

CHAPTER 2

The Core and Informant Cultural Formulation Interviews in DSM-5

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In this chapter, we introduce the DSM-5 (American Psychiatric Association 2013) core Cultural Formulation Interview (CFI) and the CFI–Informant Version. We begin with a theoretical description of the core CFI. The CFI comprises three tools for clinicians to complete a cultural assessment: 1) the core CFI of 16 questions with associated prompts for direct patient interviewing; 2) the CFI–Informant Version that can be administered to close associates of the patient, such as family, friends, caregivers, and other social supports; and 3) the 12 CFI supplementary modules that expand the number of questions by cultural domain or include topics of additional interest for certain populations. All of these tools share a common theoretical foundation, and our aim in this chapter is to describe this foundation through detailed descriptions of the core CFI and the CFI–Informant Version; Chapter 3 (“Supplementary Modules”) covers the supplementary modules in greater depth.

In addition, in this chapter we review key findings from the DSM-5 field trial that tested an earlier version of the core CFI consisting of 14 items. The field trial results were taken into account in the final revised core CFI that is included in DSM-5. More

details on field trial recruitment, inclusion and exclusion criteria, assessment instruments, and analytical strategies can be found elsewhere (Aggarwal et al. 2013; Lewis-Fernández and Aggarwal 2013). Here, we focus on three themes that may convince clinicians and administrators to implement the CFI: 1) its feasibility, acceptability, and perceived clinical utility as reported by patients and clinicians (Lewis-Fernández et al., Feasibility, acceptability and clinical utility of the core Cultural Formulation Interview: Results from the international DSM-5 field trial, manuscript in preparation, March 2015); 2) its beneficial effects on patient-clinician communication (Aggarwal et al. 2015); and 3) suggestions for overcoming barriers to implementing the CFI in clinical practice (Aggarwal et al. 2013). Clinicians are more likely to implement interventions with a robust evidence base than interventions without such empirical support (Aarons 2004; Damschroder et al. 2009), and we hope to make the case here that the CFI possesses a strong and expanding evidence base.

Development of the CFI

The three components of the CFI were developed by the DSM-5 Cross-Cultural Issues Subgroup (DCCIS) based on a review of the scientific literature since the publication of the Outline for Cultural Formulation (OCF) in DSM-IV (American Psychiatric Association 1994) and previous attempts to operationalize the OCF by researchers around the world, many of whom also served on the DCCIS (Bäärnhielm and Scarpinati Rosso 2009; Groen 2009; Kirmayer et al. 2014; Lewis-Fernández et al. 2014; Mezrich et al. 2009; Østerskov 2011; Rohlf 2008; Rohlf et al. 2002; van Dijk et al. 2012). Mental health professionals have long recognized the need to conduct accurate cultural assessments of patients to prevent misdiagnosis and promote treatment engagement. However, as explained in Chapter 1 (“Cultural Formulation Before DSM-5”), there have been many ways to conduct such assessments, and few have attempted to analyze their similarities and differences or harmonize their content. The CFI was developed as a consensus approach to guide clinicians in how to obtain the information requested by the OCF directly from patients and members of their entourage. Conceptual and practical problems in the use of the OCF that could benefit from further attention were identified through the DCCIS literature review and discussed in committee meetings. In the case of the core CFI, this resulted in an initial draft to be tested in the DSM-5 field trial (Lewis-Fernández et al. 2014). The process of conducting a comprehensive literature review to identify areas for revision, with revisions tested systematically in a field trial with human subjects, has been the revision process for DSM-5 (Kraemer et al. 2010; Kupfer et al. 2002). Owing to time and financial constraints, the CFI–Informant Version and the supplementary modules were not included in the field trial.

The core CFI consists of 16 questions with associated instructions for clinicians to use in conducting a patient-centered cultural assessment. The DCCIS also recommended that all clinicians begin every standard clinical assessment with the core CFI. This tool has been designed for use with patients of all diagnoses and in all inpatient, outpatient, emergency, and transitional settings. This broad approach acknowledges that all patients and clinicians come from cultural backgrounds that can affect clinical

care, rather than assuming that culture is only a pertinent factor in the care of racial and ethnic minorities (Aggarwal 2010; Kleinman and Benson 2006). Instructions for the core CFI have therefore addressed the gap in implementation guidelines for cultural assessments in general and for the OCF in particular.

