Psychodiagnostic assessment with refugees

Studies on the Cultural Formulation Interview and Somatization

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Psychodiagnostiek bij vluchtelingen: Studies over het culturele-formulering-interview en over somatisatie (met een samenvatting in het Nederlands)

Proefschrift

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Chapter 1

Introduction

Clinical vignette 1, part 1.

A 45 year old man from Ethiopia pays a visit to his general practitioner with a lot of complaints. He reports having difficulty falling and staying asleep. He experiences severe headaches and dizziness. And he has anger outbursts at home which are directed to his children. He wants to have a complete checkup in the hospital because he fears having a serious disease. Also, he demands medication for his headaches, sleeping problems and dizziness. The doctor examines him, finds no direct signs of diseases, and sends him to the laboratory for a routine checkup. There are no abnormalities in his blood values. At the second visit, the doctor asks about his past, and the patient tells about his traumatic experiences. The doctor decides to send him to a clinic where patients with posttraumatic stress disorders (PTSD) are being treated. The patient is very skeptical but decides to cooperate.

Refugees: general characteristics

Refugees in the Western world constitute a very diverse group of people. They are individuals from different regions and cultures: Africa, the Middle East and Iran, European regions like Bosnia-Hercegovina and Kosovo, South-Caucasian republics such as Armenia and Azerbaijan, the Far East including Sri Lanka, and Latin America. They bring along to the West very different ideas, life styles, religions, norms and values. Some are quite similar and some very different to those in the West. There are substantial differences in the way the various groups of refugees think about life and in the norms and values they maintain. Some people are orthodox and come from a rural background whereas some are urbanized persons with a preference to modern clothing and blogging on the internet. And sometimes these two apparently extreme characteristics are present in the same person.

Refugees in the Netherlands originate from over more than hundred different countries. The Central Office for Statistics makes no difference between migrants who move as a refugee or as an invited family member of a refugee. The growing number of refugees is partly responsible for the growing number of non-Western migrants in the country. Since 2000, the non-Western migrants are an increasing percentage of the population, as explained in Table 1 below (Source: Centraal Bureau voor de Statistiek, 10-4-2017; latest numbers from 2015). Growth of the non-Western migrant population is larger than growth of the native Dutch and the Western migrant population.

Table 1. Population in the Netherlands in 2015, and growth since 1.1.2000

	Number (x 1000)	Percentage of population	Growth in numbers since 1.1.2000	Growth in percentage since 1.1.2000	Mean age
Total	16 901	100	1038	6	40,1
Native Dutch	13 236	79,1	237	1.8	41,4
Western migrants	1 626	9,3	260	16	41,6
Non-western migrants	2 038	11,6	629	31	30,0

As reported by the United Nations High Commissioner for Refugees, at the end of 2015, there were 88,256 refugees and 28,051 asylum seekers (refugees with a request for an asylum) in the country. The data on largest groups of former refugees and their children born and living in the Netherlands as recorded on 1.1.2015 are shown in Table 2 (Source: Vluchtelingenwerk Nederland, 2016).

Table 2. Largest groups of former refugees and their children in the Netherlands, divided in country of origin, as reported on 1.1.2015

Country of origin	First generation	Second generation	Total
Afghanistan	33,058	10,674	43,732
Iraq	40,628	14,608	55,236
Iran	28,946	8,533	37,479
Somalia	27,275	11,856	39,131
Syria	17,908	4,660	22,568
Former Yugoslavia	52,486	30,775	83,261
Former Soviet Union	56,348	19,754	76,102

In the period between 2000 and 2010, the total number of new settled refugees in the Netherlands was 69,620. Between the years 2014 to mid-2016, there was a large influx of refugees. 42,593 refugees from Syria and 13,546 refugees from Eritrea asked for asylum in Netherlands. Therefore, the issue of receiving refugees, mainly from Islamic countries, recently became open for a public discussion.

The Netherlands has been a 'multicultural' society for many centuries. Netherlands has been hosting refugees from the 17th century. Huguenots and Jews fled away from the religious suppression in France and Spain. In the Netherlands they could find a safe haven, build an existence based on labor and trade, and practice their own religion without much repression in a relatively safe liberal climate.

In the fiftieth to the seventieth decades of the 20th century, groups of refugees came to the Netherlands because of repression and political violence: from Hungary (since 1956), Czechoslovakia (since 1968) and from Latin America (most notably from Chile and Argentina in the 1970s). Their numbers were rather small. The number of Latin American refugees in the seventies was 12,179, the number of Hungarian refugees (in 1956) 3,300, and the number of Czechoslovakian refugees (from two waves, in 1948 and in 1968) 1,500 (Source: Vluchtelingenwerk Nederland, 2016).

During the eighties, the stream of refugees became larger. It started with boat refugees migrating from Vietnam, in the aftermath of the Vietnamese war. The wars in former Yugoslavia created large groups of Croatians and Bosnians who moved to the Netherlands as temporary refugees, but were granted a permanent permission to reside, and acquire a Dutch citizenship. Other wars and suppression in the Middle East and African countries made the situation dire for their people and hence they migrated to the Netherlands.

In the first few years of the new millennium, new laws imposed restrictions on the acceptance of refugees. Hence, the number of asylum seekers decreased. In the recent years (since 2010 onwards), newer conflicts in Syria and Iraq enlarged the number again. The numbers will vary in the forthcoming years, but of course, the situation is completely dependent on the armed conflicts occurring in the world. At the moment, this number does not appear to decrease.

Refugees with mental problems and in mental health care

Since refugees arrived in the Netherlands from the middle of the 20th century, researchers have made efforts to measure their somatic and mental health status. Many refugees have experienced gruesome events in wartime, such as bombardments, shootings, confrontations with dead and heavily wounded persons, hunger, starvation and lack of physical protection. Sometimes they have been wounded by these atrocities. Some have been abused, imprisoned and tortured. Others have lost their children, close relatives, parents, and spouses by political murders or war. And some have experienced anguish in case of a missing relative, not knowing if they are alive or dead: chances of these relatives to be dead are most likely, but their bodies have not yet been found (de Jong et al., 2001). Many people seeking refuge have travelled to Western Europe through other countries where they were not welcomed. Most of them have faced challenges crossing the closed borders of 'fortress Europe'. The cost of this is loss of immense energy, efforts and money: one of the main reasons that only high and middle class refugees succeed in moving to Western Europe. All asylum seekers who move to the Netherlands have undergone the atrocious situations described above (Mooren, 2001; Huijts et al., 2012; Kermani, 2016).

Most refugees are found to suffer from mental disorders, most notably PTSD and depression. Review studies have shown a high level of distress among refugees, but also large variations in the prevalence rates of disorders and disturbances. These large differences are not only the consequence of different circumstances which the refugees undergo, but also a consequence of problems with regard to methodology such as variations in questionnaires, large drop-out rates and poorly culturally validated instruments. The depression and PTSD rates in general refugee populations vary in prevalence (Hollifield et al., 2002). In a large review, Fazel et al. (2005) found that among 6743 adult refugees in Western countries, PTSD rates were about ten times higher in the adult refugee population than in the age-matched general population. However, larger and more vigorous studies in their review showed lower prevalence rates of depression and PTSD. Steel et al. (2009) performed an even larger review of studies consisting of 81,866 refugees. Their findings concluded that in total the rate for PTSD in refugees was 30.6 % and for depression 30.8 %. Studies with small sample sizes had higher rates than studies with larger sample size. Studies which used self-questionnaires identified higher scores. Exposure to torture was a risk factor and was frequently experienced by refugees.

