Université de Montréal

The Uses of the Outline for Cultural Formulation of the DSM-IV: From Case Conceptualization to Treatment Plan

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From Case Conceptualization to Treatment Plan

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ARTICLE 1 : RÉSUMÉ

RÉSUMÉ

Amputation traumatique: Une étude de cas laotien sur l'indignation et l'injustice .

La culture est un contexte essentiel à considérer pour produire un diagnostic et un plan d'intervention psychiatrique. Une perspective culturelle met en relief le contexte social dans lequel les symptômes émergent, et comment ils sont interprétés et gérés par la personne atteinte. Des études ethnoculturelles sur les maladies nous suggèrent que la plupart des gens nous donnent des explications pour leurs symptômes qui ont un fondement culturel. Bien que ces explications contredisent la théorie biomédicale, elles soulagent la souffrance des patients et leur permettent de donner une signification à cette dernière. L'exploration des caractéristiques, contextes et antécédents des symptômes permet au patient de les communiquer au clinicien qui pourrait avoir une explication différente de sa maladie. Cette étude de cas permet de montrer comment le Guide pour Formulation Culturelle du DSM-IV (The DSM-IV Outline for Cultural Formulation) permet aux cliniciens de solliciter un récit du patient en lien avec son expérience de la maladie. Notre étude examine l'utilisation par un patient laotien de « l'indignation sociale » (« Khuâm khum khang ») comme le modèle explicatif culturel de son problème malgré le diagnostic de trouble de stress post-traumatique qui lui fut attribué après une amputation traumatique. L'explication culturelle de son problème a permis au patient d'exprimer la signification personnelle et collective à sa colère et sa frustration, émotions qu'il avait réprimées. Cet idiome culturel lui a permis d'exprimer sa détresse et de réfléchir sur le système de soins de santé et, plus précisément, le contexte dans lequel les symptômes et leurs origines sont racontés et évalués. Cette représentation laotienne a

aussi permis aux cliniciens de comprendre des expériences et les explications du client, autrement difficiles à situer dans un contexte biomédical et psychiatrique Euro-américain. Cette étude démontre comment il est possible d'améliorer les interactions entre cliniciens et patients et dès lors la qualité des soins par la compréhension de la perspective du patient et l'utilisation d'une approche culturelle.

Mots clés: Culture, signification, idiome culturel, modèle explicatif, Guide pour Formulation culturelle du DSM-IV, indignation sociale, interaction entre patient et intervenant

ARTICLE 2 : RÉSUMÉ

RÉSUMÉ

Impact de l'utilisation du *Guide pour la formulation culturelle du DSM-IV* sur la dynamique de conférences multidisciplinaires en santé mentale.

La croissance du pluralisme culturel en Amérique du nord a obligé la communauté œuvrant en santé mentale d'adopter une sensibilité culturelle accrue dans l'exercice de leur métier. Les professionnels en santé mentale doivent prendre conscience du contexte historique et social non seulement de leur clientèle mais également de leur propre profession. Les renseignements exigés pour les soins professionnels proviennent d' évaluations cliniques. Il faut examiner ces informations dans un cadre culturellement sensible pour pouvoir formuler une évaluation des cas qui permet aux cliniciens de poser un diagnostic juste et précis, et ce, à travers les frontières culturelles du patient aussi bien que celles du professionnel en santé mentale. Cette situation a suscité le développement

du *Guide pour la formulation culturelle* dans la 4ième édition du Manuel diagnostique et statistique des troubles mentaux américain (Diagnostic and Statistical Manual of Mental Disorders (4th ed., DSM-IV) de l'Association psychiatrique américaine. Ce guide est un outil pour aider les cliniciens à obtenir des informations de nature culturelle auprès du client et de sa famille afin de guider la production des soins en santé mentale. L'étude vise l'analyse conversationnelle de la conférence multidisciplinaire comme contexte d'utilisation du *Guide pour la formulation culturelle* qui sert de cadre dans lequel les pratiques discursives des professionnels de la santé mentale évoluent. Utilisant la perspective théorique de l'interactionnisme symbolique, l'étude examine comment les diverses disciplines de la santé mentale interprètent et conceptualisent les éléments culturels et les implications de ce cadre pour la collaboration interdisciplinaire dans l'évaluation, l'élaboration de plans de traitement et des soins.

Mots clé: Guide pour Formulation culturelle – Santé mentale – Psychiatrie transculturelle – Analyse conversationnelle – Interactionnisme symbolique

ARTICLE 1: ABSTRACT

ABSTRACT

Traumatic Amputation: A Case of Laotian Indignation and Injustice

Culture is an essential variable of diagnosis and treatment. A cultural perspective draws attention to the social context within which symptoms arise, are given meaning, and are managed. Ethno-cultural work on illness narratives suggests that most people can provide culturally-based explanations for their symptoms. While these explanations are inconsistent with biomedical theory, they relieve patient distress by allowing the patient to create meaning for symptoms. Exploring the characteristics, context, and antecedents of the symptoms enables the patient to convey them to the clinician who may have a divergent explanation of sickness. This case study uses the Outline for Cultural Formulation of the DSM-IV created for clinicians to elicit a narrative account of the illness experience from the patient. Our study examines how the patient, a Laotian used social indignation ("Khuâm khum khang") as an explanatory model for his ailment. He was diagnosed with post-traumatic stress disorder after having undergone a traumatic amputation. In the process of explaining his illness through a cultural idiom, the patient was able to reveal both personal and collective meaning of repressed anger and frustration, expressing them in a context that was acceptable to him. This cultural idiom allowed the patient to reflect upon the structure of the health care system and the specific context in which symptoms and their possible origins are recounted and explored. It also clarified to the treating clinicians some categories of experience and causal explanations that did not fit easily with western biomedical and psychiatric understanding. The case

study illustrates how a cultural approach to illness from the patient's perspective offers a reflexive stance on the clinician-patient interaction that allows for better patient care.

Key words: culture, meaning, cultural idiom, explanatory model, DSM-IV Outline for Cultural Formulation, social indignation, clinician-patient interaction

ARTICLE 2: ABSTRACT

ABSTRACT

Impact of the Use the DSM-IV Outline for Cultural Formulation on the Dynamics of Multidisciplinary Case Conferences in Mental Health.

The growth of cultural pluralism in North American society has required the mental health community to show a higher level of cultural sensitivity. Mental health professionals must not only be aware of the social and historical context of their clientele, but also of their profession. Clinical evaluations provide the information for clinical care. This information must be examined in a cultural-sensitive framework for assessment and case formulation that permits an accurate diagnosis across the cultural boundaries of both patient and mental-care professional. The Diagnostic and Statistical Manual of Mental Disorders (4th ed., DSM-IV; American Psychiatric Association, 1994) sets forth an Outline for Cultural Formulation (CF). It instructs clinicians not only on how to elicit culturally relevant clinical material, but also on how to assess the importance of the diverse cultural perspectives of patients and their families, thus increasing usefulness of their own cultural knowledge in treatment. This study is a conversational analysis of the nature and application of knowledge within a clinical, interdisciplinary context. It uses an

expanded version of the CF as a framework, in which the discursive practices of mental health professionals are evolving. From a symbolic interactionist perspective, it examines the way different disciplines interpret and conceptualize cultural elements and the implications of this framework for interdisciplinary collaboration of assessment, treatment plan and care.

Key words: Outline for Cultural Formulation – Mental Health – Cross-cultural psychiatry – Conversational Analysis – Symbolic Interactionism

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ABBREVIATION LIST

APA	American Psychiatric Association.
APA	American Psychological Association
DSM-IV	*Diagnostic and Statistical Diagnostic and Statistical Manual of Mental Disorders* (1994) (4th Ed.)
DSM-IV-TR	*Diagnostic and Statistical Diagnostic and Statistical Manual of Mental Disorders* (2000) – Text Revised (4th Ed.).
GAP	Group for Advancement of Psychiatry
ICD-10	The International Statistical Classification Of Diseases and Related Health Problems (10th Revision)

DEDICATION

TO MY FAMILY

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CHAPTER 1: INTRODUCTION

According to the most recent census, by the year 2020, the majority of the United States and Canadian population will be composed of individuals from the so-called ethnic minorities (U.S. Bureau of the Census, 1994; Canadian Bureau of the Census, 1994). In addition, studies have shown that ethnic and immigrant populations do not access available mental health resources at the same rates as the general population (American Psychological Association, 2005; Bui & Takeuchi, 1992; Kirmayer et al., 2007; Rousseau, Drapeau & Corin, 1996; Whitley et al., 2006) and are more likely to prematurely terminate therapeutic services (Atkinson et al., 1998; Cheung & Snowden, 1990; Kim & Lyons, 2003). Recent reports indicate that the quality of care provided to immigrant and ethnic minority patients may not be at the same level as that provided to majority group patients (Atdjian & Vega, 2005; Lu & Primm, 2006; Qureshi et al., 2008). This growing cultural diversity and pluralism of North American society and their related problems have required mental health practitioners to examine the impact of cultural factors on psychiatric illness (Lewis-Fernández & Díaz, 2002). Researchers worldwide (Bibeau, 1997; Comas-Díaz & Griffith, 1987; Corin, 1990, 1995; Groleau & Kirmayer, 2004; Guarnaccia et al., 1993; Good, 1996; Fernando, 2002, 2003; Kirmayer, 1989, 1991, 2005; Kleinman, 1977, 1987, 1988a, 1988b; Lewis-Fernández et al., 1993, 2002; Littlewood, 1991, 1993; Magaldy & Rogler, 1992, 1993; Mezzich & Berganza, 1984, 2005; Phillips et al., 1994, 2000; Pinderhughes, 1989; Rousseau et al., 1997, 2004; Young, 1988, 2000), have re-contextualized the notions of mental health, illness and disease as social and cultural as well as biological specifically the importance of considering the effect of culture on diagnosis and treatment (Good, 1992). There is a

consensus in this body of research that culture affects the clinician's impressions of normality and categories of illness (Fabrega, 1987). There is a recognition that our society is becoming multiracial, multicultural, and multilingual. Training of mental health professionals, however, has not reflected this trend; it remains largely monocultural (Sue & Sue, 1999). This has a major impact on the effectiveness of diagnosis and treatment since patients and clinicians will have different ways of seeing the same material depending on their cultural origins. Some differences will be evident, while others will not since they are embedded in different perspectives. Each party constructs a 'story' that is altered with every step of the interaction (Brown, 1993). The lived experience of a racial or ethnic minority group is embedded in a specific complex of history, social status, structural context, and culture. This experience establishes the framework in which a person's mental health problems are developed, exacerbated, and identified. It is also the framework in which the interpersonal interaction between the practitioner and the patient and the patient's caregiver takes place. This is especially true when the patient has a different cultural or ethnic background from the clinician. Culturally-diverse patients express distress and psychopathology that are less in accord with Euro-American psychiatric nosology and diagnostic categories used by mental health professionals trained in this tradition. Western biomedical approaches and methods inadequately address the psychosocial issues of patients from other cultures (Fernando, 2003; Good, 1996). As a consequence, the consultation process is flawed because neither party attains the immediate goals of consulting: To understand and intervene (the physician), to feel understood and helped (the patient).

An alternative, culturally sensitive, approach is required, with a scope beyond the levels of disease-centered, biomedical treatment of individuals. A cultural approach to mental health is person-centered, contextually inclusive, psychosocially oriented, and pluralistic in its approach from assessment to treatment plan (Groleau et al., 2006; Hays, 2001; Kirmayer, 2005; Kleinman, 1988a, 1988b; Lopez & Guarnaccia, 2000; Mezzich et al., 2002). Clinicians need to develop culturally competent knowledge, attitudes, and skills to transform knowledge and cultural awareness into mental health interventions that support and sustain healthy client system functioning within the appropriate cultural context (Ecklund & Johnson 2007; McPhatter, 1997; Sue & Sue, 1999, 2003). Transforming knowledge and awareness into effective treatment interventions can be challenging for most because the scope of cultural competence can be overwhelming, from intake assessment and diagnosis to formulating a treatment plan that will be acceptable to the patient (Lum, 1999; Rogers & Lopez, 2002; Sue, 1998).

The core activity in psychiatry, psychology and other mental health professions is consultation. This practice mostly leads to a diagnostic evaluation or case formulation which becomes the entry point for the professional intervention in the mental health care process (Mezzich et al., 1999). The American Psychiatric Association recognized that diagnostic assessment can be especially challenging when a clinician from one ethnic or cultural group evaluates 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 (DSM-IV-TR, 2000, p. xxxiv).

The American Psychological Association and the American Counseling Association have published similar guidelines for clinical competence with culturally diverse individuals (Lu et al., 1995). The American Psychological Association (1993) guidelines have acknowledged 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 importance of awareness of the beliefs of both patient and clinician, the acquisition of background knowledge about the patient, and the development of culturally competent skills (Sue et al., 1992). In addition, the ICD-10 (World Health Organization, 1992) incorporated major methodological developments such as a phenomenological organization of nosology, the 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 stated in the introduction to DSM-IV and the DSM-IV-TR (American Psychiatric Association, 1994, 2000) the impact of culture and ethnicity on diagnosis and treatment whereas the DSM-III-R (American Psychiatric Association, 1987) only briefly acknowledged the importance of culture. DSM-IV has included an appendix that contains "specific culture features" to be considered in the actual diagnostic categories, a glossary of Culture-bound Syndromes and an Outline for Cultural Formulation (hereafter, the Cultural Formulation)

to be used during assessment and diagnosis (Lu et al., 1995). The use of this cultural formulation is the main subject of this dissertation.

The dissertation is divided into two related articles. As discussed earlier, care for a multi-ethnic psychiatric population is complex and intensive (Kirmayer et al., 2003; Lehman, 2002; Poole & Higgo, 2006; Singh et al., 1999). It often involves both individual and multidisciplinary collaboration among many mental health professionals, including interpreters and cultural brokers. Consequently, the first article studies the use of the Cultural Formulation in clinical care practice by a psychologist. It is a case of a Laotian patient that illustrates the purpose of each of the components of the Cultural Formulation and how it impacts on diagnosis, treatment and outcome. The second article is a conversational analysis of the use of the Cultural Formulation by a multidisciplinary team as a framework to conduct case conferences and how it impacts on the process of interdisciplinary clinical case formulation and treatment plan.

Article 1 and 2 will be prefaced by chapters that will provide historical and conceptual backgrounds from literature reviews in order to familiarize the reader with some of the main concepts used in cross-cultural psychiatric and mental health and to contextualize the two studies within time and space. The conceptual backgrounds were drawn principally from the collective works of the DSM-IV Group on Culture and Diagnosis (1994) and the Group for Advancement of Psychiatry (2002) as well as those of individual members of these two groups, all preeminent, respected researchers in the field of cultural psychiatry and mental health.

PSYCHIATRIC CASE FORMULATION: HISTORICAL AND CONCEPTUAL BACKGROUNDS

Diagnosis and case formulation

Conventional assessment in mental health consists of information gathering, mental state and functional examinations. The two main current diagnostic systems ICD-10 (International Statistical Classification of Diseases and Related Health Problems 10th Revision) and the DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders Text Revised) are used widely in the Western medical world. The primary purpose of these manuals is to facilitate communication by establishing a 'common language' in order to enhance professional communication and foster research cooperation. This agreement on nomenclature and the adoption of rule-based classifications with explicit diagnostic criteria is a decisive step towards the internationalization of psychiatry, shown by the fact that the main current diagnostic systems (ICD-10 and DSM-IV) are currently used by most psychiatrists worldwide (Mezzich, 2002) with Canada and the U.S. favouring the use of the DSM. The current version, the DSM-IV-TR (2000), with its standard of classification of mental disorders and their corresponding diagnostic codes is sanctioned by the psychiatric professional community and used by clinicians and researchers from many disciplines and of many different theoretical orientations.

The DSM diagnostic criteria are based on a multiaxial diagnostic system that includes five axes, or domains of information. These axes are considered to be important in diagnosis, treatment plan and prognosis. They are not exhaustive but were included because they had the best empirical support and the greatest utility (McDonald & Kulick, 2001). (see: Table 1)

Table 1. Diagnostic and Statistical Manual of Mental Disorders Text Revised

Axis I: Clinical Disorders and Other Conditions That Need Clinical Attention.
Axis II: Personality Disorders and Mental Retardation.
Axis III: General Medical Conditions.
Axis IV: Psychosocial and Environmental Problems.

- Problems with primary support group.
- Problems related to the social environment.
- Educational problems.
- Housing problems.
- Economic problems.
- Problems with access to health care services.
- Problems related to interaction with the legal system/crime.
- Other psychosocial and environmental problems.

Axis V: Global Assessment of Functioning Scale (GAF). (The GAF is a 100-point scale that measures a person's overall level of psychological, social, and occupational functioning on a continuum).

(Source: DSM-IV-TR, 2000)

Diagnosis represents both a fundamental process and a crucial goal in medicine. It usually means the task of knowing and recognizing the signs that can set the identity of a given condition. Diagnosis can also, however, be understood in a much broader way, as the effort to know what is happening to the person who seeks care. In this latter sense, a diagnostic formulation and process mean portraying collaboratively (clinician, patient and family) the patient's whole clinical condition. In addition to disorders and health-related problems, this includes other relevant aspects as psychodynamics, associated contextual factors, personal and social functioning and disabilities; the patient's values, cultural background and overall quality of life being integral to such assessment as well. The underlying assumption is that gathering such comprehensive information enables better conceptualization of the illness in order to tailor an individualized treatment plan (Banzato, 2004, 2008). Consulting is thus not just a series of questions to be asked but

also a process between two people. It should ideally be a dialogue involving elements of doctor-patient negotiation to create a common reality (Lang et al., 2000) and to serve as the foundation of a therapeutic alliance. In this encounter, according to Mishler (1986), the best way to understand the individual's experience is to listen to the story that person tells. Yet, this practice has not been widely applied in the study of psychiatric interaction (Brown, 1993; Corin, 1990). The full patient agenda, however, is rarely voiced (Barry et al., 2001; Faulkner & Layzell, 2000; Thornicroft et al., 2002). This largely is the result of the overburdened public health system. It also, however, is the consequence of professional practices of the various disciplines in mental health that are increasingly based on empirical science to the detriment of the human factor.

The 'medical model' has been criticized in recent years as a 'bad thing'(Pelligrino & Thomasma, 1981; Read & Haslam, 2004; Sass, 2007) when it results in a dehumanized, genetic-pharmacological approach that ignores the cultural context. This criticism seem to be addressed to both the professional dominance of medical doctors within mental health and to the institutional models of care (Poole & Higgo, 2006) as well as psychotherapeutic and social interventions with origins that lie within medicine. The DSM is the main diagnostic tool of this medical model. It has thus been most scrutinized by cultural psychiatry, medical anthropology and other disciplines (Harwood & Rasmussen, 2003; Kleinman, 1988; Kutchins & Kirk, 1997; Lopez-Ibor, 2003; Mayou et al., 2005; Mezzich et al., 1999) when applied to the diagnosis of a multicultural clientele whose situation differs most from the western cultural context that has driven the DSM. The DSM purports to describe mental disorders across cultures; in reality, it is more heavily biased towards descriptions of psychiatric disorders in European and North-

American cultural contexts (Mezzich et al., 1999). In a standardised diagnostic interview using the DSM, clinical significant symptoms are identified. Diagnosis is then made according to the diagnostic criteria applied. Only the self-reported presence or absence of symptoms can be obtained (Cheng, 2001; Regier et al., 1998). This results in conceptualizations that are biomedical and thus technological and standardized. The results are decontextualized, i.e., studied independently of the particulars of a person's life and social circumstances. This "essentializing", according to Kirmayer (1998), abstracts many of the psychological and social aspects of the person's "lifeworld" (Mischler, 1986) as well as his or her understanding and experience of illness. This, in turn, effects treatment effectiveness and prognosis.

Cultural variables in diagnosis and assessment

Because the nature of diagnosis is to distinguish abnormal from normal, clinicians need to consider cultural norms of behavior. Clinicians need to gather information, put the data in a historical perspective to help determine the stressors, and then make an assessment of the patient's strengths and resources. All of these factors are affected by culture. Most culturally competent clinicians are familiar with the principle of cultural relativism, which holds that the language and customs of a people have to be examined in the context of that particular culture and judged primarily in terms of their utility to that culture (Johnson, 1988). If principles of cultural relativism are not used, then the clinicians may fall prone to the "category fallacy," which refers to using a classification scheme developed for one culture and applying it inappropriately to another where there is no relevance and no equivalent meaning (Kleinman, 1988). A Western clinician using

DSM-IV may naively assume that all individuals are equal (Hinton & Kleinman, 1993). In addition, the climate of psychiatric practice with its clinical time constraints within an overburdened system will exert pressure on the physician who under these circumstances will act in accordance with his primary training, within conventional medical models and scientific frameworks of consultation: Instead of clarifying health issues in a biopsychosocial context which states that patients' biological state, psychological makeup, and social environment all affect illness presentation and treatment (Engel, 1980), the psychiatrist will resort to reading physiological cues (Peltenburg et al., 2004), relying on a succinct, well-rehearsed line of questioning to elicit information considered vital for diagnosis. This is referred to as a ''doctor-driven'' or ''scientist-driven'' approach (Carillo et al., 1999). It espouses the *etic* perspective which begins with a construct generated in one's own culture but applied in another, assumed to be pan-cultural (Goodenough, 1970; Harris, 1980; Headland et al., 1990; Pike, 1967). It is encountered in biomedical practices, including psychiatry and mental health, where physicians, often influence, albeit unconsciously, the boundary of their responsibility by constructing or imposing the 'reality' on which consultations are based (Foucault, 1973; Salmon et al., 2003). This results in interventions that abstract the *emic* perspective which is derived from the individual's internal, personal and functional experience unique to one individual or one culture at a time (Goodenough, 1970; Harris, 1980; Headland et al., 1990; Pike, 1967).

The etic approach and the assumption of universality of psychiatric constructs and psychiatric practice was already questioned by Arthur Kleinman (1977), who suggested that different ways of understanding body and self could result in substantial differences

in psychopathology. He found that somatisation may be a distinctive feature of a depressive experience (1977, 1987) in some cultures, while in others, psychological expressions might be dominant. He introduced the notion that establishing a diagnosis of a mental disorder such as depression in different cultures poses a challenge (Alarcón et al., 1999; Manson, 1995). While careful not to discount the role of human biology, Good and Del Vecchio-Good (1993), argued against clinical reasoning that narrowly limits the relevance of social and cultural data. Dialogues across disciplines were also initiated during this time. For example, Kleinman & Good's (1985) classic volume, Culture and Depression, brought together the research of not only anthropologists, but also psychologists and psychiatrists. Many clinicians seek cultural codes permitting the remapping of complaints and symptoms onto 'appropriate' disease entities. Kleinman (1988) remarks that "For the practitioner, the patient's complaints (symptoms of illness) must be translated into the signs of disease" (p. 5), and in that sense, "Diagnosis is a thoroughly semiotic activity: an analysis of one symbol system followed by its translation into another" (p.10). But doctors "are not trained to be self-reflective interpreters of distinctive systems of meanings. They are turned out by medical schools as naïve realists who are led to believe that symptoms are clues to disease, evidence of a 'natural' process, a physical entity to be discovered or uncovered" (Kleinman, 1988, p.16). This reasoning echoed Michel Foucault's earlier thought about the deleterious effects of the "clinical gaze" (1975).

Studies have discovered that using the DSM in other cultures might lead to an erroneous diagnosis of psychopathology of otherwise normal behavior (Guarnaccia et al., 1993). Conduct, adjustment, anxiety, somatoform, dissociative, personality, and

dysthymic disorders can show great variation across cultures (Kleinman, 1988). On the other hand, certain schizophrenic and manic-depressive conditions show less variation across cultures, as do organic, metabolic, and substance abuse disorders (Johnson, 1988). Further, clinicians need to be aware of differences in the prevalence of mental illness among various ethnic groups to make an accurate diagnosis based on the percentages of patients having a diagnosis (Burnam et al., 1987; Canino et al., 1987; Karno et al., 1987). For example, there is some evidence that African Americans are more likely to have phobic disorder (Chapman et al., 2008). However, epidemiological data must be interpreted carefully (Horwarth et al., 1997). Although some studies have found a higher prevalence of schizophrenia in African Americans, once corrected for cultural differences, the prevalence appears to be the same as for the general population (Escobar, 1993). In 1988, Kleinman ushered in a seminal, anthropological view of psychiatric illnesses and their diagnosis across cultures: It is an understanding of the interface between personal experience and the person's social world, that is mediated by the patient's language, symbols, and values. Accordingly, the DSM diagnostic system is embedded in a social structure, in which a Western clinician is culturally congruent and competent both from professional training and personal socialization. Kleinman cautioned researchers and clinicians that while the DSM approach claims to be universal, it excludes certain diagnoses that are common in other cultures but not in the Western world. An example of a case formulation using both Eastern and Western guidelines may be useful to illustrate the differences (adapted from Kleinman, 1988).

> Mrs. A., a 28-year-old Chinese woman experiencing significant social stressors, presented to a local clinic complaining of feelings of guilt, suicidal ideation, insomnia, anorexia, anergia, anhedonia, as well as chronic headaches, dizziness, tiredness, easy fatigue, weakness, and tinnitus. She would qualify for a diagnosis of major depression by DSM-IV criteria. However, by ICD-iD criteria, she could be given a diagnosis of neurasthenia, with secondary depression, consistent with
> the Eastern view that much of the feelings experienced by individuals can be explained by somatic causes. They would explain her basic problem as a "lack of energy" in the central nervous system, where a Western evaluator might emphasize the presence of unusual stress or conflicts.
> Hence, Mrs. A. has one illness, but two diseases if one uses both systems of classification. Mrs. A.'s illness is expressed through her culturally determined idioms and social relationships. Thus, she will tell her physician of her physical complaints and leave out the emotional distress. Further, Mrs.A. knows about the syndrome of neurasthenia and will describe her symptoms in a cluster to her physician to match that syndrome, providing some certainty and order for her(Kleinman, 1988).

Clinicians can make culturally appropriate diagnoses if they have some basic information such as the patient's expectations regarding different healing systems (folk healers), their models of illness and causality, and their cultural standards of normality and abnormality (Lu et al., 1995). An individual's cultural identity influences his or her particular pattern of disease expression, the manner in which the illness is experienced, as well as the type of help he or she will seek. It is important to be able to determine how much of the patient's presentation is due to the difficulty of acculturation and how much is due to a cultural explanation like *ataques de nervios (attacks of nerves)* (Fernandez-

Marina, 1959; Guarnaccia et al., 1990, 2003; Keough et al., 2008; Lewis-Fernández et al., 2003; Tolin et al., 2007).

Case conceptualization and formulation

Following the consultation, the case is conceptualized and formulated into pertinent treatment plan. A core component of psychotherapeutic treatment, the case conceptualization and formulation is an account of a person's presentation of problems followed by the use of theory by the therapist to make explanatory inferences about causes and maintaining factors (Bieling & Kuyken, 2003; Eells et al., 1998). It elaborates on a given diagnosis to facilitate the understanding of the patient's plight. In conceptualizing the case, the clinician goes from the broad, categorical description to the particular, personalized perspective of the story. Mezzich (1995) calls case formulations idiographic statements intended "to supplement standardized diagnostic ratings with a narrative description of the cultural framework of the patient's identity, illness, and social context, and of the clinician-patient relationship" (p.649). Identifying data are a first step in this process of particularization – an epidemiological template based on features such as age, gender, family history, race, language and lifestyle. A multiaxial diagnostic system also moves from the general to the more particular, accounting for comorbidities, severity of stress, and level of functioning. This movement leads to further distillation of the case into smaller classes. An approach that elaborates on unique features of the patient's developmental history has been a cornerstone of the psychodynamic formulation, guided by psychoanalytical precepts (Gedo & Goldberg, 1973). Thus, a formulation is a detailed elaboration and substantiation of the diagnosis, a justification of

its pertinence and value. The case formulation also represents a therapeutic first step as a diagnosis of a clinical entity and has treatment implications rooted in its pathophysiology and pathogenesis. The more particular the definition of a clinical state, the more specific the therapy interventions become. Matching treatment to diagnosis is increasingly visualized through a case study method that relies on a formulation (Eells et al., 1998; Nurcombe & Gallagher, 1986).

The Outline for Cultural Formulation of the DSM-IV (1994) and of the DSM-IV-TR (2000): Historical Background

Recognizing that the DSM system needed to be more relevant and responsive to culturally issues in mental illness, the National Institute of Mental Health supported the creation in 1991 of a Group on Culture and Diagnosis (hereby, *the Group*). The Group's main goal was to advise the DSM-IV Task Force on how to make culture more central to the Manual (Lewis-Fernández & Díaz, 2002).

