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Utilizing the Cultural Formulation Model of the DSM-IV-TR with Asian Americans: A Chinese American Case Application

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Abstract

Many subtle variations of language, custom, culture, and religion exist within Asian countries. Failure to recognize distinctions between the ethnicities, plethora of languages and cultural practices can lead to misjudgments, misperceptions and misdiagnosis. While the Diagnostic Statistical Manual (DSM) deserves commendation for attempting to include cultural considerations in its latest editions, there lies the danger of reductionism for deciding what is considered “abnormal behavior.” Therefore, when working with Asian Americans it is important to ascertain where they are from, the specific customs of their ethnic group or community, as well as their level of acculturation and participation in Western values and belief.

Introduction

Asian Americans represent one of the fastest growing populations in the United States today (Yea Sun Eum Kim, 2003). According to the 2000 U.S. census, Asian Americans make up 4.3% of the total U.S. population -- that's about 12 million people who self-identify as at least part Asian. This number represents an increase of nearly 75% from the 1990 census. The Chinese were among the first Asians to come to the United States as early as the late 1700’s and are the largest subgroup of all Asian Americans comprising 23.8% of this population (U.S. Census Bureau, 2004). However, in spite of the rapid increase in numbers of people of Asian descent, many myths and misconceptions still abound. This article will provide a rationale for utilizing a culturally sensitive systemic approach to the use of the *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., *text rev*. (*DSM-IV-TR)* (American Psychiatric Association, 2000) with an Asian population. Because Chinese Americans are the largest Asian population, a case example is used to illustrate specific issues related to a Chinese American utilizing the Cultural Formulation Model.

Internal and External Barriers to Accurate Diagnoses

Traditionally, Asian Americans have underutilized mental health services (Leong & Lau, 2001; Meadows, 1997). While Asians are viewed as a model minority who adjust well and need little or no mental health services, utilization rates among providers demonstrate that when people of Asian ethnicity seek help for mental issues, their pathology is more severe than non-Asians. For instance, Meadows (1997) reports

that while Asians are under-represented, they were found to have more severe mental disturbances than non-Asians and higher suicide rates than other ethnicities. There are two categorical barriers that prevent accurate diagnosis- internal systemic barriers and external barriers.

Internal Barriers. Internal barriers connect to various *cultural beliefs*, such as; the family should solve the problems of individual members, not outsiders. Taking problems outside of the family for others to solve is a source of shame and embarrassment for the whole family. Other cultural beliefs can include a tendency not to dwell on morbid or upsetting thoughts, shame, loss of face, a need for balance, and a cultural expectation of self control (Kuo & Kavanagh, 1994).

External Barriers. External barriers can also cause a misdiagnosis. These include *cultural stereotypes* such as generalizing all Asians as hard working people who adapt easily to American culture. Second, people who are members of the dominant culture fail to recognize the *oppression and prejudice* experienced by members of the minority group. This lack of recognition can be a contributing factor to mental illness. A third external factor can be a *lack of professional training* by health and mental health workers. Without adequate knowledge and training in cross-cultural practices, a worker can under-diagnose, misdiagnose or mismanage the treatment regime of an Asian client. Finally, *language* can be a barrier for seeking mental health treatment (Hussain & Cochrane, 2002). For instance, Asian Americans have many languages and dialects that can make finding adequate interpreters a momentous task.

Mental Illness Presentation

Patel (1998) states that, "There is substantial evidence from multi-cultural Western countries that the way in which mental illnesses are perceived and the way in which appropriate health services are accessed varies considerably between ethnic groups" (p. 317). Additionally, Bal (1987) reports that an individual's culture and background are of paramount importance in how illness is understood within a culture. For example, in the Chinese culture, sickness is not viewed negatively. In fact, the presence of illness can give a person permission to avoid difficult social situations (Kuo & Kavanagh, 1994).