In comparison: the prevalence in the general population of the United States of PTSD was 4.7 % in the year 2016 and the life time rate was 6.1 % (Goldstein et al., 2016). Whereas, the prevalence of depression was 6.6 % and life time prevalence was 16.6 % (Kessler & Wang, 2009).

Studies performed in the Netherlands reported higher numbers of mental disorders among refugees. Gernaat et al. (2002) found in a population study of Afghani refugees that 57 % of the individuals were depressed and 35 % had PTSD. Laban et al. (2005) found in Iraqi asylum seekers that depressive disorders were present in 41% of the males and 61 % of the females, whereas PTSD was present in 40 % of the males and 57 % of the females. The differences seen between these outcomes in different studies are in some cases the result of the differences between self-reporting and clinician reporting questionnaires. Also, the existence or the absence of social networks can influence the prevalence of the mental disorders. These Dutch studies are examples of small studies, which according to Steel et al. (2009) show higher rates of disorders. Whether the population groups in the Netherlands had higher rates of traumatic events and torture, is not known.

The psychological status of the refugee: risks and resilience

Clinical vignette 1, part 2.

The 45 year old Ethiopian man arrives in our clinic. He has serious complaints of reliving old experiences and becoming depressed by that. He has trouble controlling his emotions. He expresses many somatic complaints.

He tells the story about his work as a journalist in a dictatorship. He was a respected man and had much support from his important family. Nevertheless, he was arrested and accused of having contacts with the opposition party, which was settled abroad due to the serious oppression in the country. He denied the contacts and refused to give any names of opposition persons inside the country. However, the secret service had some proof that he had contacts.

He was tortured heavily for several months with repeated beatings, electrical shocks on diverse body parts, waterboarding, threats to be executed. Due to a political agreement he was released from prison, but in the following year things changed again and he had to escape to another country. He had a difficult journey and then took a flight to another African country. He was arrested again because he moved to the country illegally. After being set free, he flew to India and succeeded in getting an illegal visa to the Netherlands. At the airport he asked for asylum and destroyed his passport by eating it, because he feared being sent back immediately to the country he originated from. After two years of procedures, he finally got a permit to reside in the Netherlands.

The numbers of the refugee population - as mentioned earlier - do not explain the individual psychology of an average refugee, in whom several stressors and support factors are at stake at the same time. Therefore, we are searching for alternate assessment procedures to assess the problems refugee patients encounter. We will elaborate on this further.

Four general rubrics of stressors and supports have been distinguished as follows: (Rohlof & Haans, 2005)

1. Migration and loss

Migration from one country to another has positive and negative effects on the psychology of migrants. On the positive side, there are challenges of starting a new life in a country which can offer new opportunities. In a new country, one receives political and religious freedom and there is no necessity and struggle to achieve it.

A justice system which provides sufficient attention to the rights of an individual can offer a safety net to them. To respect one's human rights is a great achievement against the injustice and humiliation most refugees underwent in their own country of origin. Making a comparison between the new situation and the old situation is useful to understand the psychological status of the working migrants in Mexico. Escobar et al. (2000) found that the mental health status of newly arrived Mexican migrants in the United States was better than that of the general population in the original country.

Refugees stay longer than other migrants in a phase of liminal vulnerability (Baird & Reed, 2015; Van Bekkum et al., 1996). This vulnerability is common among migrants. They are always in a state of transitioning from one country to another. Such migrants belong neither to their country of origin nor to the host country. They carry the norms, values and habits from the old culture to their new situation. This can produce frictions within the host society. This situation also accounts for the laws and rules of the host country. Migrants have to learn where they stand between the old and new. They gradually recognize the complicated new rules, bureaucratic procedures, and laws. Refugees may carry severe burden of this, as they are subjected to the juridical procedures about their asylum status. A positive outcome of the juridical procedure as observed has a direct improving effect on the mental health status (Drozdek et al., 2013). On the other hand, it was also observed that being involved in an asylum procedure for a longer duration has a worsening effect on the mental health status of the refugees, resulting in severe depression, increased PTSD symptoms, and somatic symptoms (Laban et al., 2004).

Another important aspect for refugees is that they are forced migrants. Their future is linear, because returning to their country of origin is not possible, especially at the beginning of their settlement. After changes in the political and the security situation, refugees can return to their home country, but very rarely do they return. For, after long periods of settlement in the host country, the younger generation adapts easily. And the better social, educational and economic situation in the new country can also play an important role in promoting their mental health status.

Forced migration often includes substantial losses such as loss of property, legal claims, and inheritance. Their social status which was often quite high in their former country diminishes. Many refugees in the West have had a middle class or higher middle class position in their country: these people were able to pay large sums of money to traffickers in order to get them to a Western country (Kermani, 2016).

Also, the contact with family, friends and fellow citizens is lost with migration. This results in loss of social support. Refugees feel isolated in the host country because fellow countrymen are living far away, and making contact with persons from the new country is nevertheless challenging.

Stress generated by these losses is usually addressed as post migration stress. It is a major factor in the contributing to the psychopathology of migrants, as found by previous studies. (Kamperman et al., 2007; Yakushko et al., 2008). In a large review, a connection between migration, the loss of cultural identity, and mental distress was found to be present. Social support showed to be a buffer against mental health problems (Bhugra, 2005).

2. Acculturation

A consequence of migration is the necessity of adapting to another culture. Acculturation is the process of cultural change and psychological change that results in some kind of integration between various cultures. So, it regards a search for meaning not only for the individual, but also for both the groups of migrants and natives. For example, the influence of religion can be different in a new country, which may result in conflicts between openly shown religious manifestations (like dress) and more hidden religiosity and spirituality in the host country. Also, education methods can be quite different, and may result in different levels of acceptability among children and child care institutions as well as acceptability on the level of parental authority between the culture of origin and the culture of the hosting country.

One of the definitions of culture build upon this notion is: the sum of meanings, values and behaviors which currently exist in the society and among its social groups (Mezzich et al., 1996). Generally, the term culture also points at the people's way of living, the rituals they follow, their ways of celebrating in a particular country and the various religions followed, languages spoken by the people, and maybe even the architecture and public space in the country.

Migrants and refugees have different adaptation strategies, when they arrive in a new culture. According to Berry (1992) they are able to:

- Integrate: adapt with the new culture while maintaining their former cultural habits
- Assimilate: acquire mannerisms of the new culture, with loss of their own culture mannerisms
- Separate: recline from the new culture and continue with the lifestyle of their old culture
- Marginalize: recline from both cultures.

