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Issues in the Assessment and Diagnosis of Culturally Diverse Individuals - Francis G. Lu, M.D., Russell F. Lim, M.D., and Juan E. Mezzich, M.D., Ph.D. Los Angeles County, California (2008)

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A consideration of culture is essential in the process of the interview, case formulation, diagnosis, and treatment of culturally diverse individuals. The evaluation of these individuals raises many issues that clinicians need to address to formulate an accurate diagnosis and treatment plan that will be acceptable to the patient. The assessment of minority patients has additional layers of complexity when compared with assessment of nonminority patients, especially when the patient has a different cultural or ethnic

background from the clinician. Thus, clinicians need to develop culturally competent knowledge, attitudes, and skills. The clinician should have some knowledge of the patient's cultural identity, and the use of a cultural consultant may be appropriate to avoid biases and misdiagnosis (Budman et al. 1992), even if the clinician and patient are of the same culture and ethnicity (Comas-Diaz and Jacobsen 1991; T. L. Cross et al. 1989; Pinderhughes 1989). Also, clinicians need to be aware of their own cultural identity and their attitudes and beliefs toward ethnic minorities, because these will affect their relationships with patients. Finally, clinicians need additional skills because traditional methods of interviewing the patient may not be effective and psychological tests may not be adequate or appropriate. Clinicians may need to use an interpreter (Westermeyer 1990) or may need to conduct family interviews, and psychological tests may need modification (Marsella 1989).

Many organizations have begun to address these issues in the assessment and diagnosis of culturally diverse individuals. Both the American Psychological Association and the American Counseling Association have recognized the importance of considering the effect of culture on diagnosis and treatment. These organizations have published similar guidelines for clinical competence with culturally diverse individuals. The American Psychological

Association (1993) guidelines acknowledge the necessity of assessing individuals in the context of their ethnicity and culture, respecting their indigenous beliefs and practices (including those involving religion and spirituality), assessing the patients’ support systems, evaluating the patients in their primary language, and taking a history that accounts for immigration and acculturation stresses. The American Counseling Association guidelines stress the awareness of both patient and clinician beliefs, the attainment of background knowledge about the patient (including his or her worldview), and the development of culturally competent skills (Sue et al. 1992).

In addition, the ICD-b (World Health Organization 1992) incorporated major methodological developments such as a phenomenological organization of nosology, use of more specific definitions for diagnostic categories, the employment of multiaxial framework, and the development of an international psychiatric lexicon (containing a description of culture-bound syndromes) as well as an international casebook. Finally, the American Psychiatric Association acknowledged the impact of culture and ethnicity on diagnosis and treatment, as stated in the introduction to DSM-IV (American Psychiatric Association 1994a):Special efforts have been made in the preparation of DSM-IV to incorporate an awareness that the manual is used in culturally diverse populations in the United States

and internationally. Clinicians are called on to evaluate individuals from numerous different ethnic groups and cultural backgrounds (including many who are recent immigrants). Diagnostic assessment can be especially challenging when a clinician from one ethnic or cultural group uses the DSM-IV Classification to evaluate an individual from a different ethnic or cultural group. A clinician who is unfamiliar with the nuances of an individual's cultural frame of reference may incorrectly judge as psychopathology those normal variations in behavior, belief, or experience that are particular to the individual's culture. (p. xxiv)Whereas in DSM-III-R (American Psychiatric Association 1987) the importance of culture was only briefly acknowledged, DSM-IV has an appendix that contains an outline for cultural formulation and a glossary of culture-bound syndromes. In addition, "specific culture features" are considered where appropriate in the actual diagnostic categories.

In summary, the consideration of cultural factors in the assessment, diagnosis, and treatment of culturally diverse individuals has gained recognition in a variety of disciplines in the last decade.In this chapter, we present a brief history of psychiatric case formulation; define culture, ethnicity, and race; and focus on an explication and elaboration of the DSM-IV outline for cultural formulation. Aspects of cultural formulation include assessing a patient's cultural

identity and understanding how culture affects the explanation of the individual's illness, support system, and the clinician-patient relationship as well as understanding how culture affects the assessment and diagnosis of culturally diverse individuals.