Utilizing the DSM Model for Cultural Diagnoses

Earlier editions of the *Diagnostic and Statistical Manual of Mental Disorders* did little to include minorities in the conceptualization of the manual. In fact, Smart & Smart (1997) report that no minorities were members of the DSM-III Task Force. The *Diagnostic and Statistical Manual of Mental Disorders,* 4th ed. is to be both commended and chastised. It attempted to include cultural considerations however this attempt relied upon reductionism – the attempt to reduce a complex phenomenon such as culture to a few fundamentals. The danger in reductionism is the tendency to rely on heuristics for deciding what is "abnormal behavior." For instance, what might be viewed as normal behavior within some cultures (e.g. avoiding eye contact) may be viewed as abnormal by others (Kposowa, Tsunokai, & Butler, 2001). Jacob (1999) reminds us that the reductionistic nature of all classifications, the inherent diversity within categories, and the variability of outcomes demand that the client's care be individualized to meet their needs.

The newest version, *DSM-IV-TR*, has an appendix that constitutes the Cultural Formulation Outline (American Psychiatric Association, 2000). As shown in Figure 1, this model has five categories: cultural identity of the individual, cultural explanation of the individual's illness, cultural factors related to psycho-social environment and levels of functioning, cultural elements of the relationship between the individual and the clinician, and overall cultural assessment for diagnosis and care (American Psychiatric Association, 2000). This is an attempt to understand the client's issue in the context of a cultural

framework (CF). Smart & Smart (1997) call this inclusion of culture bound syndromes a “tourist curriculum” because of its reliance on “brief snatches of the exotic and unusual” (p. 394).