The Group worked on the premise that the fundamental challenge that cultural analysis brings to diagnostic thinking is its capacity to render visible the socially constructed context that mediates key features of a patient's presentation and subsequent course. Thus, to convey an accurate account of the patient's situation, a cultural assessment must include intra-cultural as well as cross-cultural elements, particularly the complex interactions of gender, class, race, and other intra-cultural factors affecting the clinical presentation (Lewis-Fernández & Kleinman, 1995). Indeed, Lewis-Fernandez (1996) suggests that the assessment must go beyond explanations of cross-cultural differences in symptomatology; it must describe the cultural constituents of all clinical

phenomenologies, as well as courses and outcomes, patterns of help-seeking and etiological attributions by patients and their social circles, and diagnostic practices, institutional pressures, and modes of research by clinicians. There were discussions that a 'cultural' axis (Axis VI) should be added to the other pre-existing 5 axis. This idea was eventually abandoned by the Group for two main reasons: (1) an Axis VI might further the view that a cultural assessment of the patient is a last-minute phenomenological refinement, an ancillary and thus dispensable procedure, while leaving the rest of the diagnostic process unaffected; also given that the pressures impinging on working clinicians, who already often bypass Axes IV and V and might ignore a sixth axis, a cultural axis as it would likely be accepted into the DSM-IV might paradoxically lessen the cultural contextualization of diagnostic practice; and (2) an Axis VI would perpetuate the reductionist, nomothetic typology, favouring a categorization approach of the other axis rather than an idiographic portrayal of the person and his/her relevant sociocultural environment (Mezzich, 1995). The Group saw that what was needed instead was a framework that helped clinicians realize how culture affects every aspect of the clinical encounter. The use of narrative description was favored by the Group because (1) it allows much greater operational flexibility than the fixed DSM format. Narratives create humanized accounts of the illness experience in its cultural context and setting (Good, 1994; Kleinman,1988), (2) it includes an accounting of the role of health institutions and practitioners in the evolution of the person's illness experience (Mishler, 1995), and thus (3) it allows the profession to turn its gaze back on itself, allowing for a reflexive stance on the clinician-patient interaction, further sensitizing clinicians to assumptions in their practice that may not be valid and useful in a cross-cultural context (Lewis-Fernández,

1996). After investigating for this kind of narrative analysis within clinical practice, the Group found that the Psychodynamic Formulation is the most complementary narrative approach to the structured, multiaxial DSM diagnostics system. In fact, the Psychodynamic Formulation was often found included as part of the patient's chart next to other assessment procedures (Lewis-Fernández , 1996). It is often used by many psychotherapists to conceptualize the client's presenting problems and to guide the choice of psychological therapies (Mace, 2001, 2005; Berry et al., 2006). Because of its well-known format and its individual specificity, it is often considered superior to the generic descriptions of the axial diagnoses. For these reasons, the Group also agreed that the Psychodynamic Formulation was a good model for complementing the standard diagnostic evaluation. As a result, this form of mini-ethnographic narrative assessment came to be known as the "Cultural Formulation" (Lewis-Fernández, 1996).

Thus the Outline for Cultural Formulation was designed to help clinicians move beyond one-dimensional evaluation and conceptualization of culture and people. In addition, clinicians associated with the Group undertook a "field trial," testing the applicability of the Cultural Formulation on actual patients. Subsequently, case analyses from the four main minority groups in the United States (African Americans, American Indians, Asian Americans, and Latinos) were developed. Results showed that the Cultural Formulation could be successfully used as proposed (Lewis-Fernández , 1996). Several formats of the Cultural Formulation were drawn up to meet the needs of psychologists, social workers and other non-medical, clinical professionals who would require a longer, more detailed version of the Cultural Formulation; whereas the psychiatrists would use a shorter version as the Cultural Formulation would accompany a full Psychiatric Case

History. The Cultural Formulation was submitted to the DSM, including four cases from the field trial to serve as models of completed formulations (Mezzich et al., 1993). The Group recommended to the DSM Task Force that the Cultural Formulation be placed at the front of the Manual, immediately following the section on Multiaxial Assessment with the goal of integrating cultural considerations into the diagnostic process at the onset of the consultative process. Instead, when published, the Cultural Formulation was reduced to a single-page outline with broad sections of cultural components, relegated to the back as Appendix I (pp. 843-844) (Kirmayer, 1998; Mezzich et al., 1999). Furthermore, within the same appendix and immediately following the outline is a new section entitled "Glossary of Culture-Bound Syndromes." This was a glossary of 25 cultural categories that had been prepared by the Group as a separate submission under the title "Glossary of Cultural Syndromes and Idioms of Distress." The combination of these two disparate proposals suggests erroneously that the Cultural Formulation is only relevant to "culture-bound" presentations or "folk categories" (Hays, 2001) among non-Western ethnic groups, rather than as an evaluation process applicable to every patient in every cultural setting. Its use and inclusion are all the more surprising given long-standing criticisms of this concept by cross-cultural practitioners from all disciplines (Hughes, 1998; Levine & Gaw, 1995; Marsella, 2000, Raguram, 2001). It is deemed problematic because it 'exoticises' rather than promotes the idea that no psychiatric disorder can be understood apart from the culture in which it occurs (Lewis-Fernández, 1996; Lopez & Guarnaccia, 2000; Marsella, 1993; Marsella & Yamada, 2000). Moreover, the illustrative cases were removed, thereby decreasing the pedagogic intent for the Cultural Formulation. These alterations to the Cultural Formulation proposal were part of

an admittedly conservative editorial policy (Frances et al., 1990; Lewis-Fernández, 1996) of simplifying or rejecting many of the Group's cultural proposals in order to maintain the universalistic position of DSM endeavour (Canino & Alegria, 2008; Lewis-Fernández & Kleinman, 1995).

Despite this disappointment, the attention given to culture in DSM-IV is a major achievement. Members of the Group and other researchers in cross-cultural psychiatric work from other disciplines continued to forge forward in the promotion of the use of the Cultural Formulation. More detailed instructions and case examples came later as part of a monograph published by the Cultural Psychiatry Committee of the Group for the Advancement of Psychiatry or GAP (2001). A more complete documentation of the task force's findings is available in the DSM-IV Sourcebook (Mezzich et al., 1997) and in other publications such as a special issue of Psychiatric Clinics of North America (Alarçón, 1995), a 58-minute film with guide (Koskoff & Lu, 2005), a special issue of Transcultural Psychiatry (Kirmayer, 1998), a compilation of relevant papers (Harris et al., 2008; Kirpatrick, 2006; Eells, 2002; Lu et al., 1995; Novins et al., 1997; Smart & Smart, 1997; Takeuchi & Kim, 2000) and monographs (Hays, 2001; Lim, 2006; Tseng & Streltzer, 2004). It is recommended for implementation during the assessment phase of every clinical encounter and should be complimentary to the conventional psychiatric case history. It is also considered a tool to enable interdisciplinary practitioners to effectively collaborate and participate effectively in the care process (Dosser et al., 2001). The cultural formulation is designed to elicit the person's accounts using his or her own explanatory models (Kleinman, 1988), idioms of distress (Nichter, 1981), spirituality and

environmental influence with the goal of knowing about the "whole" person, not just the presenting problem. It encourages a systematic review of the individual's background, the role of the cultural context in the expression and evaluation of symptoms and dysfunction. It ties the cultural context to clinical care. It highlights the effect that cultural differences may have on the relationship between the client and the clinician (Kirmayer, 1998; Lewis-Fernández, 1996; Mezzich et al., 1999). The Cultural Formulation sections are summarized in Table 2 and the DSM-IV (1994) and DSM-IV-TR (2000) can be found in Appendix 1 of this paper:

Table 2. DSM-IV Outline for the Cultural Formulation

1. Cultural identity of the individual
2. Cultural explanations of the individual's illness
3. Cultural factors related to psychosocial environment and levels of functioning
4. Cultural elements of the relationship between the individual and the clinician
5. Overall cultural assessment for diagnosis and care

Source: American Psychiatric Association 1994, pp. 843-849.

CHAPTER 2: CRITICAL CONCEPTS AND THEORETICAL FRAMEWORKS IN CROSS-CULTURAL MENTAL HEALTH

The next section will explore the CF in detail. In preparation for its use, critical concepts and theoretical frameworks in cross-cultural research and practices in mental health are defined and explained in turn.

Cultural Identity of the Individual.

DSM-IV-TR Guidelines (2000): *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) (p.897).*

Culture, Race and Ethnicity

Culture is the most inclusive term but also the most general. Definitions of culture abound; common to most it forms the framework within which we understand and make sense of the world. It is the acquired knowledge people use to interpret experience and generate behaviour (Spradley, 1979, 1980). It is 'a set of guidelines…which individuals inherit as members of a particular society, and which tells them how to view the world, how to experience it emotionally, and how to behave in it in relation to other people, to supernatural forces or Gods, and to the natural environment' (Helman, 2007, p 2). Although culture is often equated with race and ethnicity, most accepted definitions of culture say nothing about biological links.

The concept of *race* was originally used by European scientists to classify people on the basis of geography and physical characteristics (i.e. skin color, hair texture, facial features) into groups of genetically related peoples (Spickard, 1992). Over the years, there have been differing classifications (Thomas & Sillen, 1972); however, underlying many was the assumption that races were organized hierarchically, with light-skinned, Christian Europeans at the top (Betancourt & López, 1993; Hays, 2001). Recognizing the danger in presenting race as a biological fact, the United Nations Educational, Scientific, and Cultural Organization (UNESCO) (1979, in Yee et al., 1993, p.1132) passed a statement recommending that the concept of *ethnic group* replace that of race.

The concept of ethnicity is defined as the "common ancestry through which individuals has evolved shared values and customs" (McGoldrick & Giordano, 1996, p.1). Although ethnicity is generally understood to involve some shared biological heritage, its most important aspects in terms of individual and group identity are those which are socially constructed (e.g. beliefs, norms, behaviours, and institutions). The concept of ethnicity does not exclude complications. For one, the term holds different meanings in different countries as in the situations of the terms Indigenous, Aboriginals, and First Nations when referring to American Indians or Aboriginal Canadians or Aboriginal Australians (Elliott & Fleras, 1992; Kirmayer et al., 2000; Young, 1995). Another problem is that ethnic groups are currently labelled very broadly, as in the use of the term Asian for people of Japanese, Korean, Chinese, Vietnamese, Cambodian, Laos, Thai, and even East Indian and Pakistani heritage (Uba, 1994). Similarly, the term Hispanic combines into one ethnicity the diverse cultures of Central American Indians, South Americans of African and Spanish heritage, Mexican Americans, Cuban

Americans, Puerto Ricans, and Dominicans (Novas, 1994). This type of grouping is not always offensive or meaningless but may present dangers in assuming an ethnic identity and a specific meaning for an individual in a particular context (Hays, 2001).

In clinical work, the ethnicity of a patient can best be assessed by taking a careful history of the patient's development and family. Clinicians can ask patients to describe their family's country of origin, religion, primary language, traditional roles, and traditional skills. Patients should be asked about their role in their family constellation as well as special practices including religious practices, holiday observances, or preparation of ethnic food that they have observed with their families. Finally, patients should be asked about the degree or frequency that these ceremonies, rituals, customs, and hobbies take place and the level of contact they have with their relatives or ethnic organizations (Lu et al., 1995).

Gender.

Like race and ethnicity, gender is a core factor in the formation of cultural identity. From the moment of birth, the labeling of an infant as a girl or by, society categorizes the individual and dictates expectations and behaviors as masculine or feminine (GAP, 2002). An individual's gender identity develops also in part on the influences and relationships of and with his/her parents and the society at large, and thus shape his/her sense of self and their ways of functioning and relating to others. Gender is a cultural variable that may influence onset, clinical presentation, course, and treatment-seeking behaviour. Fullilove (1993, 1996) outlined how minority women's status affects health status, sexual practices, and treatment settings. In *Women of Color* (1994), Comas-Díaz and Greene 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. These authors suggest treatment with a multicultural feminist therapist who would accompany and guide this group of clientele in a manner that would allow these women of color to explore their own experiences with racism, sexism within and outside their communities, their personal and cultural identities, internalization of their negative experiences with the dominant culture, and their need to distance or remain interconnected with their ethno-racial group (Comas-Diaz & Greene, 1994).

While the clinician must exercise caution about stereotyping and over generalizing, it is important to be aware of issues that are significant in the psychology of men and women across cultures and within a certain culture as well as the complex interaction of gender identity on one's cultural identity.

Age.

Age interacts with the other aspects of cultural identity to influence development and psychiatric assessment and treatment. Esquivel and colleagues (2007) offered clinical guidelines to recognize the significance of cultural variations in discrimination, coping, and help-seeking behaviours in economically disadvantaged youths from culturally diverse backgrounds. 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 is an essential aspect of one's cultural identity. Many authors (Alderson, 2003; Cabaj & Stein, 1996; Lemoire & Chen, 2005) have extensively studied the development and meaning of lesbian, gay, and bisexual identities. Assessment and treatment implications are outlined for persons with these sexual orientation identities across ethnic, age, and socio-economic groups to acknowledge the synergistic significance of these aspects of cultural identity.

Religion and Spirituality.

Religion is another key aspect of cultural identity. Many individuals and groups may identify themselves more from their religious affiliation than from their ethnic or national background. Similarly, the term "spirituality" has gained prominence relative to religion with many individuals who maintain deeply held personal beliefs about God, the meaning of life and death irrespective of religious affiliation. Religious affiliation is also a frequent source of discrimination (Tasman et al., 2008). According to Kirmayer and colleagues (2003, 2008), despite the ubiquity of religious and spiritual experience, it is frequently neglected during routine psychiatric evaluation. They recommend a thorough cultural formulation be drawn in consideration of the patient's religion and spirituality. Other areas to cover include religious identity, the role of religion in the family of origin, current religious practices (attendance at services, public and private rituals), motivation for religious behaviour (i.e., religious orientation), and specific beliefs of the individual and of his family and community.

Migration History.

An important part of the individual's cultural identity relates to his/her migration history. There are two parts to the migration history: pre-migration and immigration. (see: Table 3). The purpose of the pre-migration history is to determine the patient's background history and to measure their baseline functional level in the country of origin. The immigration history includes the reasons for details from reasons for leaving, who was left behind to experiences before the arrival to the host country such as hardships and traumas, including being victims of violence and imprisonment (Lee, 2000; Lim, 2006). Immigration is not always deleterious: voluntary migrants may gain from the experience, including better mental health whereas fleeing refugees often cannot recover from the losses and the traumas.

Table 3. 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; posttraumatic 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 development

Level of adjustment, assess developmental tasks.

Source. Adapted from Lee, 2000.

***Acculturation*.**

In a world of mass migration and intermingling of people over generations, identity is very often hybrid, multiple, and fluid (Bibeau, 1997). For immigrant and ethnic minorities, it is important to understand the degree of involvement with both the culture

of origin and the culture of residence. Contemporary definitions of acculturation emphasize the changes in social behaviours and values between groups that have ongoing contact with each other (Mavreas et al., 1988). Acculturation is therefore a social process affecting immigrant groups as well as the majority population of the host country (Berry, 1997; Sam & Berry, 2006; Trinh et al., 2009). This view encourages examination of the process on several levels (Escobar & Vega, 2000) to ascertain whether the individuals are "separated" because they do not adopt the host country customs or, conversely, "assimilated"; whether they are "integrated" or "bicultural" because they have successfully incorporated both acquired and inherited cultures or, conversely, "marginalized" or "deculturalized".

Along with the migration history, the clinician should assess separately degrees of identification with the host culture and with the original culture. Immigrants routinely experience some degree of culture shock; clinicians can assess the patient's level of adjustment by inquiring about his or her level of difficulty in learning to live in a new country. Lu and colleagues (1995) suggest that "the immigrants who have better social adjustment tend to be less at risk of mental illness 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" (p. 9). Living in an ethnic community can also buffer threats presented by the acculturation process by the support the individuals can get from family or ethnic community. Of note, the 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 (Lu et al., 1995).

***Language, Meaning and Context*.**

Language is a social practice that is essential to our daily life. Through language, we ‘construct’ ourselves as we negotiate our way through life. Language does not exist in a social void. Words do not contain meaning in themselves and meaning is not discovered in them: meaning is something we construct, as social beings, in our own minds. It is through our social and linguistic relationships with the rest of the world that we construct meaning; without these relationships our language is essentially meaningless. No linguistic form – be it a word, a phrase or a sentence – can simply be associated with one particular function or meaning. Our utterances mean what we intend them to mean, in context, and the essentially cooperative practice of our social behavior ensures that our linguistic intentions are, for the most part, understood by those with whom we interact – regardless of their syntactic form or their dictionary definitions. Thus, when a teacher asks, ‘Who’s talking?’ the interrogative form is not a question but an order to someone to stop talking. Within classroom context, her intended meaning will be perfectly understood by the students (Gusfield, 2003). The ability to communicate competently requires us to learn and understand the dynamic and shifting system of communication in context, and we learn it by becoming familiar with patterns and routines of language usage. We follow socially and culturally constructed communicative conventions, assumptions and expectations, often without necessarily realizing it at a conscious level.

Consequently, communication in a cross-cultural context, with people coming from different ‘contexts’, may depart from the patterns that our expectations lead us to predict. As culturally-diverse patients often speak more than one language, it is important to determine what language they consider their primary language. Different ethnicities

such as African Americans, Asians, Hispanics, and Native Americans, also communicate in different styles, such as different nonverbal communication, from other ethnicities, such as whites (e.g. eye contact, physical touch and different mannerisms) (Sue & Sue,1990). In a clinical encounter, the linguistic delivery of information given during diagnosis is therefore crucially important, not only for patient's understanding of their medical condition, but also for its meaning within their beliefs and attitudes towards their illness and prognosis.

Cultural Explanations of the Individual's Illness.

DSM-IV-TR Guidelines: 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; the perceived causes or explanatory models that the individual and the reference group use to explain the illness, and current preferences for and past experience with professional and popular sources of care (2000) (pp.897-898).

Different cultures express their symptoms differently (Kleinman, 1988), and concepts of illness also vary with culture. In understanding the patient's view of his or her illness helps the clinician determine assessment and negotiate treatment plan. Empirical evidence suggests that patients are most satisfied where their psychiatrist shares their model of understanding distress and treatment (Callan & Littlewood, 1998).

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).

According to Nichter (1981), greater perspective can be gained by viewing ethnopsychiatric phenomena as *idioms of distress*, underscored by symbolic and affective associations which take on contextual meaning in relation to particular stressors, the availability and social ramifications of engaging alternative expressive modes, and the communicative power of these modes given intervening variables and the responsiveness of concerned others. A common idiom of distress is *somatization*, which can be seen in Hispanics, Asians, and people from Islamic cultures, among others, who present with somatic complaints when their problem is psychological. In these cultures, most difficulties are conceptualized as somatic and mental difficulties are either not conceptualized or are stigmatizing and therefore not even talked about (Fabrega, 1990; Febo San Miguel et al., 2006; Kirmayer & Young, 1998; Pliskin, 1992). Idioms of distress can be seen in many ethnic groups, and, depending on the level of disability, any idiom of distress can be pathological. *Ataque de nervios,* for example, is a category of

distress frequently used by Latino patients. They are often triggered by a familial stressful event, are manifested in aggressive or trembling behaviours, uncontrollable crying and shouting, and followed by amnesia (Lu et al., 1995). This idiom of distress often includes nervios, a state of vulnerability to stress, expressed in headaches, irritability, dizziness, stomach problems, and poor concentration. *Ataque de nervios* has been associated with trauma since it was first described by Fernández-Marina (1961), who noted the resemblance of the syndrome to that of war neurosis observed among veterans. Lewis-Fernández (1994) and Schechter and colleagues (2000) observed that the typical precipitants of *ataque* are often "obviously traumatic" events or reminders that provoke posttraumatic symptoms while without a knowledge of the cultural meaning *of ataque de nervios*, this idiom has been often misdiagnosed as *panic disorder* or *somatization* disorder (Guarnaccia et al., 1990; Keough et al., 2008).

Explanatory Models.

According to Kirmayer (2006), "cultures provide systems of diagnosis and treatment of illness and affliction that may influence patients' experience of illness and help-seeking behaviour. In making sense of illness, people label and interpret their distress based on these systems of knowledge, which they share with others around them. Much research in medical anthropology has developed the idea of explanatory models, which may include accounts of causality, mechanism or process, course, appropriate treatment, expected outcome, and consequences. Not all of this knowledge is related directly to personal experience—much of it resides in cultural knowledge and practices carried on by others" (p. 20, in Kay & Tasman, 2006). First developed by Arthur

Kleinman (1980), the term refers to “interpretive notions about an episode of sickness and treatment that are employed by all those engaged in the clinical process” (Hogson, 2000, p.1). Importantly, both carers and patients utilise explanatory models extensively. In particular, explanatory models address five aspects of illness: The cause of the condition, the timing and mode of onset of the symptoms, the pathophysiological processes involved, the natural history and severity of the illness, and the appropriate treatments for the condition (Hogson, 2000; Kleinman, 1980).

According to Kleinman, non-professional explanatory models tend to be idiosyncratic, changeable, and heavily influenced by cultural and personal factors (1980). In a discussion of explanatory models, Helman (1994) suggests that explanatory models are how “a patient explains his or her illness. It consists of the patient’s notions of the illness etiology, timing, mode of onset, pathophysiology, natural history, severity, and appropriate treatments, and it is specific to a single episode of the illness” (p.111). An example of an explanatory model that some Westernized patients are comfortable with may be the psychodynamic model, whereas some traditional Native Americans may be more accepting of an explanation from their witch doctor that they have “broken a taboo” of their family. In addition, they may also believe that they can hear the voice of a dead person calling to them as the spirit travels to the afterworld. Unaware of this explanatory model, clinicians could diagnose the patient with a psychotic disorder (Helman, 1994). To avoid such misconceptions, clinicians should ask patients what they believe is causing their illness, why it is a problem now, what will happen if they get no treatment, and what type of treatment they desire (Kleinman, 1988).

Williams and Healy (2001) caution that first time presenters to mental health services often present explanatory models that do not come from a coherent set of beliefs, but a variety of explanations that are either held simultaneously or taken up and dismissed rapidly. Thus, according to Bhui and Bhugra (2002) when faced with such transient beliefs, it is difficult to distil a single set of causal explanations that might relate to behaviour, diagnosis or adherence to medication treatment. The term 'explanatory map' rather than 'model' is recommended, as this reflects the diversity and complexity found within systems of health beliefs (Bhui & Bhugra, 2002; Williams & Healy, 2001).

Illness and Disease.

In order to have a cross-cultural perspective, Kleinman (1978) and colleagues such as Littlewood (1991), Hahn et al. (1985), suggested a distinction between *illness* or sickness and *disease*. According to these authors, this allows the clinician to have a cross-cultural perspective on the condition. For them, illness precedes disease. When we fall sick, the first experience is illness. This is the culturally constituted, socially learned response to symptoms that includes the way we perceive, think about, express and cope with sickness. Illness is embedded in everyday life in ways that are more or less understandable to members of the same culture and lifeworld. When the sick person first visits a practitioner, the two initially communicate in terms of culturally shared illness idioms. Soon thereafter the practitioner constructs the sickness in the technical terms of his theoretical system, be it biomedicine, psychonanalysis, chiropractic, or traditional Chinese medicine. This technical reconstruction constitutes disease. This formulation emphasizes the social construction of all interpretations of sickness - lay or biomedical -

and places stress on the lay construction as most commonly the initial formulation of the problem. Disorder, a functional abnormality or disturbance, is described in diagnostic terms (Eisenberg, 1981) and is often considered more value-neutral and less stigmatizing than the terms *disease* or *illness*, and therefore is preferred terminology in some circumstances. In mental health, the term *mental disorder* is used rather than *mental disease* to acknowledge the complex interaction of biological, psychological, and social factors in psychiatric conditions. Thus, the transition from illness experience to disorder is determined by social decision points rather than biomedically determined levels of disorder (Bhui & Bhugra, 2002).

Norms.

What may be abnormal and psychopathological in Western culture may be considered normal and culturally acceptable in a non-Western society, and vice versa (Lu et al., 1995). Individuals from diverse cultures present difficulties in diagnosis and treatment because the norms and expectations they use to evaluate them may vary from one culture to another. Egland et al. (1983) studied bipolar illness in the Amish people, a culture that is known for its restraint in the expression of emotions. The Amish definitions of *grandiose* described behavior within the host culture's norms of behavior, such as driving a car or planning a vacation during the "wrong season," yet exceeded Amish's norms sufficiently to meet criteria for bipolar disorder.

Idioms of distress or culture-bound syndromes in other cultures may be considered outside the boundaries of expected illness behavior of the predominant culture (So, 2008). Errors can be made by overpathologizing what is considered normal in a

particular culture or, conversely, by ascribing to cultural normality what is actually considered psychopathological in that culture (Lu et al., 1995). Clinicians need to realize that cultural norms - including those held by the clinician - influence how particular behaviors are judged. They must have knowledge of the cultural norms of the patient's cultural identity in order to judge possible symptoms and syndromes of psychopathology. A cultural consultant or culture broker may be needed to help with this process of understanding (Kirmayer et al., 2003).

Culture-Bound Syndromes.

Culture-bound syndromes represent conditions that tend to emerge or adopt a distinct presentation in specific cultures. They express core cultural themes and have a wide range of symbolic meanings—social, moral, and psychological. They are important to identify, because the patient's definition of the illness has an impact on the effectiveness of the treatment, which must optimally operate within the patient's belief system. DSM-IV defines culture-bound syndromes as “recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category” (p. 844) (Lu et al., 1995). An example of a culture-bound syndrome is *taijin kyofusho*, described as a "culturally distinctive phobia in Japan" in DSM-IV. It refers to an individual's intense fear that his or her body or its functions are offensive to other people. This syndrome is actually listed as a diagnosis in the Japanese clinical modification of ICD-IC, classified into four subtypes: *sekimen-kyofu* (the phobia of blushing), *shubo-kyofu* (the phobia of a deformed body), *jikoshisen-kyofu* (the phobia of eye-to-eye contact), and *jikoshu-kyofu* (the phobia of one's own foul body

odor). They fit criteria of social phobia and body dysmorphic disorder in the DSM system of diagnostics (Suzuki et al., 2003). Neurasthenia or *shenjian shuairuo,* another culture-bound syndrome, is characterized by mental and physical exhaustion and may fit DSM-IV criteria for mood or anxiety disorder, as well as neurasthenia in ICD- 10 (Lu et al., 1995). However, disorders recognised in the West such as anorexia nervosa or agoraphobia may also be regarded as culture bound syndromes expressing notions of the role of women and the ideals they behold in Western society (Dein, 2000; GAP, 2002).

Help-Seeking Behavior.

Culture affects help-seeking behavior. How the patients define the problem, how it is expressed, who do they consult, and the preferred treatment strategies depend on their explanatory model of illness (Albizu-Garcia et al., 2001; Kleinman, 1988; Rogler & Cortes, 1993; Tseng, 2003). To avoid stigma of mental illness, many individuals and their families minimize or under-report them. Detailed and collateral histories are critical to obtain an accurate and comprehensive evaluative assessment. Culture also affects patients' expectations of treatment. Many first-generation ethnic minority patients, such as recently immigrated Asians, expect their clinicians to be authoritarian, not egalitarian, and are confused by a non-directive stance (Laungani, 2004; Lee, 2000). Indigenous healing practices may be utilized; examples include curanderos, shamans, medicine men, and fortune tellers (Tseng, 2003). A typical sequence of help seeking in a traditional Chinese family might include intrafamilial coping, followed by consultation with trusted, community elders and friends. The family would next seek help from traditional healers within the community such as herbalists and acupuncturists. They might then consult a

religious person, or a physician, but would present somatic complaints to the physician. If the patient continues to deteriorate, only then would the family resort to the extreme measure of hospitalization (Lee, 2000).There often is a rejection and scapegoating of the patient to decrease the shame and humiliation to the patient's family (Lin, 1981).

Cultural factors related to psychosocial environment and levels of functioning.

DSM-IV-TR Guidelines (2000): 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 (p. 898).

Stressors.

In addition to the premigration and migration stressors, recent immigrants face a specific set of postmigration stressors (Lu et al., 1995). While still coping with the sequelae of displacement and losses that dismantle the emotional, spiritual and physical connections with time and place, the new immigrant and refugee must also deal with an assault of new experiences, from basic requirements for housing to learning a new language and new social customs. Problems such as discrimination and racism are associated with specific ethnic groups. Yet they might not ask for help, not only because of lack of knowledge of how to ask for it, but also because it would be an admission of failure or a fear to add on to their negative experience. In collectivistic cultures, the individuals face an additional stressor in that any individual failure reflects on the family causing shame, "loss of face", and loss of familial reputation (Holloway, 2001). In

Fullilove's concept of the 'psychology of place' (1996), he points out that the disorientation, nostalgia and alienation following migration underscore the sense of belonging in particular and its implication for mental health in general.

Developmental, Family, and Psychosocial History.

Understanding the family as a unit including its dynamics and cultural values is crucial in assessing the patient's psychosocial environment. McGoldrick and Giordano (1996) suggest an approach that concentrates on the culture's definition of family and the life cycle of the family. This group of researchers suggest that culturally diverse individuals' expectations of their life course is affected by their stage of development and age at immigration. Expectations of the achievement of milestones and definitions of family roles change when people migrate to different cultures. Assessing the expectations for the patient's stage of development in the family life cycle is important because this is often disrupted by migration or influenced by traumatic experiences such as discrimination and racism. Children who would ordinarily be expected to have few responsibilities often suffer from role reversal when they are pressed to grow up beyond their years in adapting to the new culture. Similarly, adolescents, children and young adults in the stage of identity formation can be cut off from their social roots and heritage, feel alienated. Displaced families lose their support networks. Elderly persons, particularly, feel the losses of migration more profoundly because they leave behind more relationships, attachments and memories than the younger immigrants. Migrating at a later stage of life, make them less able to acculturate, and more at risk of the consequences of culture shock (Akhtar, 1995). They are more likely to develop culture-

bound syndromes and create difficulties in diagnosis because they typically speak only in their native language (GAP, 2002).

Thus, an analysis of the family system and structure is an important part of the assessment. Role relationships are accepted as a crucial assessment area as it is through family roles that family functions are fulfilled (Reutter, 2006). This is a particularly significant area to be explored in immigrant families because of various societal changes affecting family members' respective roles. They are faced with role transitions such as changes in the balance of power with the children adopting new role by virtue of speaking the language of the new culture or with mothers working while fathers are unemployed and relinquishing their formal status as the family's breadwinner. This potential role reversal between gender roles and generations create difficulties between spouses or parents and children can lead to conflicts and strife. The family's concept of illness is also important in treatment. Clinicians need to be cognizant of the family's explanatory models and treatment expectations as they may have considerable impact on the prognosis, the therapeutic relationship and the outcome (Reutter, 2006).

***Religion and Spirituality*.**

Religion and spirituality are critical factors of an individual's cultural identity. They also have a complex, often positive, impact upon the individual's mental health status and coping ability (Dein, 2000; Lukoff et al.,1995; Neeleman & Persaud, 1995; Rhi, 2001). Of note is the new DSM-IV "non-illness" category of religious or spiritual problem that by its introduction is an acknowledgement and a reminder that these beliefs can be understood as possible supports for the person rather than just manifestations of psychopathology. For example, Griffith and Young (1988) described the therapeutic

aspects of Christian religious ritual in African Americans. In addition, the interaction between religion and family can provide a source of support or stress that must be assessed, utilized, and addressed (Burton, 1992; Cuellar, 2000). Thus, in cross-cultural practice, these two factors should be considered in assessment, case conceptualization, and treatment plan.