CASE FORMULATION: BACKGROUND HISTORY

The formulation of cases has been essential to the assessment, diagnosis, and treatment of patients since Freud's time, and many models have been proposed to organize patient data and inform treatment. These models include the psychodynamic, the biological, the behavioral, and the biopsychosocial (Sperry et al. 1992). Earlier in this century, the psychodynamic model was the most prominent; it begins with the assumption that the patient's problems can be understood as a result of conflicts that result in anxiety (Perry et al. 1987). The biological model, which posits an organic basis for psychopathology, was more commonly associated with other medical specialties and has become more prominent since 1950 with the advent of psychotropic medications (Ayd and Blackwell 1984), the discoveries of sensitive receptor assays resulting in more specific drugs (Snyder 1985), and the development of improved structural and functional brain-imaging techniques (Andreason 1989).

The behavioral model operates on the premise that an

individual's behavior is determined by learning patterns such as disordered thoughts from an event, which then results in behaviors that are self-reinforcing (Cohen and Farrell 1988). The biopsychosocial model, which is based on systems theory, states that patients' biological state, psychological makeup, and environment all affect their illness presentation and treatment (Engel 1980).

We believe that focusing on the cultural formulation enhances the usefulness of the biopsychosocial model, especially for culturally diverse individuals. The cultural formulation highlights the effect of culture on the expression of symptoms, definition of illness, and treatment. In the past, many authors have discussed the importance of considering the effect of culture on diagnosis and treatment. Fabrega (1987) and Kleinman (1988) agreed that culture affects the clinician's impressions of normality and categories of illness. Rogler and Cortes (1993) stated that culture affects the patient's access to mental health care. Sue and Sue (1990) stated that the impetus for the increasing interest in cultural issues lies in the recognition that our society is becoming multiracial, multicultural, and multilingual, whereas the training of mental health professionals has not reflected this trend, preferring to remain monocultural.

CULTURAL FORMULATION

Hinton and Kleinman (1993) discussed a practical approach to making culturally appropriate formulations. The first step is to show empathy during the interview and then to elicit the patient's perspective on the illness. Next, the patient's experience can be assessed in the context of the patient's family, workplace, health care systems, and community. Finally, the patient's illness can be diagnosed both through DSM-IV categories and through the patient's cultural idioms of distress. Hinton and Kleinman's overall schema is similar to the one developed by the National Institute of Mental Health (NIMH) Culture and Diagnosis Group (Mezzich et al. 1993). The DSM-IV outline for cultural formulation includes the following: 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 preferences (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.

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. (American Psychiatric Association 1994a, pp. 843—844)

Before reviewing each of these topics, we need to define some key terms.

DEFINITIONS

Culture

As described by the NIMH Culture and Diagnosis Group (Mezzich et al. 1993) for incorporation into DSM-IV, culture and ethnicity are related concepts. According to that group: Culture refers to meanings, values, and behavioral norms that are learned and transmitted in the dominant society and within its social groups. Culture powerfully influences cognitions, feeling, and "self" concept, as well as the diagnostic process and treatment decisions. Ethnicity, a related concept, refers to social groupings which distinguish themselves from other groups based on ideas of shared descent and aspirations, as well as to behavioral norms and forms of personal identity associated with such groups. (p. 7)

Culture has many meanings and can be thought of as the beliefs, customs, technologic achievements, language, and history of a group of similar people (Johnson 1988). Alternatively, it can be thought of as the values, meaning, and behaviors that are transmitted by the dominant group. Its precise definition is poorly agreed on; Kroeber and Kluckhohn (1963) listed more than 150 definitions. Linton (1945) defined culture as being a shared, learned behavior transmitted from one generation to another, having both

external and internal components. The external components include beliefs, laws, traditions, customs, morals, and habits; the internal components consist of norms, rules, standards, ideals, and values.