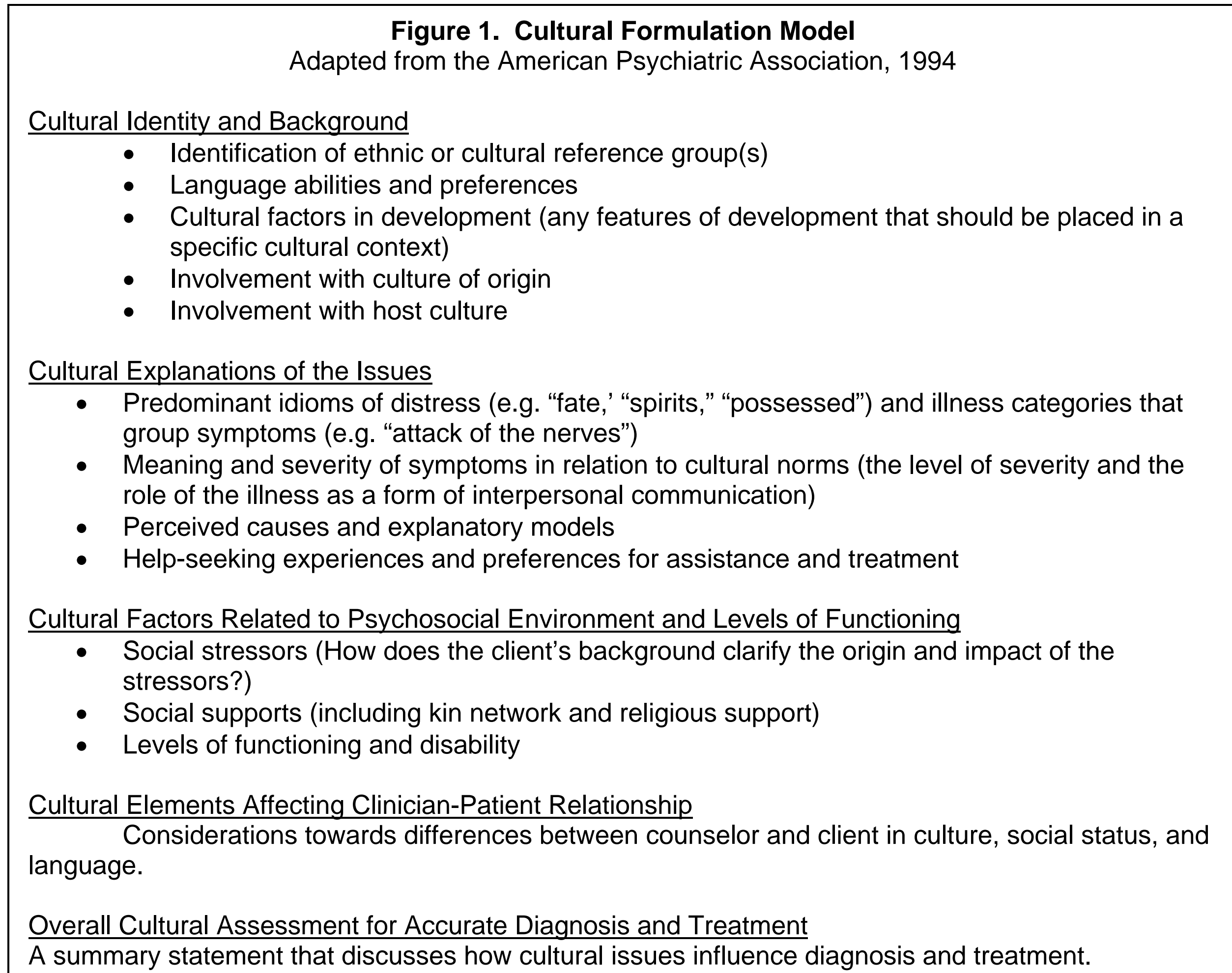

Figure 1. Cultural Formulation Model
Adapted from the American Psychiatric Association, 1994

Cultural Identity and Background

- Identification of ethnic or cultural reference group(s)
- Language abilities and preferences
- Cultural factors in development (any features of development that should be placed in a specific cultural context)
- Involvement with culture of origin
- Involvement with host culture

Cultural Explanations of the Issues

- Predominant idioms of distress (e.g. “fate,’ “spirits,” “possessed”) and illness categories that group symptoms (e.g. “attack of the nerves”)
- Meaning and severity of symptoms in relation to cultural norms (the level of severity and the role of the illness as a form of interpersonal communication)
- Perceived causes and explanatory models
- Help-seeking experiences and preferences for assistance and treatment

Cultural Factors Related to Psychosocial Environment and Levels of Functioning

- Social stressors (How does the client’s background clarify the origin and impact of the stressors?)
- Social supports (including kin network and religious support)
- Levels of functioning and disability

Cultural Elements Affecting Clinician-Patient Relationship

Considerations towards differences between counselor and client in culture, social status, and language.

Overall Cultural Assessment for Accurate Diagnosis and Treatment

A summary statement that discusses how cultural issues influence diagnosis and treatment.

The Case of Mrs. Lee

Clinical Interview Criteria for Cultural Identity of the Individual:

Identification of ethnic or cultural reference group(s)

- To which Asian group do you officially belong?
- Do you feel that you always belong to this group, or also to another one?

Language abilities and preferences

- What is your native language?
- What other language(s) do you speak?
- What language do you speak at home/with your friends?

- If you speak English: How well do you speak English? How does it feel to always have to speak English? Does it sometimes cause problems?

Cultural factors in development (any features of development that should be placed in a specific cultural context)

- If you have children: Describe how you bring up your children in the same way that you were brought up.
- If no children: Describe how you would bring up your children in the same way you were.

Involvement with culture of origin

- What aspects of your culture are most important to you? (E.g. family structures, norms and values, spiritual practices and beliefs)
- To what extent can you follow your culture's way of life here in the United States?
- Are their aspects of your culture that you find less attractive?

Involvement with host culture

- To what extent can you follow your culture's way of life here in the United States?
- Are their aspects of your culture that bother you are that you find less attractive?
- Do you interact much with American people (i.e. attend American social events, watch/read American media)?
- If so, what aspects of American culture do you like, and what aspects bother you?

Cultural Identity Summary. Mrs. Lee is a 42 year old Chinese-American woman who has been married for 17 years to her husband, also Chinese-American. They have two children, a daughter, age 16, and a son, age 11. Their third child, a daughter, died unexpectedly at the age of four after a brief battle with cancer.
Mrs. Lee grew up in a small community. Her parents were both immigrants to the U.S. after World War II. Her father worked as a pipe fitter and her mother a seamstress working out of the home. Mrs. Lee was one of three children. However, her sister died at the age of four due to smallpox. Mrs. Lee describes her relationship with her parents as “good” and with her brother as “close.”