Cultural elements of the relationship between the individual and the clinician.

DSM-IV-TR Guidelines (2000):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) (p. 898).

Race, ethnicity, and culture also affect the clinician-patient relationship, which, in turn, affects diagnosis and treatment (Rogler, 1993). In every clinical encounter, there is interplay between the culture of the patient (level of education, medical knowledge, linguistic abilities, and personal life experiences), the culture of the clinician (individual style, personal belief, professional knowledge) and the medical or mental health culture (traditions, disciplines, services embedded yet beyond medical culture developed by other mental health disciplines). This interplay influences the patient's expectations of the clinician, the understanding of the individual's illness by both parties, as well as the negotiation of a respectful therapeutic relationship that includes dealing with issues of transference and counter-transferences is crucial for effective care (Lu & Mezzich et al.,

1995). The use of interpreters or translators is required when the patient and clinician do not have a common first language.

Cultural Competence.

Cultural competence is a set of culturally congruent beliefs, attitudes, and policies that make cross-cultural work possible (Cross et al., 1989). Cultural competence has been a staple in the curricula of cross-cultural disciplines (Pedersen & Ivey, 1993; Kirmayer et al., 2008) for many decades but has not been considered by mainstream clinical courses (Tseng & Streltzer, 2004). Clinical cultural competence requires the attainment of several qualities: Cultural sensitivity, cultural knowledge, cultural empathy, flexible culturally-relevant doctor-patient relations and interaction, and cultural guidance (Lu et al., 1995; Pinderhughes, 1989, Tseng & Streltzer, 2004; Sue & Sue, 2003; Westermeyer,1989).

Even when the cultural background of the patient is not significantly different from that of the clinician, it is inevitable that differences will exist. Therefore virtually all clinical practice can be considered to be transcultural (Comas-Díaz, 1988) and to be clinically competent, every clinician needs to be culturally competent (Tseng & Streltzer, 2004). Values that are essential for cultural competence include mutual respect and the belief that cultural issues are important, that social systems are fundamental and valuable in treatment, that the family is an integral part of the patient and varies according to culture, that diversity is valuable, and that self-knowledge is necessary to deal with ethnic minority patients (Tseng, 2008). Cultural competence is marked by the genuine and informed acceptance and respect of cultural differences: Clinicians must be willing to

suspend judgment; accept new lifestyles; and approach ethnic minority patients with flexibility, warmth, understanding, and empathy (Tseng, 2008).

***Transference and Counter transference*.**

Ethnic or racial transference occurs when a patient develops a certain relationship, feeling, or attitude toward the therapist because of the therapist's gender, ethnic or racial background. Ethnic or racial counter transference is the reverse phenomenon, in which a therapist's feelings and interventions are influenced by the patient's gender, ethnic or racial background (Comas-Díaz & Jacobsen, 1991; Tseng, 2008). Similar to personal transference or counter transference, ethnic or racial transference can be positive or negative and can significantly influence the process of therapy (Gelso et al., 2002; Tang, 1996; Tseng, 2008). An example of interethnic, negative transference can be seen in a Native American's distrust of an authority figure from the dominant culture. Negative counter transference can be seen in a clinician who is excessively curious and intrusive about the individual's ethno cultural background beyond the topics that are clinically relevant. A culturally competent clinician is able to recognize at an early stage of therapy the signs of negative or positive cross-cultural transference or counter transference, take measures to guard against its ill effects or utilize its positive effects in therapy (Tseng & Streltzer, 2004).

Interpreting meanings in cultural context.

In mental health practice, it is important to grasp meanings expressed explicitly, tacitly, or symbolically. Cultural idioms may invoke subtle or symbolic meanings of

words. For instance, “my house is far away”, might mean nostalgia of the native homeland from a newly-arrived immigrant and not the geographical location of their dwelling in the host country. A cultural judgement is usually needed such as in cases of suicidal ideation where an understanding of the general custom among people in the patient’s culture of revealing a wish to end their lives may be useful to interpret that the person may be in such great despair (“I am willing to kill myself”) but is actually not suicidal because his/her faith forbids self-killing. The despair unless understood and treated however may bring a severe prognosis (Kirmayer, 2004; Tseng, 2008).

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, 1994, p. 843—844). Issues of differential diagnosis are discussed with regard to culture-bound syndromes, age, gender and cultural considerations, phenomenology, prevalence and outcomes. A comprehensive treatment plan is described as one that integrates the biological, psychological, socio-cultural and spiritual. Finally, issues specific to psychotherapy are discussed, such as indigenous therapies, cultural strategies and modification of cognitive, supportive, family and psychodynamic therapies (DSM-IV-TR, 2000, p.897).

This last section allows for a summation and conceptualization of the case, bringing about all the elements presented in the previous section to form a cultural formulation, that is, clinicians in this section must demonstrate their clinical experience, cultural and theoretical knowledge by making inferences to suggest diagnostic measures

that may include or dispute a DSM diagnosis if cultural considerations throw a different light on the patient's story (GAP, 2001) and may alter treatment plan and care.

CHAPTER 3: INTRODUCTION TO ARTICLE 1

Premise to Article 1.

The Cultural Formulation as framework for multicultural case studies has been regularly featured in *Culture, Medicine and Psychiatry* almost since the inception of the Cultural Formulation in the DSM-IV (1994). Although the growing body of recent literature (Mohatt et al., 1998; Rait et al., 1999; Panos & Panos, 2000; Guerrero et al., 2003; Orr & Day, 2004; Borra, 2008) offer instructive examples of detailed cultural formulations and substantiate its validity and importance within informed mental health diagnosis and while others provide evidence of its increased support and use in mental health settings (Kirmayer et al., 2003, 2008; Lim et al., 2008; Lu et al., 2006; Mariner 2006; Novins et al., 1997; Walsh 2004), its use has been noticeably less prominent in clinical psychology than in cultural psychiatry, psychiatric nursing and social work and limited in clinical and counselling psychology.

According to Mariner (2006), a sensitive assessment provides recognition of how the patient's cultural roots affect their healing process. Cooperation and compliance to the advice given by healthcare professionals may be enhanced by understanding the patient's cultural perceptions. They endorsed cultural formulation processes as being able to assist in developing informed recommendations to other health practitioners involved in the care of the client.

Similar to other disciplines in psychiatry and mental health, psychological case formulation or client conceptualization is a crucial practice for psychologists. Case formulation is one of the core skills of the clinical psychologist (Division of Clinical Psychology, American Psychological Association, 2001; Section of Clinical Psychology, Canadian Psychological Association, 2008) and is a central process in the role of the scientific practitioner. In forming a client conceptualization, psychologists take in a vast array of client data (symptoms, familial background, etc.) and organize this information into a model of the client using a body of theoretical psychological knowledge to a specific clinical problem in order to understand the origins, development and maintenance of that problem. While conceptualizations differ from psychologist to psychologist, based on such factors such as theoretical orientation, personal relevance attached to certain issues, and the amount of experience psychologists have, structuring the knowledge gained about clients is a common element across any conceptualization process. Its purpose is both to provide an accurate overview and explanation of the patient's problems that is open to verification through hypothesis testing, and to arrive collaboratively with the patient at a useful understanding of their problem that is meaningful to them. The latter has been termed the ''treatment utility'' of case formulation (Hayes, Nelson, & Jarrett, 1987). The case formulation is then used to inform treatment or intervention by identifying key targets for change (Tarrier & Calam, 2002).

Psychological interventions, as practiced in Canada and in the U.S., focus on the psychosocial aspects of mental illness. They leave much of the biomedical intervention to psychiatry. But the fundamental tenets of psychological treatment are based on the study of the individual as a monological self with individual agency within a clinician-driven

framework of diagnostic and treatment care. These are not much different from the models found in psychiatry. This practice often does not leave room for proper understanding of an ethnic clientele whose identity may be more interconnected and defined by familial and community ties (Chen & Yeung, 2002; Hays, 2001; Pederson & Draguns et al., 2002; Sue & Sue, 2003; Triandis, 1995). In this broader context, these individuals' behavior would be understood as an outcome of interactions with others, not just in terms of their own cognitive or behavioral models. The corollary of this view would be that a contextual view would put as much emphasis on the contexts in which a mental illness occurs as on any psychological mechanism (Seligman & Kirmayer, 2008) and that an *integrative* approach including patient-centered (Rogers, 1951), sociocentric or kinship based models would be best suited to gain understanding and insight of the clients' experience (Bhugra, 2004; Kirmayer, 2005; Mezzich, 2007). This call for diversity of models extends to the patients' family and entourage, whose members may have different models; in some instances the model of a relative or significant other may be more important than that of the patient for determining illness behavior and outcome. The Outline for Cultural Formulation provides a framework to gather this contextual information during assessment interviews. The purpose of Article 1 is to use the Outline for Cultural Formulation as a framework for cultural assessment of an individual case in order to develop and deliver an appropriate cultural formulation and treatment plan.

Methodology for Article 1.

The literature does question the rigor and vigor of cultural formulation templates within mental health settings (Kirmayer et al., 2003, 2008; Mariner, 2006; Novins et al.,

1997). Although some practitioners choose to use varying versions of cultural formulation templates, the literature suggests that current screening and assessment tools could be adapted to capture and accommodate cultural formulation information and considerations (GAP, 2001; Kirmayer et al., 2008; Lim, 2006; Tseng & Streltzer, 2004). The key is culturally appropriate processes and expertise that maximise client input rather than a focus on the tool itself. At the time that this study took place, we elected to follow an expanded version of the Cultural Formulation (Appendix 2) as outlined by *Culture, Medicine and Psychiatry*, the journal where the article was submitted and published in June 2008.

In summation of Appendix 2, Lewis-Fernández (1996) instructed authors that each case submitted to the Clinical Cases Section must contain: (1) A standard brief psychiatric description of the patient that includes a full multiaxial assessment of the DSM-IV structure. A level of detail is necessary to establish the diagnoses and to anticipate any obvious questions regarding relevant rule outs. The latter is obviously especially important when standard categories are challenged by the case data: nosologists will want to know that all the established categories have been explored before entertaining NOS (Not Otherwise Specified) or mixed-category diagnoses. Attention to help-seeking strategies and explanatory models is requested, particularly when these affect outcome. Information on long-term treatment and follow-up is especially desirable, as these validate initial diagnoses: readers may suspect that presentations appearing culturally particular at first will be revealed over time to conform to established nosologies. In order to avoid unnecessary repetition, authors are generally advised to present only "the bare facts" (patient identification, history of present illness,

psychiatric history and previous treatment, diagnostic formulation) in the Clinical History section and then discuss the topics in detail in the Cultural Formulation; (2) The Cultural Formulation should compose the bulk of the submission. The main goal of every formulation should be to enable the reader to locate the individual within his/her most relevant cultural context and to clarify the essential cultural determinants that shape the form of the clinical presenting issues. Succinct summaries of pertinent ethnic group history and of past research on the indigenous idioms of distress or the help-seeking options used by the patient may be useful, especially for purposes of comparison. Some formulations also require a subtle reflexive analysis of the author-patient interaction, including a discussion of cultural factors impacting the process of diagnostic assessment and ethnographic writing. Every submission should discuss all the elements in Appendix 2, with varying length and importance depending on the case. Some cases will present a diagnostic dilemma exclusively, or mostly an issue in health services utilization and each Cultural Formulation should also emphasize the main aspect of the case. Readers should expect to find in the Formulation specific cultural commentaries on the key facts mentioned in the Clinical History (Lewis-Fernández, 1996).

Article 1 -Formulaire A: Accord des coauteurs

ANNEXE II
ACCORD DES COAUTEURS ET PERMISSION DE L'ÉDITEUR

A) Déclaration des coauteurs d'un article

Lorsqu'un étudiant n'est pas le seul auteur d'un article qu'il veut inclure dans son mémoire ou dans sa thèse, il doit obtenir l'accord de tous les coauteurs à cet effet et joindre la déclaration signée à l'article en question. Une déclaration distincte doit accompagner chacun des articles incluse dans le mémoire ou la thèse.

1. Identification de l'étudiant et du programme
Nom de l'étudiant : My-Hoa Nathalie Dinh **Programme:** Ph.D. (psychologie) (3-220-1-0)

2. Description de l'article
Auteurs: My-Hoa Nathalie Dinh et Danielle Groleau
Titre: Traumatic Amputation: A Case of Laotian Indignation and Injustice.
Revue : *Culture, Medicine and Psychiatry, 32(3), 440-457.* (Juin 2008)

3. Déclaration de tous les coauteurs autres que l'étudiant
À titre de coauteur de l'article identifié ci-dessus, je suis d'accord pour que **My-Hoa Nathalie Dinh** inclue cet article dans sa thèse de doctorat qui a pour titre "*The Uses of the DSM-IV Outline for Cultural Formulation: From Case Conceptualization to Treatment Plan*".

Danielle Groleau_________
Coauteur

B) Permission de l'éditeur d'une revue ou d'un livre

1. Identification de la revue ou du livre
Culture, Medicine and Psychiatry ISSN: 0165-005X (Print) 1573-076X (Online)
Springer Publications - PO Box 2485
Secaucus, New Jersey 07096-2485, U.S.A

2. Identification de l'éditeur ou des éditeurs
Atwood D. Gaines, M.A, C.Phil., Ph.D., M.P.H. (Editor-in-Chief)
Brandy Schillace, M.A. (Managing Editor)

3. Identification de l'article
Dinh, NMH & Groleau, Danielle (2008). Traumatic Amputation: A Case of Laotian Indignation and Injustice. Culture, Medicine and Psychiatry, 32(3), 440-457.

L'étudiant **My-Hoa Nathalie Dinh** est autorisée à inclure l'article ci-dessus dans sa thèse de doctorat qui a pour titre "The Uses of the DSM-IV Outline for Cultural Formulation: From Case Conceptualization to Treatment Plan".

Éditeur	Signature	Date

Article 1 - Formulaire B: Permission de l'éditeur

Windows Live Hotmail

Page 1 of 1

Re: Request for permission to include article in Ph.D. Dissertation

From: **Atwood Gaines** (a
Sent: May 11, 2009 3:36:40 PM
To: Nathalie Dinh
Cc: g
(

TO: Natalie Dinh
FROM: Atwood D. Gaines

Dear Ms Dinh:
As per your request, you are herewith granted permission by Culture, Medicine and Psychiatry to include your article entitled, "Traumatic Amputation: A Case of Laotian Indignation and Injustice" which appeared in the Journal (Vol. 32, No. 3, pages 440-457) in your PhD dissertation in Psychology. The dissertation is entitled, "The Uses of the Outline for Cultural Formulation of the DSM-IV-TR: From Case Conceptualization to Treatment Plan."

Best wishes in securing your doctorate,

Atwood D. Gaines

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CHAPTER 4: ARTICLE 1

Traumatic amputation: A case of Laotian indignation and injustice.

Patient identification

Mr. B., a 49-year-old, married Laotian male, lives with his wife and two children, a boy (aged 20) and a girl (aged 14), in Laval, Québec, Canada. Although he has been in Québec, a French-speaking province of Canada, since 1985, his French is limited. He works as a heavy machine operator. He was referred to the first author for psychological consultation by the Commission de la Santé et de la Sécurité du Travail (CSST) du Québec, a provincial workmen's compensation organization, as part of a multi-faceted and multidisciplinary treatment plan that includes pharmacotherapy, physiotherapy, occupational rehabilitative therapy, acupuncture, and treatment for pain.

History of present illness

On January 13, 2005, Mr. B. suffered an accident at the workplace when his gloved, left hand was caught in a machine that he was operating. He had tried to pull his hand out, but his middle and fourth finger were severed and he fell backward and hit his head against another machine nearby. Mr. B. was victim of a traumatic amputation. A traumatic amputation is the loss of a body part that occurs as the result of an accident or trauma. His colleagues stopped the machine he was operating on, picked up the severed parts of the fingers from the floor and put them on ice in a small cooler.

Mr. B. was transported immediately by ambulance to a nearby hospital. After he was examined by a nurse who administered first aid care by bandaging his hand and by

giving morphine for his pain, he was sent to the corridor of the emergency room (ER) area, where he waited for an hour before the surgeon on duty came to examine his hand. During the examination, Mr. B. pointed to the small cooler underneath the stretcher where he was sitting and informed the surgeon that the severed part of the fingers were saved and iced. He also asked the surgeon to reattach them to the fingers. According to Mr. B., the surgeon informed him that this would not be possible because the tendons were dead. Mr. B. protested and, by moving his two severed fingers up and down, demonstrated to the surgeon that he could still move his fingers and that the tendons were not affected. The surgeon did not respond but sent Mr. B. to radiography to have X-rays taken. Afterwards, Mr. B. waited for another three hours in Emergency Room. He reported feeling very dizzy, nauseous, weak and disoriented from the sedation. Because the co-worker who accompanied him to the hospital had gone and no family members had arrived, he felt alone and frightened. When the surgeon reappeared, he showed Mr. B. the X-ray results and advised him that he needed to perform an amputation of one phalanx of each of his two severed fingers. Mr. B. told the doctor again that he could still feel his tendons and, since it was a clean cut, he wished to keep his fingers by having the severed parts sewn back on. The doctor ignored this request and repeated that his fingers had to be amputated. Mr. B. pleaded with him vehemently ("Please, please, don't cut my fingers"…. "No, No, No!!!") and became quite agitated when the doctor reiterated that he must amputate. Mr. B. was then sedated and placed in restraints.

When he awoke from the surgery, Mr. B. recalled that he felt pain and numbness at the same time. When he realized that he was in the hospital, the memories of the accident came rushing back. When he felt the pain in his fingers, he felt a rush of cold

sweat realizing that his fingers may be amputated. He remembered not daring to look at his left hand but touched it with his right hand instead. When he felt the big bandage, he started to tremble and whimper, knowing that his fingers had been amputated. He did not remember much of this.

The next thing he remembered was the visit from his wife and children. It seemed to him that it had been an eternity since he had last seen them. They looked very distraught and helpless, and asked many questions that he could not answer. Shortly thereafter, the surgeon and the nurse came in to examine his fingers and apply new bandages. The surgeon asked a few questions, but Mr. B. did not feel able to talk to him. He explained later during psychotherapy that he felt too sad and beaten to talk to this clinician. In fact, despite many follow-up visits after his release from the hospital, he only attempted once to inquire about the reason for amputation from the surgeon. After what he felt was a vague answer given in an exasperated manner by the doctor, he reasoned that he should stop asking questions for fear of receiving poor care.

Psychiatric history and previous treatment

Mr. B. had never before received psychiatric treatment.

Social and developmental history

Mr. B. was born in Saysomboun, a rural area about 600 kilometres from Vientiane, the capital of Laos. His parents were deceased. He comes from a family of 11 siblings. Some are deceased and others live in the U.S. He has an older and a younger sister who lived in Montreal and who sponsored him for entry to Canada. He still has a young brother in Laos. His childhood was comfortable. His father had a small grocery

store and owned a small taxi company. His father died when Mr. B. was 14 years old. Mr. B. attended regular school until the 9th grade and then went to a technical school to study to be a machinist.

Mr. B. left Laos as a political refugee at the end of 1979, to escape from the Pathet Lao ("Land of Laos") communist regime. He was newly married when he embarked on a fishing boat in Thailand with his wife and in-laws, having fled Laos by foot. His wife was in her second trimester of pregnancy. They spent about two weeks on the boat. When they sighted a Thai naval base, they had to jump into the water and swim to shore because the owner of the boat was not allowed to berth. There was a refugee camp on the grounds of the naval base, but very few officials were present to facilitate refugee status and process immigration papers. After five years in the camp, they finally saw an official from the Canadian Embassy. Mr. B and his family arrived in Montreal in 1985. The refugee camp had been slated for closing since 1981, so they were among the last ones accepted.

Family history

Mr. B. has no knowledge of psychiatric illness in his family.

Course and outcome

In the months following the surgery, Mr. B.'s fingers healed well and the CSST coordinated rehabilitating treatments for him. He stopped seeing the surgeon but instead had bi-weekly follow-up visits with his family doctor. In addition, he received regular, intensive treatments in physiotherapy and in occupational therapy. Later, massage therapy and acupuncture treatments were added, when he complained to the CSST coordinator that the ligaments on the thumb and the little finger, neither amputated, had been injured by the surgery. He also complained of a loss of sensitivity in his entire left arm, up to the

shoulder, that somehow made physiotherapy exercises excruciatingly painful. Physical examinations and physiotherapy reports indicated that his left arm had weakened, but it was difficult to ascertain that surgery was the cause. He has not been able to reach the weight-lifting threshold necessary for him to perform his job. The physiotherapist and the occupational therapist felt that, although he was able, Mr. B. resisted following their instructions for improvement.

During his accident, when Mr. B. tried to pull his fingers out of the machine, he fell backwards and bumped his head on a machine in the next work station. Since the accident, he reported some loss of hearing in the left ear. Tests also have confirmed these claims, but hospital records showed that this is a recurrent problem, since he had had a prior operation in the same ear. This recurrence of the same problem may or may not be a result of the accident, but ultimately he will have to undergo another operation to correct this problem.

Psychotherapy was added to the treatment plan because of treatment resistance, but also because the CSST coordinator, who was in regular contact with Mr. B., noticed his increasing pre-occupation with the surgeon's disregard of his wishes and with his difficulties in accepting the amputation. She often wondered whether Mr. B. meant 'incompetence' with regard to the surgeon, but did not know the proper word or whether he was too reserved or polite to be directly accuse the surgeon. She was also concerned about his state of mind because of his repeated use of the word "triste" (sad) whenever she inquired about his health and because of his increasingly despondent demeanor. The CSST coordinator felt that a psychologist who had a similar ethnic background as Mr. B. would be best suited to help him. She contacted the Quebec Order of Psychologists who

referred her to the first author, who is Vietnamese, since there was no Laotian psychologist listed. The common language used was French.

In the first psychotherapy session, Mr. B. hid his left hand behind his back when he shook hands with the therapist. Then, throughout the session, he hid the same hand with the amputated fingers by wrapping his windbreaker around it. In the subsequent two sessions, Mr. B. was reluctant to divulge much and seemed unmotivated and lethargic. After the fourth session, he seemed more relaxed, more at ease, and seemed relieved to unburden himself of his ordeal when he decided to talk. He was very technical when he described his accident, but perspired profusely, raised his voice and became animated when he described his emergency room experience and his dealings with the orthopedic surgeon. He intimated that he was grateful for the therapeutic care that followed the amputation, but he also felt resentful when pushed by the physiotherapist and the occupational therapist to perform beyond his physical capabilities. He often questioned the motives behind all these therapies, suspecting that the "push" for his return to work was more important that his actual healing process. In fact, he typically vacillated between gratitude which he expressed verbally and warmly toward the rehabilitation team and repressed anger which was manifested in cool politeness for the orthopedic surgeon and the ER team. Even when asked to describe his feelings towards the surgeon, Mr. B. only demurely said that he felt "sad" or that he did not know how he feels about what had happened and that he must "think" about the next steps to take. He seemed also in a state of disbelief about the turn of events, seldom looking at his amputated fingers, or hiding them by putting them under his thigh.

After Mr. B. started to engage in the psychotherapeutic process, the psychologist recommended that Mr. B. be referred to a psychiatrist and undergo psychological testing for diagnostic purposes. Because of Mr. B.'s linguistic limitations, the questions from the tests were read to him. The tests used were French versions of the Beck Depression Inventory II (BDI-II: Beck, 1996) and the PTSD Checklist-Civilian Version (PCL-C; Weathers, Huska and Keane, 1991). While Mr. B.'s scores on the BDI showed that he was in a depressive state, he was not clinically depressed. The PCL-C scores showed that Mr. B. had symptoms of PTSD but did not meet avoidance criteria for PTSD because he was able to talk about the trauma and was able to sustain talking about the trauma.

Diagnostic formulation

DSM-IV-TR (2000)

Axis 1: Posttraumatic Stress Disorder
Major Depression Disorder.
Axis II: None
Axis III: Cholestatomy of the left ear with mixed deafness, traumatic amputation of two fingers of the left hand, and possible tendonitis of the left shoulder
Axis IV: Sick leave – Financial difficulty
Axis V: GAF: 55 – 60 Body Image Disturbances features

Cultural Formulation

A. Cultural identity

Cultural reference group(s).

In Laos, although his family was not wealthy, Mr. B. felt they were not lacking in means and that life was good prior to communism. After 1975, life in communist Laos had become untenable. Mr. B. got married in early 1979. His marriage was arranged; he

had known his wife since adolescence. In the same year, he left Laos with his new bride and her family by foot and then by boat. They reached Thailand and stayed in a refugee camp.

He applied for refugee status in Canada. He had two sisters in this country and wished to join them. It took five years before he and his extended family received resettlement papers allowing them to immigrate to Canada. They arrived in Montreal as political refugees in 1985.

At the time of his accident, he had been married for almost 25 years. He seemed to be a dedicated father and husband. Although his children are multilingual, the family communicates in Laotian because his wife is unilingual. He reported having multi-ethnic friends at his work and mainly Laotian friends outside of work. He seems to have a best friend to whom he referred on many occasions. This friend has helped him with transportation and in discussions concerning his situation. He seems to have adequate social support for daily assistance, such as getting lifts to and from the many appointments for his rehabilitation. At first, he shared his convalescing experience with family members and friends, but he found himself withdrawing socially because he felt that they did not fully understand the effect of his amputation ordeal and because he feared boring them with his concerns. He reported that although most people who know of his case have advised him to look more into his amputation, as they suspect that his fingers could have been saved, no one has offered to help him through the process. He feels much alone with his troubles.

Language

He speaks French with his co-workers and Laotian to his friends. His French is heavily accented with a restricted vocabulary and incorrect grammar. Despite the linguistic challenges, he is still able to communicate his symptoms and attend to his daily life needs.

He seems to understand the goals of his various therapies, including psychotherapy. He has difficulty expressing his feelings and emotions, but from his body language, he expresses tension, frustration and repressed anger. He says that he tries to be a "monk," to be forgiving, but this seems very difficult for him whenever he speaks of and about the orthopedic surgeon. On this subject he is often aroused, raising his voice and hinting that his amputation is a result of injustice and oppression.

Cultural factors in development

Born in 1956, Mr. B. grew up in a tightly knit, rural community where the practice of Theravada Buddhism and Animism permeated the Laotian social structure of interdependence. He recalled that his father often did not collect money immediately from people who could not afford to pay, but allowed them to take the goods from his grocery store on credit. Mr. B. was nostalgic about large extended family reunions to worship ancestors, eat, and rejoice to be amongst kin, as tradition dictated. These gatherings served to build and solidify his belief system that living a kind and responsible life leads to good karma and eventually to rebirth to a better state, based on merit.

Despite this relatively conflict-free life during his teenage years, he was still aware when he was growing up that his country latently struggled to find its identity, despite having achieved full independence from French colonialism. The life he knew ended and was replaced by hardship and fear when the communist Pathet Lao emerged to seize control of the country in 1975. He felt that his community had been caught off guard and was unprepared for the ensuing years of living under strict communist restrictions, reforms and re-education. After nearly five years of this untenable life and many attempts to flee the country, he and his family finally managed to buy their escape to Thailand by boat.

The voyage was made in a rickety, overcrowded, under-stocked boat, and being exposed to the elements was traumatic. At the last leg of the voyage, when the Thai refugee camp was sighted, the owner of the boat forced the passengers to disembark and swim to shore.

Mr. B. had to swim dragging and supporting his new bride, who could not swim. Life in the camp amongst strangers, once again, necessitated another drastic readjustment. The focus was on daily, physical survival with scarce goods, crowded conditions, poor sanitation, minimal health care, frequent violence and hopelessness. But because the fear of repatriation loomed large, and because no resettlement plans were in sight, Mr. B. accepted his fate willingly. Mr. B. recalled that after the loss of the baby that his wife was carrying, he often questioned whether his belief system still held true. He felt a sense of betrayal because he tried to live a good life; and although he could no longer bear this "string of bad luck," he decided to stay "on course" for his wife and her family. He forced himself to cling to life, and onto the idea of living, following the virtuous Buddhist

teachings of equanimity and compassion, and thus managed to live through the 5 years of "incarceration."

Involvement with culture of origin

The first few years in Quebec required, once again, intense re-adjustment. Mr. B. found adjusting to a new culture, new ways of life and a new climate both invigorating and isolating. He was happy with the opportunities for a new life, but was apprehensive about the future because of his linguistic and educational limitations. The Laotian community in Montreal, albeit small, became his refuge and his religious beliefs became his sanctuary. He followed the progress of other Laotians keenly and took pride in their success. The interdependency of the extended family and Laotian community was still strong, although more spiritually than economically. Since the accident, Mr. B., already a devout Buddhist, found himself becoming even more entrenched in its teachings. He has grown close to his community's priest, whose company he has sought out more since the operation. He stated that he had become more spiritual since the operation, attending prayer services almost daily. He found solace in prayers and meditation to overcome first, the physical pain, and second, what he perceived as injustice.

Despite French lessons subsidized by the Government, his wife had difficulty learning both English and French and, consequently, does not work outside of the home. Instead, she bakes Laotian traditional specialties, such as spring rolls and sweet desserts, and sells them on consignment in local, Laotian or Asian grocery stores. The birth and upbringing of their two children also occupied her fully. Mr. B. was thus virtually the sole family provider.

Involvement with host culture

When he first arrived in Quebec, Mr. B. worked as a manual laborer in various factories until the present employer hired him as a machinist. He has been there for 10 years. He stated that he liked the employer and his co-workers, and had found "his place." He reported that his difficulties in French were not a problem, but rather evoked helpfulness from his co-workers, who were eager to facilitate his adaptation to the company. He seemed to have a good relationship with his co-workers. The mutual appreciation between Mr. B. and his colleagues and supervisor was clear when, during his sick leave, he dropped by the shop for a quick visit and brought homemade spring rolls for them. In their warm welcome, his co-workers clearly showed that they were glad to see Mr. B. and joked that they missed the rolls.