Cultural orientation is not absolute neither static. There are many subtle similarities between the above mentioned positions. Cultural orientation is also dependent on the situation: one can feel Dutch between colleagues, and Turkish at home. The various forms of acculturation were studied from a cultural perspective, in the aftermath of the so-called 'Firework Factory disaster' in Enschede, the Netherlands (Drogendijk et al., 2005). In a qualitative study, they found that Turkish victims of this disaster were much more inclined to find external explanations for their psychological problems, probably influenced by preventing the loss of esteem, social status or stigmatization.

3. Traumatization

Refugees may have experienced many kinds of traumatic experiences. Sometimes they have encountered war situations with the risk of getting wounded, or horrors of seeing family members or other close persons killed. Some have been imprisoned because of political conviction, or just belonging to another religion group, or ethnic group, or having a sexual orientation that is considered inappropriate in their country of origin. The prevalence of being tortured is high among refugees (Steel et al., 2009). Also, many of them have endured unfavorable and traumatic situations during their flight: the dangers of being discovered, being imprisoned in other countries because of illegal crossing, seeing people get injured and drowning in the sea during travelling.

The connection between these traumatic experiences and psychopathology in refugees has been the subject of many studies in recent years, as explained in the first part of this chapter. Original studies on the occurrence of PTSD symptoms after traumatic experiences were published in the forties of the twentieth century (Kardiner, 1941), although some argue that the renowned French psychiatrist, Pierre Janet first wrote about this matter in the 1880s. Arousal, avoidance, numbing and intrusion were defined as the core symptoms of PTSD. Biological studies have shown that traumatization leads to changes in the cerebral anatomy and physiology (Yehuda, 1998), which result in poor adaptation. Newer insights lead to the concept of stress sensitization: susceptibility to stressors in later life, following traumatic experiences. It was studied in military personnel (Smid et al., 2013). This could also play a major role in the declining psychopathology among refugees. Recent studies have also stressed the point that refugees can encounter so-called Post Traumatic Growth (PTG), making them highly capable to handle future stressors. In a review, factors that define PTG were identified as social support, certain coping styles, religiosity, and optimism (Chan et al., 2016).

Many researchers have questioned the concept of PTSD as a real disorder, stating that it is an entity constructed as much from sociopolitical ideas as from psychiatric ones. They link the increase in the diagnosis of post-traumatic stress disorder in society to changes in the relation between "personhood" and modern life. Moreover, they view symptoms of anxiety, depression, and sleep problems not as a distinct syndrome after a disaster or war has taken place, and connect the problems also on the relief of war veterans and other traumatized persons in society (Summerfield, 2001). As with regard to the refugees, it is stressed that only a small part of those who are diagnosed with PTSD and depression seek mental health counselling (Summerfield, 2003). Some authors compare the discovery of PTSD to a constructed process which enforces itself by believers (Young, 1995, 2007). However, this was later perceived as an overly academic view, since PTSD in refugees consists of complex typical symptoms which are all observed among refugee patients, and are also identified in large reviews (Steel et al., 2009).

4 Social Marginalization

Refugees in the West are socially marginalized. Asylum seekers mostly stay in centers located in remote areas for many years. Refugees with a permit to reside in the Netherlands have the possibility to leave the reception centers, but they encounter great difficulties in this process. Most cities cannot provide sufficient housing facilities for them, as they are dependent on the low-priced rent sector, and they have to compete with a large group of native citizens. The next step is to provide language courses and education. Education is important because their already present diplomas are not often recognized in Europe. Furthermore, the distribution of refugees all over the country makes it harder to maintain contact with compatriots and persons from the same culture and/or religion.

Some refugees seek support from compatriots. Others do not use this strategy, because of previous poor experiences and because of mistrust. Social networks are absent and loose among the refugees. It is striking because social support is one of the most essential coping mechanisms to deal with the effects of traumatization (Hall et al., 2014; Tol et al., 2011) and also helps in the prevention of PTSD and depression. A study in Ruanda showed a notable improvement in mental health problems facilitated through a psychosocial intervention program with the purpose to improve social bonding (Scholte et al., 2011). Whether these kinds of intervention have the same effect in the Western world, is unfortunately not known.

Communication and Diagnostics in Refugees

Although the group of refugees holds a higher prevalence of psychopathology, as explained earlier, they frequently do not find the path which leads to adequate mental health care. The main reasons for this are language barriers and a poor knowledge among refugees of the existing customs and the access to care (Fassaert et al., 2009). Researchers in The Netherlands found high numbers of mental health problems in refugees, but low numbers of refugees who went to a mental health professional (Gerritsen et al., 2006; Laban et al., 2007).

Many mental health professionals regard the communication with non-western migrants as problematic, and experience difficulties with continuing the mental health treatment, also because of differences between clinicians and patients about the goals and possibilities of treatment. In general, ethnic minority groups show a high absent rate and drop-out rate, often more than twice as much in comparison with native Dutch patients (Blom et al., 2010). Migrants may thus benefit to a lower extent from mental health care than native patients (De Haan et al., 2014; Knipscheer, Mooren & Kurt, 2012; Verhulp et al., 2017).

So, when refugees are referred to a mental health care institute, and arrive there for an assessment interview, the challenge will be to have a consensus about the goals of and expectations from the treatment. And if they do not speak Dutch or English, there lies effort in establishing communication through the use of interpreters (Bot & Wadensjö, 2004).

Furthermore, once this is managed, the professional has to start with a diagnostic procedure. This diagnostic process has to acknowledge the many diverse symptoms of mental illness, the complexity of the psychosocial situation of refugees, the way they understand their problems, their personal style of coping with the problems, the support available from the family, and the personal history which includes experiences and former ways of handling problems.

In a comparison between the DSM-IV and the DSM-5 diagnosis of PTSD in refugees, Schnyder et al. (2015) concluded that with DSM-IV criteria 60 % of traumatized refugees who were referred to a mental health clinic met the criteria for PTSD, while less than 50 % were diagnosed with PTSD with DSM-5 criteria. This means that a firm diagnosis of PTSD according to DSM-criteria can be difficult in a traumatized refugee group. Others have found that traumatized refugees frequently express complex reactions like blame, anger outbursts, shame, guilt, impulsiveness, emotional dysregulation, and reckless behavior (Nickerson et al., 2011). There is also a focus on somatic symptoms as signs of PTSD in refugees (Hinton & Lewis-Fernández, 2011).

These findings are an indication of the need for a more sophisticated way to perform the diagnostic procedure in refugees. A shortcut to the diagnosis of PTSD, and a quick choice for one of the usual treatments for PTSD, does not seem to be effective in refugees with trauma.

Outline for a Cultural Formulation and Cultural Interview

It is by now clear that refugees form a population in mental health in which a proper psycho-diagnostic assessment is difficult. All the above mentioned aspects of their life, their experiences, their cultural beliefs and norms, and their expectations are hard to describe in a single protocolled assessment. This highlights the need to use more sophisticated methods in conducting an assessment.

In the present study, we will assess the content, the development, and the experience of a cultural interview in the first meeting with a refugee. A cultural interview may be better suited for the complex nature of complaints and problems a refugee expresses in his first contacts with a mental health professional. This cultural interview not only considers the culture of the refugee patient, but also covers other crucial issues in the context of mental health of patients.