The DCCIS also deliberated over the order of questions in the core CFI. Several cultural domains of the DSM-IV OCF had been criticized for being too indistinct and overlapping (Ton and Lim 2008), often leading to redundant information (Caballero-Martínez 2009). It was unclear whether clinicians were to obtain information under these domains in the specific order listed in the OCF. DCCIS members decided to reorganize the OCF domains to facilitate use of the core CFI at the beginning of every clinical assessment. For example, whereas the OCF starts with consideration of the patient's cultural identity, the core CFI initiates the assessment with the cultural elements of the patient's and social network's definition of the clinical problem. This parallels a routine mental health evaluation, in which establishing the patient's presented complaint helps the clinician organize the rest of the interview. Patients may otherwise find it odd to lead off with questions about their cultural identity prior to an assessment of the current problems that cause them to seek care. Appendix A presents the core CFI that appears in DSM-5 and is based on revisions from the version used in the field trial.

The core CFI is intended to obtain cultural views and practices in a patient-centered way. For example, the introduction to the core CFI reiterates that "there are no right or wrong answers." This acknowledgment emphasizes that the patient has a right to narrate his or her illness experience. This introduction also affirms that the patient's understanding of illness may differ from the clinician's biomedical understanding of the disease process (Eisenberg 1977).

Content of the Core CFI

The core CFI is divided into four main domains. The first domain, "Cultural Definition of the Problem," consists of the first three questions. Question 1 is meant to be a broad and open-ended inquiry about the patient's presenting concerns. The prompt invites the patient to describe his or her problems and emphasizes an understanding of the patient's illness narrative (Kleinman 1988), even if these descriptions are "similar to or different from how doctors describe the problem." Question 2 seeks to clarify further the patient's description of the problem as he or she would discuss it with close associates such as family or friends, a recognition that culture can influence how information is shared differentially depending on audience and social context (Kirmayer 2006). At this early point in the interview, patients may be reticent to describe the problem in ways that the clinician might find unusual and therefore may consciously or inadvertently censor nonmedical descriptions. By framing the question in relation to the person's social network, the goal is to facilitate the patient's report of as wide a range of descriptions of the situation as is salient in his or her immediate social environment. Question 3, which asks what troubles the patient most about the problem, is designed to explore what is most at stake for the individual during the illness experience (Kleinman and Benson 2006).

Questions 4–10 are grouped in the second core CFI domain, “Cultural Perceptions of Cause, Context, and Support.” Questions 4, 6, and 7 focus the interview on the patient’s explanatory models regarding the causes of the problem (Kleinman 1980; Kleinman et al. 1978), social supports that make the problem better, and social stressors that contribute to the problem (Mezzich et al. 2009). Question 4 includes the placeholder “[PROBLEM],” which is designed to solicit the patient’s own terms and phrases for how a problem is framed in the clinical setting—these are known as *idioms of distress* (Nichter 1981). The interviewer can then substitute the patient’s vocabulary for the placeholder throughout the interview, which helps to build rapport and bridge linguistic differences in patient and clinician understandings of illness. In some cases, the patient might use biomedical vocabulary, such as when a patient says, “I might have depression.” In other cases, the patient might use a more psychosocial description, such as “I worry about my rent, my electricity, my phone bill.” Terms that communicate the problem presented may vary greatly, and the CFI can reveal how patients frame issues so that clinicians can tailor treatment strategies most effectively.

Additionally, question 5 asks the patient to consider what friends, family, and close associates might understand as the cause of illness; this question is included to explore one understanding of culture—that is, as the meanings and viewpoints transmitted within social groups (American Psychiatric Association 2013). In this instance, the meanings being transmitted are the understandings of illness, and the social group is the patient’s network of close associates. As with question 2 on the definition of the problem, framing the inquiry in terms of the social network encourages patients to report a fuller range of explanations in their social environment that may be influencing their explanatory models. For example, in video 1, *Full CFI*, that accompanies this book, when asked about her “inability to relate to others,” the patient answers, “They just don’t understand what’s going on.... They just think that I’m crazy.” This information suggests that the patient’s presented problem is not culturally normative within her social network.



[Video Illustration 1: Full CFI](#) (6:57)

One understanding of culture in DSM-5 is “the influence of family, friends, and other community members (the individual’s *social network*) on the individual’s illness experience” (p. 750). The relationship between the individual and her social network is on display in the video illustrating use of the core CFI, which includes segments of a full CFI evaluation. The video begins with the interviewer asking the open-ended, first question, “What brings you here today?” The woman also responds in an open-ended manner, discussing concerns about starting college as context before conveying that she hears the voice of her deceased grandmother. “She keeps telling me to go to Panama and just start my life over,” the woman says. The interviewer continues by asking how the patient would describe the problem to others in her social network, and the patient answers that she cannot discuss this problem with them. In response to what troubles her most about the problem, she says, “Nobody is taking me seriously.” Just from these initial questions, we learn that the patient experiences significant distance from her social network with respect to her problem.