Mr. B. lives in a predominantly French-speaking, working-class to low middle-class suburb of Montreal. The family blends in well within this community in their daily living, mostly because the children, born and educated in Quebec, were fully assimilated. At home, however, both parents and children identify themselves, culturally and socially, with the small, tightly knit Laotian community.

B. Cultural explanation of illness

Predominant idioms of distress and local illness categories

Amputation is a profound loss that affects both the individual and family on all levels: physical, social, spiritual, financial, cognitive, and emotional (Wald, 2004).

"My fingers are my life."

Metaphorically, Mr. B., as head of the family and its sole provider, equates his fingers to his livelihood. The dominant stressor for Mr. B. is economical. From a rehabilitative stance, this stressor was the motivating force behind his high compliance in his physiotherapy and occupation therapies, and his subsequent progress physically. He has taken his physical pain and challenges in stride, stoically, although he was concerned about his recurring earache and his left shoulder, matters that may or may not be related to the accident or the amputation. According to the physiotherapist and the occupational therapist, Mr. B. would bring up these concerns in the session following one that had been particularly challenging for him physically. The therapists referred Mr. B. to a pain clinic, but tests were inconclusive about the presence of tendonitis in his left shoulder.

From a psychological perspective, after close to a year in psychotherapy, Mr. B. still struggles with what he perceives as an "unjustified" amputation. Pervasive throughout all sessions and serving as the greatest impediment to the process of grieving and emotional adjustment to the loss of his limbs are Mr. B.'s contained anger, frustration and refusal to accept the decision made by the orthopedic surgeon to amputate his fingers when he wanted them to be reattached. The Posttraumatic Stress Disorder (PTSD) diagnosis seems to apply exclusively to the amputation in that the intrusive recollection of this event leads to hyper-arousal and avoidance, two behaviors that are symptomatic of this disorder.

Conversely, the PTSD diagnosis does not seem applicable to the work-related accident. Indeed, while on sick leave, Mr. B. has returned to the accident site to visit his co-workers and, surrounded by the machines and factory noises, he did not show marked

anxiety responses. Mr. B. was only happy to see his colleagues and curious about the new machine which replaced the old one that he had operated.

Although he did not talk deliberately about the work injury that led to amputation during psychotherapy sessions, and even avoided the subject when asked, this may be less of a symptom of PTSD and more of a defense mechanism to avoid blaming himself for the accident, while displacing guilt onto the orthopedic surgeon. Indeed, if there are manifestations of PTSD symptoms, they seem to be reactivated by repressed negative emotions caused by past traumas experienced during the "boat people" and refugee sequelae, which Mr. B. now subconsciously associates with present events, even though there are no apparent similarities in content or context (with the exception of perceived oppression and powerlessness). Altogether, negative associations and interpretations of these traumatic memories, rumination about them, and anger cognition are highly predictive of chronic PTSD in Mr. B.'s case.

Mr. B. saw himself only as a victim. He did not associate the surgery with saving his severed fingers nor possibly his hand from infection, but only with taking "life" away from him. He equated his experience to that of "animals." He felt like an animal brought to the slaughterhouse when he was wheeled into the operating room. He was strapped, alone, powerless, screaming like "a pig." This image of himself, together with his uneasiness in showing or looking at the stumps, suggested the presence of features of mild Body Image Disturbances, not uncommon in cases of traumatic amputation. It is of interest to note that although prosthetic fingers were discussed with Mr. B. as a rehabilitative option, he did not consider them, partly because he was afraid of another surgical procedure but mainly because, as a believer of Buddhist teachings, the fingers

were part of a holistic entity and their loss was part of human suffering and hardship that provide the catalysts for change and development. Indeed, Mr. B. expressed his wish to receive training to align him to a long nurtured ambition to become assistant foreman in the case that he could no longer perform his job as a machinist. Since his written French was not proficient, he knew that this goal was unrealistic and was distressed about his lack of job options. He lamented that he was “stupid and slow.”

Mr. B. also displayed emotional numbing, restricted range of affect and a sense of a foreshortened future. While these symptoms may represent another cluster of PTSD symptoms, they may also reflect Mr. B.’s way of coping with loss, anger, and grief, helping him not to be overcome with anxiety about the future. As he has become more devout, he likens himself to a “monk” dealing with suffering and hardships, a referent to Buddhist stoic response, which is part of what he believes to be his religious awakening. Therefore, he considered that his illness and disability journey could provide valuable lessons of self-transcendence.

As for the diagnosis of Major Depression Disorder (MDD), Mr. B. did not display suicidal ideation, but rather objective worries about his prospects of getting back to work. He also expressed subjective hopelessness stemming from animistic, folk and religious beliefs of ‘H’wen’ (Miles, 1973), that he was under the influence of malevolent spirits or that he was paying for bad deeds from his previous life. When in this mindset, Mr. B. entertained the idea that the surgeon is an important leader and healer who has the power to afflict punishments to him, Mr. B., because he has not lived a life of merits. According to Miles (1973), most Laotians believe that health is dependent upon the status of the 12 souls that make up a person’s life force or ‘H’wen’. These 12 souls correspond to 12 parts

of the body (i.e., eyes, ears, mouth and nose, neck, arms, chest and upper back, abdomen and lower back, legs, left side of the head, right side of the head, feet and hands). Thus, illness may be produced when there is a loss of H'wen. According to Mr. B., the amputated fingers are a loss of H'wen, robbing him of life's force.

Mr. B. is most confused when he attempts to reconcile the dissonance between living in a "civilized" and "gentle" land with the "barbarous" and "debasing" treatment received from a doctor whose profession he holds in high regard. Consequently, he is confused as to what feelings he is entitled to have towards the surgeon, someone who has power, and from whom he expected care and protection. He vacillates between bewilderment and repressed anger when recounting the treatment received. The high regard in which he holds the surgeon may explain partly why Mr. B. has not expressed these negative feelings directly to the doctor himself. However, on many occasions during the post-operative period, he chose to share his negative feelings towards the surgeon with all members of the CSST multidisciplinary team, including the CSST coordinator and the family doctor. Although he has never explicitly asked for interference from them in his case, he often expresses his sense of helplessness due to his low social status and lack of education as compared to that of the doctors. In mid-treatment, it became apparent to the team that while Mr. B. could have a better physical prognosis, it was held back by his obsessive, brooding conviction that his fingers would have been "whole" again if the surgeon had listened to him, as Mr. B. knew his body best. Consequently, Mr. B. slowed the process of physiotherapy down by complaining about his shoulder, and showed irritation when he felt "pushed" to perform more during physiotherapy.

Meaning and severity of symptoms in relation to cultural norms.

According to Xue (2002), expatriate Laotians who have lived under Pathet Lao communism or who have experienced extended stay in refugee camps rarely examine their own feelings when faced with trauma. They believe that everything is caused by society and the political system. There is no need for introspection and contemplation. Having experienced living conditions that were so poor and inhumane, they have learned to blame nothing on themselves. There is hardly a journey 'inward'. They know how to send the energy out, how to outwardly move themselves and engage in living, in surviving.

For Mr. B., faced with multiple traumas, the best psychological defense to losing his fingers was to blame the orthopaedic surgeon and the emergency medical team. Thus, it was the secondary trauma that served both the roles of buffer and risk for mental decompensation. The "cold and uncaring" treatment given by the medical team while he was in a vulnerable state plunged him back to the last experience where he felt so powerless and incapable to protect himself from perceived harm. He fell back, as Xue posits, to the outward-oriented defense mechanism he had learned previously to survive this latest ordeal.

As for the loss of his fingers, Mr. B. felt that he has accepted that and learned with time and from physiotherapy and occupational therapy to use his left hand, even if two fingers were half-amputated. As for the care received from the medical staff, especially from the surgeon, he does not accept the PTSD diagnosis, as he perceives that it would

absolve the staff of responsibility for making the wrong decision by amputating his fingers.

Cognitive restructuring to help him identify another perspective or other alternative explanations have met with little success because his belief of the medical team's wrong doing is so absolute; he rejects the possibility that they may have made the right medical decision, despite their poor bedside manner displayed towards him. Similarly, psycho-education on the subjects of traumatic amputation, grief and phantom limb has met with polite acknowledgement but with no change of opinion.

As for the diagnosis of MDD, Mr. B. did not qualify himself 'depressed,' but used 'triste' ('sad') to convey that he is resigned to living with the feeling that he has been victimized by the same people who were supposed to provide care and help him. He felt that he had suffered "shame and humiliation" because the medical team chose to ignore his requests and took control over such an important part of him. Although the hospital chart indicated that he signed the consent form authorizing the amputation, he did not remember signing such a paper. He said that even if he did, it was under the effect of drugs, and this supported his claims of oppression exercised by the medical team. Asked in session if he could compare this to any previous experiences, he looked surprised and said "no," but he did on one occasion compare the hospital experience with his life under communist Laos although, surprisingly, not with that of the refugee camp in Thailand. Asked for the reasons for this differentiation between life under communist Laos and the refugee camp, he replied that he "chose" to flee his country and would accept what was awaiting, whereas in Laos, he felt stripped of his "citizenship," his "dignity" and control over his life, akin to his experience at the hospital emergency room.

Perceived causes and explanatory models.

His narrative contained two common themes reminiscent of 'Uất ức' (Groleau & Kirmayer, 2004[*]), a set of complex negative emotions related to feeling 'indignant' because of some form of social injustice used in the narratives of some Vietnamese immigrants to express psychological distress. These emotions include anger, sadness, indignation, bitterness, stress, hate, and frustration (Groleau & Kirmayer, 2004). Because of the similarity with the emotions felt by Mr. B., the first author asked Mr. B. what Laotian expressions he would use to describe how he felt to his wife or a Laotian friend; he replied: "Khuâm khum khang" and "Ep Khựt" which translate in the Lao-English dictionary (Marcus, 2001), respectively, as "indignation" and "unworthy of respect." Mr. B. seemed relieved immediately after he said those two expressions. Asked how he felt, he answered that he was glad because now he can express his feelings without using so many different words as he had done in the past. Furthermore, he sensed that the therapist understood these expressions because she was Vietnamese. He added that Asians who have lived under oppressive regimes would understand this feeling, although others may not. Asked if he would now use the word 'indignation' if he talked about his feelings to the other members of the CSST team, his answer was "no, they would not understand," but he added that the general practitioner would, because he was also of Vietnamese origin.

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[*] where 'uất ức' is spelled 'uâ`t u'ć' (phonetically)

When asked how he planned to redress the unjust situation to his satisfaction, he replied that he did not see a way because “no one would believe an immigrant over a powerful doctor,” and that was why he had to “think hard” to find a way of getting rid of the “pressing” sensation of not being able to breathe: “It will be my head that will save my heart.” He explained that with the loss of his two fingers—and he continued to insist that they could have been saved—he lost control over his life because he did not even have authority over his limbs; someone else who did not live in his body took away that right. He felt “shamed, diminished” as a man, a husband, a father. It was with his hands that he made a living, and now he feared he was no longer capable of taking care of his family. This unjust situation made him feel that, if not relieved of anger and indignation, his heart would explode. He felt that he was not deserving of bad ‘H’wen’ because he had always tried to live with decency and compassion.

This description of Laotian ‘khuâm khung khang’ is very similar to Vietnamese ‘uất ức’. Both present a sociosomatic explanation in which certain social events lead to a psycho-physiological process in which strong negative emotions are trapped inside the body through various vital organs weakening the person’s ‘vital energy’. This is known as ‘chi`i’, in Vietnamese and ‘h’wen’, in Laotian. Mr. B. was robbed of life’s force by the loss of his fingers.

Help-seeking experience and plans.

Mr. B. dutifully adhered to the multidisciplinary treatment plans as proposed by the CSST rehabilitation team. In the beginning, he faithfully and mechanically went from therapy to therapy. In physiotherapy and occupational therapy, he had a detached but

polite and respectful rapport with the team members; he followed instructions and was not very expressive verbally or emotionally, even when he was in physical pain. He complained only to his wife and confided to her that he was not so sure where all this will lead because by the end of a day full of treatments and exercises, he felt tired and physically spent as though no progress had been made in rehabilitation. Gradually, he warmed up to the professionals, who also became quite fond of him. Collectively, the team felt that he had developed trust towards them compared to his previous, guarded behavior. Mr. B. also started to ask questions about his amputation and sought their opinions about the surgeon's decision. He expressed his unhappiness with the decision to amputate and balked when some team members hinted that it might have been medically sound after all. In these instances, the team noticed that he would regress by quietly resisting physiotherapy and occupational therapy. It was suggested to Mr. B., at a time when he still had follow-up examinations with the surgeon, that in order to get clear answers to the issues he was struggling with, he should ask the surgeon directly about the facts and the reasoning behind the decision to amputate, but he never did.

Mr. B. did, however, request massotherapy and acupuncture to be added to his treatment to alleviate the pain that he believed was caused by the amputation and compounded by an aggressive physiotherapy program. The CSST program coordinator, with whom he had a close and trusting relationship and to whom he confided that he was sad and had difficulty sleeping, granted his request; she even searched for the best services available in close proximity to his house. She eventually suggested that he see a psychologist and made all the arrangements for him, including the search for an Asian psychologist who she thought would be beneficial for him.

While Mr. B. also developed a strong therapeutic bond with the psychologist (and, admittedly, therapy helped him deal with his anger and distress within the framework of 'khuâm khung khang'), she felt that he was still guarded and thus was still following the treatment plan as designed by the CSST mainly out of duty. He personally and actively sought solace in the Laotian community. Prayer services, advice and encouragement from the monks gave him the spiritual strength needed to restore vital energy. This is similar to the Vietnamese who suffered from 'uất ức,' who also resorted back to religious and culture-specific rituals to help them accept otherwise unacceptable social injustice (Groleau & Kirmayer, 2004).

C. Cultural factors related to psychosocial environment and levels of functioning

Social stressors.

Mr. B. is the sole family provider: His son was a full-time university student, his daughter was in junior high school and his wife, restricted by her poor knowledge of both French and English, was not able to find work outside the home. Post-accident, they lived on 85% of his machinist's salary, covered by workman's compensation insurance and under the CSST's stewardship. His wife and children worried about the extent of his physical recovery, whether he could keep the same position or would have to accept a lower paid post if he did not fully recover the use of his left hand. Underlying these financial difficulties, but un-addressed by Mr. B., was his guilt about the accident that changed his life, and consequently that of his family. What he acknowledged, however, was his gratitude and indebtedness to the small Laotian- Canadian community upon

whose financial help he has relied to make ends meet. This community, albeit in urban Montreal, is no different from others in rural Laos in that the nuclear family lives in close proximity to the extended family; family members are interdependent socially, spiritually and financially, sharing many common values and beliefs (Keovilay et al., 2000; Min & Bankston, 1998). While he felt the support, Mr. B. believed that he had lost social status within the community, not on account of financial difficulties, but mainly because they reflected his inability to work, thus failing to uphold a fundamental tenet of immigrant community value and pride: hard work.

Social supports.

In addition to the support from the Laotian community, Mr. B. and his family receive support from his sisters and their families, as well as from their religious community where Mr. B. often discusses his concerns about the future with the monks, who, in turn, give him advice and encouragement. Mr. B. also seems to possess a strong bond with his coworkers. They called him often to inquire about his health and invited him to visit the factory when he felt better. They did not pressure him with questions about his return.

Similarly, the company's management demonstrated no pressure and was actually most cooperative during a multidisciplinary team meeting, organized by the CSST, in offering realistic work options and additional training should Mr. B. meet difficulties in operating the type of machine he operated before the accident. Mr. B. who was also present at this meeting stated that he appreciated everyone's help but declined to

collaborate on a progressive work reintegration schedule that would include continual therapies as well as additional job training.

Level of functioning and disability.

Physically, while he progressively gained strength, Mr. B. had not reached full functionality of his left hand and arm. He continued complaining about the pain in his left shoulder although test results were inconclusive. Mentally, Mr. B. felt ready to return to a work routine and felt the financial pressure of a prolonged sick leave, but he feared finding out that he could no longer operate heavy machinery, since he had not met the strength threshold set by the physiotherapist. He felt immense distress when he thought about the prospect of other options that the company had in store for him; he wished for additional training and a better position, but since his written French was poor, he knew that a demotion was more imminent than a promotion. Entertaining these thoughts typically plunged him back to obsessive rumination about the unjust amputation followed by all the negative emotions that it entailed, while causing him to withdraw from the CSST team through treatment resistance.

D. Cultural elements of the clinician-patient relationship

Early on in psychotherapy, Mr. B. was reticent to answer questions, perhaps because he perceived the therapist as an authority figure in a medical setting, and thus associated with the medical team that he fears and resents. The therapist’s gender may also have been a factor in his reticence for disclosure. He refused weekly sessions but agreed to bi-weekly meetings, more out of compliance to the rehabilitation treatment than

because he felt that psychotherapy would be beneficial. However, the reluctance displayed initially only lasted about three sessions, and therapeutic alliance was established shortly afterwards because the therapist did not press him to talk about his recent ordeal but encouraged him to talk about his life in general. Mr. B. intimated in later sessions that it was helpful to have a Vietnamese therapist about his own age because he felt that she could relate to his ethnic background and, presumably, his refugee and immigrant experiences, which he did not hesitate to share. But when speaking about the medical team, he continued to sublimate many of his negative emotions by not naming them; also, he was clearly obsessed with the treatment he received and distressed in his perceived inability to redress the injustice he felt he had suffered. However, once 'uất ức' was identified by the therapist and identified by him as 'khuâm khum khang' and 'ep khựt,' he felt a cathartic effect because these expressions allowed him a legitimized outlet of venting distress, anger and pain, within a social and political framework that did not compromise his dignity and stoicism.

Accounts from the other clinicians on Mr. B.'s rehabilitation team indicate that Mr. B. is very likable because he is gentle, hard working, and respectful. Although, he was slow in understanding the rehabilitation process and suspicious of the team's intentions at first, he gradually grew to be more compliant. Around the time that the 'khuâm khum khang' discussions began, i.e. in late fall 2005, he seemed to have changed. At that turning point, he clearly engaged in all his therapies with a sense of purpose, monitoring his progress. He even asked the CSST coordinator about receiving training for other positions in his company if he was no longer able to perform his old job, whereas in the past, he was passive from quiet despair of working again. The identification of 'uất

ức' was instrumental in Mr. B.'s treatment outcome because it created an acceptable social space for him to safely express deep feelings of anger and indignation towards the surgeon, a person whom he associated with power, within a therapeutic context which, until 'khuâm khum khang,' evoked in him feelings of isolation and injustice, and awakened in him past fears, sorrows and cultural depersonalization.

E. Overall cultural assessment

Traumatic amputation resulting from work injury is catastrophic, involving both physical and psychological trauma: the accident and the amputation are, respectively, a sudden, messy loss of limb followed by a calculated, medical act of severing the same limb to prevent additional damage or infection. The trauma of amputation was even more severe in Mr. B.'s case because he objected to it and was overruled by the surgeon. Secondary traumas are present from peri-operative to postoperative stages to rehabilitation to adaptation, and to work reintegration or permanent disability. Thus, trauma management and rehabilitation ideally require a multi-disciplinary approach of physical and rehabilitation medicine, psychology, vocational rehabilitation and other services. Massage therapy and acupuncture were added to the Mr. B.'s treatment plan when he complained about the pain on his shoulder.

Mr. B.'s case presents an interesting ethno-cultural study of the patterning of psychosocial and physical causes in the representation of illness between traumatic amputation and PTSD, two examples of non-contagious physical and mental illness. Amputation is a phenomenon for which biomedicine provides both a clear physical explanation and a fairly successful mechanical solution. For PTSD, both biomedical and

psychosocial explanations are widely available. Both amputation and PTSD can impede the process of adaptation and can be debilitating if the relationship between objective physical variables and psychosocial variables in adjustment from physical injuries is not identified.

Although Mr. B. made timely progress physically, his rehabilitation treatment was tenuous and inconsistent by all accounts from the multidisciplinary team until the emotional breakthrough provided by the identification of 'khuâm khum khang,' which helped him better explain his psychosocial distress and allowed the treating team to better contextualize his 'symptoms' in multiple social spaces, past and present. Although it did not provide him with a resolution or a closure, it seemed to relieve him of both objective and subjective burdens that stayed with him since the accident, allowing him to "save face" regarding his own role in the accident and empowered him to engage more into his rehabilitation, without abandoning his grievance against the surgeon.

Recounting his ordeal in the context of indignation as a social disease allowed Mr. B.'s suffering to reflect the structure of the health care system and the specific context in which symptoms and their possible origins are recounted and explored. In the process of his own analysis of illness through narrative, Mr. B. was able to reveal both personal and collective meaning of repressed anger and frustration, expressing them in a context that was acceptable to him. By doing so, Mr. B. clarified to those involved in his care some categories of experience and causal explanations that did not fit easily with western psychiatric understanding.

Mr. B.'s case provided both argument and support for 'uất ức' as outlined by Groleau and Kirmayer (2004) in their study of Vietnamese immigrants. While they posit that it is socially unacceptable to talk about one's experience of 'uất ức,' it is this very sentiment that served as a conduit for Mr. B.'s verbal and emotional outpour, cathartic to his treatment. This difference between Mr. B. and the Vietnamese immigrants may be explained by the different contexts and degrees of familiarity in which social indignation was disclosed. Mr. B., for instance, was in a psychotherapeutic context in which he had developed a strong therapeutic alliance, over time, with a therapist with similar South-East Asian background compared with the Vietnamese immigrants in Groleau and Kirmayer's study who were interviewed, once, by a researcher of a different ethnic background, often in the presence of an interpreter. Mr. B.'s hesitation in divulging how he felt while he obsessed over being unjustly treated supports Groleau and Kirmayer's assumption that 'uất ức' is difficult to share because it risks challenging the social order, something that Mr. B. was, and still is, careful to preserve while dealing with the feeling of injustice that he privately rehearsed but, initially, suppressed.

The introduction of 'uất ức' to the CSST rehabilitative team was also cathartic for the therapists. It introduced a historical-socio-political and cultural context into the biopsychosocial treatment framework of traumatic amputation, PTSD and Depression, which had been, until then, a missing link. It allowed the team members to understand dimensions and layers of Mr. B.'s particular experience. These had been inaccessible to the therapists for linguistic reasons and because of overwhelming reactivation of strong negative emotions associated with his social and political sense of disempowerment, experienced in Pathet Lao and in the refugee experience and transposed to the surgical

and rehabilitation teams. Although, initially, they empathized with Mr. B.'s feelings about the uncaring treatment he received from the surgeon, the CSST team members refrained from making statements against him since they did not have all the facts. When they understood the importance of 'uất ức,' they realized that their silence had impeded Mr. B.'s validation of his indignation. Their reticence to discuss the treatment he received from the surgical team may have caused him to associate the therapists with an uncaring medical system. As a result of this association, he became ambivalent toward his treatment; his progress was irregular on many therapeutic fronts. Understanding 'uất ức' allowed team members to restructure Mr.B.'s treatment plan. They adopted a more holistic healing approach, starting by respecting Mr. B.'s level of progress regardless of the employer's timeline for speedier work reintegration. They also determined that an interpersonally focused approach would yield a better corrective response than the previously directive approach. Through understanding and compassion, they offered a socio-political response to Mr. B.'s feelings of inequity and disenfranchisement. They dissociated themselves from the surgeon's medical team. By redressing injustice through compassion, they also practiced one of the Buddhist principles for healing, and hoped that this would be a more compatible approach to Mr. B.'s healing process.

The latest progress notes report Mr. B. showing increased active participation in his physiotherapy and occupational therapies, while his worries and complaints have diminished.

CONCLUSION FOR ARTICLE 1

According to Lewis-Fernández and Díaz (2002), at a time in which the value of delivering culturally congruent care is so crucial with calls for cultural assessments to be incorporated into treatment guidelines and professional training curricula (Bibeau, 1997; Kirmayer et al., 2008; Rousseau et al., 1995), the Cultural Formulation model represents, one of the main existing methods for attaining and implementing a culturally valid approach to care. Regular use of the model teaches clinicians not only how to *elicit* culturally relevant clinical material, but also exposes them over time to the *content* of many cultural perspectives from diverse patients and their families, thus increasing caregivers' fund of cultural knowledge. This case study demonstrates that the use of the Cultural Formulation for individual case conceptualization offers the clinician an exciting, clinical challenge of providing the space for some of the "thick description" (Geertz, 1973) that raises the real-world cultural complexity of clinical work (Lewis-Fernández & Diaz, 2002). The five sections of the Cultural Formulation allow for a more comprehensive, elaborate format into any given individual's story. As a clinical tool, the Cultural Formulation, thus, fulfills many of the goals of cultural psychiatry and psychology, expanding the conventional nosology used for diagnostics and epidemiology, providing clinicians with a concrete methodology for incorporating cultural analysis from evaluation to treatment plan. As a teaching tool, the Cultural Formulation can provide psychiatric residents and other mental health trainees an early understanding within their training how to develop and integrate a contextualizing and processual understanding of their patients' suffering into established clinical assessment models and methods. Finally, as a research tool, the Cultural Formulation can contribute toward

operationalizing the cultural assessment of clinical effectiveness required for valid outcome research.

CHAPTER 5: INTRODUCTION TO ARTICLE 2

Different disciplines bring different skills and perspectives to the treatment of individuals with mental illness. From its introduction by William Menninger and colleagues in the 1940s, the multidisciplinary team has grown in importance and size to meet the rising challenges of today's mental health. Psychiatry is arguably ahead of many medical disciplines in its recognition that most severe disorders have a multifactorial, biopsychosociocultural etiology, requiring corresponding multimodal intervention responses (Rosen, & Callaly, 2005). In hospital- based psychiatry, the multidisciplinary mental health team has long provided the foundation for comprehensive care, integrating multiple specialized treatment components within a stable and therapeutic treatment milieu (Fitchner, et al., 2001). These teams have developed in parallel with the demise of large asylums in the developed world (Leff et al., 2000). Their growth has been pragmatic, largely atheoretical and relatively unresearched, reflecting a clinical view that 'the needs of the severely mentally ill can rarely be met by a single individual' (Onvett, 2003; Burns & Lloyd, 2004). Today, cultural psychiatric and mental health care worldwide provides intensive, multiple solutions to the rising and complex needs of the multicultural psychiatric clientele, including the services of interpreters and cultural brokers (Kirmayer et al., 2003; Lehman, 2002; Poole & Higgo, 2006; Rosen, 2005; Singh et al., 1999). Practice guidelines have prominently featured clinical teams for such disparate problems as eating disorders (Schechter, 1994), anxiety disorders (Dahlgern,

Pollard, & Brown, 1994; Pollard, Merkel, & Obermeier, 1986), severe mental illness (Corrigan & McCracken, 1995; Yank, Barber, Hargrove, & Whitt, 1992), child residential services (Bendicsen & Carlton, 1990), integrated services for children and their families (Stone, 1988), and case management tasks for community mental health (Paradis, 1987). Liberman's study (2001) demonstrated that quality of life in severely mentally ill individuals with substance abuse increased with multidisciplinary practice.

DEFINITION

Multidisciplinary mental health teams have been defined as "a group of practitioners with different professional training, employed by more than one agency, who meet regularly to coordinate their work providing services to one or more clients in a defined area" (Øvretveit, 1993, p.9). In practice, health care teams function somewhere along a continuum of degrees of interaction among team members and their degrees of responsibility for patient care. Different points on this continuum are represented by the *multidisciplinary team*, the *interdisciplinary* team and the *transdisciplinary* team. The multidisciplinary team allows for each discipline to independently contribute its particular expertise to an individual patient's care. Traditionally, it has been the physician who is responsible for prescribing the contribution other disciplines could make and for coordination of services (McKenna, 1981). Team members work in parallel; direct interdisciplinary communication is minimal except through the physician in charge (Clark et al., 1996). The interdisciplinary team refers to a team whose members work together closely and communicate frequently to optimize care for the patient. The team is

organized around solving a common set of problems (Clark et al., 1996), as opposed to being organized around a single physician. It meets frequently to consult. Team members preserve specialized functions while maintaining continuous lines of communication with each other in order to provide holistic care (Beneriakis, 1995; Elliott-Miller et al., 2002). This teamwork is often seen in complex patient care areas such as mental health (Bloom, 1976). In transdisciplinary work, roles of the individual team members are blurred as their professional functions overlap. According to Hall & Weaver (2001) “each team member must become sufficiently familiar with the concepts and approaches of his/her colleagues to be able to assume significant portions of the others' roles” (p.868). The flexibility of role extensions between health care team professionals comes from cross-disciplinary education. This team approach helps break down the barriers between professions as is often seen in geriatric care (Johnson & Danhauer, 2002). As both multidisciplinary and interdisciplinary teams exist in mental health care, these terms will be used interchangeably in this paper.

Multidisciplinary Teams In Clinical Context

In a modern mental health service, according to Rosen & Callaly (2005) an interdisciplinary team integrates specialist assessments and individualized care. It is the underlying mechanism for case allocation, clinical decision-making, teaching, training and supervision and the application of the necessary skills mix for the best outcomes for service users (Renouf et al., 2001). Five professional disciplines are usually found within interdisciplinary mental health teams: psychiatry, psychiatric nursing, psychology,

occupational therapy and social work. In the organisation of these teams, roles are often defined along disciplinary lines. Only the psychiatrist can perform medical functions (Ranz et al., 2000). Psychiatric nurses perform standard nursing functions but also may be involved in treatment or crisis intervention on a regular basis - tasks requiring excellent interpersonal skills (Barker, 2002). There are psychological assessments and types of therapies that only the psychologist is trained to perform (Farhall, 2001). Medical, pharmacy, and nursing students, as well as psychology and social work interns, often become participants or observers (Rodenhauser, 1996). Other professionals who often work in close liaison with mental health service teams include general practitioners, primary health-care workers, health educators, indigenous and transcultural workers (e.g. bilingual counsellors, cultural brokers), consumer peer support workers, family carer support workers and educators, and rehabilitation and vocational counsellors. These professionals may not be able to participate full time in the interdisciplinary mental health team for practical purposes, but may become essential members of the ad hoc interdisciplinary team set up around particular service users and their families (Rosen & Callaly, 2005).