Cultures also differ in their conception of personal identity. In general, Eastern cultures favor a group identity, whereas Western cultures favor individual autonomy. Another significant difference is the concept of the body. Western societies tend to see the mind and body as separate, whereas Eastern societies tend to see the mind and body as a whole.

Cultural expectations and norms determine if a constellation of symptoms is judged as pathological or not. Various disorders have differing prevalences in different ethnic groups, and each group has variations in the expression of the illness (Burnam et al. 1987; G. J. Canino et al. 1987; Karno et al. 1987). For example, many Australians, who typically value independence, may have a more difficult time with depression because it makes them more dependent on others, whereas many Japanese, who value community-based decisions, may have less difficulty with depression (Radford et al. 1991). Each culture has its own range of communication style (e.g., language, gestures, and rituals), eating behaviors, family roles (e.g., marital, gender, and leadership roles), beliefs and rituals

(e.g., child rearing and sexual practices), and ways of regulating aggressive and sexual drives. In summary, culture can be understood as a complex construct of socially transmitted ideas, feelings, and attitudes that shape behavior, organize perceptions, and label experiences.

Ethnicity

Ethnicity refers to an individual’s sense of belonging to a group of people sharing a common origin and history, along with similar cultural and social beliefs (Group for the Advancement of Psychiatry 1987). It is thus closely linked to the individual’s self-image. Ethnicity also refers to shared descent and aspirations, as well as behavioral norms and personal identity. Finally, ethnicity may imply national and geographical origin, as well as religious beliefs. Incorrect assumptions about ethnicity, based on language or appearance alone, can lead to misun-derstanding and misdiagnosis of culturally diverse minority individuals (Del Castillo 1970; Hughes 1993).

Race

In contrast to ethnicity and culture, race is not mentioned in DSM-IV; it refers to the biologically determined similarities of a group, which affect the interactions with others when perceived differences lead to the use of value hierarchies embodied in bias or prejudice. According to Pinderhughes

(1989), race has “a different level of cultural meaning than ethnicity” (p. 71). For example, a West Indian black is ethnically and culturally different from an African American, yet both may be treated with the same prejudiced attitudes by whites. Pinderhughes stated that race has social meaning, assigns status, limits opportunities, and influences interactions between patients and clinicians. For example, the psychological effect of a person’s facial complexion can be traced to the racism that has as its roots the history of conflicts between certain social groups in the United States. Racial prejudices influence the expectations that people have of one another and can lead clinicians to stereotype individuals.

CULTURAL IDENTITY

There are many components to a patient’s cultural identity that go beyond the concepts of ethnicity and race, because a person may have several cultural reference groups. For example, two Hispanic persons may come from Mexico but may have different cultural identities depending on what socioeconomic status and geographical region from which they originated. Multiple factors affect an individual’s cultural identity (Table 18—1).

It is vital to know these multiple aspects about patients’ cultural identity to avoid misconceptions based on ignorance or stereotypes related to ethnicity and race or

any one aspect of cultural identity. Clinicians need to explore the patient's developmental history to understand what makes him or her either different from or similar to a person born and raised in the predominant host culture in the United States. These characteristics may include country of origin, family structure, customs, values, and beliefs, as well as attitudes about medicine and psychiatry. If patients are recent immigrants, clinicians need to explore the immigration experience, including any trauma, separation, losses, alienation, class displacements, or disappointments. If the patients are not recent immigrants but belong to later generations, focus can be placed on the level of their acculturation, which refers to the degree to which they have adopted the beliefs, values, and practices of the host culture (Westermeyer 1993).

Previous work on the concept of cultural identity includes the concept of worldview, whether Eurocentric or multicultural, which avoids the use of labels that can oversimplify and stereotype (Ivey et al. 1993). Patients' histories can be thought of in terms of their personal, family, and cultural histories. These histories are held by the patients as constructs, which can be detected by their use of key words or words that they use over and over as they interact with the clinician. Kelly (1955) stated that constructs are not the concrete reality, but the individual's personal explanation and meaning. Family constructs can

be elicited with a genogram and a developmental history. Finally, cultural constructs can be assessed by asking about gender, religious, or ethnic and racial issues among other aspects (Table 18—1).