Next, the interviewer transitions into questions about the patient's explanations for her current experiences. In responding to a question on associated stressors, she says, "Now I have the answer that I need. My grandmother is telling me what I need to do.... I guess what's stressing me out now is I need to figure out how to get to Panama." Here the CFI assists the clinician in interpreting degrees of social impairment.

Afterward, the CFI questions on identity invite the patient to share experiences about her background. In response to a question about how her background or identity relates to the problem, the patient answers that she used to be close to her family and specifically names her brothers and grandmother. When considered in relation to earlier answers, we learn that hearing her grandmother's voice may contribute to her present sense of estrangement from her family. Notably, the family unit is central to her sense of self and its relationship to the problem she presents. Despite being a woman of Panamanian background, she does not identify gender, ethnicity, or geographical origin as the social groups that most influence her illness experience. These markers of background and identity may be important in other situations but do not seem pertinent in this health care setting. Therefore, the CFI is able to clarify that the family unit is the group she regards as most clinically relevant.

Finally, the interviewer asks about the patient's past and present forms of coping and help seeking. We learn that the patient has tried to write as a form of self-coping upon encouragement from others, but this has not been particularly successful. She has also sought help from her family, who, in turn, have said, "Go talk to a therapist." The examiner asks about barriers to care, and the patient answers, "Everyone... Nobody understands what is happening.... I can't trust anybody." She remains focused on moving to Panama and obeying the wishes of her grandmother in response to what would best help her now. "The people that I tried to confide in don't understand me.... I need someone who will take me seriously." Interpersonal problems appear to distress her, and the CFI has now uncovered two clinical problems that could be addressed in the future: 1) her relationship to her social network and 2) hearing the voice of her deceased grandmother. A standard interview could also provide information on hearing voices, but it is unlikely that details about the social network would be obtained unless an extensive social history was obtained. With this foundation, the clinician can use the CFI supplementary module on the social network with the patient or the CFI-Informant Version with key members from the patient's social network—with patient consent—to better understand their perspectives.

Questions 8, 9, and 10 also belong to this second domain, but they orient the interview toward the patient's cultural identity. Question 8 is preceded by a brief introduction that clinicians can use to clarify the meaning of *cultural background or identity* as relevant to the health care context. The introduction also provides examples of identities that may be important for the patient, such as language, ethnicity, religion, and

sexual orientation. Question 8 then asks the patient directly about the most important aspects of background or identity. This method of allowing the patient to name his or her cultural identity departs from previous models of cultural competence that have often made assumptions about patient identities based on a group affiliation such as race or ethnicity without accounting for their importance to the individual (Aggarwal 2012). For example, one patient in the field trial initially named his identity as Cuban but then explained that identifying as a Christian was more helpful in understanding his suffering existentially. In his case, a model of cultural competence that assumed ethnicity was the patient's most important group affiliation—without accounting for his self-ascribed identity—might have overlooked the role of religion in providing meaning to the illness experience. Question 9 then asks the patient how this identity may impact the current illness experience, predicament, or other patient-centered definition of the clinical problem. Question 10 asks the patient to consider how identity may cause other problems throughout life that may not initially come to mind as related to the illness but may, nonetheless, be important for clinicians to understand, such as problems with migration, gender roles, or intergenerational conflict.

Questions 11, 12, and 13 form the third domain, "Cultural Factors Affecting Self-Coping and Past Help Seeking." The goal of this domain is to encourage patients to share past forms of self-coping and help seeking, a recognition that most forms of help are sought outside of the biomedical health care system (Rogler and Cortés 1993). Question 11 addresses the patient's coping practices, and question 12 considers help seeking broadly, to include help within and outside of the biomedical system (e.g., religion-based support, support groups). One patient, for example, mentioned that going to church meetings that were specifically tailored to his age group provided the most comfort during exacerbations of auditory hallucinations. An additional prompt for question 12 clarifies the types of help that have been most and least helpful. This information may aid the clinician in developing a treatment plan for the current illness episode. Question 13 asks about past barriers to treatment. This information may also prove useful in devising the current treatment plan around available resources.

The final three questions of the CFI constitute the last domain, "Cultural Factors Affecting Current Help Seeking." Question 14 asks the patient about current treatment preferences, and question 15 explores treatment preferences that may be expressed by close associates. As with the questions on patient terms for illness or other self-definitions of the clinical situation, and their causes, this question on treatment preferences is examined at the individual and social levels. Finally, question 16 is preceded by an open-ended statement for the patient to anticipate how any perceived differences with the clinician can adversely affect care. By asking the patient directly about this potential barrier, the clinician can validate patient concerns and work to resolve such differences. Even if the question is not answered directly during the initial visit, the clinician's openness to the topic may empower the patient to raise concerns about the patient-clinician relationship later in the treatment.