LITERATURE REVIEW

Even though multidisciplinary work has characterized psychiatry and mental health since the 1940s, literature searches performed on Medline, PubMed and PsycINFO data bases found that studies mostly had a focus on group composition or group dynamics

and the professional functioning of multidisciplinary teams, including the subject of team leadership (Burns et al., 2004; Thornicroft et al., 1998). Much remains unresearched.

Team dynamic and team leadership

Studies show that good teamwork in mental health depends on clear structure and accountability, good leadership, clear task delineation, clear role definition and assignment and mechanisms to resolve role conflicts (Diamond et al., 1992; Øvreitvet, 2002; Renouf et al., 2001; Rosen, 2001). Trauer and colleagues (1998) conducted a review on an Australian interdisciplinary teamwork and found that continuity of care, the capacity to take a broad and comprehensive view of the patients' problems, the availability of a range of skills and synergistic working between providers via mutual support and reciprocal education, all contribute toward advantages of working in a team (Rosen & Callaly, 2005). Team affiliation also can prevent professional isolation and lead to cross-fertilization of approaches and skills (Beneriakis, 1995; Miller, 1995, Mohmar et al., 1995). Opie (1997) concluded that advantages of the interdisciplinary team include not only the development of quality care for users through coordinated and collaborative inputs from diverse disciplines but also higher productivity, greater professional stimulation and increased job satisfaction. Studies on protective factors against "burnout" (Corrigan, et al.,1998) and identification with the team (Campbell-Heider & Pollock, 1997; Cott, 1998; Onyett et al.,1995) found that the staff who have the highest job satisfaction and lowest burnout are those who have strong identification with the team and profession, and who are clear about team functions and their role within it.

Conversely, interprofessional differences, rivalries, confusion of roles, or alternatively high group cohesion to the point of "groupthink" are characteristics of or result from problematic teams (Luntz, 1985; Jones, 1992; Trauer et al., 1998). Unclear roles for team members represent another problematic area. Slade and colleagues (1995) found that the roles of professions within a mental health multidisciplinary setting need to be clarified, especially that of team leader. According to Messinger (2007), nonmedical clinical occupational groups ought to be seen not as "naturally" subordinate counterparts to allopathic physicians but as products of diverse histories and epistemologies that have come together in a particular social arrangement. Indeed, many of the various occupational groups associated with cosmopolitan medicine developed independently from each other. Psychiatric nursing emerged in Europe in the 1850s during the Crimean War. Nursing was considered less an "occupation" but a specific set of behaviours and skills associated with the care for sick family members (Messinger, 2007). This view is reminiscent of early findings that nursing was seen as both a natural quality of women and their familial and social obligation (Reverby, 1987). The professionalization of U.S. nursing emerged during the Civil War and became, ironically, formally subordinated to physicians (mostly male at the time) as a condition of allowing volunteer female nurses to treat Union wounded soldiers (Reverby, 1987). Social work also developed into a distinct occupation toward the end of the 19th century with the rise of the progressive era in the United States (Messinger, 2007). Social workers investigated public relief cases and also did background investigations on patients in hospitals. Psychologists, although team members but, by the nature of their work in individual psychotherapy, group therapy, and specialties such as cognitive-behavioural therapy and psychological testing, have mostly

operated as “specialists” within the team (Farhall, 2001). Tice (1998) suggests that these mental health professionals began their close association both in their work and as part of the world of medicine, almost half-haphazardly, because they all became linked with hospitals (Tice, 1998). Epistemologically, medical doctors, although familiar with the biopsychosocial model of health care, ascribed more to the disease-centered approach that presupposes a morally neutral medical universe where sociocultural aspects of illness are often considered to be of marginal importance (Cicourel, 1999, 2006). This is in contrast to social scientists (Bury, 1998; Jordanova, 1995; Richardson, 2003) who often proffered that all knowledge, including medical knowledge, is “socially constructed” and employed by “human beings to bring into existence their own lives and experiences (Wright & Treacher, 1988, p.300).”

The debate over team leadership is another main topic of mental heath literature on teamwork. Proponents of leadership to psychiatrists (Boyce & Tobin, 1998; Tobin & Edwards, 2002) have argued in favour of psychiatrist supervision of other health professionals, with direct psychiatrist overview of and accountability for every case. Others have argued for increased leadership of other professions, claiming that medical responsibility should be limited to those tasks for which physicians are recognized as competent as a result of their medical training (Obholzer, 1994). According to this view, the insistence on leadership by psychiatrists is not warranted; it would, in fact, waste scarce, much-needed medical expertise, delay treatment, augment waitlists or drop-outs (Rosen, 2001). If indeed psychiatrists were to assume leadership, they should first get pertinent training to be equipped with the skills needed for multidisciplinary practice (Sims, 1989). Others have suggested that roles should be determined on the basis of

skills, rather than by discipline (Muijen, 1993). Many Australian centres, for example, employ mental health workers, who act primarily as generic case managers. In England, there is often a more specialized, discipline-based distribution of work. Others recommend that role definitions be built into job descriptions when planning a team (Øvretveit, 1993).

Another topic has been the establishment of legitimacy of interdisciplinary teams through interdisciplinary standards (Smyth, 2000) and team processes such as communication and decision-making (Halstead et al., 1985; Heinemann et al., 1994; Hopkins-Rintala et al., 1986; McClelland & Sands, 1993; Opie, 1997; Sands, 1990), and power (Drinka & Ray, 1987; Fiorelli, 1988; Fried, 1989;). One of the challenges elaborated by Vetere (2007) was the recognition that while each profession should maintain autonomy, there is a need to harmonize the varying methods and philosophies of different professionals into an integrative, cohesive care plan that works toward a unified treatment goal. She suggested the adoption of systemic thinking and approach to multidisciplinary care. Satcher (1999) suggested that the interdisciplinary team perform the intake interview (or initial assessment) of the patient in a group setting to ensure unity in their treatment approach, and then follow up with regularly scheduled meetings to create the treatment plan, adjusting it as necessary as they follow the patient's progress.

Our literature search indicated that much work had been done on the interactive process between client and practitioner (Atkinson, 1999; Drew & Heritage, 1992; Edward & Sines, 2007; Erickson & Rittenberg, 1987; Fisher & Todd, 1983; Frankel, 1984; Hak, 1994; Mishler, 1984; Ong et al., 1995; Silverman, 2001; Waitzkin, 1990; West, 1984), but none on the process of team work with mental health users. In cultural psychiatric and

mental health, there was no empirical work on multidisciplinary teamwork with the exception of a study from Kirmayer and colleagues (2008) on the use of the Outline for Cultural Formulation by various cultural consultants. Consequently, the study, discussed in Article 2, examines the ways the Cultural Formulation is used in a multidisciplinary, clinical setting for clinical assessment, diagnosis, case formulation and treatment. The study examines:

(1) how using the Cultural Formulation as framework influences team dynamics of a group of multidisciplinary Mental Health professionals during cultural case and,

(2) the implications of using the Cultural Formulation as meeting framework for interdisciplinary collaboration in assessment, treatment plan and care.

THEORETICAL FRAMEWORK

Symbolic Interactionism

Symbolic Interactionism is chosen as a theoretical framework from which to study the conversations of a team of mental health care practitioners in the dynamic context of case conference meetings where members discuss patients' case history and treatment alternatives from a cultural perspective.

Symbolic Interactionism as a term was used by Herbert Blumer (1969), drawing primarily on the work of Mead (1912, 1913, 1934, 1982) to propose a new perspective for the study of social issues. Although Symbolic Interactionism has evolved from its early days as a reaction to the dominant positivist paradigm in sociology, it has retained its primary focus of study which are human conduct and human group life, thus a close theoretical position to psychology, particularly social psychology. The individual is

regarded as determining rather than determined and society is constructed through the purposive interactions of individuals and groups (Blumer, 1969). In addition to its humanistic thrust and social interaction, two other interrelated and overlapping tenets of Symbolic Interactionism are language and meaning (Gusfield, 2003). Symbolic Interactionism (SI) posits that (1) individuals' action arises out of meanings that situations have for them, (2) meanings are represented symbolically in action and in language (3) meanings arise from social interaction with others, (4) individuals modify meanings in process of thinking through issues and interacting further with other individuals (Blumer, 1969; Heracleous & Barrett, 2001). Meaningful human interaction, therefore is best if studied within natural, dynamic contexts.

Self and society

One of SI's assumptions is that human beings and society co-determine one another in the interactions that form both and in the worlds constructed out of such acts. Interaction is not merely the shadow act of society, the manifestation of larger social forces; it is the space where these forces are created, sustained and transformed. Society in all its reach and complexity exists in these interactions because societies are organized systems of meaning and knowledge (Carey, 2002). The concept of interaction in Symbolic Interactionism refers to interaction between the acting unit and its environment in general. In human society, the most typical form of interaction occurs at the level of symbolic interaction, in which the acting unit brings its own perspective to bear on the world. "The perspective is the world in its relationship to the actor and the actor in its relationship to the world" (Maines, 2001; Mead, 1938, p. 115). To the extent that the

actor is successful in materializing its perspective, it makes a difference in the world (including society) as well as in itself.

Furthermore, in Mead's paradigm, interaction is a process in which the actor and the environment respond to each other on the basis of mutual conditioning. Each change in the actor's action will lead to certain change in the response of the environment, and vice versa. Therefore, interaction tends to involve continual permutations in both the actions of the actor and the responses of the environment. The responses of the environment may originate from other actors in the environment, from social structure and culture, and even from objects in the natural world (Chang, 2004).

Language, Symbolism and Meaning.

Central to SI's view of the human subject is the idea that everyone is a meaning-making person (Gusfield, 2003). Human events and objects have to be understood and interpreted. Even the situation to which people respond is a matter of interpretation, as ethnomethodologists and cognitive sociologists have shown (Cicourel, 1973; Garfinkel, 1969; Gusfield, 2003). Events, objects, and situations have a multiplicity of possible meanings; their character cannot be assumed by the observer —the researcher. The observer cannot simply assume the meaning or meanings a situation has for the subject. According to Hollander & Gordon (2006), the natural science method of hypothesis generation, data collection and analysis, and theory development is limiting; if used as the sole way of understanding human behaviour, this method is also wrong. To study human behaviour, as Symbolic Interactionism teaches, the observer must, as much as possible,

"take the role of the other," try to see, as much as possible, from the other's perspective. Much of human experience entails the mediation of verbal symbols and their interpretations. We live in the "forest of symbols" described by Victor Turner in his 1967 book of that name. We respond to what things mean in and through symbols (Gusfield, 2003). Since human beings have complex ways of communicating, this gives rise to the idea that meanings are produced and transmitted through language. Human action and interaction take place in an environment of linguistic exchange; meaning and situations are transmitted through language in an almost infinite diversity of expression. As analysts, we need to be conscious of the denotation and connotations of language: "I am firm, you are stubborn, he is pig-headed." The observer must have some experience of the phenomenon of study even to be able to frame a research problem and to develop the appropriate methods of study. Nowhere has this point made with greater clarity than in Noam Chomsky's (1967) classic review of B. F. Skinner's Verbal Behavior. Chomsky points out that the stimulus, in the stimulus-response approach, is not a given fact. The stimulus depends on how the respondent—not the researcher—sees the object or event. Thus, human beings interpret events, objects and situations and respond in accordance with their interpretations (Gusfield, 2003).

According to Hollander & Gordon (2006), researchers must examine how people construct meaning, identity, or social institutions, instead of simply claiming that they do. Scholars should pay more attention to the social nature of social construction. Blumer (1969), following Mead, maintains that interaction plays a pivotal role in the development of meaning. West and Zimmerman's foundational piece on "doing gender" declares that "gender itself is constituted through interaction" (1987, p.129), and Lyng and Franks'

(2002) stress the importance of "transaction." Yet much published empirical research relies on individuals' thoughts or reports about interaction (often obtained through individual interviews) or media messages (Hollander & Gordon, 2006). There is a paucity of research analyzing the interaction itself. Individual utterances and media messages are, of course, social products. Even when alone, individuals interact with imagined others. Media messages are the result of complex social processes. Despite this, the analysis of the concrete details of interaction is notably absent from most SI research.

Interactionist epistemology

Symbolic Interactionism truly commits itself to a dialectical logic. Reality is not "accomplished" as much as it is negotiated between actors or with an obdurate material world. This act of negotiation establishes a relationship between the actors in which each becomes "answerable" or "accountable" to the other giving rise to a responsive "social act"—to use a Meadian term. Each party is answerable to the other as well as to him or herself, leading thus to a complex social act (Perinbanayangam, 2003).

Interactional Processes

An interactionist epistemology, then, focuses on the processes of everyday life without attributing a causal significance a priori to only one part or aspect of the process. There are no easy distinctions between "independent" and "dependent" variables in an

interactionist epistemology. Mead (1938) and Blumer (1951) proposed several principles to study social life and humans' interactional processes.

The Principle of Emergence

The principle of emergence focuses on the dynamic side of social life and its potential for clarification or change, not only in the organization of social life, but also in associated meanings and feelings. The principle of emergence includes processes out of which new or revitalized social entities, or cognitive and emotional states, arise that constitute departures from everyday routines or perspectives. Furthermore, Snow (2001) stipulates that the central ideas of the principle of emergence to Symbolic Interactionism are rooted partly in Mead's (1938) emphasis on the novel and emergent nature of the act and in Blumer's (1951) conceptualization of the various forms of collective behaviour not only as emergent phenomena but as new forms of social life as well (Snow, 2001). These changes affect not only how we view ourselves, but our views of other groups and our relationships to and with them (Turner, 1983). The principle of emergence is fundamental to SI research on those moments and interactions in which emergence is at play, whether in the case of individual or collective identity (Schwalbe & Mason-Shrock, 1996; Snow & McAdam 2000), epiphanic turning points (Denzin, 1989), claims-making activities associated with social problems (Spector & Kitsuse, 1987) or the generation of collective action frames (Benford & Snow, 2000).

The Principle of Human Agency

This principle stresses the active, wilful character of human actors. Human beings are neither "hard-wired robots" responding to internal codes nor passive social actors following extant structural and cultural directives and constraints (Snow, 2001). Symbolic Interactionism does not reject biological, structural, and cultural factors in human actions but views these factors as predispositions or constraints on action without automatically or necessarily determining the character of that action. Thus social actors take into account the structural and cultural constraints such as social roles and expectations, norms and values that affect instances where they are on their own course of taking their own action (Snow, 2003).

The study of cultural case formulation discourse by a multidisciplinary Mental Health team would be very well served using Symbolic Interactionism as its theoretical framework to explain the group members in action. From this interaction, the assumption, following SI, is that the participants, more familiar with the medical approach, will be in a state of flux, changing themselves or being changed in varying degrees while discussing various aspects of the patient's socio-cultural world. Their respective disciplinary training and practice are not so much a determining factor as a strong influence in the interaction. They would actively participate in the present, during the meeting, to define what 'is' at that moment. From that interaction with others and with themselves, they may shift their direction, their action, and their definition of world and self (Charron, 1998) and in the process affect others.

METHODOLOGY

Conversation Analysis

We chose Conversation Analysis (Sacks et al., 1974) as a discursive analytical methodology because with Symbolic Interactionism as a theoretical framework, it provides pertinent directions to study the construction of culture and functional dimensions of discourse of this group of multidisciplinary Mental Health professionals during a normal course of case discussions.

Conversation Analysis lies at a unique interface between sociology and other major disciplines - principally linguistics and social psychology (Hutchby & Woofitt, 1998). The theoretical basis of Conversation Analysis draws on a rich lineage of writers who each believed, not unlike the Symbolic Interactionists, that *talk* is a central aspect of social life. Conversation Analysis deals solely with 'naturally occurring' speech and, while recognizing that there is no value-free observation, is careful not to impose pre-established structures and definitions on how speakers 'talk-in-interaction' or 'language-in-use' (Potter & Wetherell, 1987). In this way, Conversation Analysis aims to study how conversational behaviour relates to the creation of social roles, social relationships and a sense of social order (Woods, 2006). Conversation Analysis seeks to provide a detailed analysis of talk and texts as instances of everyday social practice. In particular, Erving Goffman's exploration of interaction order (1959) and Harold Garfinkel's programme of ethnomethodology (1969) were drawn together by Harold Sacks and colleagues (1974) into a method for the analysis of naturally-occurring interaction (see Heritage, 1984 and Potter, 1996 for a fuller discussion of the theoretical background).

Conversation Analysis is characterized by the view that how talk is produced, and how the meanings of talk are determined, are the practical, social, and interactional accomplishments of members of a culture. Talk is not seen simply as the product of two 'speaker-hearers' who attempt to exchange information or convey messages to each other (Hutchby & Gooffitt, 2008). Rather, participants in conversation are seen as mutually oriented to, and collaborating in order to achieve, orderly and meaningful communication. At least in part, the aim of Conversation Analysis is thus to reveal the organized reasoning procedures which inform the production of naturally occurring talk. The way in which utterances are designed is informed by procedures, methods and resources, which are tied to the contexts in which they are produced and are available to participants by virtue of their membership in a natural language community (Hutchby & Wooffitt, 2008).

According to Jones (2003) who has studied nurses talking to patients, Conversation Analysis has played a very important role in organizational research, in particular in the analysis of naturally occurring health care discourse (Bolden, 2000; Fairclough & Wodak, 1997; Heritage & Stivers, 1999; Iedema & Wodak, 1999; Peräkylä, 1995). Conversation Analysis's analytical approach to discourse will be instrumental in unpacking the detail of conversations between health care professionals and service users (Beach & Dixson, 2001; Crowe, 2001). Using Conversation Analysis techniques on naturally occurring data reveals the realities of healthcare communication in practice, especially the habitual or "unthinking" discourse used in everyday conversation (Jones, 2003). While Conversation Analysis has been instrumental in studying discourse in health care, little work has been done on everyday life in psychiatric settings (Atkinson & Heath,

1981; Heath & Hindmarsh, 2002). Our study will contribute toward this body of work in professional discourse in various health disciplines, including that of the health care users.

The conversation -“Text” - can also be studied as instrumentations through which one person presents a self and which is read by the other who in turn presents his or her self by the same means. In and through conversations each actor creates dialogic interactions and invests his or her words with addressivity and answerability (Perinbanayagam, 2003), thereby also presenting themselves, expressing a mood, indicating intentions. Dialogic interactions, then, are composed of elements during the interaction, including spatial, temporal, tactile and olfactory ones as discourse. They are complex processes, the basic tool with which the drama of human relations is constructed and staged.

The construction of interactions

Conversation analysis, and to a lesser extent ethnomethodology more generally, has focused on detailed sequences of interaction: how interacting individuals structure conversation, achieve interactional orderliness, establish and maintain intersubjectivity, and construct “reality.” The fundamental processes in dialogic interactions are the acts of taking and giving “turns.” Conversation analysis refers to this as a concern with the sequential order of talk (Hutchby & Wooffitt, 2008; Ten Have, 1999). According to Perinbanayagam (2003), it is by the methods of turn-taking that the solitary ego allows itself to be involved with others and enables others to enter one’s own domain. To give a turn to another is to recognize his or her rights to be a participant as it is to invite him or her to participate, just as for the other to take the turn is to acknowledge the recognition

and the invitation. Turn-taking and turn-giving in conversation, as in other arenas of social life, is the dynamic process by which interactions as such, and indeed "society," are allowed to emerge. Another aspect of this is that the relationship between turns reveals how the participants themselves actively analyse the ongoing production of talk in order to negotiate their own, situated participation in it. Moreover, a second important dimension revealed in speakers' turns is their analysis and understanding of the action the prior turn has been designed to do. This is the inferential order of talk: the kinds of cultural and interpretive resources participants rely on to understand one another in appropriate way. A third dimension that emerges from studying turn-taking is that talk-in-interaction is grounded in temporal orders: Talk is produced in time, in series of turns themselves that are constructed or 'turn constructional unit' out of which turn-taking takes place and turns are produced within a series of sequences of conversation. They are vehicles for action – complaints, requests, offers, warnings, and refusals (Perinbanayagam, 2003).

Conversation analysis, as an analytical method, is thus profoundly empirical and social: it starts with the data of everyday, real-world conversations, and analyzes sequences of interactions, not simply individual utterances. In these ways, conversation analysis takes precisely the approach of focussing on the meaning of particular actions produced in interaction (e.g., questions or requests), and how individuals jointly construct these meanings. Through talk and the construction of meaning, the production and reproduction of social relationships (micro-level) and of social structure (macro-level) occur.

For a multidisciplinary team, consequential action is not the result of disconnected utterances or isolated texts in team conversation. It draws on broader professional paradigmatic discourse. As prescribed by Conversation analysis, features of conversations that we will be studying will be the styles of talk used by the actors such as the tone, style, rhythm, and format of conversations which each actor engage in. Styles of talk are critical in collaboration because they provide the emotional energy necessary for participants to translate various professional identities into effective collaboration. In addition, we will focus in the management of overlapping talk, because we are studying a group; and repair and correction in conversation (Schegloff et al., 1977). Repair involves the temporary suspension of a turn or sequence in progress in order to attend to an emergent trouble of some kind in the conversation; this emergent trouble is not restricted to errors of fact, logic, correctness or arguments between any given participants but part of the temporal organization of talk-in-interaction.

Together Symbolic Interactionism and Conversation Analysis provide an appropriate theoretical framework and analytical methodology for our study of the dynamic of a Mental Health care team, the constructive and functional dimensions of their talk and the meaning and impact of a cross-cultural case discussions upon their respective practice.

Data and Transcription

Conversational analysis emphasizes the use of extracts from transcriptions of audio-recorded, naturally occurring interactions. According to Paul ten Have (1999), there are hardly any prescriptions to be followed, if one wants to do 'good Conversation

Analysis'. The basic reasoning in Conversation Analysis seems to be that methodological procedures should be adequate for the materials at hand and the problems one is dealing with, rather than them being pre-specified on a priori grounds. While the essential characteristics of the materials, i.e. records of streams of interaction, and the general purposes of study, i.e. a procedural analysis of those streams, sets broad limits to what an analyst can responsibly do, it leaves the researcher with ample room to develop his own best fitting heuristic and argumentative procedures (Sacks et al., 1974; Schegloff et al., 1977, 1992b). Consequently, the model of Conversation Analysis's practices that we have established for the data analysis of our study have the following premises:

1. The data is derived from audio tape-recorded team meetings. The decision to record a particular conversation involving certain participants in a particular setting at that time lies with the researchers. As long as the recording sounds 'natural' (most people who know they are being recorded get used to that idea quickly), it is considered to provide useful data (Ten Have & Psathas, 1995). This primary data-base can be made more accessible by transcription, but it remains available in its original form.
2. From the recordings, transcriptions are made in a manner that is a practical compromise given various objectives, considerations and circumstances. Two transcribers, who did not participate in the meetings, were responsible for the transcriptions. We understand that even with established transcription protocole, it is inevitable that the transcribers have experience and knowledge that would 'predispose' them to certain hearings that could translate into incomplete or biased representation of what was said and how it was said. Consequently, the researcher checked the

transcriptions against the recordings herself to ensure that there are less 'drifts' between the transcription of the meetings. Transcriptions follow conventional protocoles (Appendix 3).

3. The episodes to be analyzed can be selected from the transcripts based on a variety of considerations. One can select a particular set of circumstances, such as consultation openings, or one can be intuitively intrigued by some materials. The episode will generally consist of one or more sequences, in which a participant initiates an action and (the) other(s) react(s) to it (ten Have, 1999).

4. The researcher, then, tries to make sense of the episode, using mainly his common sense (Turner, 1983). This knowledge is in principle procedurally similar to the one used by the participants themselves in recognizing and producing the episode under consideration.

5. For this study, we will (1) describe the sequence within the context of the meeting. In other words, in this phase of the analysis the researcher uses both the details of the interaction within the sequence of the context in which it happened, (2) interpret and explain the sequence from a theoretical perspective (thus from an Symbolic Interactionist perspective). As explained above, a major resource for supporting an analysis of a particular utterance is inspecting its sequelae, subsequent utterances and sequences. By explaining a talk-in-interaction sequence using a theoretical framework, the current episode and its analysis can be compared to or entertextualized with other sequences from this study or from studies from other authors.

Starting from step 4, a local common sense interpretation of an episode, the scheme suggests that this interpretation is considered repeatedly in subsequent conversation sequences, explicating and possibly revising it. The ultimate goal is not to argue for the best possible interpretation, but to formulate the means used by the members in their situated interactions.

Article 2 – Formulaire A: Accord des coauteurs

ANNEXE II
ACCORD DES COAUTEURS ET PERMISSION DE L'ÉDITEUR

A) Déclaration des coauteurs d'un article

1. Identification de l'étudiant et du programme
Nom de l'étudiant : My-Hoa Nathalie Dinh **Programme:** Ph.D. (psychologie) (3-220-1-0)

2. Description de l'article (en soumission)
Auteurs: My-Hoa Nathalie Dinh, Danielle Groleau, Laurence J. Kirmayer, Rosario Rodriguez, Gilles Bibeau
Titre: Impact of the Use of the DSM-IV Outline for Cultural Formulation on the Dynamics of a Multidisciplinary Case Conference
Revue : Social Science and Medicine

3. Déclaration de tous les coauteurs autres que l'étudiant
À titre de coauteur de l'article identifié ci-dessus, je suis d'accord pour que **My-Hoa Nathalie Dinh** inclue cet article dans sa thèse de doctorat qui a pour titre "The Uses of the DSM-IV Outline for Cultural Formulation: From Case Conceptualization to Treatment Plan".

Danielle Groleau__________
Coauteur Signature Date

Laurence J. Kirmayer __________
Coauteur

Rosario Rodriguez__________
Coauteur Signature Date

Gilles Bibeau__________
Coauteur

B) Permission de l'éditeur d'une revue ou d'un livre

1. Identification de la revue ou du livre
Social Science and Medicine **ISSN:** 0277-9536
Elsevier Ltd. , Amsterdam, Netherlands

2. Identification de l'éditeur ou des éditeurs
Ellen Annandale, M.A. Ph.D. (Editor-in-Chief)

3. Identification de l'article
Dinh, NMH, Groleau, D., Kirmayer, LJ, Rodriguez, R., Bibeau, G. Impact of the Use of the DSM-IV Outline for Cultural Formulation on the Dynamics of a Multidisciplinary Case Conference (submitted for review)

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Éditeur Signature Date

Article 2 – Formulaire A: Accord des coauteurs (suite)

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Coauteur Signature Date

Laurence J. Kirmayer ______________________________
Coauteur Signature Date

CHARO
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Éditeur Signature Date

CHAPTER 6: ARTICLE 2

Impact of the Use the DSM-IV Outline for Cultural Formulation on the Dynamics of Multidisciplinary Case Conferences in Mental Health

Introduction and Background

Over the past several years, the growing cultural diversity and pluralism of North American society has required mental health practitioners to examine the impact of cultural factors on psychiatric illness (Lewis-Fernández & Diaz, 2002). Culture is important in all aspects of treatment. It establishes the framework in which (a) a person's mental health problems are developed, exacerbated, and identified as well as (b) the interpersonal interaction between the practitioner and the patient and the patient's caregiver takes place. Culturally-diverse patients express distress and psychopathology that are less in accord with Euro-American psychiatric nosology and diagnostic categories used by mental health professionals trained in this tradition. Western biomedical approaches and methods inadequately address the psychosocial issues of patients from other cultures (Fernando, 2003; Good, 1996). In addition, studies have shown that ethnic and immigrant populations do not access available mental health resources at the same rates as the general population (Bui & Takeuchi, 1992; Kirmayer & Young, 1998; Sue, 1990; Whitley et al., 2006) and are more likely to prematurely terminate therapeutic services (Atkinson et al., 1998; Cheung & Snowden, 1990; Kim & Lyons, 2003). Recent reports indicate that the quality of care provided to immigrant and ethnic minority patients may not be at the same level as that provided to majority group patients (Qureshi et al., 2008).

In an attempt to respond to this complexity, cultural psychiatric care often involves intensive, multidisciplinary collaboration among many mental health professionals, including interpreters and cultural brokers (Kirmayer et al., 2003; Lehman, 2002; Singh et al., 1999). *Multidisciplinary mental health teams*, have been defined as 'a group of practitioners with different professional training, employed by more than one agency, who meet regularly to coordinate their work providing services to one or more clients in a defined area' (Ovretveit, 1993; Burns & Lloyd, 2004). Although not a recent development, multidisciplinary work has grown in importance and size to meet the rising and complex needs of the multicultural psychiatric clientele. Different disciplines bring different perspectives and skills to all the processes of treatment plan (Poole & Higgo, 2006).

Similarly, an alternative, culturally sensitive, approach is required, with a scope beyond the levels of disease-centered, biomedically treatment of individuals. A cultural approach to mental health is person-centered, contextually inclusive, psychosocially oriented, and pluralistic in its approach from assessment to treatment plan. Consequently, *cultural competence* has been recognised as a required skill set for all mental health professionals. It is the ability to transform knowledge and cultural awareness into mental health interventions that support and sustain healthy client functioning within the appropriate cultural context (Ecklund & Johnson 2007; McPhatter, 1997; Sue & Sue, 1999, 2003). Transforming knowledge and awareness into effective treatment interventions can be challenging for most because the scope of cultural competence can be overwhelming, from intake assessment and diagnosis to culturally appropriate treatment plan (Lum, 1999; Rogers & Lopez, 2002; Sue et al., 1998).

The American Psychiatric Association (1994) provided initial guidance in the provision of culturally competent assessment by incorporating the Outline for Cultural Formulation in the Diagnostic and Statistical Manual of Mental Disorders (4th ed., DSM-IV and DSM-IV-TR, 1994, 2000) (Appendix 1).

