**The 12th Conference on Health Care of the Chinese in North America**

**DSM-IV Outline for Cultural Formulation**

**Francis G. Lu, MD**

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Clinical cultural competence enables the clinician to work effectively with culturally diverse individuals and families as well as when cultural differences exist between the clinician and the individual. One concise clinical tool to aid the clinician in this process is the DSM-IV Outline for Cultural Formulation found in Appendix I[1]. Although originally intended for use in conjunction with the DSM-IV in the assessment of mental disorders, the Outline is applicable to other clinical encounters. It 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. The clinician provides a narrative summary for each of the following categories:

A. 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).

B. 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.

C. 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.

D. 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).

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

Several teaching tools exist, which explicate both the content and process of using the Outline[2-6]. Also clinical cases demonstrating the use of the Outline are published periodically in the quarterly journal Culture, Medicine and Psychiatry.

Brief comments about the five sections follow. The clinician assesses the first four interrelated sections, which provides information that will impact on the fifth section on differential diagnosis and the treatment plan. Clinicians must cultivate an attitude of "cultural humility"[7] in knowing their limits of knowledge and skills in applying the Outline with accuracy rather than reinforcing potentially damaging stereotypes and over-generalizations. Cultural Identity involves a range of variables including not only ethnicity, acculturation/biculturality and language, but also age, gender, socioeconomic status, sexual orientation, religious/spiritual beliefs, disabilities, political orientation among other factors. In addition, assessment of cultural identity must move from merely the clinician's perspective to include the patient's self-construal of identity over time[8].

The second section also asks the clinician to inquire about the patient's idiom of distress, explanatory models and treatment pathways and to assess these against the norms of the cultural reference group. The third section does highlight the importance of the assessment of family/kin systems and religion/spirituality. The fourth section focuses on the complex nature of the interaction between the clinician and the individual including the transference and countertransference which may either aid or interfere with the treatment relationship. The final section should summarize and our understanding of the previous sections and apply it to differential diagnosis and treatment planning.

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References


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Op-Ed 1 The challenges of providing behavorial treatment to Asian Americans 

Op-Ed 2 The poor mental health care of Asian Americans 

Op-Ed 3 Depressive disorders in Asian Americans adults