have you made in Sweden?

What new opportunities have you had in Sweden?

Pose follow-up questions about work, education, housing and other current conditions.

How has your family been affected by the move?

Has the move to Sweden affected your health? (Pose follow-up questions about how the patient perceives the situation.)

In what way?

Were you subjected to threats or violence in your neighbourhood**?

Were you subjected to threats or violence on the way to Sweden?

How has this affected you? (If relevant.)

Were your relatives subjected to threats or violence in your neighbourhood **?

Were your relatives subjected to threats or violence on the way to Sweden?

How has this affected your relatives? (If relevant.)

How has this affected you? (If relevant.)

Do you often think of your neighbourhood ** and the past?

What are your expectations and hopes regarding the future?

Cultural identity of the individual

I shall now ask some questions about your cultural, ethnic and religious background and affiliation.

Is there any group, or groups, that are important to you? I am thinking of, for example, national, ethnic, cultural, religious, social or other groups (exemplify if needed).

Do you think of yourself as – exemplify with ethnic group, e.g. "Kurdish" (Exemplify from the response given).

Do you think of yourself as Swedish?

How do you think that others see you? (Exemplify if needed using earlier responses.)

What does the group**** mean to you? (****Use the term for group affiliation that the patient uses; in the case of affiliation with several groups ask about all of them.)

What is it like to belong to several groups****? (If relevant.)

What problems does it create?

What opportunities does it create?

Has your experience of belonging to a particular group**** changed over time?

What has this meant for you? (If relevant.)

Is there anything you miss?

Is there anything that has given you new opportunities?

How is your group **** treated by those in your surroundings?

Have you experienced misunderstandings or been subjected to unfair treatment because of your group affiliation****?

Is there any group, or several groups, that are important to your family? I am thinking, for example, of national, ethnic, cultural, and social or other groups (exemplify if needed).

What does the group **** mean to your family? (****Use the term for group affiliation that the patient uses, in the case of affiliation with several groups ask about all of them.)

How does it work for your family belonging to several groups ****? (If relevant.)

I shall now ask some questions about your language situation.

What languages can you speak?

What language do you prefer to use?

In which situations do you use the different languages, at home, with the family, at work, in contact with healthcare services?

When did you learn to speak the different languages?

In what language do you dream?

Cultural factors related to psychosocial environment and levels of functioning

I shall now ask some questions about how your problems affect you.

How do your problems affect your everyday life? (Exemplify if needed with everyday activities.)

How do your problems affect your contacts with others? (For example, family, friends, work colleagues, etc.)

How do your problems affect your ability to be active?

How do your problems affect your ability to cope at home?

How do your problems affect your ability to work?

Is there anything in your everyday life that contributes to, or has contributed to, you having problems?

What affects, or has affected you? (If relevant.)

How have you been affected?

I shall now ask some questions about what you can receive in terms of advice, support and help.

Is there anyone, or any persons, that you trust and can talk with about your problems and your situation?

Are you able to talk with your family and your relatives about your problems?

Are there any difficulties in doing so?

How do you let others know that you need help?

What sort of help do you need in your everyday life?

From whom can you receive advice, support and help in your everyday life?

What sort of advice, support and help can you receive in your everyday life?

Do you have a faith or belong to a religious community that is a support and help for you?

What sort of advice, support and help do you receive? (If relevant.)

Cultural elements of the relationship between the individual and the clinician

In conclusion, I wonder what you think about this interview and your contact with this unit (unit in question.)

What has it been like to describe and explain your problems and your situation for me?

What has it meant for you to be able/not be able to use your mother tongue with me?

What has it been like using an interpreter during our conversation? (If relevant.)

Did you need an interpreter? (If relevant.)

What do you think about the questions I have asked?

Is there anything important that you would like to tell me that we have not talked about?

What has been easy to explain?

What has been difficult to explain?

How well do you think that I have understood your problems and your situation?

How well do you think that others at this unit have understood your problems and your situation?

Finally the interviewer assesses how he/she thinks the interview has been. Suggested questions to consider are given below.

What was the relationship with the patient like?

What has made it difficult/easy to form a good relationship?

What was the communication like?

What has made it difficult/easy to create good communication?

How has the language worked during the session?

What has it meant that you do not have the same mother tongue? (If relevant.)

What has it meant that you have used an interpreter?

Did you need an interpreter?

What was the level of intimacy?

What has made it difficult/easy to attain an adequate level of intimacy?

How do you assess your possibility of understanding the patient's problems?

What has made understanding more difficult/easy?

How do you assess your possibility of understanding the patient's life situation and social context?

What has made understanding more difficult/easy?

How do you assess your possibility of understanding the patient's self-image and expectations of the healthcare services?

What has made understanding more difficult/easy?

What feelings and reactions has the patient awoken in you?

How have you managed your feelings and reactions?

How do you assess your possibility to decide what is normal and pathological with regard to the patient's problems?

How reliable do you think your diagnostics are? Regarding categorisation (Axes I and II)?

Regarding other DSM-IV Axes?

How do you assess your possibility of suggesting an adequate treatment?

How do you assess your possibility of making your diagnostic assessment comprehensible for the patient?

What is the importance of your and the patient's ethnic, social and cultural affiliations in your encounter? (Reflect upon what you believe that these factors have had for significance in your encounter).

Other reflections?

Overall cultural assessment for diagnosing and care

In conclusion, an assessment is made of how cultural aspects affect diagnostics and suggestions to the patient regarding care.

Own notes

” A patient must never be ascribed a notion due to her/his culture or ethnicity. The care professional needs to actively find out what the individual patient is trying to communicate and what significance, what meaning she/he gives her/his problem and situation.”

With this Manual we want to offer staff within health care a tool for psychiatric diagnosis in multicultural care environments. The Manual uses the Cultural Formulation in DSM-IV as its point of departure and aims to support care staff in exploring the individual patient’s perspective on illness and problems with reference to her/his social and cultural context. The Cultural Formulation is intended to be used as a complement to DSM-IV’s other axes. It is our hope that the Manual will contribute to understanding and a good working alliance in clinical work.

Telephone +46 (0) 8 672 29 10 · E-mail tc@sll.se

Website: www.slso.sll.se/tc