The Outline for Cultural Formulation and the Research Questions

The Outline for Cultural Formulation (hereafter referred to as the Cultural Formulation) was designed to help clinicians move beyond one-dimensional evaluation and conceptualization of culture and people. The Cultural Formulation is the contribution of the Culture and Diagnosis Work Group, a group within the DSM-IV Task Force composed of many of the leading clinical and scholarly experts on culture in the mental health disciplines, to address culture in DSM-IV (Mezzich et al., 1999). The Cultural Formulation is based on an extensive review of the literature that identified five major areas in which culture had major influences on mental health and illness. This finding was further substantiated by field trials (Mezzich et al., 2001). Although a significant portion of the Work Group's recommendations was omitted in the final text, the original Cultural Formulation guideline was published in the DSM-IV (Appendix I, p. 843), along with a glossary of culture-bound syndromes. It was initially a brief, single-page outline with broad sections of cultural components to look for during an interview. More detailed instructions and case examples came later as part of a monograph published by the Group for the Advancement of Psychiatry or "GAP" (2001). The Cultural Formulation is recommended for implementation during the assessment phase of every clinical encounter, complementary the conventional psychiatric case history. In recent literature,

it has been suggested that the Cultural Formulation be considered a tool to foster interdisciplinary collaboration, allowing practitioners with differing expertise to participate more effectively in the care process (Eshu, 2009; Dosser et al., 2001).

The Cultural Formulation should not be mistaken for case formulation. Case formulation is a core component of psychotherapeutic treatment; it is an account of a person's presentation of problems followed by the use of theory by the therapist to make explanatory inferences about causes and maintaining factors (Bieling & Kuyken, 2003; Eells, 1999). The Cultural Formulation, on the other hand, is designed to elicit the person's account using his or her own explanatory models (Kleinman, 1988), idioms of distress (Nichter, 1981), spirituality and environmental influence, including the cultural context in which they are embedded, with the goal of knowing about the "whole" person, not just the presenting problem.

The Cultural Formulation is an important contribution to the DSM system. It encourages a systematic review of the individual's background, including the role of cultural in the expression and evaluation of symptoms and dysfunction. It ties the cultural context to clinical care, from assessment to treatment plans. It highlights the effect that cultural differences may have on the relationship between the client and the clinician (Kirmayer, 1998; Lewis-Fernández, 1996; Mezzich et al., 1999).

The Cultural Formulation adds several important factors to the psychiatric case history and the general psychological case formulation: (1) cultural identity of the individual, (2) cultural explanations of the individual's illness, (3) cultural factors related to psychosocial environment and level of functioning, (4) cultural elements of the relationship between patient and clinician and (5) overall cultural assessment for

diagnosis and care, which allows for a summation of the significant issues discovered in the four other areas (DSM-IV and DSM-IV-TR, 1994, 2000).

The Cultural Formulation has been regularly featured as framework for multicultural case studies in the journal *Culture, Medicine and Psychiatry* soon after its publication in the DSM-IV (1994). Although the growing body of recent literature provides instructive examples of detailed uni-disciplinary, cultural formulations, it offers little information on the process of creating the cultural formulation (Borra, 2008; Dinh & Groleau, 2008; GAP, 2001; Mohatt et al., 1998; Orr & Day, 2004; Panos & Panos, 2000; Rait et al., 1999; Yilmaz & Weiss, 2000). Others have provided illustrations of its use in cross-cultural, cross-disciplinary clinical contexts (Kirmayer et al., 2003, 2008; Mariner, 2006; Walsh, 2004). While Mariner (2006) noted that these findings substantiate its validity and importance within informed mental health diagnosis, he suggests that the "key is culturally appropriate processes and expertise that maximize client input rather than a focus on the tool itself (p. 5)". Presently, there is no process study[1] on how information is collected using the Cultural Formulation and how the Cultural Formulation affects the process of clinical case formulation.

Similarly, much work in medical settings has focused on the interaction that occurs between clinicians and their patients (Atkinson, 1995; Drew & Heritage, 1992; Erickson & Rittenberg, 1987; Fisher & Todd, 1983; Frankel, 1984; Heath, 1986; Mishler, 1984; Ong et al., 1995; West, 1984) but relatively little work has been done on mental health multidisciplinary teams, specifically, on team members' interaction with each other

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[1] The word "process" has come to take on such a variety of meanings that communication can be difficult (Langley, 2007). In this study, process research or studies is concerned with understanding how things evolve over time and why they evolve in this way (see Van de Ven & Huber, 1990). Data used in process research therefore consist largely of stories about what happened and who did what when – that is, events, activities, and choices over time (Langley, 1999).

during case formulation. More pertinent to the present study, there is no process study on multidisciplinary mental health team using the cultural case formulation. Consequently, this study examines the ways the Cultural Formulation is used in the multidisciplinary setting of a cultural consultation service for clinical assessment, diagnosis, case formulation and treatment. It uses Conversation Analysis methodology to analyze clinical case conferences and to examine:

(1) how using the Cultural Formulation as framework influences team dynamics of a group of multidisciplinary Mental Health professionals during cultural case and,

(2) the implications of using the Cultural Formulation as meeting framework for interdisciplinary collaboration in assessment, treatment plan and care.

Theoretical Framework

Symbolic Interactionism

This study utilizes Symbolic Interactionism as a theoretical framework.

Symbolic Interactionism was introduced by Herbert Blumer (1969). Drawing primarily on the work of the social psychologist George Herbert Mead (1912, 1913), Blumer proposed a new perspective for the study of social issues. Although Symbolic Interactionism has evolved from its early days as a reaction to the dominant positivist paradigm in sociology, it has retained its primary focus on human conduct and group life. The individual is regarded as determining rather than determined by society, which is constructed through the purposive interactions of individuals and groups (Blumer, 1969). In addition to this humanistic thrust and focus on social interaction, two other interrelated

and overlapping tenets of Symbolic Interactionism are its focus on language and meaning (Gusfield, 2003): Symbolic Interactionism postulates that: (1) individuals' actions arise out of the meanings that situations have for them; (2) meanings are represented symbolically in language and in action; action is the result of "language-in-use"; (3) meanings arise from social interaction with others; and (4) individuals modify meanings in process of thinking through issues and interacting further with other individuals (Blumer, 1969; Heracleous & Barrett, 2001; Thomas & Thomas, 1970). Meaningful human interaction therefore is best studied within natural, dynamic contexts.

This study uses Symbolic Interactionism to examine the cultural perspectives of mental health care practitioners in the dynamic context of meetings to discuss a patient's case history and treatment alternatives. Most of the participants are more familiar with the medical approach; some are more culturally conversant than others. From the perspective of Symbolic Interactionism, their meaning-making actions would be expected to be in a state of flux, their views changing or being changed to varying degrees while discussing with others the particulars of patient's socio-cultural world. The focus on this fluid process of negotiated and (re)construction of cultural meanings can shed light on how the Cultural Formulation functions as a framework for making meaning in clinical case formulation.

Methodology

The study uses Conversation Analysis to study clinical case conferences of a specialized cultural consultation service utilizing the cultural formulation to assess mental health problems of referred patients.

Conversation Analysis

We chose Conversation Analysis as a discursive analysis methodology because with Symbolic Interactionism as a theoretical framework, it provides pertinent directions to study the construction of culture and functional dimensions of discourse of this group of multidisciplinary Mental Health professionals during a normal course of case discussions as they occur.

Conversation Analysis has played an important role in organizational research, in particular in the analysis of naturally occurring health care discourse (Bolden, 2000; Fairclough & Wodak, 1997; Heritage and Stivers, 1999; Iedema and Wodak, 1999). It is well-suited as a qualitative research method for analysis because it studies language in use (Sacks et al., 1974). An interface between sociology, social psychology, linguistics and related disciplines (Hutchby & Woofitt, 1998), Conversation Analysis draws on the works of writers who posit that talk is a central, revealing aspect of social life. Erving Goffman's exploration of interaction order and Harold Garfinkel's programme of ethnomethodology were drawn together by Harold Sacks and colleagues (1974) into a method for the analysis of naturally-occurring interaction (see Heritage, 1984; Potter, 1996 for a fuller discussion of the theoretical background). Recently published studies illustrate the usefulness of Conversation Analysis in unpacking conversations between health care professionals and service users (Beach & Dixson, 2001; Crowe, 2001), revealing the underlying significance of their habitual or "unthinking" discourse (Jones, 2003).

Setting and participants

The Cultural Consultation Service (CCS) of the Jewish General Hospital is located in Montreal in a multiethnic inner city neighbourhood which is home to many newly- arrived immigrants and asylum-seeking refugees, with varied levels of social economic status. The CCS is a regional service, developed in collaboration with the Regional Board of Health and Social Services of Montreal to provide not only psychiatric cultural consultation but also to develop information resources for cultural consultations and to provide training to mental health professionals for intercultural work. The service receives requests for assistance from primary care providers and mental health professionals throughout the region who are facing difficulties with the assessment or treatment of ethnically diverse patients. The CCS core team has a clinical coordinator, three part-time psychiatrists and a network of available interpreters and cultural consultants or "culture brokers", most of whom are multilingual and multicultural clinicians (psychiatrists, psychologists, social workers and other therapists), anthropologists, paraprofessionals or knowledgeable members of specific ethnocultural communities.

After initial screening and intake over the telephone by the clinical coordinator, one of the psychiatrists of the CCS assesses the patient. This might require one or several interviews. The interviews may be with the aid of an interpreter and/or a culture broker. Sometimes, the latter conducts his or her own interviews with the patient or members of their entourage without the presence of the psychiatrist when more cultural background information is required, such as additional information regarding the immigration experience.

After these assessment interviews, the cases are presented at weekly CCS clinical case conference meetings during which the psychiatrist presents the initial diagnostic impressions and the cultural consultant or culture broker presents additional background and information from scientific and cultural literature for discussion and formulation of the case with the a multi-disciplinary group of mental health professionals. These case conference meetings last from 1 to 2 hours and are the setting of our study. They are routinely tape-recorded and transcribed as part of ongoing research on the process of cultural consultation.

Culture broker

The culture brokers in the CCS network are generally mental health professionals or paraprofessionals with a consultative role. They are independent workers or employees of other institutions. Their assistance is called upon by the CCS to facilitate and guide both patients and clinicians involved in the case during the cultural consultation process of patients with the same linguistic and ethnic background. Although the CCS uses many different cultural brokers, the same cultural broker was present for the 12 meetings that will be discussed and analyzed in this paper. This cultural broker is a counselling psychologist of Chinese descent. Her mandate with the CCS is to work exclusively as a consultant. She is the cultural broker employed by the CCS for most Chinese clientele as she speaks both Cantonese and Mandarin. During joint sessions with the psychiatrist, however, there often was an interpreter as well, since this allowed the cultural broker to focus her attention on the patient and interviewing process. This cultural broker is well versed on the use of the Cultural Formulation, as are the psychiatrists with whom she

works, and she formulates her assessment according to this outline. She uses an adapted Cultural Formulation, expanded by the CCS, to conduct her interviews and write her report (Appendix 2).

Participants

CCS meetings are chaired by one of the three psychiatrists of the core team. Regular meeting attendees may include the other two psychiatrists as well as a variety of multidisciplinary mental health clinicians and researchers who are staff of the hospital where the CCS is based. Invited regular attendees include the referring clinician(s) and the cultural broker. Other attendees include research assistants, medical students, multidisciplinary graduate students and post-doctoral fellows. This last group is more transient, international in citizenship, varying from meeting to meeting, due to temporary postings. Most have had some cross-cultural psychiatric and psychological training. They attend for additional learning and for the purpose of their own research projects (Kirmayer et al., 2003, 2008).

Data

Twelve (12) taped and transcribed CCS case conference meetings were chosen for study from an available pool of 177 CCS meetings during a four-year period (2002 to 2006). All 12 cases involved the same cultural broker as discussed above. The choice of all 12 cases seen by a single culture broker avoided potential cultural bias and the first author's clinical and cultural expertise in Asian culture facilitate the close analysis of the case conference process. Cases included individual, couple or a family. The CCS data are

collected pursuant to an ongoing research protocol approved by the ethics committee of the university-affiliated hospital that supports the CCS. Participants give informed consent to use of the data for research during initial screening and intake stages. CCS meeting members must confirm the acceptance of strict rules of confidentiality.

Audiotaping and Transcription

CCS meetings are routinely audio-taped and transcribed for ongoing research on the process of cultural consultation. The first author has reviewed all twelve tapes and standardised the twelve transcripts following sociolinguistic and conversation analysis guidelines in considering interruptions, pauses, questions, simultaneous speech, changes in tone of voice, laughter, and similar features in interpersonal speech (Waitzkin, 1990). Transcription conventions follow the standards for the representation of spoken action for the purposes of conversation analysis and discourse analysis as proposed by Mishler (1984) and West (1984) (Appendix 3). Utterances have been numbered in a continual sequence within data extracts for ease of reference.

Analysis

As prescribed by Conversation Analysis, features of CCS conversations that will be studied will be the styles of talk used by the actors such as the tone, style, rhythm, and format of conversations in which each actor engages. Styles of talk are critical in collaboration because they provide the emotional energy necessary for participants to translate various professional identities into effective collaboration.

Procedures for interpreting were decided in advance. The first reading was to standardize tapes and transcripts following discursive guidelines discussed above for purposes of reliability. Subsequent readings were for the purpose of interpretation.

Interpretive guidelines were established according to the theoretical framework, Symbolic Interactionism, and the methodology, Conversational Analysis. Transcripts of the twelve meetings were examined to discern the overarching themes as well as the context as framed by the cultural formulation's outline. We noted conversation turn-taking, interruptions, simultaneous speech, hesitation to study their effect on member and group interactions as well as quasi-verbal elements that might clarify a deeper structure underlying beneath the discourse.

Results

Five stages of discussion emerged in each meeting. The first four stages were not explicitly announced by the chairperson; they seem to be spontaneously flow from the use of the Cultural Formulation to frame the cultural presentation by the Cultural Broker. While the transition from one stage to another was seamless, each stage clearly served a different function. The fifth and last stage is usually announced by the chairperson to signal the end of the meetings. Our results will be presented following the order of these five stages. The conversation analysis will be first described then interpreted according to the Symbolic Interactionist perspective. Only excerpts and quotations that represent common instances found in most of the 12 cases will be used as illustrations of process or content of these discussions. The average duration of each meeting was 90 minutes.

Stage 1: Psychiatric clinical history (15-20 minutes)

The clinical director of the CCS who chairs the meetings welcomes everyone and briefly introduces the referring party who is customarily invited to these meetings. After reminding attendees that the meeting is audiotaped and that rules of confidentiality must be respected, he invites attendees to introduce themselves. The atmosphere is collegial

and friendly. The chairing psychiatrist or a psychiatric resident then proceeds with the case presentation, gathered from the psychiatrist's interview with the patient. The presentation of the patient's identity is usually a summary (and sometimes disguised) as the psychiatrist moves quickly to a review of symptoms:

001 **Chairing Psychiatrist:**(…)Mr. I. explains that when he feels
002 nervous his hands shake and his heart beats faster, but
003 he denies dizziness, fainting, feeling like fainting,
004 nausea, vomiting. He also denies sustained suppressed mood.
005 Denies suicidal or homicidal thoughts. Denies auditory
006 Hallucinations and denies substance and alcohol.(…)So I
007 raised the question of a possible Axis 1 of a delusional
008 disorder, persecutory type, although it may be a rule out
009 of delusional disorder at this point. Axis 2, I felt that
010 there is mental retardation, mild, which is present in DSM-IV.
011 Axis 3 there is nothing acute. Axis 4 was chronic
012 dissatisfaction with school program and his role in his
013 future and the school system. In addition, there seems lik
014 some fighting at home. I put his overall level of functioning
015 at a fairly low 35. He's not really able to provide for
016 himself or care for himself completely.

The presenter's tone is neutral and professional, conveying objectivity and confidence. The pace is not rushed, allowing the audience to settle in. This discourse is unmistakably biomedical with its highly conventionalized linguistic rituals, accompanied by progressive elaboration of a canonical speech genre, the "case presentation" (Atkinson, 1995). Although a few symptoms may reflect the patients own clinical

presentation or “chief complaints” most of what is discussed reflects the formal organization of nosology in terms of symptoms as criteria and the patients responses to a corresponding series of closed-ended questions designed to elicit symptom-related answers. This system, ostensibly, presents a “true” picture of the disorder, the perception of which is enabled by the psychiatrist’s expertise whose line of inquiry is objective and exact while the patient’s account of his illness is subjective and inexact. When a symptom is absent it is described as “denied” by the patient. The frequent use of the verb to “deny” casts doubt on the patient’s account of his illness while implying that the psychiatrist knows the “truth” about the nature of the patient’s illness. Metaphorically, the verb to “deny” intertextualizes the psychiatric consultative discourse with the legal discourse, inquiring and adversarial, rendering the clinical encounter even more contentious for the patient rather than offering the reassurance he was seeking.

Psychiatric discourse is largely “doctor-driven”, constructed within a precise, scientific framework that rarely gives the patient the opportunity to tell their own story. The patient’s “personhood” becomes an abstraction, lost in medical conceptualization and categorization: the employment of figures of speech that represent the patient as their disease, the use of “adversarial” metaphors which symbolically represent medical care as a battle between doctors and diseases, displacing the patient and the patient’s concerns. For the patient, this objectification amounts to dehumanization and disempowerment. It creates a strain in the doctor-patient relationship that can hinder care and compliance to treatment (Savett, 2002).

From a symbolic interactionist perspective, physicians are immersed in the biomedical culture, so thoroughly socialized during their long training that it has become invisible to them (Quinn, 2005). On the basis of the symptoms confirmed and denied, the psychiatrist proceeds toward constructing the diagnosis by seemingly abstracting the patient's voice and decontextualising events (Mishler, 1984). This inequality in mutual influence in the clinical encounter is surprisingly counter-indicative to symbolic interactionist views. The power exercised by the medical profession transcends human beings' natural propensity to affect each other bi-directionally.

After about twenty minutes of psychiatric case presentation, including medication prescription, the chairing psychiatrist typically indicates the end of his presentation by mentioning that there are cultural issues needing a closer look. At this point, he usually introduces the culture broker, informing the group that she had either conducted an interview with him and/or conducted some on her own. With this introduction, he signals that the meeting is about to take a "cultural turn" and hands the meeting over to the cultural broker. The next excerpt is a typical introduction from one of the 12 cases:

017 **Chairing Psychiatrist:** So I have proposed a team meeting
018 to discuss certain cultural issues and also figure out
019 how we can help the mother and the father just in ..
020 steering their son X in the proper path, how to help them
021 all feel more comfortable with X's limitations. And the other
022 thing that I thought about was .. maybe … to have the mother
023 assessed at some point for depressive disorder because she was
024 just so distraught and really didn't seem to be consolable in
025 the interview, and left feeling very low and angry.

Despite the focus being clearly biomedical at this stage, the initial presentations of all 12 cases show evidence of cultural sensitivity. The referring clinicians and the CCS director recognize that there are underlying cultural issues that biomedicine cannot explain for which they need help. This is indicative of primary agenda of the service and of professional self-reflection (or reflexivity) in recognizing their respective limits of cultural and systemic competence, displaying openness to alternative views and interdisciplinary help and professional humility (Tervalon & Murray-Garcia, 1998) in calling for cross-disciplinary assistance. The discourse is one of *repair* (Sacks et al., 1974) in which the psychiatrist indicates that the psychiatric history is incomplete. This sets the tone for interdisciplinary participation and knowledge exchange:

026 **Chairing Psychiatrist**: Also… we wanted to explore why she
027 may have been more open with you [the CB] than with us on
028 certain issues…and it may have been related to some of the
029 interactions with the people present during the interview.
030 And there were a few other points that we may discuss as
031 well about difficulty adjusting to life in Canada and the
032 illness presentation…it wasn't purely somatic it was a heavy
033 somatic presentation.<2> So anyway… with that I'll turn it
034 over to you maybe, and then after we can proceed and ask
035 questions.
036 **Cultural Broker (CB):** Thank you…I think…um…I will do my best
037 to clarify cultural aspects…I will not go over what you
038 have presented…

The exchange between the two is courteous, respectful and friendly—each marks off their respective professional territory and acknowledges the other's competence. The interactionist perspective would raise the question on the possibility that as early at this stage there is existence of mutual accommodation, ratification or consensus building between the cultural broker and the psychiatrist whereby divergent themes may be muted in an effort to establish and maintain a shared perspective.

Stage 2: Cultural conceptualization & formulation (30-40 minutes)

The second phase in the case conference is a presentation of case material by the cultural broker in accordance with the Outline for Cultural Formulation of the DSM-IV. The presentation follows the first four of the five sections described earlier in this text (see Cultural Formulation). In the following section, we describe how these sections of the Cultural Formulation frame the meetings and are used and interpret the team's discussion.

2.1. Cultural identity of the individual

The cultural broker's presentation focuses on the individual rather than the illness. It incorporates cultural elements not presented in Stage 1 and follows the Cultural Formulation guidelines such as the identification of ethnic and cultural reference groups, the cultural factors in development, the migration history, the level of acculturation, the degree of involvement with culture of origin, and host culture, language use and

preference, and religious and spiritual beliefs, when deemed relevant. From one of the 12 cases, the following excerpt illustrates some of these elements of identity:

```
039     CB: Mr. Y…um…he's from Singapore. And…um…it's a
040     very diverse cultural background and (  ) about
041     75% of the population is Chinese from China and
042     then…um…the rest are Malaysia and Indians; so Mr. Y
043     grew up in a very multicultural background, however
044     he emphasized Chinese culture is very important for
045     him, and in the Chinese community in Singapore they
046     have a…um… division between the English-speaking
047     Chinese and the Chinese-speaking Chinese.
050     The client associates himself with the Chinese group.
```

The identity of the patient becomes clearer with cultural features added to the presentation, contextualizing the individual. As during Stage 1 where only the voice of the psychiatrist is heard, the audience is very quiet, listening carefully to this new information. Symbolic Interactionism posits that members learn from talking to each other. Since the Cultural Broker is the only person speaking at this point, we surmise that the group members are incorporating this new information with the psychiatric clinical history using their respective disciplinary perspectives and clinical experience. This conceptualization process at this early stage is individual and internal since there is no verbal interaction with others.

2.2. Cultural Explanations of the Individual's illness

The Cultural Formulation allows the cultural broker to transfer her cultural knowledge explicitly. Setting the cultural stage, the cultural broker typically starts by identifying salient but general aspects of the Chinese culture deemed pertinent to the case. From another case:

```
051    CB: ..Um..There are 5 major relations in the Chinese
052    culture: One is the empire and the subject and the
053    people served in the empire; um…the second, is father
054    and son; the third is husband and wife; and the fourth…
055    um… is the elder brother and younger brother; the last
056    one, is friend and friend. You can see these
057    relationships, except friend to friend, (…) are constructed
058    in an hierarchical pattern, and the relationship rooted by
059    correct behaviour which include both rights and responsibility
060    for both parties.
```

These cultural generalities soon give way to a cross-cultural perspective. The cultural broker relates Chinese culture to the local context in accordance with the Cultural Formulation guidelines referring to predominant idioms of distress[2] and illness categories, meaning and severity of symptoms in relation to cultural norms, perceived causes and explanatory models[3] and help-seeking experiences. Below is a sample of this process

[2] In any given culture a variety of ways exist to express distress. Idioms of distress are expressive modes that are culturally constituted in that they initiate particular types of interaction and are associated with culturally pervasive values, norms, generative themes, and health concerns. They are cultural explanations in which the patients may articulate their experience of illness and at the same time evoke a response from caregivers who understand the help-seeking behaviour as a shared means of communication (Nichter, 1981)

[3] First developed by Arthur Kleinman (1980), the term refers to interpretive notions about an episode of sickness and treatment that are employed by all those engaged in the clinical process. Importantly, both carers and patients utilise explanatory models extensively. In particular, explanatory models address 5 aspects of illness: the cause of the

illustrated by an explanatory model of depression brought upon by de-valued social status and stigma:

061 **CB:** Similarly to Western cultures, in traditional
062 Chinese culture there are numerous… um… negative
063 stereotypes and metaphors of stepfamilies. Okay..so
064 ..One such metaphor is "used goods" (*yee sau for*)
065 to illustrate that second wife or husband is considered
066 to be *second best*. Divorce and remarriage shames the
067 whole family. The difference with Western culture, is
068 that in Chinese families,… the divorced status of the
069 stepmother..um.. carries social stigma and if she had
070 children, they are are looked down upon. The boys of
071 a divorced woman who remarries are called
072 "*yau ping chai*", and for girls are called "*yau ping nui*".
073 That means literally "*boy/girl of a greasy bottle*," which
074 means the offspring carries "grease" which will never be
075 washed away because the shame and filth of the remarried
076 mother will cast on her children forever… So to avoid
077 negative… labelling …… some stepmothers entered into
078 loneliness and social isolation, which resulted in poor
079 mental health…Um… This seems to be our client's situation…

---

condition, the timing and mode of onset of the symptoms, the pathophysiological processes involved, the natural history and severity of the illness, appropriate treatments for the condition. According to Kleinman, non-professional explanatory models tend to be idiosyncratic, changeable, and heavily influenced by cultural and personal factors.

Throughout the 12 cases, the presentation by the cultural broker is typically interrupted by questions or comments from the other participants involved in the case or familiar with the culture. This often takes the form of additional information obtained from the patients and their entourage or from other clinicians such as social workers and psychologists. The conversation gradually shifts to an open discussion. In the example below, a participant involved in the case introduces a symptom report made by a patient in the presentation of her illness and the cultural broker offers cultural explanations of its idiomatic use and its implications for help-seeking practices of the patient:

080 **Psychologist**: So… um… the eye problems began… had began
081 about 3 months previous to that, and they'd improved
082 a little bit since the emergency visit…she was seen by
083 ophthalmology in early November, but the exam was
084 reportedly unremarkable…"
085 **Chairing Psychiatrist:**" The emergency department did not
086 find an objective pathology on November 21st, although
087 they noted that she was in significant distress…"
088 **Psychologist:**"Well,you know… my eyes have been quite
089 shallow,"was what she said to me… um, like a presenting
090 problem…
091 **CB:** That's probably to describe "being tearful" in Chinese.
092 It's a very common expression. That's how they express
093 sadness, but there's no direct expression of the emotions
094 that caused the tears… Okay, so… um… the client knows it's
095 the psychiatric department, but the first thing she talked
096 about was her eye. Um… actually for Chinese people, other
097 cultures may have the same difficulties too… uh… to have

```
098        mental illness carries a lot of shame and guilt for a person…
099        for the family, you bring this to the family. So to somatise
100        the mental illness or her symptoms(…) to help her to overcome
101        those fears, I think that's one of the reasons. And another
102        reason is (…)in Chinese medicine, physical illness and mental
103        illness, the mind and the body is not totally separate.
104        We see… um… our physical health as very very related to
105        our mental health, to… a particular organ, or a part of
106        your body is related to part of the emotions… so it's
107        understandable that she put her physical health and
108        mental health together…[silence in the group]
109        Social Worker (SW): Interesting… um… 'cause by maybe
110        somatising, her help-seeking trajectory is to the ER but
111        it led her to psychiatry anyway or… instead, was it
112        intentional?…"
```

Pauses and silences at this stage are rare at this stage of group discussion. In general, there is an easy flow in discourse. Turn-taking to speak is respected, punctuated by neutral conversational markers, called "continuers" such as "Um", "Uh, huh", "you know" (Mischler, 1984; West, 1984). These encourage speakers to continue tentatively while allowing others to reflect. Members do not address their comments to any particular participant. They are rather participating in collective musing over the case: thinking, interrogating, and negotiating clinical meaning from cultural information. Cohesiveness and common understanding of cultural aspects of the case emerge from this exercise. It also expands the level of complexity of the case while increasing participation.

At this point, the various participants manifest differing levels of cultural competence vis-à-vis the background of the case, providing an opportunity to be exposed to a new culture and to learn a different worldview, as illustrated in the excerpt below:

113 **Chairing Psychiatrist**: You had a comment?
114 **Community Social Worker 1**: Yeah....Um…I don't believe
115 it is social phobia…
116 **Psychiatrist 2**: Yeah, It's less likely to be social
117 phobia, but social sensitivity.
118 **Community SW 1**: Yeah…Uh huh
119 **Psychiatrist 2:** It could be because of the anxiety or
120 it could be because of…
121 **Research Assistant: [** This social sensitivity she
122 had this in China as well?
123 **Community SW 2**: She's always been this way(…) She's
124 described herself as…uh…as always being…um…uh…socially
125 cold…yeah, cold to people
126 **Psychiatry resident 2**: **[**I just have a question.
127 It's a digression. Could this…uh…desire to not work,
128 could it be…you know…an idiom of distress?
129 **Community SW 1**: A what?
130 **Psychiatric Resident 2**: An idiom of distress.
131 **Community SW 1**: An idiom of distress.
132 **Psychiatric Resident 2**: I'll clarify (…)Um… Could it be
133 that… [choosing his words] it's an expression she uses…uh…
134 you know like…um… everywhere she goes you know people…
135 talk down on her...you know? She feels… uh… she feels
136 useless… you know? Without… uh… value in any way,

137 when she is… um… clearly qualified. So by saying that…

138 it's like… being she said "valueless",you know

139 **Psychiatrist 2**: **[** Yeah…I mean I would just start with the

140 basic notion that in her social background everybody can

141 judge and comment about her

142 **Psychiatric Resident 2: [** But what it implies is that

143 probably… she really doesn't want to work… work evokes

144 devaluation of self

145 **Psychiatrist 2**: **[** She doesn't want to.