In summary, the core CFI adopts an ecological approach to culture by first asking the patient about the illness, moving outward to the role of social supports and stressors, and then finishing broadly with the illness in relation to the health care system.

Development of the CFI–Informant Version

The purpose of the CFI–Informant Version is to assist clinicians in conducting a cultural assessment of the presenting clinical problem from the perspective of a key informant, such as a spouse, other family member, or friend who may be present during the clinical encounter. Patients are often accompanied by family or other potential informants during clinic visits, providing clinicians with the opportunity to include these close associates in the process of psychiatric diagnosis and treatment planning. The mental health literature has documented the many ways that social relationships can have profound effects—both positive and negative—on pathways to and through mental health treatment, including decisions about when or whether to seek care, participation in clinic visits, and implementation of treatment plans in the home, including adherence to medication (Jenkins and Karno 1992; Lefley 1996). As mentioned in the section “Development of the CFI,” the expected roles of close associates and these individuals’ perspectives on illness and treatment are rooted in culture. In this section, we describe the rationale for the CFI–Informant Version, clinical situations when this version may be useful, and issues for the clinician to anticipate when using the CFI–Informant Version in clinical practice. We do not explain each question of the CFI–Informant Version because it shares the same theoretical basis as the core CFI. The CFI–Informant Version is reproduced in Appendix B.

To be most effective, psychiatric diagnosis and treatment planning often require consultation with relatives or friends of individuals with mental illness. Certain aspects of culture may be shared among patients and others within the social network, but there may be important and unexpected differences even within families. For example, an older Vietnamese man who is depressed and most comfortable speaking Vietnamese may be accompanied by an adult child who speaks English and has adopted Anglo-European cultural values. In such cases, the patient and the informant may have quite different explanatory models for the patient’s depression or view of treatment. In such situations, the CFI–Informant Version can assist in eliciting the cultural perspectives of key informants, enabling a deeper understanding of the patient’s illness and the interpersonal dimensions of care. These varieties of perspective can open up opportunities for negotiation and the development of shared understandings of illness and goals for treatment.

After the decision has been made to conduct a cultural assessment, administration of the CFI–Informant Version can play an important role in clinical care in several types of clinical situations when an informant is available. In some instances, the informant may be the primary or sole source of information that is needed to assess the role of cultural factors in psychiatric diagnosis and treatment. This may occur, for example, when the clinician is assessing someone who is not able to give a meaningful or coherent history because of conditions such as severe cognitive impairment (e.g., due to a neurodegenerative brain process such as Alzheimer’s disease or a head injury), catatonia, severe paranoia, or agitation. Similarly, if the patient is a young child, it may be necessary to conduct a cultural assessment of the parent’s or another caregiver’s perspective. In other cases, the clinician may seek clarification from the informant when the patient’s responses to the CFI are ambiguous or partial (e.g., when

asking the patient about how others in his or her cultural group would view the symptoms). The clinician may also choose to administer the CFI–Informant Version if there is an identified family member or friend who is perceived to be influential and active in the patient’s clinical care and decision making. In certain situations, decisions about care may reside fully with a family member or other significant person in the patient’s life. In these situations, conducting a cultural assessment of the informant’s perspective may help to negotiate and implement a treatment plan. Finally, the CFI–Informant Version may be useful when treatment hits an impasse and a fuller assessment of the social context may identify underlying causes. The following is a summary of the types of clinical situations in which use of the CFI–Informant Version may be helpful: 1) the patient is unable to give a coherent account of illness (e.g., because of significant cognitive impairment); 2) the patient’s history is vague, contradictory, or ambiguous, and collateral information would be beneficial for clarification; 3) the informant plays a significant role in health care decision making and/or caregiving; 4) the patient has a strong preference for including the family member in the cultural assessment (e.g., for cultural or other reasons); and 5) diagnostic or treatment challenges emerge later in the course of treatment, and additional collateral information may be useful.