We have considered the Outline for a Cultural Formulation (OCF) (Lewis-Fernández, 1996) as a quite useful concept in the diagnostic procedure. This OCF was published in DSM-IV as a guideline to diagnose on a more sophisticated level the mental health problems of migrants and refugees (American Psychiatric Association, 2000). This ideology is further elaborated and studied in Chapter 2.

The OCF was operationalized in the so-called Cultural Interview and the Cultural Formulation Interview. The former mentioned instrument was designed by us in The Netherlands , and the latter version was used internationally. It was designed by a group of people, in which we also have made a contribution. This will be explained in later chapters.

The OCF is focused on different aspects of the patient: the cultural identity, the symptom presentation and treatment seeking behavior, stressors and support, and the patient-clinician relationship.

Cultural Identity

At first, patients bring along their cultural identity (as do their mental health professionals). Cultural identity has been defined '... as a multifaceted core set of identities that contribute to how an individual understands his or her environment. Ethnic identity is often a crucial facet of an individual's overall cultural identity, but many other facets may contribute to it as well. The greater the amount of details a clinician is able to ascertain about the individual's cultural identity, the better understanding he or she will have of the individual's perspectives on health, illness, and the mental health system' (Ton & Lim, 2006, p 10).

In the proposed OCF of the DSM-5, this cultural identity has got an extensive formulation, view the note[1].

Symptom presentation and treatment seeking

Secondly, much research has been conducted on the differences of symptom presentation and expression of emotions between persons from diverse cultural backgrounds. Although basic emotions are identified across cultures, thus universal, the value of these emotions may be different in various cultures (Mesquita et al., 2016). Emotions that are accepted in a specific culture, like signs of assertiveness, as anger, are more common and more desired. In other cultures emotions which are connected to humility, like a constant showing of friendliness, are better evaluated. This means that persons who migrate will encounter a different validation of their emotions. Not only emotions are different, but so are cognitions, because meanings, expectations and views are different between cultures (Ji & Yap, 2016). This could lead to misunderstandings in mental health care, where therapists carry preferences of emotions and cognitions from the host country, and patients carry preferences of their culture of origin. As a consequence, therapists could be mistaken in setting goals for treatment which are not accepted in the cultural perspective of their patients (Kirmayer & Ryder, 2016).

Thirdly, there is a difference in treatment seeking attitude and in the expectations about the effect of treatment between persons from different cultures and regions of the world. For instance, a survey on Turkish immigrants in Germany showed that they expected more social support and a survey among Arab Australians showed poor mental health literacy, and stigma feelings among them (Balkir, 2013; Kayrouz et al., 2015). In a systematic review conducted in the UK, it has been shown that Black immigrant patients have higher rates of in-patient and

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[1] Cultural identity of the individual: Describe the individual's racial, ethnic, or cultural reference groups that may influence his or her relationships with others, access to sources, and developmental and current challenges, conflicts, or predicaments. For immigrants and racial or ethnic communities, the degree and kinds of involvement with both the culture of origin and the host culture should be noted separately. Language abilities, preferences, and patterns of use are relevant for identifying difficulties with access to care, social integration, and the need for an interpreter. Other clinically relevant aspects of identity may include religious affiliation, socioeconomic background, personal and family places of birth and growing up, migrant status, and sexual orientation (APA, 2013, pp 749-750).

compulsory admissions as compared to White patients, with highly complex pathways to specialist care. There are differences in the perceived need to seek help from a mental health professional, which led to lower voluntary use among Black immigrants than White persons (Bhui, 2003).

Furthermore, refugees from different parts of the world use different idioms of illness. As Hinton and Kirmayer (2013) showed, there is a multiplex model of symptom generation in traumatized refugees, which include cognitive, social and physiological mechanisms. They also showed that there is a healing effect of certain rituals and interventions which are not a part of the Western evidence-based medicine. The OCF has reformulated these concepts of distress and help-seeking patterns[2].

Stressors and support

Refugees may confront different cultural determined psychosocial stressors, and may have different cultural features of vulnerability and resilience. Clinicians may therefore have to put more effort in determining these. Clinicians face issues with identifying stressors such as fear of future, in the lives of refugees. Stress occurs if an individual appraises a situation or perceives a threat to his or her well-being and believes that he or she does not have the resources to deal with it (Qureshi et al., 2016). Refugees have to manage stress manifestations such as post-traumatic stress and acculturative stress. Acculturation is a complex phenomenon, as explained before, with effects on a cultural and on a psychological level. Acculturative stress is further divided into four sections such as perceived discrimination, intercultural contact stress, cultural bereavement and bicultural identity stress (Berry, 2002). In a survey among 321 Muslim immigrants living in the Netherlands, it was found that successful contact and participation in Dutch society and maintenance of cultural heritage and identity were moderately associated with low psychological distress. Also, improving mastery of the dominant language in the host societies, and allowing migrants to preserve their traditions, might be effective measures in

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[2] Cultural conceptualizations of distress: Describe the cultural constructs that influence how the individual experiences, understands, and communicates his or her symptoms or problems to others. These constructs may include cultural syndromes, idioms of distress, and explanatory models or perceived causes. The level of severity and meaning of the distressing experiences should be assessed in relation to the norms of the individual's cultural reference groups. Assessment of coping and help-seeking patterns should consider the use of professional as well as traditional, alternative, or complementary sources of care (APA, 2013, p. 750).

improving the mental well-being of migrants (Fassaert et al., 2011). This has been considered under the OCF[3].

Patient-clinician relationship

The relationship between the patient and the clinician is at stake in the last section of the OCF. This relationship should be based on mutual trust and respect, and is a state which encourages patients to be willing to openly discuss their thoughts, emotions and behaviors. Lack of an effective clinical alliance will result in challenges to formulate an accurate diagnosis, and problems in compliance and effect of treatment. The OCF has tried to pay attention to this aspect of clinician-patient relationship in the last section[4].

These are the items which are described in the OCF. Another barrier in the psycho-diagnostic assessment among refugees is the problem of somatization.

Somatization

Since refugees present many somatic symptoms, it is a troublesome aspect in the beginning of treatment. Therefore, we aimed to investigate the concept of somatization, i.e. somatic articulation, and somatic illness equivalents as a sign for traumatization among refugees.

As we will show, somatization is a complex concept. There are various clinical manifestations and many possible causes. Somatization can be considered as a form of somatic disease, as an unrecognized expression of mental illness, which is a more acceptable way of expressing stress, or as an effect of alexithymia. In chapter 8, we will elaborate on all these different forms of somatization.

Somatization among refugees has to be taken seriously. We aim to provide further suggestions on treatment options, wherein somatic symptoms receive more and necessary attention than they get in a standard mental health treatment.

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[3] Psychosocial stressors and cultural features of vulnerability and resilience: Identify key stressors and supports in the individual's social environment (which may include both local and distant events) and the role of religion, family, and other social networks (e.g. friends, neighbours, co-workers) in providing emotional, instrumental, and informational support. Social stressors and social support vary with cultural interpretation of events, family structure, developmental tasks, and social context. Levels of functioning, disability, and resilience should be assessed in light of individual's cultural reference groups (APA, 2013, p. 750).

