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Bridging culture and psychopathology in mental health care

The increasing occurrence of patients whose racial/cultural/ethnic origins are different from their clinicians represents a series of new challenges to the provision of quality mental health services [1]. In youth mental health services, the consideration of culture entails a significant change for clinicians, especially when they are not trained in (trans)cultural psychiatry or rarely encounter families from culturally diverse backgrounds.

In this article, the field of cultural psychiatry and the cultural influences on psychopathology are reflected on, drawing on the Cultural Formulation as a possible starting point within clinical practice.

Cultural psychiatry

Since the past 100 years, cultural psychiatry has been developing as a speciality in its own right. It stands at the crossroads of different disciplines (anthropology, sociology, psychology, psychiatry, etc) concerned with the impact of culture on behavior and experience. Interested in the occurrence and expression of mental illness across cultures [2], psychiatric nosology founder Kraepelin traveled to Indonesia to study 'amok' and examine the universality of psychoses in 1904. Many questions that were raised by Kraepelin are still at the forefront in current psychiatry: are there forms of mental illness unique to specific cultures? To what extent is the expression of mental illness shaped by social and cultural factors? Only in 1977, Kleinman proclaimed the arrival of a new 'Cultural Psychiatry.' In his seminal book 'Rethinking Psychiatry' [3], Kleinman pointed out that psychiatry itself is constrained by social systems, and its categories determined by history and culture as much as biology. Cultural psychiatry is an important speciality that still reflects on the universality or cross-cultural applicability of psychiatry theory and practice.

"Culture" can be defined in a variety of ways. The most used definition corresponds to its current use in anthropology: "cultures consists of the 'shared elements' involved in 'perceiving, believing, evaluating, communicating, and acting' that are passed down from generation to generation with modifications" [4]. Culture is not a static concept: it is, on the contrary, by definition constantly evolving.

Culture and psychopathology

In general, the same methods that are effective in diagnosing and treating common mental health problems in mental health care for the general population can be extended to migrants from diverse backgrounds. However, experts in migrant mental health agree that, for maximum effectiveness, attention must be given to various contextual issues that influence illness behavior [5].

Although it still takes many efforts to understand the ways that culture shapes psychopathology, there is now a large body of evidence on the impact of culture on illness behavior and experience [6]. Cultural settings shape definitions of normality and pathology, the duration of symptoms required for defining impairment, and the phenomenology of the disorder as well as the course and response to treatment of the syndromes [7]. The cultural variations in the presentations of symptoms influence clinicians' capacity to detect and correctly interpret problems. Idioms of distress are ways in which different cultures express experience and cope with feelings of distress. An example is somatization or the expression of distress through physical symptoms [8]. Not with standing the wide prevalence of anxiety

disorders in many cultures, for instance, these disorders are expressed differently across cultures [9]. It is, therefore, of utmost importance to search for a problem definition that is meaningful to the patient, the family, and the clinician.

Research is still needed to explore the precise nature of the interaction between psychopathological processes and cultural idioms of distress in the genesis and course of disorders.

Cultural formulation in the DSM

A milestone in the history of the consideration of culture in mental health care, the 1994 Outline for Cultural Formulation in DSM-IV, is a set of guidelines developed to alert clinicians to the need to understand symptoms and behavior in a cultural context. The DSM-5 provides a revised edition of the Cultural Formulation [10].

The Cultural Formulation calls for systematic assessment of five distinct categories:

- *Cultural identity of the individual.* Recognition of one's cultural identity is essential for her/his well-being. The cultural identity consists of one's racial, ethnic, or cultural reference groups and other relevant aspects of identity, such as degree of involvement with the culture of origin versus host culture, religion, socioeconomic background, place of origin, migrant background, and sexual orientation. Particularly, in a context of mass migration and globalization, identity must be considered a fluid, dynamic, and multidimensional concept.
- *Cultural conceptualization of illness*. This includes the influence of cultural beliefs on the individual's experience, conceptualization, and expression of symptoms or problems. Coping and help-seeking experiences, including the use of professional as well as the traditional or alternative sources of care, need to be highlighted.
- *Psychosocial stressors* and *cultural features of vulnerability and resilience*, including key stressors and supports in the individual's sociocultural environment, such as religion, family, and social support, from community relationships.
- *Cultural features of the relationship between the individual and the clinician*, such as dynamics of differences based on cultural, socioeconomic, language, and social status that may cause differences in communication and influence diagnosis and treatment.
- *Overall cultural assessment* summarizing the implications of these aspects for diagnosis, plan of care, and other clinically relevant issues.

The Cultural Formulation Interview has been added in DSM-5. It is a relatively new clinical tool that aims to refine diagnostic assessment by helping clinicians to gather information about the social and cultural dimensions of illness experience. The Cultural Interview is a 16-item semi-structured interview containing 4 assessment domains: cultural definition of the problem; cultural perceptions of cause, context, and support; cultural factors affecting self-coping and past help-seeking; and cultural factors affecting current help-seeking. The Cultural Formulation Interview was field tested for diagnostic utility among clinicians and acceptability among patients as part of the DSM field trials, although the trials, remarkably and unfortunately, did not include children and youth [10].