In choosing whether to use the CFI–Informant Version, the clinician should ponder several issues. Initially, it is critical for the clinician to discuss the involvement of an informant with the patient and to respect the patient’s desire for autonomy and privacy. Patients may have many different reasons for not wanting a family member involved, including concerns about burdening family members, shame about certain aspects of the problem, or discomfort with discussing conflicts with the informant that are contributing to the patient’s problem. In these situations, the clinician may need to negotiate family involvement over time, after the patient and clinician have established rapport. In other situations, such as when the patient insists on having family members present during the clinical encounter and defers to them, the clinician may need to negotiate time during the visit to meet individually with the patient to provide an opportunity for sensitive issues to be discussed that might involve family members (e.g., conflict, abuse). After the informant interview, the clinician may need to decide whether to reinterview the family member (or other informant) in the presence of the patient and vice versa. Ultimately, this decision should be based on the preferences of the patient.

A related issue is that the clinician may find important differences between the views of patients and informants (e.g., in their illness explanatory models or in the extent to which behavior is viewed as normative for their cultural group). One possible approach to such situations is to present the different perspectives in a nonjudgmental way, together with the biomedical view of illness, and then to try to negotiate a partially shared understanding of illness and treatment (Hinton and Kleinman 1993). When multiple perspectives cannot be resolved in this way, at least documenting the differences may assist the clinician in seeking additional information to clarify diagnostic issues or help in anticipating obstacles to implementing the treatment plan.

It is also essential to note that the clinician has flexibility in the timing and administration of the CFI–Informant Version. For example, the clinician can decide whether

to use the Informant Version at the initial visit or later in the course of treatment. In addition, the clinician may choose to use all of the Informant Version or only the part that seems most relevant to clinical care. Third, in situations with multiple family members or caregivers, the clinician needs to make pragmatic decisions about whom to interview based on patient preference as well as the informant's knowledge of the patient and the extent to which he or she is involved in day-to-day caregiving. Finally, the supplementary modules may be useful in conjunction with the CFI–Informant Version, particularly the Caregivers supplementary module, which explores in greater depth the role of cultural factors in the experience and enactment of caregiving.

Key Findings From the DSM-5 Field Trial

Having introduced the core CFI and the CFI–Informant Version, we now turn to findings from the international DSM-5 field trial. The field trial tested an earlier version of the core CFI, and data analyses conducted midway led to the revision of the core CFI that is now included in DSM-5. We briefly present an overview of the study design to help clinicians contextualize key results.

Overview

The international composition of the DCCIS allowed us to expand the scope of the DSM-5 field trials beyond the United States. Between 2011 and 2012, field trials were conducted in 14 sites across six countries (5 in the United States, 1 in Peru, 2 in Canada, 3 in the Netherlands, 1 in Kenya, and 2 in India). Table 2–1 lists all participating sites by country, along with local primary investigators.

Apart from the three clinics in the Netherlands that agreed to act as a single consortium site, all other individual sites sought to enroll at least 30 patients and five clinicians to test the core CFI's feasibility (Is it doable?), acceptability (Do people like it?), and perceived clinical utility (Is it helpful?). Patients were recruited by treating clinicians who made study referrals to research staff at each site. Appreciating that many clinicians work in busy service settings, the DCCIS created the core CFI so that it could be completed in 15–20 minutes, reasoning that a full cultural and clinical assessment could be completed within 1 hour. Our assumption was that core CFI questions would reduce the need to obtain redundant information with respect to the history of present illness, past psychiatric history, and social history. Clinicians and patients completed questionnaires before and after the CFI session on experiences with the core CFI.

Study Participants

Patients ages 18–80 years were enrolled because patients in this age group can directly provide informed consent. We enrolled patients of any race or ethnicity in recognition that all people—not only individuals from racial and ethnic minority groups—have a culture. To reduce any bias arising from cultural information obtained by interpreters, all patients and clinicians were matched by language. Patients with all psychiatric diagnoses were enrolled, and these psychiatric diagnoses were determined by referring clinicians.

TABLE 2–1. All participating sites by country in the DSM-5 core Cultural Formulation Interview field trial

Country	Local institutions (site investigators)
Canada	McGill University (Laurence Kirmayer) University of Toronto (Monica Scalco)
India	Dr. Ram Manohar Lohia Hospital (Smita Deshpande and Sushrut Jadhav) KEM Hospital Research Centre (Vasudeo Paralikar and Mitchell Weiss)
Kenya	University of Nairobi (David Ndetei)
Netherlands	Centrum '45 (Hans Rohlof) De Evenaar Centre for Transcultural Psychiatry North Netherlands (Simon Groen) Parnassia Bavo Groep (Rob van Dijk)
Peru	Universidad Peruana Cayetano Heredia (Renato Alarcón and Johann Vega-Dienstmaier)
United States	Columbia University and the New York State Psychiatric Institute (Roberto Lewis-Fernández and Neil Krishan Aggarwal) Richmond Area Multi-Services (Kavoos Bassiri) University of California–Davis (Sergio Aguilar-Gaxiola and Oanh Meyer) University of Minnesota (Joseph Westermeyer) Yale University (Esperanza Díaz)

We excluded patients who were acutely suicidal or homicidal at the time of the interview for safety reasons, as well as patients with conditions that could interfere with the interview process (e.g., acute substance intoxication or withdrawal, dementia, florid psychosis, mental retardation). As with other DSM-5 field trials that tested new diagnoses or revisions to diagnoses from DSM-IV, all patients and clinicians who volunteered were enrolled (Clarke et al. 2013). A total of 314 patients were included.