[4] Cultural features of the relationship between the individual and the clinician: Identify differences in culture, language, and social status between an individual and clinician that may cause difficulties in communication and may influence diagnosis and treatment. Experiences of racism and discrimination in the larger society may impede establishing trust and safety in the clinical diagnostic encounter. Effects may include problems eliciting symptoms, misunderstanding of the cultural and clinical significance of symptoms and behaviors, and difficulty establishing or maintaining the rapport needed for an effective clinical alliance (APA, 2013, p.750).

Combination of providing physical treatment with psychotherapy seems to be the answer, which we will present in chapter 9.

Research questions in this thesis

This thesis is focused on two research questions:

1. Can the Cultural Interview and the Cultural Formulation Interview be considered as feasible, acceptable and potential clinically useful and effective instruments in the diagnostic procedure for traumatized refugees?
2. What is the role of the somatic articulation in the symptom presentation among refugees: is somatization a common phenomenon among refugees, and where does the concept of somatization originate in the refugee population?

Design of the thesis

The base of the research is the problematic psycho-diagnostic assessment of refugees. The focus of the research is thus on formulating methods which make the assessment easier and feasible to administer, and more acceptable among both the patient and the clinicians. A better evaluated assessment may have greater effect on the outcomes of the treatment.

In chapter 2, the use of the Outline for a Cultural Formulation of Diagnosis (OCF) will be highlighted in the phase of assessment of the refugees. Different aspects which are relevant for psychiatric diagnosis among refugees are mentioned in this chapter. This highlights the position of the OCF in the psycho-diagnostic assessment procedure carried out among the refugees. Also, an earlier version of the Cultural Formulation Interview (CFI) will be introduced.

In chapter 3, the present state of the art of operating the OCF will be clarified, with a review of the scientific literature present currently. The idea is to identify the limitations of using the OCF in clinical practice. Based on the present literature review, it is clear that there is a need to study the use of the OCF, through the medium of the Cultural Formulation Interview.

In chapter 4, we will elaborate on the findings of our research study regarding the CFI which concern improving the cultural competence of the clinicians who were contributors of the research on the CFI. We will present various methods to educate and train clinicians to enhance their cultural competence.

In chapter 5, a revised version of the CFI will be introduced, derived from the OCF. Furthermore, an evaluative study will be described in which the utility of this interview in the clinical practice in the Netherlands will be assessed. This section was part of the international field trial which studied the use of the revised CFI.

In chapter 6, the international field trial which assessed the use of the revised CFI will be presented. We will focus on feasibility, acceptability, and potential clinical utility. Quantitative and qualitative data of this study will be presented.

In chapter 7, information will be presented on one of the items in the CFI: the patient-clinician relationship. The existing literature on this subject will be reviewed. The supplementary interview on the Patient-Clinician Relationship will be introduced. Guidelines on how to use this interview will also be mentioned.

In chapter 8, a literature review will be presented on somatization as another problem in the psycho-diagnostic assessment of refugees. Conclusions from this literature review will be reported.

In chapter 9, an empirical study about the relation between torture and somatization in traumatized refugees, will be presented. Torture may be an underdiagnosed item in the assessment of refugees. An earlier diagnosis of this will improve the choices to be made in the assessment phase. This will result in formulating solutions which can be found in the overuse of somatic treatment options, and in the problems of somatization in the mental health treatment. This may constitute to suggest further improvements in the assessment.

In chapter 10, a general discussion will follow about the way the research questions can be addressed according to the study findings from the previous chapters. Also, clinical implications and suggestions for future research will be discussed.

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Chapter 2

Use of the Cultural Formulation with Refugees

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Abstract

This article discusses the experiences of mental health professionals who applied the Cultural Formulation (OCF) of the DSM-IV for assessment of psychopathology and treatment needs of refugees in the Netherlands. The OCF approach proved to be a useful tool in the assessment and diagnostic phase of clinical treatment. However, patients reported problems with defining their own culture and providing explanations of illness and therapists had difficulty identifying culturally-based difficulties in the clinical relationship. Additional information was needed about working with interpreters, therapists' attitudes towards the culture of the patient and towards their own culture, patients' previous experiences with discrimination and inaccessibility of care, gender issues, and specific cultures and subcultures. A more structured approach to conducting the OCF is recommended. We developed the "Cultural Formulation Interview" for this purpose. The adaptations are aimed at improving the OCF for use with refugee populations, as well as for more general use in transcultural psychiatry.

Key words
• assessment • cultural formulation • cultural interview • psychodiagnostics
• refugees

In the fourth edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (APA, 2000) an appendix was published with the text of the Cultural Formulation (OCF). This Cultural Formulation was developed to help clinicians and their patients bridge the gap between their different cultures. For example, the explanatory models used by ethnic minority patients were described in the OCF as opposed to the biomedical "meanings of distress and suffering" idiom used by western educated professionals (Lewis-Fernández, 1996). Four main areas of inquiry were identified in the OCF: cultural identity, cultural explanation of the illness, cultural factors related to the psychosocial environment of the patient, and cultural elements of the relationship between the individual and the clinician. Since the development of the Cultural Formulation, no substantial changes or comments have been made to improve this approach, although recently two publications have illustrated the original OCF form with current findings (Committee on Cultural Psychiatry [COCP], 2002; Lewis-Fernández, & Díaz, 2002).

In the Netherlands, the Cultural Formulation was welcomed as an important contribution to clinical work with psychiatric patients from different cultures. In 2002, a book was published in Dutch containing two theoretical chapters, 17 clinical cases, and a concluding chapter with comments on the approach and application of the Cultural Formulation (Borra, van Dijk, & Rohlof, 2002). The clinical cases included patients from the former Dutch colonies of Surinam and the Dutch East Indies, economic immigrants from Turkey, Morocco and other African countries and political refugees from Africa and Asia. The book was well received by those psychiatrists, psychologists and health care workers who provide treatment to ethnic minority patients and looked for a guide to improve the process of intercultural diagnosis and assessment.

The application of the OCF was of particular interest in the Netherlands because, like other western European countries, the population of non-western migrants and refugees is rapidly growing. Of the current population of 16.4m people, the number of foreign-born residents was 1.2m in 1995 and 1.6m in 2004. The number of individuals with at least one foreign-born parent rose from 1.2m in 1995 to nearly 3.2m in 2007, of which about 300,000 are refugees (Dutch Central Office for Statistics, 2007). By January 2007 about 56,000 people born in former Yugoslavia, 44,000 people from Iraq, 29,000 from Iran, 37,000 from Afghanistan, 19,000 from Somalia, and 12,000 from Vietnam resided in the Netherlands. These groups included 50,000 children in total. These numbers include only legal inhabitants, and do not take into account asylum seekers and illegal entrants (Engelhard, 2007).

Refugees are a heterogeneous group in terms of country of birth, language, religion and culture. What they share is a history of persecution, forced migration and often traumatization (Kleber, Figley, & Gersons, 1995). In the host country they often experience the tensions of exile, such as uprooting, social marginalization and social drift (Ekblad & Jaranson, 2004). Refugees are often regarded as difficult to work with in mental health care, both because they may experience many stressors, and because of potential problems with communication and diagnosis (Sue & Sue, 2003).