Another method of conceptualizing cultural identity is through an interpersonal grid, which involves assessing the patient's worldview by using system variables. The clinician attempts to discuss particular topic areas such as demographic (age, gender, and location), status (social, educational, and economic), and affiliations (ethnic, religious, and family) and the behaviors, expectations, and values associated with these factors (Pedersen and Ivey 1993). Thus, clinicians are better able to interpret and predict their patients' behaviors if they are aware of the differences between their own and their patients' explanations of behaviors. This model helps the clinician to understand that the same behavior can have different meanings to others and that behavior needs to be interpreted in the context of these topic areas.

Table Table 18-1.

Aspects of Cultural Identity Development

Ethnicity

Gender

Race

Age

Country of Origin

Sexual orientation

Language

Religious and spiritual beliefs

Acculturation

Socioeconomic class and education

Finally, another schema for understanding cultural identity is the multicultural cube, which adds the dimension of level of “cultural identity development” (p. 100) (Ivey et al. 1993). Cultural identity development refers to how the culturally diverse individual sees himself or herself in respect to the host culture. The least developed level is acceptance or conformity, which describes a compliant position. Following that level is one of dissonance, where the individual is in conflict with his or her own cultural identity and that of society. The next level is resistance, in which the individual rejects all that is the host culture. Following that level is one of introspection, which implies that both cultures can coexist, but that the host culture is irrelevant. Finally, there is the level of integrative awareness, in which individuals can accept the best and worst aspects of both cultures (Atkinson et al. 1989). Similar well-researched schema of racial and ethnic identity development has focused on African Americans (W. Cross 1991), African Americans and whites (Helms 1990), Asian Americans (Sue and Sue 1990), and Hispanics (Bernal and Knight 1993).

Assessment of Ethnicity

The ethnicity of a patient can be assessed by taking a careful history of the patient's development and family. Clinicians can ask patients to describe their grandparents' and parents' country of origin, religion, primary language, traditional roles, and traditional skills. Patients should be asked about their socialization experiences (such as their proficiency with their culture's native language), their role in their family constellation, special rituals during certain ages (rites of passage), religious practices, holiday observances, or preparation of ethnic food that they have observed with their families. Finally, patients should be asked to what extent they are following the ceremonies, rituals, customs, and hobbies of their ancestors and the level of contact they have with their relatives or ethnic organizations.

Language

Language identifies and codifies an individual's experience, which is not readily translated from one language to another without distortion. Because culturally diverse patients sometimes speak more than one language, it is important to determine what language they consider their primary language. Usually this is the language first learned however, it may not be the language of their ethnic culture, but of their host culture. It is the one in which they feel the most comfortable expressing

themselves. If a secondary language is used, a more limited, and possibly inaccurate, history can result in misdiagnosis (Del Castillo 1970; Marcos et al. 1973). Advanced forms of communication—such as humor; assertiveness; and the expression of displeasure, frustration, and love-are hampered by the patient's lack of fluency in the new language (Westermeyer 1989). In addition, communication includes nonverbal communication, such as distance between speakers, eye contact, physical touch, and local forms of gesticulation. Different ethnicities also communicate in different styles. For example, Sue and Sue (1990) stated that there are high content groups, such as African Americans, Asians, Hispanics, and Native Americans, who use different nonverbal communication than other ethnicities, such as whites.

Migration History

For recently immigrated patients, an important part of their cultural identity relates to their migration history, which should be recorded in the psychosocial history section of the written evaluation. As described by Lee (1990) (Table 18—2), the purpose of a migration history is to determine the patient's background history and to measure their baseline functional level as well as the generational status of the patient. There are actually two parts to the migration

history: the premigration history and the immigration history.A pre-migration history includes country of origin, position in the family, education, employment status, level of support, political issues, experiences of war, and traumatic events. It may be helpful to know the recent history of the region, common religious beliefs, and from which social class the patient originated. The clinician's goal is to understand the patient's former baseline life experience in their native country prior to migration.