All clinicians in the field trial were already on staff at each site and possessed a terminal degree (MD, MSW, PhD, or a local equivalent) that allowed them to practice independently. Clinicians accepted into the field trial had to agree to attend a 2-hour training session on the core CFI. During the session, the core CFI and its guidelines were reviewed, a video was shown of the core CFI in a simulated scenario, and role-playing exercises were conducted in which clinicians practiced questions with each other. All clinicians were asked to complete the core CFI in its entirety before transitioning into their usual diagnostic assessment. Interviews were recorded only with patient and clinician consent. A total of 75 clinicians were included.

Main Results

Feasibility, Acceptability, and Perceived Clinical Utility of the Core CFI

Patients and clinicians completed surveys on their perceptions of the feasibility, acceptability, and clinical utility of the core CFI after every encounter. Items were scored

TABLE 2–2. Feasibility, acceptability, and clinical utility subscores by patients and clinicians participating in field trial

	Patients		Clinicians	
	Mean	Standard deviation	Mean	Standard deviation
Feasibility	1.33	0.57	0.77	0.89
Acceptability	1.27	0.71	1.01	0.72
Clinical utility	1.30	0.52	0.93	0.72

Note. Numerical range from which patients and clinicians chose scores for feasibility, acceptability, and clinical utility: -2 =strongly disagree; -1 =disagree; 1 =agree; 2 =strongly agree.

on a four-point scale: -2 (strongly disagree), -1 (disagree), 1 (agree), and 2 (strongly agree). Scores on the negative half of the scale indicated greater disagreement with the core CFI as feasible, acceptable, or clinically useful, whereas positive scores indicated greater agreement on those factors. We assessed feasibility, acceptability, and perceived clinical utility as separate subscales.

Although survey length and wording differed between the patient and clinician versions, the fundamental concepts ascertained by the survey subscales were considered comparable. Psychometric analyses were performed on the survey subscales to generate Cronbach α , as a measure of internal consistency (Cronbach 1951). For the clinician version of the subscales, these analyses showed adequate internal consistency: feasibility $\alpha=0.77$, acceptability $\alpha=0.78$, and clinical utility $\alpha=0.89$. For the patient version of the survey, removal of one negatively worded item from the feasibility and acceptability subscales that demonstrated poor correlation with the rest of the subscale items led to acceptable internal consistency: feasibility $\alpha=0.45$ and acceptability $\alpha=0.46$. The patient clinical utility subscale scores demonstrated good internal consistency ($\alpha=0.82$), and no item was removed from this subscale for analytical purposes. These data suggest that the scales created for the DSM-5 field trial had adequate to good internal consistency.

Table 2–2 lists the mean scores and standard deviations of these final subscales for patients and clinicians. Patients generally rated each construct with higher scores than did clinicians, but both groups appear to appreciate the core CFI as feasible, acceptable, and clinically useful (no negative mean values).

CFI's Effects on Medical Communication

To understand why patients and clinicians reported that the core CFI was feasible, acceptable, and clinically useful, we analyzed debriefing questionnaires given to all participants after the CFI session. Case reports on the OCF have suggested that cultural questions help clinicians overcome communication barriers and improve patient satisfaction (Groen 2009; Caballero-Martínez 2009). Therefore, we sought to assess clinician and patient perspectives of the core CFI's effects on medical communication.

A team of three people from the New York State Psychiatric Institute coded all of the New York interviews to explore how participants believed the core CFI affected

medical communication based on a framework widely used in medical education (Lazare et al. 1995). This framework suggests that the medical interview has three main functions: 1) to determine and monitor the problem presented; 2) to develop, maintain, and conclude the therapeutic relationship; and 3) to carry out patient education and implementation of treatment plans. Each task is further divided into specific tasks. Table 2–3 presents code rankings from patient and clinicians interviews.