In order to understand the needs and expectations of refugee patients in mental health care, we used the OCF in the assessment phase of clinical work with refugees. This article describes our efforts with the OCF, and addresses two research questions:

1. What is the value of the OCF in the assessment of refugees?
2. What should be changed in the OCF to improve its application to the assessment of psychiatric symptoms in refugees?

In this article we will discuss these questions and provide answers based on case documentation (Borra et al., 2002) and our own clinical experience.

Working with the Cultural Formulation

The OCF was designed as a succinct means of describing the influence of the patient's culture on psychiatric assessment. Working with the OCF gives the clinician tools for evaluating cultural aspects of diagnosis. To this end, we have used the OCF as the basis for an interview protocol, which we called the Cultural Formulation Interview. As a tool, the OCF was also meant to facilitate among clinicians a less static and more dialogical understanding of culture in the processes of assessment and treatment (Kleinman & Benson, 2006). Finally, the OCF was also useful in making therapists in the clinic more culturally sensitive. Descriptions of patients in the OCF format gave insight into parts of the patients' lives, which were not revealed during a normal assessment procedure. In the following sections we discuss the different clusters in the OCF, as they arose in the assessment phase of refugees with psychiatric symptoms (as was common in the clinic) or after their treatment. Throughout this discussion, we explore how the different clusters worked out in refugees. We also propose some slight changes to the concept of the OCF.

1. Cultural Identity of the Individual

Cultural or ethnic identity is described according to the particular background of the patient, and it refers to the individual's preoccupations, memories, value judgments, attitudes, ambitions and emotional responses (COCP, 2002). While the cultural identity of refugees is linked to their country and region of origin, language, religion, norms and values, this link is complex because of the ambivalent relationship many refugees have with their home country. Most of our patients had difficulties describing their own cultural identities, which had undergone many changes. For instance, an Iranian Muslim had to describe himself as an Iranian, a Muslim, a person coming from a certain ethnically different province, or from Teheran, or as an asylum seeker without a status and with a diminished identity in a unfamiliar and often migrant-hostile surrounding, as part of an ethnic minority. We found, in our clinical work, that unlike people belonging to the large ethnic minorities in the Netherlands, refugees tended either to adapt to the society of the host country or to isolate themselves from it. They are, according to the acculturation model of Berry (1992), either assimilated or marginalized. In the Netherlands there are no neighbourhoods where refugees from the same country live together. This is partly due to the government policy of "spreading immigrants all over the country" and partly due to mistrust and avoidance of fellow countrymen by the refugees themselves. The words of a Bosnian refugee in the next case example illustrate this mistrust.

Case Example

I am from Bosnia, or rather from former Yugoslavia. My parents got married in the time of President Tito. They were both confirmed socialists and did not believe in God, however they were baptized: my father as orthodox Christian, and my mother as Muslim. They raised me with their belief in socialism and anticlericalism. When the war in Bosnia started they had to separate, since they belonged to different ethnic and religious groups that were hostile to one another. They were both killed. I succeeded in fleeing to your country. I mistrust both Muslims and Christians. I am not a socialist anymore, since I saw the ending of socialism in Eastern Europe. I am not religious, never belonged to a religion. I try to feel and think like a good citizen in your country. But I am aware that people look at me as a stranger. When they ask where I come from, I often say: Italy. That sounds better than Bosnia and they don't ask further about the war and so on. I try to avoid people from my country. My friends are mostly other migrants, from Morocco, Turkey and Surinam. I feel more like an Dutchman with an Italian look than a Bosnian refugee.

The example shows that it can be difficult for a refugee to determine his 'real' cultural and ethnic identity. Moreover, some patients have a much more fluid conceptualization of identity than the therapist who makes an initial ascription of identity based on a patient's skin colour, country of origin, or name.

2. Cultural Explanation of the Individual's Illness

This cluster of the OCF evaluates the following issues: (1) predominant idioms of distress through which symptoms or the need for social support are communicated, (2) meaning and perceived severity of the individual's symptoms in relation to norms of the cultural reference group(s), (3) local illness categories used by the individual's family and community to identify the condition, (4) perceived causes and explanatory models that the individual and the reference group(s) use to explain the illness and (5) current preferences for and past experiences with professional and popular sources of care. These cultural elements are very useful in the assessment of refugees.

This cluster helps the clinician to identify patients' ideas about their illness, which are embedded in their culture, and have a substantial effect on treatment seeking. The cluster is based on the theory of difference in explanatory models, according to which, a treatment will be more successful if a clinician and a patient share similar ideas about the etiology of an illness, the time and onset of the symptoms, the pathophysiology, the course of the sickness, including both degree of severity and type of sick role, and the type of treatment (Kleinman, 1980). For example, there is often disagreement between clinicians and patients about how to diagnose and treat somatic complaints. Many refugees do not see themselves as psychiatric patients who somatize, but as medical patients who have been wrongly referred to a psychiatrist. In earlier research we found that traumatized refugees are more likely than other traumatized persons to use somatic idioms for their complaints (Rohlof, Penning, Kleijn, & Oei, 2006). Somatic complaints in refugees are often seen as a result of injuries, of war, or injuries by maltreatment and torture during imprisonment. In most cases, a direct relationship between the complaints and an organic disease cannot be found, but there is a strong connection with the emotional aftermath. Performing the OCF often helps to draw out the stories of such traumatic experiences.

Additionally, clinicians may have their blind spots. Many link the psychiatric symptoms of depressive and anxious refugees with their histories of traumatization, because of war, imprisonment, persecution and the effects of a difficult and dangerous flight. However, this is often in tension with refugees' own accounts, which tend to link symptoms with their present social and juridical situations: not having a definitive permit to stay, not having adequate housing, or work, having to worry about their families in the country of origin, having to struggle with tensions with their family members here, having to learn a new language and trying to adapt to a new culture and society with all its different rules, norms and values, while experiencing nostalgia for their past life (see also Knipscheer & Kleber, 2006).

Some refugees describe their symptoms as resulting from guilty feelings about family members who died or have been left behind under bad circumstances. This can take the form of hearing the voices of their relatives telling them to take revenge or to return and save them – an experience that can be a long-lasting burden. Women, and men, who have been raped may feel a strong urge to talk about their traumatic experiences but may hesitate because in most of their cultures this is a great taboo. In some cultural settings women who have been raped are rejected and are forced to divorce. The following case example illustrates the explanatory model articulated by a Kurdish woman.

Case Example

I came as a female refugee from Turkish Kurdistan. I am a Muslim. I see my headache and the feeling of heaviness in my head as the effect of brain diseases. My backache is surely due to heavily beatings and torture in a police cell. I don't want to talk about the group rape by policemen to other people besides the clinician. I am afraid that my husband will leave me, when he hears of it. My lack of sleep and energy come from a curse by my mother who feels abandoned by me: she swore that I would not feel better until I have returned to her. During the night I hear her voice. I feel unable to change anything about my situation. I feel alone in this asylum centre, I don't have any friends. All is in the hands of Allah. My prayers just do not help.