Members' discourses overlap often, offering hypotheses, although there is no attempt at a full conceptualization because the explanations of the illness by the patients and their entourage are not obvious to team members. Collectively, the members attempt to unpack the patient's discourse, to put themselves in the proper cultural context, in order to uncover the possible significance of these explanations. At the same time, the team members try to assimilate the information from the cultural broker's presentation as well as expressions that are often unknown to the members: "Falun Gong"; "Qi Gong"; "Yellow River" or with evocative metaphors: "greasy children", "the Great Leap Forward"; and proverbs such as: "siblings are like the five fingers of the hand"; "those who work with their heads will rule while those who work with their hands will serve" ; or "being talentless is virtuous". The group's interest and curiosity are stirred, prompting many questions about their meanings that risk becoming detractions. The chairing psychiatrist, as group leader and facilitator, plays a crucial role in framing the discussion so that it stays at the level of cultural description and analysis but focused on the case ("Okay, let's keep those thoughts…let's move on"). According to symbolic interactionist

views, when context, meaning and activity meet, interaction between individuals takes the form of *interstimulation* and *response.* It could thus be argued that, at this stage, the cultural broker's introduction of new information enabled participants to form new, maybe common meanings and shift direction, values, or attitudes (Charon, 1998; Ellwood, 1939; Loconto & Jones-Pruett, 2006). This is an atmosphere conducive to transferring and exchanging experiences and knowledge.

2.3. Cultural factors related to the psychosocial environment of the patient

This section of the Cultural Formulation allows clinicians to collect information on stressors to which multi-ethnic patients are often subjected to and their reactions to these situations including: the impact of migration, acculturation, discrimination; the social supports available to them; their help-seeking pathways and the services they have used; and the contexts in which their levels of functioning should be measured (Mezzich et al., 1999). Below is a sample of how participants discuss these areas:

146 **Social Worker:** You know? It's a cross-cultural union…
147 there are reasons… that it may work but there are many
148 areas of… I mean… because if they really knew each other
149 at all… like she might be very demanding or depressive,
150 he might be very Muslim of a particular type and… you know…
151 **Chairing Psychiatrist:** So… um… so for her I think… um… she has
152 difficulty to… < 5 >.. give up her own culture. At the
153 beginning she felt… I feel she felt herself… okay… to be
154 in the relationship and forget about her own culture, but
155 after a while she finds it's not possible. Um… she feels

156 very repressed

157 **CB: [** The loss… um… loss of country, loss of friends…

158 appearance, one thing… identity… um… she can't deal with it…

159 um… but at the same time she can't give up this man because

160 this man is taking care of her…(…) And… um… and second thing

161 is about her ability to deal with *separation*… After she came

162 here… she can't deal with the separation with her daughter…

163 And then… um… she wasn't able to transfer her *vocational*

164 *identity*. Um… that makes a *big difference* because it's one of

165 the…identities a person can have…and you can't keep the same

166 type of job after immigration. And then in terms of

167 *social support*… um… her daughter is in China still, distant

168 relationship with her father and siblings…Um…as a Chinese

169 woman, it's difficult to connect with the people at

170 the mosque because most of them are Arabic people. And in

171 terms of *level functioning* and disabilities… um… in the past

172 it sounds like she was able to keep a job in the professional

173 level, but now she's not able to. Um… she loves her vocational

174 identity, financial independency and now she is on welfare…

175 uh… I guess she feels very *powerless* because of that and now

176 she wasn't… even not able to do a factory job… she tried but

177 she felt very nervous.

178 **Chairing Psychiatrist**: **[** …this does not bode well for social

179 support, here or back in China…

In the following excerpt from a different case, nonverbal cues, such as signalling or showing using hand gestures, deemed especially pertinent by the cultural broker, are singled out for discussion:

179 **CB**: …another point about level of functioning, I feel we
180 need to be carefully with his emotions. In Chinese culture,
181 it's very inappropriate to express strong emotions…(…)such
182 as grief…clients hold back emotions when meeting with
183 professionals. Not communicating emotions is to show
184 respect, to keep harmony with people, not to be extreme,
185 not to burden. So it's very easy for professionals from
186 other cultures to underestimate a client's emotional
187 suffering. If the subtlety of expression is not being
188 recognized…Um… Examples like…
189 **SW; [** so it's probably much more distress than he was
190 leading on…
191 **CB**: Uh,huh… like when, for example, you, Dr. X., asked the
192 client about his feelings towards the incident, he would
193 bring out paper cuttings, family photos, letters from the
194 school, and family photos (…) to show how good the family
195 life was, how good the children are in school, and the
196 newspaper cuttings show how traumatic his tragedy. So to put
197 two things together means the tragedy took away something very
198 precious from the client's life and he feels extremely sad…
199 yeah… um
200 **Psychiatrist**[completing CB's statement]: He doesn't have to
201 say "I'm extremely sad," he says, "Look at this. I know how I
202 feel; I don't have to tell you directly."
203 **CB:** Yeah… subtlety of nonverbals…

In the exchange above, the cultural broker is clearly the “voice of cultural authority”. The participants seem to implicitly understand why she chose to focus upon certain areas. They quickly take hold of her explanations and integrate the cultural information into existing elements of the case. Their comments or questions stem from the process of information integration. The cultural broker then ratifies their explanations or attempts at rephrasing points she made earlier, thus moving case formulation along cultural and clinical lines.

2.4. Cultural elements of the relationship between the individual and the clinician

Interactions between the patient and the practitioner occur in the context of a therapeutic relationship. The patient is seeking help but has little information about the care provider; the reverse, however, is not true. This inequality of power is rarely explicitly explored by clinicians, during the assessment stage, making this section, a unique feature of the Cultural Formulation. Attention to the dynamics of power in the clinical encounter may be an especially important addition to the diagnostic process when practitioners are dealing with individuals who have already experienced powerlessness in many other forms in their own cultures such as displacement, translocation, and exclusion. In all 12 CCS meetings, the clinician-patient relationship is the most consistently explored and discussed topic; it could be argued that, similarly to the psychiatric case history, with time, the systematic use of the CF as framework, groups such as the CCS produce their own ritualistic case discussion conventions. Below are illustrations of how this issue is addressed:

204 **Referring Psychologist:** Well, when I referred him here…
205 uh… it was basically because I was trying to help, and
206 it wasn't getting *anywhere* it seemed… during the sessions.
207 So… I was asking myself is there any clue about… uh… the
208 ethnicity or his… uh… being a Chinese man that could have
209 impede me from doing the best I could with him. Uh… and I
210 had that in mind, and I was thinking that maybe you could…
211 uh…give me some clue about where to go if it was the case.
212 And… uh… well, I also wanted to help him because I tried to
213 help him with the managing of his anxiety label, and he wasn't
214 responding as much as I would… uh… want from somebody like
215 him, because I had other people before, and they were able
216 to…to catch on and to apply things that I taught them, but
217 he wasn't. So I was asking myself is there any other things
218 that I should have done, or that I should do… and should I
219 be the one to do it. That was also a question that I had
220 in mind.

The CCS provides a forum where professionals can acknowledge their limitations, share constraints, and learn from others from other disciplines and institutions. Case complexity and professional self-reflexivity may be reasons why professionals who do acknowledge the scope of the case as well as the limitations of their areas of expertise or level of cultural experience are likely to refer cases. In the next excerpt, the patient-clinician therapeutic relationship is raised by the cultural broker in a direct manner, in contrast to her diplomatic manner in the previous sections of the Cultural Formulation. This shift in her behaviour may indicate that in her position as the expert in Chinese

culture, and having interviewed the client, this area of the Cultural Formulation is where the referring clinician needed the most information or was experiencing difficulty, explaining the shift in her delivery:

221 **CB:**…thank you… Um… But I will start with the dynamic
222 in the room first, and then we'll talk about all the
223 contents. I met with the interpreter outside because
224 she came early and then in the room with two Chinese
225 working women and one Chinese woman who is unemployed
226 and who is the one being helped, it might create pressure
227 to the client. Um… she is a visible minority, female
228 patient, with psychiatric problems. She can feel she
229 is in a very vulnerable and powerless position. And
230 she also can't speak the language very fluently. And then…
231 and as a Chinese client seeing A white Caucasian
232 psychiatrist…male… the power is very…
233 **Chairing Psychiatrist:** All the bad words… I was the token
234 white male in the room… [Quiet laughter from group]
235 **CB:** [tone is serious] Yes, for her…it's a bit… uh… extreme,
236 overwhelming. [With a smile in her voice] Yep, It's all your
237 fault…It's the culture/gender issue, language issue all
238 mixed together. Um… so the client felt quite powerless,
239 and I think that's one of the reasons why she presented
240 herself as very strong… presented the good side of what
241 she's accomplished, what her family's accomplished too,
242 but at the same time, with you, Dr. Y, despite the gender
243 aspect,it could still be good…uh… she may feel more safe
244 to have a social distance with you because you're not part

245 of the community so she feel… um…you can keep confidential,
246 that's the difference. However…
247 **Psychiatrist: [** That may apply to others,… to *you* anyway…
248 socially.
249 **CB:** Yeah, yeah, of course… but differently… the bad side
250 of it is… to have two Chinese women in the room…um…the
251 first thing she say… "Oh,I'm the one who needs help here"…
252 the presence of two other Asian women, working women,
253 contrast her problem… makes her problem look bigger… but
254 it could also be positive… um… for the first time she feels
255 more connected with somebody from the same culture…who can
256 interpret for her, who can understand what QiGong is all
257 about, understand what immigration is all about, what's the
258 pain behind all this… So this…not all bad…

In this discussion, participants are self-reflexive and recognize that gender and occupational power differentials are embedded in the wider socio-political forces, played out in the helping relationship. Issues of power are dealt with gentle, self-deprecating humor, a strategy initiated by the psychiatrist and picked up by the cultural broker and other participants. This does not diminish the importance of the subject matter, but instead allows sensitive issues to be discussed with safety.

While the discourse at Stage 1 of the case conference was biomedical, Stage 2 is cultural and psychosocial. Compared to the medico-scientific perspective of Stage 1, an emic view dominates as the "lifeworld" (Mishler, 1984) of the individual figures predominantly in case presentation and discussions. Just as the verb "deny" was evocative of medical power and knowledge, cultural metaphors such as "used goods', "second-hand

mother", "grease children" bring the patient's cultural world into the clinical discussion. The sections of the Cultural Formulation used by the cultural broker help participants, as indicated by the questions and discussions, collectively shift initial clinician-driven, symptom-searching view of the case to a patient-centered outlook where "symptoms" or "problems" are explained and discussed, couched in the patient's cultural, social and/or political contexts .

Stage 3: Overall cultural assessment and interdisciplinary negotiation (20 - 30 minutes)

The cultural broker usually signals the end of Stage 2 by stating that the formal part of her presentation has come to an end and soliciting questions. At this point, most members are ready to express their opinions. This stage of the meeting is framed by the Cultural Formulation's last section entitled "Overall Cultural Assessment for Diagnosis and Care" that allows for a summation of the significant issues discovered in the previous stages (GAP, 2001). The team uses this time to flesh out the information gathered, medically and culturally, to prepare for case conceptualization.

259 **CB**:... Um… I think I am done with my part… do you have
260 any questions or comments?
261 **Psychiatric Resident**: I have a question.
262 **Chairing Psychiatrist**: Sure.
263 **Psychiatric Resident**: You were describing *losing face*, uh…
264 a Chinese tradition and culture. I was using my own
265 touchstones, what I've learned growing up from my own
266 cultural tradition. I wonder if there are points or

267 anecdotes which would help me understand if there's a
268 qualitative difference in some areas or there is a disconnect
269 where there are some areas where losing face could be applied.
270 It sounds familiar when I hear it, it sounds more like there's
271 a greater sensitivity but I understand it but I'm wondering
272 what aspects may be non-familiar that I'm not understanding
273 By going through this..
274 **CB**: Um… I hope I understand your question. It's hard for
275 me to answer this question because I don't know how
276 different the concept of losing face in your culture
277 compares to the Chinese…I think if you understand his
278 wife's problem as mental illness (…) it is hard for him
279 to bring the problem *out* to the community onto his
280 friends. It's shameful.
281 **Chairing Psychiatrist**: It's bringing dishonour onto the
282 whole family this problem, not just personal pride.
283 **Social Worker**: But maybe one of the points to emphasise,
284 if I'm understanding this right, is that there is a lot
285 of focus on *her* mental illness but the truth is, as if
286 *he* lost face, (…) it took a lot of guts for these women
287 to harm his wife in his presence.. I don't know if there
288 would be shame associated with the fact that he didn't
289 act as any real protector toward his wife…
290 **Research Assistant:** When he was present, they didn't respect
291 the fact that he was there..they continued to do whatever
292 they planned to do. He lost face, of course
293 **Social Worker**: Right, right… So I'm thinking (…) His focus
294 that his wife has mental illness may be a bit
295 self-facilitating in a way or protective as much as it

296 still is a shameful thing. Just a speculation.

During this phase, there is a shift in group dynamics as participants “brainstorm”, manifested by an increase in energy and more involvement of the participants. Comments flow quickly; speech is faster, the tone, excited. In the next excerpt, culture has become the point of convergence without obscuring members’ respective disciplinary backgrounds:

297 **Medical Anthropology Graduate Student:**I don’t know about
298 China but I know in Iran and India and Pakistan, there’s
299 a strong belief that if the mother is very sad during
300 pregnancy or especially when she’s feeding the baby,
301 that’s going to effect the baby’s life, mother’s
302 depression is passed onto the child.
303 **Chairing Psychiatrist**: It’s probably culturally constant
304 **Medical Anthropology Graduate Student:** I think there is,
305 I mean I don’t know, theoretically the hormones that are
306 created through stress or depression could have an effect.
307 **Chairing Psychiatrist**: But it’s an open question still,
308 basically. We don’t know, it may be.
309 **Psychologist**: [There’s no evidence.
310 **Chairing Psychiatrist**: [We don’t know.
311 **Medical Anthropology Graduate Student:** There are cultural
312 morals whether it’s real or not.
313 **Psychologist: [**…and there’s absolutely no evidence.
314 **Medical Anthropology Graduate Student:** But it is real,
315 Like if the mother is very depressed, can’t do anything

316 and so she neglects her pregnancy, it's *real*. < 3 >
317 And if depressed people abuse substances, then of course
318 you get into a whole other thing.
319 **Psychologist:** It's the behaviour, but also the question
320 that, I think, we have to look at, is her ability to
321 nurture and have abilities because she's really upset.
322 So I think this is an important issue.

In the course of conceptualization, the clinicians negotiate emergent meanings from their respective disciplinary lenses. Their discourse underscores ontological differences and creates tension. Symbolic interactionist theory would posit that this energy is creative and translates into advancing knowledge, deepening mutual learning across disciplines while enriching the conceptualization layers of the case.

As group members' participation rises, discussion turn-taking is ignored; there are many interruptions and simultaneous utterances. As conceptualization of the case becomes more involved, elements presented in Stage 1 are brought into the discussion. Often, in light of the cultural aspects presented in Stage 2, the diagnosis is reviewed by team members. When opinions differ, the discussion turns into a negotiation across disciplines:

323 **Chairing Psychiatrist**: Ok, so with regard to the earlier
324 diagnosis, it's kind of sad, I mean the boy's very young
325 he's 13 and has a psychotic episode already. And it was
326 without question.
327 **Female Social Worker:…** that it was a psychotic episode?
328 **Chairing Psychiatrist**: Yes, clearly he is heading for

329 a longer course of mental illness…

330 **Female Social Worker:[** It's very interesting because now

331 he's been without any psychotic symptoms. He's on medication.

332 I'll see through the summary if he's diminished the medication

333 to see if he's still without symptoms but he's been with no

334 symptoms for many months now so he did stay quite a long time

335 in the hospital, so though it's less of the common diagnosis

336 but it couldn't have been a brief psychosis because it lasted

337 too long. Could it be just *one* episode? …Of course, I'm not so

338 sure but …I would say he got better without any symptoms but

339 sometimes we find him fit a few symptoms here and there after

340 the episode so it was a bit hoping… there is stress of the

341 newly arrived… family psychoeducation…

342 **Chairing Psychiatrist**: **[** We'll see.

343 **Female Social Worker:** *"We'll see?"* but… of course it is at

344 13 years old to have a first psychotic episode is quite

345 recent.

344 **Chairing Psychiatrist:** Do you do in-patient work at

345 Hospital XX?

There is advocacy for the absent patient in the social worker's challenge of the physician's prognosis of illness chronicity. While she can support her argument with her observations and professional opinion, professional hierarchy and gender dominance undercut the effectiveness of her negotiating attempt. The psychiatrist's tone is firm, authoritative. His sentences are declarations of fact. In contrast, the female social worker's speech is oblique; she couches her scepticism with a preface marker *("It's very interesting")* followed by questions and self-deprecating turns *("Of course, I'm not so*

sure"). By hedging, she conveys her limited diagnostic experience as well as her timidity in crossing disciplinary boundaries. She weakens her argument while leaving herself open to be contradicted by the psychiatrist, who, clearly irritated, challenges her credibility by asking her about her inpatient experience — presumably a place where one would learn about psychotic disorders. He, thus, implicitly raises a question about her competence to challenge his diagnosis and prognosis. Interestingly, during this interchange, no other member intervened. One interpretation of the silence is that it is tacit acceptance of medical hegemony, undisputable, at least where diagnosis is concerned. Alternative interpretations may also be fear of antagonizing the team leader, or performative acquiescence, which may be followed later by tacit (or overt) resistance. Underscoring these interpretations is the overall tone of the meetings and the dominant role of the team leader.

The next excerpt from a different case depicts another cross-disciplinary re-negotiation of the facts, this time behavioural, in which participants piece together and reconstruct the patient's predicament in light of psychosocial and cultural information that may contradict the initial clinical information:

345 **Chairing Psychiatrist:** The report says he admitted doing
346 this since the son came home from the hospital, that's what
347 it says here, but it must have happened before the son was
348 hospitalized as well. This is an ongoing pattern; sometimes
349 he loses control and slaps the child.
350 **Postdoctoral Fellow:** Um… My feeling is that… I don't know,
351 it's funny, that's interesting… is the multiplicity of stories
352 when patients go through the system, I think what is reported

353 here is, he did it *before* hospitalization, when his son was
354 hysterical, he slapped…to calm him down…
355 **Chairing Psychiatrist: PHS:** Before the hospitalization?
356 Is that what you remember?
357 **Postdoctoral Fellow:** Because there is no story of tantrums
358 since he's been *out* of the hospital.
359 **Visiting Scholar: [** Yes, that's my impression too.
360 **Social Worker**: My own feeling is that it's reported
361 *as if* it happened again. I mean, I have difficulty saying
362 that this man would often lose temper.
363 **Postdoctoral Fellow:** I met them both and saw them in their
364 home and it was an hour and a half interview and they were so
365 *unbelievably* sweet.
366 **Social Worker**: I've seen many times a relationship with his
367 son and he's trying always to accommodate, very careful.
368 **Postdoctoral Fellow:** They watch him everywhere he moves,
369 my impression too is that, if anything, they're so concerned
370 about their son…
371 **CB:** Um… yeah… Chinese people, in fact Asian people, when
372 Speaking English, they tend to use present tense… when it's
373 in the past… it's dangerous this misunderstanding… the
374 assumptions that he still abuses his child…
375 **Chairing Psychiatrist**:…When there is context…(it)seems
376 clearer

Here the postdoctoral fellows, researchers. and social worker's testimonials contextualize the situation, overruling the information in the medical chart from which

the psychiatrist drew his information, illustrating how cross-cultural misunderstandings can lead to confusion over the facts.

The tentative, hesitant and deferential style of talk (“*I was just curious”, “It’s funny”, “I don’t know*”) establishes a non-threatening tone, facilitating participation, and inviting differing points of view to advance the case formulation. From a symbolic interactionist perspective, this tentative style may be important for the process of Stage 3 because a rich case conceptualization calls for active member interaction. From this exchange, the case presentation, not only disputes information in the patient’s medical record, but is no longer based on one individual practitioner’s personal testimony alone. It incorporates a number of discursive strands, including those of the patient’s and the non-psychiatric professionals involved in his care.

After 20-30 minutes of this type of exchange, the chairing psychiatrist signals to the group, still in animated discussion, to move on (“*Let’s take a few minutes to try and come up with some treatment ideas”).* This typically brings the lively talk to an end. As a transition to the treatment recommendation stage, the psychiatrist summarizes the key points discussed in this stage and the previous ones. This excerpt is representative of conceptualization at end of Stage 3:

377 **Chairing Psychiatrist**: Let me talk about this thing
378 about social support and shame. . .
379 Although the couple has made Chinese friends from the
380 same hometown, they don’t feel their friends can accept
381 their having a child being in such a bad financial condition.
382 < 3 > The worries of not being accepted by friends contradict
383 with Ms X’s beliefs that her friends in her French class

384 support the idea of her having a child, so she has a lot of
385 these things, inconsistent, you know she's distressed
386 and conflicted. The couple cannot accept to be on welfare,
387 they think that Chinese people would talk about them:
388 "Since we cannot support ourselves and the baby, why we live,
389 why we have kids," is what she said. If the couple is on
390 welfare, Mr Y feels inferior if he's compared with other
391 people. Most Chinese people try to deal with problems
392 without seeking professional help. < 3 > Traditional Chinese
393 families usually seek help from the family members first
394 because it is considered to be a collective responsibility
395 of the family to take care of each other. Keeping problems
396 from outsiders is a result of fear of shame, guilt and
397 stigma that may be brought up on the family. It's commonly
398 believed that it is a shame to rely on someone else or
399 be a burden to society.
400 Although the social assistance could be a temporary
401 solution, it will bring dishonour upon themselves and
402 upon their families. Being on welfare shows that the
403 family failed to support its members. Because of the shame
404 feelings the couple would further isolate themselves from
405 their own community to avoid shame and embarrassment
406 feelings among their friends. That's her take on
407 it anyway, so I'm not sure what it will be like when you
408 meet them next. They may be very desperate. "hh"s". .

This is a sharp contrast to the discourse in Stage 1. The chairing psychiatrist's style has changed from curt and constrained listing of symptoms and signs couched in

tradition of diagnostic categorization to an insightful narrative where different accounts and opinions for different sources are interwoven, particularizing the patient's social situation. His assessment has shifted from an individual focus to a relational focus. The richness of the formulation of the patient's experiential and socio-cultural worlds summarized from the group discussion is a testament to effectiveness of the interdisciplinary consultation to bring issues of culture and context to clinical attention. Symbolic interactionists would explicate this phenomenom to "situatedness"[4] where the psychiatrist's own experience evolved from diagnosing alone to giving a case summation where multiple disciplinary voices were heard. The Cultural Formulation provided a framework where through extended discussions and meaning constructions an individual endeavour was transformed to a collective endeavour.

Stage 4: Interdisciplinary Deliberation of course of action (15-20 minutes)

In Stage 4, participants from each discipline contribute ideas to the treatment plan and recommendations for follow-up. Consequently, the treatment plan may reflect social and cultural dimensions highlighted by the models of the respective disciplines, including, for example, an acknowledgement of the intrinsic help-giving networks that are more suitable and meaningful to the patient. The following excerpts are drawn from all different cases:

409 **Excerpt A**

410 **Medical Anthropologist:** If it fits with his beliefs,

[4] For Symbolic Internactionims and Cognitive Systems, it is the interplay between agent, situation, and context (divided into inter- and intra context) (Gusfield, 2003; Rohlfing et al., 2003).

411 it seems reasonable, not to mention, supportive to let
412 him use both types of meds (medications)
413 **Post-Doctoral Researcher**: Were you thinking of a herbalist?
414 I'm thinking that he… uh… he can check the legitimacy of
415 his other pills
416 **CB:** Yeah … we had called on a herbalist before…

417 **Excerpt B**

418 **Psychiatric Nurse:** What do you think about the meds?
419 I mean I have nobody to reassess her… right now, I know
420 Your role Is consultative only but you think that you could
421 continue…
422 **Chairing Psychiatrist**: Yeah. You're going to be by yourself
423 On this case?
424 **Psychiatric Nurse:** Do you think that she would benefit… I mean
425 she doesn't wantmore meds at this point. I offered her the last
426 time…we can arrange another meeting with you present
427 **Chairing Psychiatrist**: **[** Yeah, good. . Is she suicidal? […]
428 I would stay on then.

429 **Excerpt C**

430 **Medical Anthropology Graduate Student:** Could you explain again
431 how Qi Gong might be therapeutic…?
432 **CB:** Uh… Tai Chi… for instance is to maintain good health (…)
433 Qi Gong is more to improve bad health, for healing… for medical
434 purposes
435 **Psychiatrist:** What's a little worrisome in this case is that
436 she's using Qi Gong curatively… a little bit. She's trying to

437 recover from eye pain through practicing this preventative
438 style or this preventative philosophy
439 **Psychologist 1:** For the eye pain, no,… but the depression
440 Might be very well treated… actually… I would think by…
441 to be in a focused meditation, to not be thinking about
442 her problems being in a structured discipline for many
443 hours a day, I mean it's a little overkill, but I can see
444 that it might have some positive effects on her.
445 **Psychologist 2:** Yeah, I think so. And I think that if we
446 have a chance to see her again… it's very important to
447 validate her way of treatment… practicing QiGong…
448 keep on doing it, it's very good for you plus *coming here*.
449 Actually one way to engage her… I don't know, let's ask her
450 to come and to tell you what is Qi Gong all about.
451 "How is it helping you?"

Discussions and suggestions are made principally to ensure that the modalities of care chosen are realistic and aligned with the needs of the patient and to the care already provided. Where Stage 3 involved brainstorming, focused on problem conceptualization, Stage 4 centers on solutions for treatment. The discourse therefore is less exploratory, more pragmatic and, given the paucity of resources in community and public mental health services, more sobering. In most cases, the treatment plan is multimodal and holistic, including biomedical and alternative treatments, that address the patient's spirituality needs as well as outreach to cultural community groups:

452 **Medical Anthropology Graduate Student:** I was just curious

453 about what you mentioned that she started to go or her
454 daughter started to go to a Protestant church. What was
455 the name of this church? Because sometimes from my own
456 kind of research that I've done I see that many Chinese
457 people use the Protestant church where they speak Mandarin
458 as their social network. Then there is a lot of moral
459 support. So I don't know, she mentioned, I mean I don't
460 know what was the role of the church, but she might find
461 some kind of similar support.
462 **CB:** Yes, yes, that's a good idea, if they find a Chinese
463 church.
464 **Psychiatrist: Wasn't it a Chinese church there?**
465 **CB:** I don't… oh, yes… there is an English church…
466 but for Chinese

In this stage, the shared understanding about the patient emerges out of the interactive sequences. Indeed, it can be argued that here, because the CCS is a consultative, clinical service, backed by medical authority, 'decision-making' is not the prime function of the spoken interaction. Rather than simple 'decisions', we have here a set of interests concerned more centrally with *authority* and *responsibility: Team members, including the chairing psychiatrist, share with each other their respective professional rights and authority to offer valid treatment instructions or plans whereas it is with the chairing psychiatrist, as head of the CCS service, and as a medical professional that lies the obligation (responsibility) to achieve certain objectives. Thus, r*ecommendations are interdisciplinary but the chairing psychiatrist has professional and institutional responsibility for the consult:

467 **Social Worker:** Her disability company… they want her back to
468 work, but I think it would be disastrous if she's going back
469 there.
470 **Visiting Post-Doctoral Fellow**:…bad, bad idea… couldn't Dr. Y
471 write a letter stating that this is a consequence of something
472 that happened at work and she should *not* go back...
473 **Psychiatric Resident**:…our report will mention that
474 specifically that she shouldn't go back. It's *clearly*
475 a case of racism and phobia…I think that it was traumatic
476 for both, the couple… it's a very simple thing to do our
477 recommendation
478 **Chairing Psychiatrist**: Yeah, we can write, I will let Dr. Y
479 know that, that she should do that.

In the progression of the case conference from stages 1 to 4, narrowly biomedical frameworks and mental health disciplinary compartmentalization have been augmented by the integration of cross-cultural knowledge, cross-disciplinary ideas and attention to social contexts. In the course of this discussion, clinicians become aware of cultural practices and treatments that can complement the curative process or hinder treatment. In one of the excerpts, the group considers the roles of Tai Chi and Qi Gong in the lives of a patent and concludes that their impact is neutral or positive. The conclusion requires no intervention. A practice could also have a negative impact, whether biomedical or socio-economic and could require intervention for treatment to succeed. These determinations challenge the objectivity of members, requiring the group to evaluate activities outside their normal frame of reference.

Stage 5: Wrap-up (5-10 minutes)

Before ending the session, the chairing psychiatrist asks the referring parties if they have anything else that needs addressing. At this point, they often respond by asking questions for clarification on issues previously discussed, on the procedure for reports procedure, or by thanking participants for their help. The following excerpt is an illustration of a typical closing of CCS meetings:

480 **Chairing Psychiatrist**: Well, I think we're covered most
481 areas that needed more exploring…Do you have anything
482 else you would like to address?
483 **Social Worker/Referring party:** Thank you, I appreciate
484 meeting with you, your team and the fact that I can
485 consult with someone else.., but I tried to plow along as
486 best as I could…I tried very hard, I felt there were moments
487 where I was almost feeling despair, because I thought they
488 might do something drastic, that's when I called you,
489 "help, could you please see them?" …now, we'll see if we
490 could help reach a compromise or solution that they felt
491 they could save some face and her also
492 **Chairing Psychiatrist**: Yeah, but probably you may have helped
493 them get to this new equilibrium before we came into the
494 picture, because if you think about it, the parents have
495 moved quite a bit, following the work you've done with them
496 **Social Worker/Referring party:** Still, I think you addressed
497 some of the issues that I did have questions about…like could
498 there be some other motivation also for coming to Canada?

499 I think you helped a lot with what you offered.

500 **CB**: Maybe for her now is more settled, she is able to live

501 with it for a while.

502 **Social Worker/Referring party:** If they were to want to

503 consult again, would you be available to meet with them again?

504 (…)I will certainly be available to them. And I think what you

505 have shared with me is very helpful

506 **Chairing Psychiatrist:** Of course.

507 **Social Worker/Referring party:** Can I get a copy of your

508 comments?

509 **Chairing Psychiatrist:** Oh,yes, we will send you them as a

510 report, mine and XX's (the CB's) cultural formulation.

511 **Social Worker/Referring party:** (Tone of relief) *Thank you*,

512 I've learned *so much* about them, it'll help in establishing

513 a connection with them, things can happen. They do trust me,

514 they certainly do. I'm not saying that I'm ready to have

515 another couple [General laughter]… but they are very likeable.