The immigration history includes the reasons for leaving, who was left behind, who paid for the trip, and hardships endured and trauma suffered, including experiences of torture, beatings, starvation, rape, and imprisonment in a refugee or detention camp. Patients can be described as "migrants" or "refugees"; migrants leave their country voluntarily and often easily, whereas refugees are either forced out or flee the country surreptitiously, encountering many traumas and losses. Clinicians need to explore the extent of loss and traumatic experiences. These can include the loss of family members, relatives, and friends; material losses of property, financial resources, businesses, and careers; and loss of their cultural milieu, community support, and religious and spritual support.

Degree of Acculturation

Immigrants routinely experience some degree of culture shock, and clinicians can assess the patient's level of adjustment by inquiring about his or her competence in the English language and in negotiating the tasks of learning to live in this country. This can be seen in activities such as the successful attainment of housing, employment, and childcare and a mastery of public transportation. Demographic information can help assess the rate of acculturation. Important variables include the number of years spent in the United States, the age at the time of immigration, exposure to Western culture in the country of origin, and contacts with native-born Americans. Younger immigrants acculturate more quickly and learn English faster than older immigrants. Standard parts of the psychosocial history should be utilized to assess the rate of acculturation; these include occupational and social histories. The occupational history should survey the difference between the patient's work status in the United States and in the patient's home country.

Table 18—2.

Migration history
Premigration history
Country of origin, family, education, socioeconomic status, community and family support, political issues, war, trauma.

Experience of migration

Migrant versus refugee:

Why did they leave?
Who was left behind?
Who paid for their trip?
Means of escape, trauma.

Degree of loss

Loss of family members, relatives, friends.

Material losses: business, careers, properties.Loss of cultural milieu, community, religious, spiritual support.

Traumatic experience

Physical: Torture, rape, starvation, imprisonment.

Psychological: Rage, depression, guilt, grief; post-traumatic stress disorder.

Work and financial history

Original line of work, current occupation, socioeconomic status.

Support systems

Community support, religion, family.

Medical history

Beliefs in herbal medicine, somatic complaints.

Family's concept of illness

What do family members think the problem is? Its cause? What do they do for help? What result is expected?

Level of acculturation

First or second generation.Impact on developmentLevel of adjustment, assess developmental tasks.
Source. Adapted from Lee, 1990.

A patient with a history of downward mobility in his or her occupational status could develop lowered self-esteem and insecurity, which might precipitate a mental disorder. The social history can also help determine how much support the patient can rely on from family or an extended network, such as family organizations or churches. Living in an ethnic community can also buffer the acculturation process. The patient’s proficiency in English and contact with others outside of the cultural enclave are useful measures of acculturation. Of note is that DSM-IV has a new category for “acculturation problem” in the section titled “Other Conditions That May Be a Focus of Clinical Attention,” indicating that distressing acculturation experiences can occur without necessarily labeling them as symptoms of a mental disorder.

Another way of assessing the degree of acculturation of patients is by a framework that is numerative (i.e., first generation, second generation, third generation) or

descriptive (i.e., traditional, transitional, bicultural, Americanized) (Lee 1990). Traditional families are born and raised in their country of origin. In general, these immigrants speak only their native language, live in ethnic enclaves (like Chinatown or "Little Italy" in New York City), and could have a rural background. They tend to approach problems in a more concrete manner and are more likely to have adjustment disorders and major depression and to describe their problems in somatic terms. Transitional families have parents that speak very little English, whereas their children are better acculturated. They commonly have parent-child conflicts, role confusion, and marital difficulties. These families suffer from the erosion of the authority of the parents by their dependence on their children for linguistic and cultural translation. The most effective therapies for these patients are cognitive and behavioral. Bicultural families have parents who are professionals or business owners and are primarily English speaking. The parental authority is egalitarian as opposed to patriarchal. These families traditionally live in the suburbs. They are often more stable than the above two family structures.

Finally, Americanized families are usually several generations removed from immigration. Often the original native culture is lost, because parents and children speak only English. Interethnic marriage is more common, and

families are individualistic, competitive, and egalitarian. They are usually stable and present no significant differences from Westernized patients.