Patients and clinicians thought that the main functions of the core CFI were 1) to determine and monitor the nature of the problem and 2) to develop, maintain, and conclude the therapeutic relationship. They also responded most positively to four main tasks within these functions: eliciting data, eliciting the patient’s perspective, perceiving data at multiple levels, and enhancing rapport through satisfaction with the interview. We expected high scores for the first two tasks because the core CFI was created to obtain patient experiences of illness. Our analysis observed fewer themes for the third function, patient education and implementation of treatment plans. This may be due to the nature of our study, in which patients and study clinicians met once in order to test the interview. Patients were not educated about diagnoses, and treatment plans were not implemented.

Our most significant finding was our code for a new theme that did not appear in the original medical communication framework (Lazare et al. 1995). We defined this theme as “enhancing patient-clinician rapport through satisfaction with the CFI.” Patients believed that the core CFI itself possessed communication properties that were therapeutic, independent of the clinician’s ability to establish rapport. The coding team included this theme under the function of developing, maintaining, and concluding the therapeutic relationship. These data suggest that the actual structure of the core CFI may elicit positive communication. The CFI invites patients to participate actively throughout the clinical encounter via the use of a nonjudgmental introduction, open-ended questions on illness experience, patient-clinician word matching, and a patient-centered approach to how culture is relevant for the individual’s illness. We hypothesize that these communication strategies may be responsible for increased satisfaction, although more studies on patient-clinician communication exchange through the core CFI are necessary to isolate exact linguistic properties. More studies are also needed on whether increased patient satisfaction through use of the core CFI improves overall treatment response, such as symptom reduction or improvements in quality of life. Nonetheless, these results build the evidence base that the core CFI may operate successfully at the level of content through the elicitation of patient cultural views and at the level of process through improved patient-clinician communication.

Barriers to Implementing the Core CFI in Clinical Practice

Finally, we wanted to understand how patients and clinicians reported limitations in the core CFI’s feasibility, acceptability, and clinical utility. We analyzed the same debriefing interviews for problems with the core CFI. We used another framework on the barriers encountered when new interventions are introduced in clinical settings (Gearing et al. 2011), which differentiates problems related to the intervention from problems associated with its implementation. For example, problems related to the

TABLE 2–3. Core Cultural Formulation Interview’s (CFI’s) effects on medical communication as coded in debriefing interviews

	Patient rank ^a	Clinician rank ^a
Determining and monitoring the nature of the problem		
<i>Diseases and disorders:</i> The CFI helps clinicians make a biomedical diagnosis.	7	7
<i>Psychosocial issues:</i> The CFI illustrates how patients respond to their condition before entering medical care.	9	6
<i>Eliciting data:</i> The CFI encourages communications skills by letting patients tell their own stories, facilitating narration, easing flow of the interview, using appropriate questions, or summarizing information.	2	2
<i>Perceived data at multiple levels:</i> The CFI helps clinicians use their five senses and their own personal responses.	4	2
<i>Generating and testing hypothesis:</i> The CFI helps clinicians create or test hypotheses based on patient data.	Last	5
Developing, maintaining, and concluding the therapeutic relationship		
<i>Defining the relationship:</i> The CFI helps clinicians clarify their exact role in the patient’s care.	8	8
<i>Communicating expertise:</i> The CFI helps clinicians demonstrate scientific competence and wisdom in their judgment and decisions.	Last	9
<i>Communicating care:</i> The CFI helps clinicians communicate positive emotions such as rapport, interest, respect, support, and empathy.	3	4
<i>Recognizing communication barriers:</i> The CFI helps clinicians recognize and resolve communication problems with patients by openly discussing differences, overcoming patient psychological barriers, providing emotional support, or negotiating communication differences.	5	4
<i>Eliciting the patient’s perspective:</i> The CFI elicits the patient’s perspective on definition, causes, mechanisms, fears, and goals related to the problem.	4	1
<i>Enhancing rapport through satisfaction with the interview:</i> The CFI increases rapport among patients and clinicians.	1	3
Patient education and implementation of treatment plans		
<i>Determining areas of difference:</i> The CFI helps clarify where patients and clinicians may disagree about ideas regarding patient’s sickness.	6	5
<i>Communicating diagnostic significance:</i> The CFI helps clinicians communicate the significance of the problem from a biomedical perspective, taking into account the patient’s concerns, beliefs, and fears.	Last	Last
<i>Negotiating diagnostic procedures and treatment:</i> The CFI helps clinicians discuss diagnosis and treatment options.	Last	10
<i>Negotiating preventive measures:</i> The CFI helps clinicians negotiate and recommend preventive measures.	Last	Last
<i>Enhancing coping:</i> The CFI helps clinicians work with patients to discuss coping strategies related to worsening social and psychological functioning from the illness or treatment.	8	9

Note. ^aTied rank is based on number of references in all interviews.