516 Well, thank you very much, everyone.

517 **Chairing Psychiatrist:** Thank you everyone.

[The meeting breaks-out with sounds of casual talks…

The tape is shut off]

With a question addressed to the referring party, the psychiatrist gives the social worker the opportunity to bring up unexplored issues. By choosing to express remnants of the anxiety she carried while struggling to understand the case on her own ("*I tried to plow along…I tried very hard…I was almost feeling despair*"), the social worker is using "repair" talk that serves as a "closure" in that she expressed relief and thus satisfaction in the advice she has received from the CCS participants, even if she recognizes the

ambiguity and dilemmas in the work left to be pursued. After over an hour of intense discussion and sharing, her self-deprecating humorous note in closing and the collegial laughter received in response, validate their mutual appreciation and support. For the CCS participants, accustomed to patient care after conceptualization, the end of meeting often means an end of their involvement in the case. They may *not* experience closure but rather a sense of unfinished business. In this example, the psychiatrist closes the meeting by informing the social worker that she will receive a formal report with a cultural formulation, confirming that the consultative process has not ended.

Discussion

According to Mead (1938, p.641), "[W]hen things get together, there then arises something that was not there before." When living forms interact with their environment, new objects emerge.

The study of the 12 CCS case conferences show that they are structured by (i) presenting the conventional medical-psychiatric history followed by a separate cultural formulation; (ii) following the DSM outline for the cultural formulation as a kind of agenda. Although both would seem to be potentially highly limiting frames, they nonetheless contribute to valuable shifts in the process of the interdisciplinary exchange.

In Stage 1, the discourse of the psychiatrist in the presentation of the clinical history is predominantly biomedical It reflects what Aspach (1988) calls the "de-personalisation" aspect of medicine and what Foucault (1975) calls "the clinical

mentality". These terms refer to the technical and scientific framework within which Western medicine has developed its code of conduct as well as a range of practices and treatments. The case presentation gives a glimpse of one of these practices, the psychiatric interviewing processes, that Kirmayer (2005) has suggested to be fundamentally one of "essentialising" symptoms with the goal of disorder classification. For this purpose, questioning is often conducted so that only the psychiatrist determines whether patients fall inside or outside the pre-determined boundaries of a psychiatric diagnosis, thus discounting any other factors not included in this system. The traditional psychiatric interviewing process uses language based upon tacit and subtle assumptions that serve to impose beliefs and values concerning patients, medical knowledge and practice. It could be argued that this is psychiatrists' training to fulfill their job for which respect and power are reserved for scientists who can "fix" diseases (Maback & Oleson, 1997). Symbolic interactionists would counter argue that it does not however diminish its iatrogenic effect in its attempt to cure. By using the verb "deny" repeatedly when referring to the patient negative answers to his questions, the psychiatrist questions the patient's account of the relevant facts, indirectly judging him, imposing on the patient his medical worldview. Although this verb may not be used in the presence of the patient, it has the effect of diminishing, if not discounting, the patient's account of his experience. This common locution in medicine reflects a larger "hermeneutic of suspicion" conveyed unconsciously to a multidisciplinary audience who does not ascribe to the same discursive vocabulary. It establishes the atmosphere in which the client will be discussed. This reductive interviewing technique may be even more depersonalizing and intimidating in a cross-cultural clinical context where communication between patient and clinician is

difficult due to linguistic constraints and differences in cultural background. The blinkered clinician is less likely to get his diagnosis right in a context he does not understand. But the psychiatric clinical history, in its conventional form, is still the starting point of a cultural consultation, confirming the presumption and legitimacy of psychiatric authority.

In Stage 2, the culture broker's discourse is predominantly cultural. She uses the adapted CCS version of the Cultural Formulation to guide her interview and, later, to substantiate the information gathered from the client with research of her own as well as her own cultural experience and knowledge of the Chinese culture. Thus, without conceptualizing the case, she presents the team with rich information about the patient's and family members' accounts of illness underpinned by and embedded in the Chinese culture. As consultant who has worked repeatedly for the CCS, she functions as a linguistic and cultural bridge (Singh et al., 1999) while having the unique position to interview the patients using the Cultural Formulation and to present them in this format, not as an authority, but in the spirit of *knowledge transfer*. Although this concept is usually reserved to scientists trying to apply the products of their research, Graham and colleagues (2006) would agree that the cultural broker's work with the group would qualify as part of transfer of knowledge because of her "approach that *systematically* capture, collect and share tacit knowledge in order for it to become explicit knowledge" (p.15). Her role as culture broker and her use of the Cultural Formulation "synthesized, adapted and presented essential information, which previously was known only to herself" (p. 15) and place her in the role of educator as described in the knowledge

transfer literature (Arredondo et al., 2006; Boydell et al., 2008; Graham et al., 2006, 2007; Hall et al., 2001). In this role, she provides a mediating influence that allows this "culturally-sensitized" group to cross professional and disciplinary boundaries by weaving in other relevant information of the person's lifeworld, seamlessly re-framing their collective, clinical gaze of the case toward a cultural, psychosocial perspective. Mead (1938) and colleagues (Blumer,1969; Cooley, 1998; Goffman, 1956; Yeung & Martin, 2003) would explicate this situation interactionally that as reflective animals, human beings interpret situations and respond in creative and unpredictable ways. Central to symbolic interactionist's view of the human subject is the idea that everyone is a *meaning-making* person. Human events and objects have to be understood and interpreted. Even the situation to which people respond is a matter of interpretation, as ethnomethodologists have underscored earlier and cognitive sociologists have shown (e.g., Cicourel, 1973; Garfinkel, 1969; Gusfield, 2003). Events, objects, and situations have a multiplicity of possible meanings; their character cannot be assumed by the observer—the researcher. The observer cannot simply *assume* the meaning or meanings a situation has for the subject. To study human behavior, as the perspective teaches, the observer must, as much as is possible, "take the role of the other," try to see, as much as possible, from the other's perspective (Gusfield, 2003, p.122). Human beings interpret events and objects and situations and respond to their interpretations.

The cultural perspective of Stage 2 enables much greater interdisciplinary interaction in Stage 3. While assimilating new cultural information, participants negotiate meaning along multidisciplinary paradigmatic lines. While anchored in their respective disciplines, they acquire the attitudes and abilities needed to collaborate. The social

worker questions the psychiatrist's prognosis; the psychologist challenges the medical anthropologist on a clinical impression. Disciplinary rivalries persist, but the participants, guided by the Cultural Formulation patient-centered framework, manage to focus on what is preferable for the patient and for the referring party. Guided by this framework, they avoid a battle of competing discourses. Thus, participants communicate and negotiate different systems of meaning, incorporating the psychosocial aspects without discounting the biomedical while deepening their own level of professional self-reflection. This natural coordination and the collaborative problem-solving fosters true "*knowledge exchange"* (Graham et al., 2006, 2007). Members produce and apply existing or new knowledge in ways that foster mutual learning. For symbolic interactionists, this context of knowledge exchange is called *situatedness* in which participants respond to the experience of those around them, as well as reflect on their own (Mead, 1934; Gusfield, 2003). The concept of "situatedness" proffers that change and continuity take place in a context in which the person takes account of his or her interpretations of the persons, places, and events in which the knowledge exchange and learning occur. In assimilating new knowledge, discussing the case from the perspective of the patient's experience and cultural background, participants connect. They intercontextualize. They ground their discussions on the structural, sociological, cultural and political context in which their work and their clients' lives evolve. This case conceptualization starts out as multidisciplinary but ends up being interdisciplinary, the result of recognition, utilization and integration of the expertise and perspectives of the different professions represented in the room (Rosen et al., 2005). Pluralistic disciplinary silos crumble, enabling more flexible, integrative clinical analysis.

In Stage 4, the discourse focuses on the development of a treatment plan. Discussion is oriented toward the goal of integrating the respective knowledge and experience of various rehabilitative methods or resources best-suited for the care for the client. In the terms proposed by Graham et al. (2006, 2007) this process of ethically-sound application of knowledge with a common goal is a form of "*knowledge translation"* (p.15). The participants discourse involves a collaborative process of identifying and aggregating potential solutions for the purpose of improving the patient's treatment or "rehabilitation." In addition to refining the "medical" intervention, the participants focus on the "psychosocial" services available in the client's community, on a culturally-appropriate comprehensive approach to intervention. This interactive, adaptive process is known by symbolic interactionist researchers as *emergence* (Blumer, 1969; Gusfield, 2003; Joas, 1996; Maines, 2001; Mead, 1934; Mihata, 2002; Perinbanayagam, 1986; Saxton, 1993; Snow, 2001). It defines how individuals, small groups, communities, and collectivities alter their plans of action and change the direction and pace of activity after having detected change, redefined premises and created new meanings (Saxton, 1993), meanings that should be more accessible to the clients, their caregivers and other people in their support networks.

In Stage 5, the chairing psychiatrist's announcement of the end of the meeting brings the participants back to the context of time and place. The end of the meeting reminds the participants of the CCS's consultative mandate to provide guidance to culturally pluralistic, complex, psychiatric cases involving many stakeholders. It moves

the group from the case conference context to institutional and procedural contexts underpinning the clinical and consultative process that has just taken place, illustrating an entextualization of the micro/macro interplay of face-to-face relations and structural contexts (Silverstein & Urban, 1996; Yoel & Clair, 1995).

Historically the psychiatrist has been the pre-eminent mental care professional, to whom multi-disciplinary teams deferred (Bennett, 1988; Rosen, 2005; Sims, 1989). The results of our study show a different model at work. Despite the fact that the clinical director of the CSS is a psychiatrist, the structure of the meetings framed by the Cultural Formulation moves the clinical discussion from an emphasis on biomedical diagnostic issues toward a focus on social and cultural issues. This shift allows the participants to move from deference based on professional status (primacy of the psychiatrist) to deference on what appears to be a promising course of action for both the referring party and his or her patient, regardless of its proponents' discipline or status. The course of action suggested may not be optimal but has an explanatory, grounding blueprint value for the referring party for continuing dialogue with the patient. Less tangible but transcendental of the group interaction is the support extended to the referring party, a conception of human action, from symbolic interactionist perspective, a humanistic thrust (Gusfield, 2003), that emerged from the meaning of the relation between the participants and the social act (here, the cultural conceptualization) and not as a simple response of the participants to that act. This thrust is expressed both in action and through language as illustrated by the extract of the referring party's effusive appreciation of the participants' contribution to the elucidation of the case. It needs to be underscored here, that for Mead

(1934), language derives not from communication alone, but also from the indispensable part that it plays in the emergence of human sociality.

Throughout this process, the CCS team's leadership provided by the psychiatrist is essential. He encourages participation, shows respect for their input and expertise in identifying the problem most appropriate treatment plan. These actions demonstrate clinical, cultural and managerial competence – all likely prerequisites for the successful application of the Cultural Formulation. Despite the leadership role still residing with the psychiatrist, the use of the Cultural Formulation framework as an agenda for the CCS case conferences shifts the dynamics in three important ways:

(1) By facilitating knowledge transfer, exchange and translation across disciplines and the emergence of a transdisciplinary language in cultural competence;

(2) By allowing the construction of new types of meaning that transcends the narrow frame of disease or disorder-centred psychiatric diagnosis and assessment; by providing a place to systematically introduce different perspectives and levels of description;

(3) By facilitating a process of power sharing that alters the traditional hierarchy in multidisciplinary health teams (Fichtner et al., 2000; Liberman et al., 2001; Rodenhauser, 1996; Rosen & Calally, 2005; Slade et al., 1995; Vinokur-Kaplan, 1995; Wells at al., 2005); by giving a place for non-psychiatrist/non-medical speakers - including the patient's voice by proxy - and valuing their alternative views of the case.

This study has limitations. The sample size of the cases is small. Several criteria of an appropriate conversational analysis are applied: recordings, standards of transcriptions, full transcripts available for review, procedures for interpretation. On the other hand, only the first author (NMHD) has studied the data in its entirety. This analysis has not been validated by multiple observers. Nevertheless, the study benefitted from the partial review of the data by the other authors as well as their contribution to the procedures, methodology and theory applied. The choice of all 12 cases seen by a single culture broker avoided potential cultural bias and the first author's clinical and cultural expertise in Asian culture facilitate the close analysis of the case conference process. This work needs to be replicated and extended with larger case series involving multiple culture brokers and patients from diverse cultural groups.

Conclusion

Diagnostic evaluation is the entry point of professional intervention in the mental health process; it provides the information base for subsequent clinical care. Through the use of the Cultural Formulation, this study demonstrates the critical role of culture and how it should be an integral part of psychiatric consultation, from interview to case conceptualization, diagnosis and treatment of culturally diverse individuals.

In the 12 CCS meetings analyzed in this study, the sections of the Cultural Formulation provided a rudimentary structure to the case conferences that allowed social, political, cultural and personal issues to emerge from the report of the previously conducted interviews. This added frames put institutional medical discourse in context,

reducing its dominance, and associated bias that might have dissuaded sharing inconsistent information or alternative perspectives. The Cultural Formulation provided a framework within which to “construct” the patients’ lifeworld and their experience of illness, deconstructing monolithic medical “truths”. It also provided a space for disciplinary pluralism, allowing multiple professional points of view at the critical assessment stage that might otherwise be dominated by or exclusive to psychiatry.

The meetings indicate the possible evolution from interdisciplinary to transdisciplinary teamwork, from cooperation among disciplines to patient-focussed collaboration utilizing a common language in the conceptualization of that patient’s needs. In this “transdisciplinary teamworking”, as identified by Opie (1997) and Onyett (2003), participants attain a significantly higher level of work integration, a shared vocabulary and a treatment plan better adapted to the patient’s cultural and psychosocial context.

The study in Article 2 further indicates the usefulness and the relevance of the Cultural Formulation as a tool for consensus formulation. As an assessment framework, it allowed the participants to identify community resources and caretakers to assist in the healing process, alleviating the burden upon traditional Mental Health professionals.

The Cultural Formulation helps narrow the gap between Dilthey’s concept of Verstehen (understanding) (1911) and Weber’s Wissenschaft (science) (1922) by providing a framework for interdisciplinary collaboration and unity in assessment work. It introduced the humanistic side of work in mental health and psychiatry that challenges, instructs and enriches our capacities for self-reflection, interpretation and imagination. It provides a context enabling professionals to grasp a pluralistic world, to see alternatives

to the conventional and bounded views that would otherwise emerge only from their more limited personal experience and professional bias.

The CCS approach appears to have fostered knowledge transfer, but more study is required. Arguably the perceived improved medical care of the studied patients resulted in part from the greater attention given to their individual cases, elevating the patients' clinical status, enabling better social outcomes. The assessment of consultation outcomes made difficult by the great heterogeneity of cases seen and the indirect effects of the time-limited consultation on the long-term outcomes. Unfortunately, there is a dearth of research evaluating the effectiveness of multidisciplinary mental health team approaches such as the CCS team (Burns et al., 2004). Limited resources constrain its use. More research is required to evaluate its treatment efficacy and its cost-effectiveness before one can expect the process to become widespread.

CHAPTER 7
GENERAL DISCUSSION

The case conceptualizations produced by the use of the Cultural Formulation in both Articles 1 and 2 made sense of patients' often puzzling or disturbing symptoms and behaviours by placing them in social and cultural contexts. This helped clarify the patient's predicament and increased the clinicians' empathy for the patient. Whether used as a tool for case studies or as a framework for multidisciplinary assessments, the Cultural Formulation revealed the complexity of the case. It transformed clinician's frustration into an appreciation of the intellectual and professional challenge, increasing clinician's interest and motivation to remain actively involved.

Both articles focus on the deficiencies of one culture when dealing with the mental health of someone from another and the resulting utility of the Cultural Formulation. As used in Article 1, the Cultural Formulation facilitates a strengths-based approach to diagnosis that fosters the treatment of the person as a whole. This approach is consonant and timely with "person-centered integrative diagnosis", an emergent movement in psychiatry and non-psychiatry disciplines at large responding to increasing clinical complexity in the mental health field (Mezzich, 2007). It is a paradigmatic shift from a disease-oriented to a person-centered perspective beyond the biopsychosocial model (Engel, 1977; Huyse et al., 2001) in that it promotes patients as active agents in managing, coping with and recovering from their disease. Mezzich (2008) acclaims "person-centered integrative diagnosis" as the promotion of "a psychiatry of the person, by the person, for the person and with the person" (p.129). The Cultural Formulation provides communicative techniques so doctors can obtain a more comprehensive assessment of a patient's situation, enabling a more empathetic relationship with them.

Illustrated in Article 1, the cultural formulation approach allows a flexible, comprehensive and idiosyncratic understanding of each patient's problems irrespective of their diagnostic classification. It provides information that gives proper recognition to the deep and enduring cultural roots of the patient whose background differs from that of the caretakers. The information can include epidemiological information on vulnerability and risk, a systemic approach to problem maintenance and the patient's interpersonal and social context. This approach is further advantageous in that a targeted and individualized treatment can be produced from the formulation that is specific to the needs of that

individual in a way that is particularly advantageous in complex cases (Tarrier, Wells, & Haddock, 1998).

The Cultural Formulation was created in recognition that an understanding of a patient's culture is a fundamental component of mental heath care. The confrontation of cultures can trigger or exacerbate disorders; it can cause that same person to hide or disguise his ailment. Conversely, behaviour manifested in one culture can be misdiagnosed by a person unfamiliar with it; indeed, what might be normal for a person can be misperceived as a disorder by a person with another world-view. In Article 1, information gathered in the psychological interviews and history taking provided key pieces required to solve the puzzle of ailments that had been presented in a "routine" case of traumatic amputation where rehabilitative protocols could not address the patient's cultural perceptions of his experience.

The Cultural Formulation also creates a useful framework to characterize and, if necessary, deal with behaviour that is not limited to multicultural contexts. It provides an array of communicative techniques through which the patient can describe and explain their expressions of distress and through which clinicians can obtain a more comprehensive assessment of a patient's situation, enabling a more empathetic relationship with them. Ultimately the Cultural Formulation helps balance power relationships between biomedically-trained professionals (including the physiological rehabilitative team in Article 1) and the patients as it provides guidelines to deconstruct the case from a positivist, biomedical perspective (Lindau, 2003; Tauber, 2005) into a social constructivist, contextualized perspective (Lewis, 1996; Walker, 2006). An openness and sensitivity to the patient's view of the world is critical for proper care. This

includes an understanding of their unique description of how they view their illness. This openness enables the construction of more decentralized interdisciplinary boundaries, from physiological to psychological. It gives rise to the common transdisciplinary understanding and language required for genuine knowledge exchange in clinical settings.

Similarly the CCS described in Article 2 was created in recognition of the need for a variety of perspectives to formulate a culturally-sensitive treatment plan that was appropriate for all of the circumstances of the patient, not just the biomedical ones. An analysis of CCS sessions reveals the different perspectives of the various disciplines. Presented first in disciplinary silos, these perspectives then clash during the process of knowledge transfer. The result is a more focused, sensitive, adapted synthesis of the relevant information, a "triangulation" of perspectives that has, in the opinion of participants, enabled more effective treatment. This cultural assessment by the CSS adds information to that gathered in the clinical interview and history taking, enabling the proper recognition to the deep and enduring cultural roots of the ethnically-diverse patient. This additional information provides key pieces to the puzzle of ailments presented. In turn, cooperation with and compliance to the advice given by professionals may also be enhanced they understand the patient's cultural perceptions (Panos & Panos, 1999).

The starting point for this dialogue remains the initial assessment generally made by a psychiatrist with years of bio-medical experience and little cross-cultural expertise. The basic premise of the Cultural Formulation is that a methodology is required to free the diagnosis from the preconceptions developed during years of medical training and practice. The essence of traditional western medicine is that conditions are objective, not

idiosyncratic. Psychiatric discourse is largely "doctor-driven", constructed within a precise, scientific framework that rarely gives the patient the opportunity to tell their own story. The patient's "personhood" becomes an abstraction, lost in medical conceptualization and categorization, seen in the CCS transcripts: the employment of figures of speech that represent the patient as their disease, the use of "adversarial" metaphors which symbolically represent medical care as a battle between doctors and diseases, displacing the patient and the patient's concerns. For the patient, this objectification amounts to dehumanization and disempowerment. It creates a strain in the doctor-patient relationship that can hinder care and compliance to treatment (Savett, 2002).

The essence of culture is that the same objective conditions can lead different peoples to different conclusions, to different actions, to different treatment. Sensitive to this, the Cultural Formulation enabled the CCS members to take the bio-medically-biased initial diagnosis of the treating psychiatrist and place it in a larger context. Whereas another methodology might have had similar results, this study demonstrates that the Cultural Formulation can impose the discipline required to see the collected information from a different perspective; to identify issues that can have meaning for the patient and the patient's caretakers.

The Cultural Formulation establishes guidelines, cross-cultural parameters that keep the consultations (Article 1) and the discussions (Article 2) centered on the patient. The cultural formulation provides its users to approach the interview or to discuss the client's situation from the client's perspective, whether the client is present or not. Before any meeting with the individual, discussion or conceptualization, members are primed to

be the patient's advocates. In Article 1, the psychologist was able to formulate to the rehabilitative team an account of the client's distress through an idiom that was deeply couched in his political, social, and migratory fabric, undetected by conventional - assumed to be pan-cultural - approaches to dealing with traumatic amputation. Finding and expressing *Khuâm khum khang* to appropriately express years of pent-up indignation, unleashed by the latest humiliating experience to his personhood, was cathartic for the Laotian and thus, for his treating team.

In Article 2, armed with more knowledge after the cultural broker's presentation, that the CCS participants collectively constructed, their conversation turns to brain-storming potential treatments for the patients. Unlike the conventional physician's evaluation, the CCS assessment is better informed from a bio-psychological and cultural point of view. It manifests openness and sensitivity to the patient's worldview and how that impacts his perception of his illness. This discussion remains arguably paternalistic, representative of "multi-clinician" power over a patient who is not present. But unlike the traditional medical setting, members of the CCS understand the patient's environment outside the heath-care facility: their communities, families, work facilities, economic conditions. They are positioned to understand the impact that a plan of care might have on the patient, on his willingness to accept it, on the willingness of his family and other caretakers to assist. The end result is to lower the risk of an iatrogenic treatment plan – a plan with a solid bio-medical basis but unrealistic or inapplicable in the patient's environment.

The Cultural Formulation does not contain culture-specific information. It is a tool that can only help if cross-cultural knowledge is made available to the therapist so

that he can "fill in the blanks" of his knowledge (Hays, 2001). At the CCS, the cultural broker is charged with this task. Furthermore, the Cultural Formulation can only work if there is enough accurate and relevant knowledge assembled to transcend the biomedical limitations of traditional care. This is accomplished only if members feel competent and willing to voice their concerns. In the examples studied, diverging expertise was shared; differing points of view expressed and, after initial reticence, utilized in formulating treatment plans that would not have been considered by the treating psychiatrist without this interaction. The symbolic interactionism that took place, quite simply, worked.

The Cultural Formulation has limitations. Its focus is on culture – singling it out as something distinctive, a 'thing' to study. This can be perceived as "depersonalization" that is as paternalistic as conventional medical behaviour even if intended to be supportive and protective. The use of the Cultural Formulation at the CCS is time consuming, involves many actors, and is thus costly. The CCS generally meets after a number of other meetings have taken place with the patient and possibly his caretakers. The Cultural Formulation requires culturally sensitive and competent mental health professionals. The flexibility and knowledge required to apply the Cultural Formulation is not always available. The process is only as effective as the individuals who participate in it and not all clinicians can integrate all the information that the Cultural Formulation offers. This model's use is relatively low across disciplines (Eshu, 2009; Lewis-Fernandez & Diaz, 2002) despite its availability since 1994 due to its location in Appendix I in both DSM-IV (p. 843) and DSM-IV-TR (p. 897). Nonetheless, the systematic use of the Cultural Formulation may ultimately prove to be economical because it fosters tailored care that may be beneficial for the patient, and thus, yield better

outcome, diminishing relapse. As in the model of the CCS, the Cultural Formulation can serve as an invaluable teaching, training and supervisory tool in cultural competence for multidisciplinary clinicians. Research is needed in its costs and benefits as an integrative clinical and teaching assessment tool.

Our two studies are testimonials that (1) It is possible to systematically integrate the patient's subjective view of his condition into the professional's medical assessment and (2) that the personal, socio-historical and cultural context of the patient would be considered in the treatment plan. They consider that culture and language are more than a means of communication. If the patient's illness is more associated with human experience than with an objective biological disease, cultural knowledge can help identify the most effective way of producing change, healing, and well-being. Despite some challenges, the studies demonstrate the potential of the Cultural Formulation when utilized by competent professionals. Its cost can be managed by focusing on cases where it is truly of use. Furthermore the Cultural Formulation is an effective tool in identifying community resources and caretakers to assist in the healing process. This can alleviate the burden upon traditional, biomedically-focused professionals. In addition, the cumulate effect of its use is knowledge transfer and increased efficacy of treatment.

GENERAL CONCLUSION

The two studies discussed in this paper explored a humanistic and holistic approach to diagnosis enabled by the Cultural Formulation that gives consideration to and treats the whole person. Good clinicians bring their humanity to their work. This allows the patient to relate to another real human being. This dyad shares not just human failings,

but also human strengths. Admittedly, there is a downside for the mental health professional: being emotionally engaged to people living with mental illness is distressing. But there is also a reward because engagement allows the mental health professional to get alongside the patient, in a facilitative, not dependent, relationship, allowing the professional to assist, rather than impede, recovery (Poole & Higgo, 2006).

For these reasons, the author recommend that the Cultural Formulation become an essential component of basic medical education and practice, increasing cultural sensitivity and awareness, lessening (if not eliminating) the bio-medical bias. The methodology of Cultural Formulation should be utilized in psychiatry and associated mental health disciplines, even in the absence of a multicultural element, to view mental health in the broadest context and to enable aspects of the patient's outside context that are relevant to the diagnosis and treatment process. The Cultural Formulation should then be "upgraded" from an appendix in the DSM to an important tool in cross-cultural curriculum and treatment. This requires more study, from the perspective of the diverse professions represented in the CCS.

Our two studies suggest how the Cultural Formulation can help Mental Health professionals deal more effectively with the increased demands of a multi-cultural clientele, how to benefit more systematically from the related expertise of professionals from other disciplines. These techniques are applicable to their practice at large. They would enable a cultural turn for Mental Health clinical practice, a paradigmatic shift of clinical work.

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Appendix 1

The DSM-IV-TR Outline for Cultural Formulation

(American Psychiatric Association, 1994, pp. 897-898)

The following outline for cultural formulation is meant to supplement the multiaxial 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 (see p. xxiv), it is important that the clinician take 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 behaviour 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.

Appendix 2

The Outline for Cultural Formulation
(Expanded version from Culture, Medicine and Psychiatry, 1996)

Items to be included in the journal of *Culture, Medicine and Psychiatry* case studies

CLINICAL HISTORY

1. Patient identification
2. History of present illness
3. Psychiatric history and previous treatment
4. Social and developmental history
5. Family history
6. Course and outcome
7. Diagnostic formulation (Axes I-V)

CULTURAL FORMULATION
CULTURAL IDENTIFY

1. Cultural reference group(s)
2. Language
3. Cultural factors in development
4. Involvement with culture of origin
5. Involvement with host culture
6.

CULTURAL EXPLANATIONS OF THE ILLNESS

1. Predominant idioms of distress and local illness categories
2. Meaning and severity of symptoms in relation to cultural norms
3. Perceived causes and explanatory models
4. Help-seeking experiences and plans
5.

CULTURAL FACTORS RELATED TO PSYCHOSOCIAL ENVIRONMENT AND LEVELS OF FUNCTIONING

1. Social stressors
2. Social supports
3. Levels of functioning and disability
4.

CULTURAL ELEMENTS OF THE CLINICIAN-PATIENT RELATIONSHIP
OVERALL CULTURAL ASSESSMENT

Reference:

Lewis-Fernández, R. (2006). Cultural Formulation Of Psychiatric Diagnosis. *Culture, Medicine and Psychiatry, 20*, 133-144.

Appendix 3

Transcription Conventions

1. Line Number
001 002 999
Typescript lines are numbered sequentially from the first line.

2. Speaker
In-full, then, in initials
Cultural Broker CB

3. Turn/Utterance
Each new turn, that is, the beginnings of utterances by speakers in a sequence
Location generally starts at the beginning of a line in the transcript. Gaps and overlaps are indicated by appropriate markers.

4. Overlap
[
If a speaker begins to talk while the other is still talking, the point of beginning overlap is marked by a bracket [between the lines.

5. Pause and Silence
<1,2, >
Timed pause in seconds
. . . ...
Pauses under one second
. . . . (34)
Silences within speaker utterances and between speakers are marked by a series of dots; each dot represents one second. Long pauses are denoted by number of seconds in parentheses. These silences are assigned to the previous speaker if they occur between speakers, that is, they are given the meaning of a post-utterance pause.

6. Unclarity
(cold) / (. . .)
Where a word(s) is heard but remains unclear, it is included in parentheses; if there are speaking sounds that are unintelligible, this is noted as dots with parentheses.
( )
Indicates inaudible or unstranscribable passage

7. Speech features
?/.
Punctuation marks are used when intonation clearly marks the utterance as a question or as the end of a sentence.
:
If a word is stretched, this is marked by a colon as in “Wel : l”
-

	If a speaker breaks off in the middle of a word or phrase, this is marked by a hyphen (-), as in "haven't felt like-" ((softly)) Double parentheses enclose descriptions, not transcribed utterances. .hh, hh, eh-heh,.engh-henh These are breathing and laughing indicators. A period followed by "hh"s" Marks an inhalation. The "eh-heh" and ".engh-henh" are laughter syllables (inhaled when preceded by a period). _(Italics) or CAPS An underline or capital letters are used if there is a marked increase in loudness and/or emphasis. <word> Noticeable slowing of speech tempo >word< Noticeable increase in speech tempo
8. Names	XX To protect confidentiality, XX substitute for proper names.
9. Information	[ ] Contextual Information [General laughter]

Adapted from Mishler (1984) and West (1984).

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