Mrs. Lee works as an accountant for a large, predominately white, insurance firm. During the first six months after the death of her child, she continued to work without problems in performance or attendance. When Mrs. Lee was asked how she was feeling, she always reported that she was doing well causing her co-workers and supervisor to believe that she had successfully mourned the death. Recently this has changed. Mrs. Lee has called in sick on six separate days over the last six months. Her boss also became worried that her work performance, which has always been exemplary, was slipping. When he approached Mrs. Lee about her absences and poor performance, she appeared embarrassed and said she had been feeling ill with stomach pains and headaches. He recommended that Mrs. Lee see a medical doctor. During a medical exam, Mrs. Lee acknowledged the death of her child but focused on her physical complaints. She told the doctor about her stomach aches and headaches which were causing her to lose weight and sleep and were contributing to her poor work performance and absences. After ruling out any physical foundations to the somatic complaints, the physician referred Mrs. Lee to a counselor.

During the clinical interview, Mrs. Lee stated after the death of her child, she found it difficult at times to function. She started feeling nauseous and had chronic headaches. She described a depressed mood, insomnia, decreased concentration, feelings of worthlessness, impaired short-term memory, irritability, and decreased appetite. At home she could not keep up with her daily

household routines, such as cooking the family meals, and sometimes neglected personal care routines (such as bathing and personal grooming). Mrs. Lee confided to her husband that she believed their daughter was speaking to her through toys still in her room. Her husband became very agitated and was embarrassed at his wife's disclosure. He told her "That's crazy!" and that "Toys don't talk." He encouraged her not to discuss this with anyone else and assured her that this problem would go away in time. With no one to turn to, Mrs. Lee became increasingly more depressed and started having thoughts of suicide and fantasized that she would soon join her daughter.

Mrs. Lee adheres to a hierarchical family system. She seeks the advice of her parents and expects her husband to establish the sanctions of the family. This has been a source of distress for Mrs. Lee who wants to discuss her complaints with her mother, but is forbidden by her husband to mention her conversations with the deceased daughter.

Clinical Interview Criteria for Cultural Explanations of the Individual's Illness:

Predominant idioms of distress (e.g. "fate,' "spirits," "possessed") and illness categories that group symptoms (e.g. "attack of the nerves")

- What are your worst symptoms?
- What do you call them in your own language?

Perceived causes and explanatory models

- How do you think your symptoms started?
- How do your friends, family and those around you explain your symptoms?
- How would people of your culture explain your symptoms?

Help-seeking experiences and preferences for assistance and treatment

- How would people of your culture try to help you?
- Are you being cared for in that way now?
- Do people in your culture sometimes make use of alternative healers, or do they go to an American doctor or hospital?
- What kind of help have you had up to now for your symptoms?
- What helped most?
- What kind of treatment would you like to receive now?

Summary of Cultural Explanations of the Individual's Illness. Mrs. Lee states that it is "bad luck" that she lost a sister and now a daughter both at the age of four years. The belief that humans are controlled by forces outside oneself, such as fate, luck, or chance is an Asian worldview connected with an external locus of control (Pham, 2007). Seeking help has been avoided in order to not "shame" her family. The role her illness plays is an attempt to communicate her grief and fears of "bad luck" through somatic complaints.

Clinical Criteria for Cultural Factors Related to Psychosocial Environment and Functioning:

Social stressors (How does the client's background clarify the origin and impact of the stressors?)

- Have there been important changes in your social position in recent years? If yes, what does this mean for you?
- To which social class did you belong in your country of origin? Did you live in a town or in the countryside? What education have you had?

Social supports (including kin network and religious support)

- Are you married or living with someone? If married/cohabitating: Describe your relationship with your spouse/roommate. Is this different to what it was like in your country of origin? Can you go to this person for help, support or advice?
- Do you have a family here? What is your position in you family? Is this different to the situation in your country of origin? How is your relationship with your family? Is this different to what it was in your country of origin? Is there someone in your family who people go to for help, support or advice?
- Are you involved with a religious group or community? Describe your level of participation. Has your faith changed since experiencing your illness? Is there anyone in this group/community that you can go to for help, support or advice?
- If you have a practical problem, such as something you do not understand (e.g. train journeys, the immigration service, a letter from your lawyer) whom would you ask about it? From whom would you get the information?