A final way of looking at acculturation was described by Padilla (1980), who suggested both that acculturation can be thought of in more than one dimension and that the clinician should assess separately degrees of identification with the host culture and with the original culture. In connection with this, bicultural individuals seem to have better social adjustment and performance than those who either identify only with the new culture and lose affiliation with their family origins or identify only with the original culture and seclude themselves into cultural ghettos.

Gender

Gender identity issues also interact synergistically with ethnic identity to shape one's cultural identity and have many implications for assessment and treatment. Notman et al. (1991) and Myers (1991) concisely reviewed the impact of both female and male gender identity or development across the life cycle. They pointed out the complex interaction of gender identity and age on one's cultural identity. Fullilove (1993) outlined how minority women's status affects health status, sexual practices, and treatment settings. Comas-Diaz and Greene (1994) stressed the heterogeneity among women of color by

integrating culturally relevant and gender-sensitive issues into guidelines for clinical practice with African American, Latina / Hispanic, Asian American, American Indian women, and West and East Indian women.

Age

Psychiatry has long acknowledged the impact of age on one's identity formation. As with gender, age interacts with the other aspects of cultural identity to influence development and psychiatric assessment and treatment. For example, I. Canino and Spurlock (1994) offered clinical guidelines for working with economically disadvantaged children and adolescents from culturally diverse backgrounds that recognize the significance of cultural variations in help-seeking behavior, discrimination, and socioeconomic pressures on children's adaptive responses and mental health. The American Psychiatric Association (1994b) Task Force on Ethnic Minority Elderly also presented specific outlines for clinical care of the elderly from the four major ethnic minority groups.

Sexual Orientation

Sexual orientation defines an essential aspect of one's cultural identity. Stein (1993) extensively reviewed the development and meaning of lesbian, gay, and bisexual identities. Furthermore, assessment and treatment

implications are outlined for persons with these sexual orientation identities across ethnic, age, and class groups to acknowledge the synergistic impact of these aspects of cultural identity. This work will be greatly expanded on in a forthcoming work by Cabaj and Stein (in press).

Religion and Spirituality

Diverse cultures possess diverse religious and spiritual beliefs that are an important aspect of cultural identity and that affect health (Numbers and Amundsen 1986; Sullivan 1989) and mental health. Fitchett (1993)

CULTURAL EXPLANATIONS FOR ILLNESSES

From a clinical point of view, understanding the patient's view of his or her illness helps determine our assessment and our treatment plan. Different cultures express their symptoms differently (Kleinman 1988), and concepts of illness also vary with culture. For example, for the Chinese in Hong Kong, Cheung (1987) found that patients had three explanatory models for mental disorders. They could explain their illness as based on psychological, somatic, or mixed factors. Their explanation of the illness influenced how they went about getting help. The patients who had purely psychological explanations were the least likely to seek help. Because of this, Cheung recommended that clinicians specifically inquire about psychological symptoms, because these patients were not likely to

volunteer them.

Idioms of Distress

Idioms of distress were defined by Nichter (1981) as the ways in which individuals “express, experience, and cope with feelings of distress” (p. 399). These are further described as “culturally constituted in the sense that they initiate particular types of interaction and are associated with culturally pervasive values, norms, generative themes, and health concerns” (p. 379).In the DSM-IV appendix on culture-bound syndromes, there is a glossary listing “some of the best-studied culture-bound syndromes and idioms of distress that may be encountered in clinical practice in North America” (pp. 844—845). An example listed is ataque de nervios, a syndrome of uncontrollable shouting, crying, trembling, and aggression typically triggered by a stressful event involving family and followed by amnesia. Also included is nervios, a state of vulnerability to stress, marked by headaches, irritability, stomach problems, inability to concentrate, and dizziness. These two idioms are typically seen in Latino patients. Another example is zar, a syndrome of being possessed by spirits, evidenced by shouting, singing, crying, and a withdrawal from daily tasks.