The importance of cultural competence in mental health

No matter how useful the Cultural Formulation could be as a tool, its effectiveness and intrinsic value fully depend on the extent to which the clinicians working with it are culturally sensitive. Increasingly, cultural competence is widely recognized as an essential skill set for all mental health professionals.

Cultural competence has been variously defined in the literature. One of the most common definitions is "the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs" [11].

The combination of knowledge, skills, and attitude comprises the foundation of cultural competence. It is a multifaceted and complex process. Knowledge and skills of the clinician have to respond to the cultural- and migration-related aspects of mental health. Effective application of cultural knowledge using effective skills requires the third essential component: the attitude and awareness of the clinician. The basis of cultural competence begins with the clinician's *awareness* of his or her own (ethnocultural) identity and the implicit assumptions that bring [12]. It is essential to investigate your own cultural heritage, based on the awareness that we all have the risk to think in a stereotypical way. Clinicians' personal beliefs are often reflected in their values concerning therapy. The effort to respond to diversity in the psychiatric clinic forces psychiatrists and other mental health workers to confront their own value systems. At the same time, the cultural critique of psychiatry and the concern to hear the voices of others self-evidently do not mean abandoning scientific empiricism or clarity of thought [12].

Another aspect of cultural competence involves knowledge and skills pertaining to a specific cultural group, which may include history, emotional expression, cultural explanations of illness, and so on. Learning to work with interpreters, for example, to better understand the cultural context of a patient and overcome language barriers, is undoubtedly a sensible skill to be trained in. An enormous

caveat must be raised; however, specific knowledge about cultures is only useful inasmuch as it is approached as a set of non-binding guidelines but does not convert into stereotypes that serve to obscure the individuality of the patient [1]. Taking into account the impact of culture on mental health without using a rigid concept of culture, presents a continuous challenge in clinical practice. Therefore it is important to keep a clear focus on how to connect with the patient in every unique clinical encounter.

Cultural competence can be addressed at different levels, including the organization of health systems and institutions, but also the specific models of care or types of intervention.

Ideally, cultural competence training in psychiatry would be fully integrated as a core competence. As pointed out, cultural competence is multidimensional. Correspondingly, training must be comprehensive and multimodal to be able to respond to the different competence domains. Optimal training will attend to cognitive, technical, and attitudinal competencies [1].

Culture in clinical practice

The Cultural Formulation tool and cultural competence prerequisite represent useful approaches to exploring clinically relevant dimensions of patients' cultural backgrounds. Nevertheless, they should be applied in a sensitive and dynamic way. There is always a risk to essentialize concepts of 'culture' and 'competence', which is counter productive for the process of intercultural understanding between the clinician and the patient.

Factors to consider when working with migrants

Working with migrants necessitates being attentive towards pre-migratory, migratory, and post-migratory events. Premigratory factors encompass past trauma, family separation, the pre-migration lifestyle of the patient, and so on. During migration, immigrants are likely to experience prolonged and/or severed uncertainty about all stages of their life. The post-migration factors, finally, also influence adaptation and health outcomes, and are diverse: host country institutions' policies towards migrants, changes in family ties, loss of status, language barriers, financial difficulties, dealing with racism, and uncertainty about possible resettlement experiences.

Focus on child psychiatry

In child psychiatry, the patient's developmental history is a key issue in diagnostic assessment. This has to consider the wide variations in cultural norms of child development, including differences in developmental milestones and in the expected age of acquisition of autonomous behaviors (for example, in terms of sleeping and eating), as well as divergent methods of parenting and disciplining [13].

Respecting the role played by cultural identity is even more crucial during adolescence, since identity formation is evidently one of the most substantial tasks adolescents face. For immigrant adolescents, an additional challenge is created: they have to learn to negotiate different cultural identities.

Promoting intercultural understanding

Kirmayer [12] proposes clear strategies that promote intercultural understanding, and that have been proven useful in clinical practice.

- Approach each case as unique but with a focus on the shifting sociocultural context of the behavior and experience of the identified patient and his/her family.
- Emphasize knowledge of culture and language as modes of inquiry rather than as *a priori* answers to the dilemmas of a specific case.
- Move beyond the individual focus of psychiatric nosology to consider social context and culturally meaningful developmental tasks and issues of power and identity.
- Understand the range of variation in a cultural group and its significance for individuals and the group.
- Negotiate a problem definition and therapeutic strategy meaningful and acceptable to patient, family, and clinician.

Conclusion

As a clinical discipline concerned with disorders of behavior, experience, and emotions, psychiatry is engaged with questions of culture both in delivering service to diverse populations and in its fundamental theory, which must incorporate knowledge of our nature as cultural beings with individual and collective histories [14]. To work effectively with patients of diverse identities, we must be willing to critically examine our own value systems, beliefs, and sociocultural contexts. Using the Cultural Formulation in a cultural competent way is an important starting point to use in clinical practice. The Cultural Formulation considers different factors, such as cultural identity and cultural conceptualization of illness, but also focuses on the patient–caretaker relationship.

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Compliance with ethical standards

Conflict of interest The author declares that she has no conflict of interest.

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