Summary of Cultural Factors Related to Psychosocial Environment and Functioning. During the first six months after her daughter's death, Mrs. Lee found solace in the support of her family and condolences of friends and co-workers. However, during the last six months, Mrs. Lee felt as if her daughter's death is now forgotten by all. Mrs. Lee interprets her coworkers no longer asking how she is doing as a lack of concern and an expectation that she should be finished grieving. In addition, the client's work environment unknowingly reinforces the "model minority" myth of Mrs. Lee as a hard worker and fails to recognize her delayed grief over the loss of her child.

Clinical Criteria for Cultural Elements of the Relationship Between the Individual and the Clinician:

Considerations towards differences between counselor and client in culture, social status, and language

- If you had a free choice in selecting the personnel treating you, would you prefer male or female personnel?
- If you had a free choice in selecting the personnel treating you, would you prefer personnel with a similar cultural background to yourself, or do you not think that this matters?
- How do you feel about the fact that you don't receive therapy in your own language? Would you like to be given therapy in your own language? Would it help you feel that you were being understood properly?
- If an interpreter is being used: How does it feel to work with an interpreter? If you could choose would you prefer a male or a female interpreter?

Summary of Cultural Elements of the Relationship Between the Individual and the Clinician. The counselor may be unfamiliar with the idiom of "bad luck" and its cultural relevance to the client's problem. Asking the client to share cultural knowledge will help build the therapeutic alliance and facilitate appropriate treatment options. In addition, cultural practices for grieving may be in conflict with stereotypes, belief and biases of the counselor. For instance, while the traditionally Western concept of assigning five stages of grief (denial, anger, bargaining, reluctance, and acceptance) can be universally applied, it is important not to attempt to have a client fit the script, but to be culturally sensitive to the model presented by the client.

Overall Cultural Assessment for Diagnosis and Treatment (summary statement that discusses how cultural issues influence diagnosis and treatment). Mrs. Lee has two prevalent issues: (1) a fatalistic outlook on life that is reinforced by the "bad luck" of the deaths of her sister and daughter both at the age of four, and; (2) a delay in grief that has resulted in a significant depression lasting at least six months and manifesting in somatic complaints. Mrs. Lee is diagnosed as having Major Depressive Disorder with psychotic features (DSM-IV-TR - 296.24 – Mood Congruent). This is based on her self-report of feeling tired, listless, having little or no energy, and no appetite. She also states her stomach hurts and she feels her arms tingle (like pins and needles). Additionally, she reports that her child is speaking to her. Her child, who has been deceased for several months, appears to her frequently using toys as a medium for communication. Mrs. Lee knows it is her daughter because they discuss things that only her daughter could know. She reports that these visits reinforce her loneliness and grief and at times wishes she could die to be with her child.

Case Discussion

In *The Case of Mrs. Lee,* coworkers and counselors may misinterpret Mrs. Lee's stoic affect and short responses when asking how she feels reluctant to discuss the grief or that she has successfully finished grieving. The following two systemic cultural dynamics, collectivism vs. individualism and somatic complaints, were taken into consideration when assessing Mrs. Lee.

Collectivism vs. Individualism. In traditional Asian societies, interpersonal relationships are governed by a proscribed set of rules that emphasize the need for balance and harmony and an emphasis on group mentality over individual freedoms (Kuo & Kavanaugh, 1994). This emphasis on the collective good of the family largely restricts individual freedoms. Jing & Wan (1997) state that in the Chinese culture "all family members feel ashamed if one member does something wrong, and feel proud when he/she achieves success" (p. 62). Kim (1997) helps us to understand that socialization practices that emphasize individualism lead to a conception of self that is autonomous and abstract, whereas socialization practices of collectivism leads to a self-concept that is embedded and situated. As with *The Case of Mrs. Lee*, understanding this dynamic urges clinicians to address mental illness as a family problem, a concept that has been pulling the mental health community away from looking at the individual as a solitary entity.

Somatic Complaints. Hinton et al. (1994) found that when a patient is from an ethnic background other than European American, the chances that their depression will remain undetected increases significantly. For instance, Chan & Parker (2004), report that Chinese people tend to either deny depression or to express it somatically. In addition, Yeung, Chang, Gresham, Nierenberg, & Fava (2004) found that many Chinese Americans do not consider depression to be something that needs to be reported to a physician and many are unfamiliar with the concept as a treatable disorder. Under-diagnosis increases when the clinician and patient do not speak the same language.