Source. Adapted from Aggarwal et al. 2015.

intervention could include its complexity, lack of clarity, and problems with standardization, whereas problems related to organizational or clinician factors could include frequent clinician turnover, training costs, and difficulties with scheduling that make implementation difficult. Table 2–4 presents barriers to implementing the core CFI as reported by patients and clinicians.

Notably, more clinicians than patients reported barriers for each theme, perhaps because clinicians are responsible for implementation of the CFI. The highest-ranked barrier reported by clinicians was that they could not see how the core CFI responds to the need for a cultural assessment. To overcome this barrier, the DCCIS made the following revisions in the final core CFI version included in DSM-5: defined culture in the core CFI guidelines, provided specific indications for when a cultural assessment is necessary, and explained the purpose of each question. The second barrier is lack of motivation based on patient and clinicians responses combined. For example, the field trial version of the core CFI included a question on the patient-clinician relationship that troubled some clinicians: “Is there anything about my own background that might make it difficult for me to understand or help you with your [PROBLEM]?” Many clinicians reported that this question was too direct and could lead to negative emotions such as discomfort or awkwardness. Consequently, this question was revised to question 16 in the final version of the core CFI: “Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations. Have you been concerned about this and is there anything that we can do to provide you with the care you need?” With awareness of this reported barrier, the DCCIS was able to improve the core CFI in order to increase its feasibility, acceptability, and clinical utility.

Three responses tied for the third most-reported barriers to the core CFI. Some clinicians found the field trial version of the core CFI to be too repetitive. This concern also became apparent for the OCF during the DCCIS systematic literature review (Lewis-Fernández et al. 2014). Subsequently, the DCCIS revised the core CFI during the field trial to ensure that cultural topics would be unique and not repetitive. Finally, some clinicians raised doubts about whether the core CFI could be used in its entirety during the initial diagnostic assessment and whether certain illnesses such as psychotic disorders would render the core CFI difficult to use.

Conclusion

In this chapter, we introduced the core CFI, the CFI–Informant Version, and the CFI evidence base through key findings from the DSM-5 field trial. We hope that clinicians and administrators will find the scholarship on the CFI convincing and will attempt its implementation in their service settings (as discussed in Chapter 4, “Clinical Implementation of the Cultural Formulation Interview”). Research is ongoing on the best ways to use all three components and the extent to which their use affects illness outcomes. The CFI represents the state of the art in cultural assessment throughout the mental health professions. Widespread use of the CFI—especially the core CFI—by clinicians and administrators is expected to help close the research–practice gap in cultural assessment and inform the next round of revisions for future DSMs.

TABLE 2–4. Barriers to implementing the core Cultural Formulation Interview (CFI) in clinical practice

Theme	Patient reported (n=32)	Clinician reported (n=32)	Barrier rank (of 64 interviews)
Internal barriers to using the core CFI			
<i>Repetition</i> : Parts of the CFI may be too repetitive	—	20	3 ^a
<i>Drift in procedures</i> : Doubts about using the CFI in its entirety at the beginning of the evaluation	—	20	3 ^a
<i>Lack of motivation/buy-in</i> : Negative attitudes or emotions regarding the CFI (such as questions on past illnesses or on religion)	8	14	2
<i>Severity of the individual's illness</i> : Concerns that the patient's illness presentation would affect CFI implementation	1	19	3 ^a
External barriers to using the core CFI			
<i>Lack of conceptual relevance between the CFI and culture</i> : Comments that the purpose of the CFI or specific questions lacked clarity	—	31	1

Note. Dash indicates none reported.

^aThe rankings are based on total references in patient and clinician interviews combined.

Source. Adapted from Aggarwal et al. 2013.

KEY CLINICAL POINTS

- The core and informant versions of the Cultural Formulation Interview (CFI) constitute a state-of-the-art cultural assessment in mental health that builds off the existing evidence base in the social and clinical sciences.
 - The core CFI is a semistructured questionnaire of 16 questions that can be used with all patients to assess relevant cultural variables in every clinical encounter. The CFI–Informant Version obtains similar information from a collateral historian.
 - Patients and clinicians found the core CFI generally to be feasible, acceptable, and useful for practice. Field trial data were used to revise the core CFI questions for inclusion in DSM-5.
 - The CFI improves medical communication.
-

Questions

1. How does the DSM-5 CFI differ from the DSM-IV OCF?
2. With what patient populations can the core CFI and CFI–Informant Version be used?
3. What are some of the core CFI effects on medical communication?
4. What kinds of barriers can be anticipated so that the core CFI is more feasible, acceptable, and useful in clinical practice?
5. In what clinical settings can the core CFI be used?

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