In order to help us to identify local illness categories, we asked refugees to describe, in their native languages, the illnesses they thought they had (sometimes with the help of an interpreter). Refugees often do not know all the existing treatment possibilities in their country of origin. Contact with their own country of origin has often been cut off, and in many cases their illness started after their flight, so they have not had experience with medical or alternative practices. While this often makes it difficult for refugees to explain what their treatment of choice in their country of origin would have been, the advice they receive from more knowledgeable family members may influence their treatment seeking behaviour.

Research conducted by Starmans (2005) is particularly interesting in this regard. Using the OCF, he studied the illness explanations of Turkish, Moroccan and Surinamese patients in a general medical practice with chronic complaints, often of psychosocial or psychiatric origin. Only the Turkish patients expressed themselves in the same idiom as the medical doctor. Moroccan patients gave no explanation for their illnesses, and Surinamese patients predominantly referred to a somatic origin. All of the patients mentioned long-past events as possible causal factors, and none of them used psychiatric concepts such as depression or anxiety (see for comparable findings also: Hosper, Knipscheer, Kleber, & Vollebergh, 1999; Knipscheer, 2000; Knipscheer & Kleber, 2005).

3. Cultural Factors related to the Psychosocial Environment of the Patient

The third cluster of the Cultural Formulation, cultural factors related to psychosocial environment and levels of functioning, was helpful in evoking more information about the social and cultural situation of the refugees. Refugees live under different social conditions than do native patients or other migrants. Like all migrants, refugees not only must adapt to a new culture, they also face discrimination and sometimes overt racism. Moreover, refugees must cope with the long-lasting loss of ties to their home country. Because their family members are often absent refugees are also confronted with a loss of social support to a much higher degree than migrants who have their own communities in the Netherlands.

While refugees are still asylum seekers they live in separate asylum centres, which are often situated far away from cities. There is some support by organizations in these centres, and refugees sometimes are in contact with fellow countrymen they trust. But there is also significant isolation, and mistrust in the centres, as well as conditions which may increase the incidence of psychiatric complaints. Asylum seekers in reception centres have to cope with feelings of meaninglessness and worthlessness linked to forced unemployment. The length of an asylum procedure can thus play a considerable role in the origin of symptoms among refugees (Laban, Gernaat, Komproe, Schreuders, & De Jong, 2004). Due to the politics of the Dutch government, refugees are spread out over the country after receiving asylum, mainly into small villages where they are unlikely to encounter other migrants form their country of origin. More isolation is likely to follow if they do not make contact with Dutch citizens and receive support from them.

Refugees described receiving support from specific refugee organizations, from the extended family (by telephone), and from religious groups and practices. Some refugees, particularly those migrating from Africa, make contact with small evangelical groups, while others have a more individualistic approach to religion.

Taken together, the third cluster of the OCF urges the clinician to ask more specific questions about the social and cultural background of refugees, helping, in turn, to question stereotypes that the clinician may hold.

Case Example

I come from Cambodia and have suffered from the events of the Khmer Rouge regime, from my fifth year on. Although most of my family members survived, we all had to cope with difficult and life dangerous circumstances, all of us separated from each other. I am a Buddhist and I pray regularly, sitting at home before my Buddha statue. This calms me and let me accept all the things which happened to me. After a prayer I can cope with life again.

This accords with the findings of Sack, Him and Dickason (1999), who found symptoms of posttraumatic stress disorder (PTSD) coinciding with better than expected levels of functioning in a large sample of individuals who survived the so-called Cambodian killing fields. They attributed this seeming mismatch between symptoms and dysfunction to the Buddhist religion of Cambodians, which encourages the acceptance of historic events to a much greater degree than many other worldviews (Sack, Him, & Dickason, 1999; Van de Put & van der Veer, 2001).

4. Cultural Elements of the Relationship Between the Individual and the Clinician

Clinicians encountered the greatest problems working with this cluster. A substantial level of self-reflection was needed in order for clinicians to understand how their own cultural views influenced and hindered communication with patients. This required what one clinician called a "helicopter view" on the clinical relationship so as to understand both their own culture and that of the patient. This helped the professionals to achieve a deeper therapeutic relationship with their patients. Some of the clinicians who worked with refugees feared that aspects of their own identity would be a problem. For example a female Dutch therapist feared that her male Arab patient would not accept her because of her gender. An African doctor working with a Kurdish female patient who had been raped, thought that his patient would not have full trust in him. Both clinicians discovered, however, that this was not the case: with the respect they showed for the social situation and the cultural beliefs of their patients, a trusting relationship was soon established in which intimate details about experiences could be shared. All clinicians had to make a significant effort to learn about the culture of their patients, not only for the purposes of documentation, but also to improve the therapeutic outcome. One clinician decided to give his patient a written report of the cultural formulation, and asked for his comments. As a result of this exchange, the clinician was able to highlight issues which had previously been neglected, and the patient gained respect for the effort his therapist had made in trying to understand him, which made him more open about sharing information about his specific ethnic group. In this way, both became experts for the other, arguably resulting in a more equal relationship. Such techniques may be particularly important in working with those refugees who have had negative experiences with authorities, and thus are particularly.

Comas-Diaz and Jacobsen (1991) describe the potential pitfalls in therapeutic relationships that are cross-cultural, as well as those between patients and therapists from the same ethnic group, in terms of inter-ethnic and intra-ethnic transference and counter-transference. In inter-ethnic transference one can encounter mistrust, suspicion and hostility, or on the other hand friendliness and denial of ethnicity and culture. Intra-ethnic transference (between individuals from the same ethnicity) is characterized by patients' perception of the therapist as omnipotent, or alternately, a self-hating traitor. In inter-ethnic counter-transference the therapist acts as a clinical anthropologist, finding exotic syndromes in every patient, or as a guilty, or aggressive person. Intra-ethnic counter-transference could entail over-identification with the patient dividing the world into "us-and-them", and feelings of anger and survivor guilt. Being more aware of cultural elements entails having substantial knowledge about these mechanisms and about self-analysis.

In the assessment and therapy of refugees, many of these mechanisms play an important role. Because refugees are often seen as normal individuals who have experienced abnormal situations, there is always a danger of over-identification and over-involvement with these patients. In particular, clinicians tend to be more benevolent when refugees request formal statements from them, than when other patients make similar requests. Refugees may need statements from clinicians regarding their psychiatric disorders for a number of reasons, including legal procedures, housing, the validation of their inability to learn the Dutch language because of psychiatric problems (which is important for obtaining Dutch citizenship), social services, and categorization as being unable to work. However, sympathy can quickly change into antipathy: many clinicians tire of these requests, and begin to reject refugees as patients, conceiving of them simply as statement requesters rather than "real patients." Clinicians who share their patient's culture can experience greater difficulties with these requests, since they are often seen as omnipotent, but also as westernized people who dislike the most recently arrived migrants. All clinicians face the danger of potentially being viewed by their patients as part of the system that denies refugees the right to live in the new country.

Case Example

A 45-year old man from Bosnia was referred for psychiatric treatment for the third time, showing severe depressive symptoms with hallucinations, and heavy weight loss. He also seemed to be quite suspicious and hostile. He was tired of repeatedly telling his story. He said that he had waited a long time before consulting a psychiatrist. This became clearer when he mentioned that treatment was refused to him three times, since it was suspected by former clinicians that he would use being in treatment as an argument for obtaining legal status. In the meantime, he received no treatment at all, and his depression, linked to war experiences and existential problems, worsened. Apart from this, he obtained legal status a year ago.