An argument could be made, however, that mental disorders such as depression are actually experienced in different ways depending on the culture of the individual. Kress, Eriksen, Rayle & Ford (2005) contend that "culture influences the duration, the course, and the outcome of mental illness" (p. 99). In the Asian culture, for example, the mind and body are not seen as disjointed parts, but a consistent whole. Hussain & Cochrane (2002) point out that Eastern culture takes a more holistic approach to the mind and body (viewing both as an extension of the other). Therefore, an imbalance of energy can result in illness or other maladies. Cross-cultural studies have led to moving away from a disease-centered approach because "how disease is defined will obviously effect how diagnosis is made" (Twemlow, 1995, p. 48). Hussain & Cochrane (2002) remind us that culture exerts an influence on both the perception of mental illness and the expression of distress which is situated within a cultural framework. For example, Kleinman (1977) states those psychiatrists in Chinese cultural areas have noted

the tendency of Chinese patients to present somatic complaints in place of psychological complaints. Therefore, as seen in *The Case of Mrs. Lee*, it is important to recognize the issue of somatic complaints and gradually ease into the problematic life situation.

The following questions were modified from Kleinman (1980) to elicit the patient's explanatory model:

1. What do you call your problem in your culture? Does it have a name?
2. What do you think has caused your problem and why did it start when it did?
3. What does the problem do to you? How does it work?
4. How severe is it? How long will it last?
4. What do you fear most about your problem?
6. What are your main problems caused by the problem?
7. What kind of help would work best for you and how would it help?

Going Beyond the Cultural Formulation Model

In order to offset the danger that a client may be diagnosed without giving due consideration to cultural contexts, Lewis-Fernandez (1996) advocates the use of a mini-ethnography which would address such issues as the patient's clinical history, cultural identity, and cultural explanation of the illness. Levine & Matsuda (2003) also presented a cogent case for this argument. A detailed case study of a young Japanese woman, hospitalized in Melbourne, Australia, resulted in an initial diagnosis of major depressive disorder and an axis II diagnosis of Borderline Personality disorder, because of the patient's threats to harm herself. However, when the cultural contexts that surrounded the young woman were taken into account, her diagnosis was changed from a mood disorder to an anxiety disorder centered on isolation and oppression.

Lewis-Fernandez & Diaz (2002) contend that clinicians need to go beyond the guidelines of the DSM and utilize a model that elicits and evaluates cultural information in order to render an accurate diagnosis. They argue, in order to avoid stereotyping, cultural factors need to be individualized rather than described in solely collective terms. This argument is echoed by Hsu, Davies, & Hansen (2004), who in their work with Southeast Asian refugees, point out that "cultural factors are important because they affect the individual's subjective perception of both the traumatic experience and the adaptation process" (p. 197).

It is possible, that the cultural/contextual confluence could lead to a misdiagnosis. Yeung et al. (2004) report that in a study of Chinese-Americans who were treated for depression, only a small percentage (14%) reported psychological symptoms such as rumination, irritability or poor memory. Most listed physical symptoms as their chief complaint. The authors report that many of these could have been diagnosed as somatization (another DSM diagnosis). Yet, when assessed with a depression inventory, over 90% of them endorsed having depressed mood.

Conclusions

As Hinton et al. (1994) point out, the United States population is becoming more ethnically diverse and clinicians increasingly find themselves faced with patients from a plethora of ethnic and cultural backgrounds. In order to provide competent and ethical treatment, we need an approach that encompasses the individual's cognitive processes, emotional state, strengths, weaknesses, cultural and ethnic identity, and worldview. Almost 20 years ago, Frey (1987) advocated that "each ethnic group is essentially viewed, and best understood, as a separate, unique community" (p. 42). In essence, we need to stop trying to force clients to fit into a pre-arranged package and begin to examine their pathology in terms of a larger, more holistic approach that include cultural context. Therefore, when working with

Asian-Americans, Faulkner & Faulkner (2005) stress that "it is important to ascertain where, exactly, they are from; what are the specific customs of their ethnic group or community; and, as with all ethnic groups, what is their own level of acculturation and participation in Western values and belief" (p. 39). The *DSM-IV-TR* utilizes a model that has five categories: cultural identity of the individual, cultural explanation of the individual's illness, cultural factors related to psycho-social environment and levels of functioning, cultural elements of the relationship between the individual and the clinician, and overall cultural assessment for diagnosis and care (American Psychological Association, 2000). Lewis-Fernandez & Diaz (2002) recommend expanding on this taxonomy for each category to help understand the client and their cultural orientation. Kress et al. (2005) recommend a derivation of the *DSM-IV-TR* that includes assessing the client's world view, assessing the client's cultural identity, assessing sources of cultural information relevant to the client, assessing the cultural meaning of a client's problem and symptoms, assessing the impact and effects of family, work, and community on the complaint, and assessing stigmas associated with the problem. Finally, an Indochinese Psychiatry Clinic (IPC) model advocates an assessment that looks at five spheres of life - social, physical, intellectual, emotional, and spiritual - to see if they are in balance (Allden, 1998).

The following suggestions can be a guide for clinicians:

1. Elicit differences in values, communication styles, spirituality, and definition of family that are specific to the specific Asian subgroup AND be accepting of those differences. Assessing the specific worldview may reveal existential and spiritual concerns that affect the clinical process. The FICA model is suggested by Josephson and Peteet (2005) and consists of examining: (1) **F**aith and religious/spiritual beliefs; (2) **I**nvolvement in the practices associated with a faith or belief; (3) **C**ommunity of support related to a faith or beliefs, and; (4) **A**ddress how these beliefs, practices, and community are to be integrated in health and mental health care.

2. Be aware of ones own cultural values and identity and understand how cultural conditioning influences our beliefs about human behavior, values, communication, biases, etc. Du (2005) recommends a technique using a model titled LEARN: **L**isten with sympathy and understanding to the patient's perception of the problem, **E**xplain your perception of the problems, **A**cknowledge and discuss differences and similarities, **R**ecommend treatment and **N**egotiate agreement.

3. Be aware of potential risk and protective factors common to mental health problems. The U.S. Department of Health and Human Services (2001a) reports several risk and protective factors within individual, family and community or social systems. Examples of individual risk factors include: genetic vulnerability, gender, low birth weight, neuropsychological deficits, language disabilities/limitations, chronic physical illness, below-average intelligence, and history child abuse or neglect. Examples of family risk factors include severe marital discord, social disadvantage, overcrowding or large family size, paternal criminality, maternal mental disorder and admission to foster care. Examples of community/social risk factors are violence, poverty, community disorganization, inadequate schools and racism/discrimination.

   Protective factors for individuals include positive temperament, above-average intelligence, social competence and spirituality/religion. Examples of family protective factors are smaller family structure, supportive relationships with parents, good sibling relationships, and adequate rule setting/monitoring by parents. Protective factors for community/social systems include availability of health services, social cohesion and commitment to school.

4. Develop necessary adaptations when delivering services which reflect an understanding of diversity between and within cultures. Yeung et al. (2005) concluded that recognition alone of Major Depressive Disorder among Chinese Americans does not lead to adequate initiation of treatment for depression by primary care physicians. In fact, a customized treatment approach should be negotiated. Yeung (2005) suggests the following: (1) Provide a rationale for use of medications; (2) Disclose side effects and offer reassurance; (3) Elicit patient's resistance to medication; (4) Discuss alternative treatment options; (5) Negotiate to reach consensus on treatment; (6) Explain the importance of taking the prescribed dose, and; (7) Convey hope and optimism.

In working with Asian Americans it is important to remember that, like other ethnic communities, the Asian community is not one monolithic group. Even within individual regions (such as China, Japan, Korea, Vietnam or Cambodia) there exist many subtle variations of language, custom, culture, and religion. For Asians, who are often lumped together into one homogenous group, this is often misunderstood. Failure to recognize distinctions between the diverse ethnicities, plethora of languages and cultural practices can lead to gross misjudgments and misperceptions. Our knowledge of the mental health issues of Asian Americans is very limited and even more so when working with a specific sub-group such as Chinese Americans. Attention to cultural-specific assessment and intervention is needed to affect greater service utilization and better treatment outcomes (U.S. DHHS, 2001b).

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