Some refugees emphasize that they should not be seen as migrants, and actively deny their culture and origin, in order to receive a regular psychiatric assessment and treatment. This strategy makes sense, given that refugees are generally seen as difficult to handle psychiatric patients (Sue & Sue, 2003). When patients taking such an approach try to communicate in the language of the clinician, without really mastering this language, communication can unnecessarily become more difficult.

Towards a Systematic Application of the OCF: The Construction of the Cultural Formulation Interview

All the cases described in our book on the OCF (Borra et al., 2002) were written immediately after the end of the treatment, and thus were told with the benefit of hindsight. In effect, they are reconstructions of what could be said of a case with better knowledge and better skills than one may have possessed at the time. However, in the clinic we employ the OCF in the assessment phase, as it is meant to be used. In the course of this work, we have found that a systematic method for working with the OCF is not available. There are a number of reasons why this is the case. For example, the lack of a systematic method could be seen as in concordance with the narrative character of the OCF: a structured examination would seem to interfere with obtaining a narrative account. Also, the OCF could be meant to be a dynamic construct: eliciting all the information from a patient during the assessment phase runs counter to the idea that constant attention to changing cultural differences is needed throughout the course of treatment. Kleinman and Benson (2006) propose to transform the OCF approach into a mini-ethnography. For them, the most important components of the OCF are the patient's ethnic identity, eliciting what is at stake for the patient, the illness narrative, psychosocial stresses, and the influence of culture – including the culture of biomedicine – on clinical relationships. Their advice is to reduce the OCF to an activity that "even the busiest clinician should be able to find time to do" (Kleinman & Benson, 2006, p. 1676).

Although we favour his approach, we thought it would be helpful in the assessment of refugees with psychiatric problems to have a more extensive and complete interview for the OCF. The reason for this is that refugees often arrive from countries which are relatively unknown by most clinicians. Also, their cultural background is much more complicated than that of other migrants or members of ethnic minorities, in that it consists of several transitions (for example, war and peace, freedom and imprisonment), a series of countries (country of origin, first country of refuge, final host country), and a series of residence facilities (reception centre, asylum centre, permanent housing). Finally, refugees are often quite suspicious and not very eager to talk about their backgrounds. Having a low-profile interview seemed likely to make them more at ease, and more willing to talk about difficult events.

The interview could be conducted after the initial assessment interviews, possibly by an assistant in psychometrics or a student in psychology. For this purpose, we developed the Cultural Formulation Interview (see http://www.rohlof.nl/culturalint.htm), a semi-structured interview which follows the structure of the OCF, but attempts to translate this structure into practical and easy-to-ask questions. The goal of the interview is to provide the clinician with advice for diagnosis and treatment from a cultural viewpoint. Examples of questions are: What aspects of your culture are important for you? If someone in your home community was sick, or had roughly the same symptoms as you, how would those around them try to help (e.g., pray for them, leave them to rest, care for them)? 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) who would you ask about it? From whom would you seek the information?

In a pilot study of 20 refugees performed in our clinic (Foundation Centrum '45, the national expert centre for the treatment of traumatized refugees), we found that the interview is feasible, well-tolerated, lasts about one-and-a-half hours, and gives sufficient information about all the clusters of the cultural formulation. The interview can be conducted by a healthcare professional without a doctoral degree. We see the interview as a cost-effective psychodiagnostic tool (Rohlof & Ghane, 2003). Of course, an interview at the start of the treatment is not an excuse for the therapist to ignore cultural elements later on in the clinical process.

Discussion: Cultural Formulation Omissions and Improvements

In this section, we discuss key issues that clinicians reported to be lacking in the current OCF approach. We also provide suggestions that could improve the use of the OCF in therapy.

Working with Interpreters

Although the OCF pays attention to the language abilities of the patient, there is no discussion concerning the influence of working with interpreters. In sessions with refugees, we use an interpreter about 60% of the time, making it an important factor in the therapeutic setting. There should be an account of whether the patient prefers interpreters or not, or whether he or she prefers interpreters "live" or via the telephone. Fearing the potential of sexism or the violation of privacy, some patients refuse male interpreters or prefer interpreters who are not from their country of origin. This gap in the cultural formulation was addressed in a discussion on the use of interpreters in the recent book of the COCP (2002, pp. 38–41). They write about pitfalls in translation, including distortions, condensations, omissions and substitutions. Interpreters should provide a verbatim translation, especially when the patient is psychotic and words are difficult to understand.

Case Examples

An Azeri man wanted to have a Russian interpreter, although Russian is not his mother tongue. He was quite suspicious about Azeri translators because of his problems with the Azeri administration. However, he was also suspicious of Russian-born interpreters, and for that reason he demands a Dutch-born interpreter.

An Arab male refugee met his interpreter in the waiting room and started a discussion with him. The interpreter thought that the patient, while being a good Muslim, should visit the mosque more frequently. During the assessment interview the interpreter offered interpretations about the patient to the clinician. The clinician answered that it was the clinician's role to make the interpretations. Both the patient and the clinician rejected further collaboration with this interpreter and demanded one who was less moralistic.

Recent research has shown that in working with interpreters, the personality of the interpreter and her influence on the therapeutic process should be taken into account (Bot, 2005; Bot, & Wadensjö, 2004). One can speak of a three-person dynamic, in which the third person is the interpreter. The interpreter can be of great help in a clinical setting because of her accepting attitude and nonverbal signs of support to the patient. Patients consider interpreters to be important, which is noticeable in the frequency with which they ask for a particular interpreter, or sometimes refuse another. Research conducted by Bot (2005) on the possibilities of improving translation processes in therapy makes clear that it is useful to make working conditions more comfortable for interpreters. Translations by telephone should be avoided, although this is not always possible. In the Netherlands professional interpreters are provided free of charge to patients and clinicians: they are funded by the government, and are available to work in approximately 100 different languages. Unfortunately, this is not the case everywhere.

More attention to the influence of interpreters is necessary in the cultural formulation. It is important to note in the assessment phase whether or not an interpreter has been used in the conversation, which interpreter (from and to which language) and whether or not the use of an interpreter was helpful. Preferences for specific interpreters could be mentioned – both by the patient and by the therapist.

Some therapists prefer to work with an interpreter who gives specific information about the patient's culture, country of origin and linguistic dialect. The most logical place to describe these items in the OCF would be in cluster D: "Cultural Elements of the Clinician-Patient Relationship."

Attitude towards Culture of the Therapist

Clinician and patient attitudes toward each other's' cultures can have considerable impact on their relationship. This is not only the case when the therapist is ethnocentric, or has a feeling of animosity towards the patient's cultural group. Therapists from cultural minority groups may also have blind spots when treating patients from the same culture (Comas-Diaz & Jacobsen, 1991). It is overly simplistic to consider patients experts in the culture of their ethnic or national group (for further discussion on the topic of ethnic matching in the therapist-patient dyad, see Knipscheer & Kleber, 2004a,b). The advantage of the OCF is that the culture of the patient is made "personal": it is the patient's individual perception of a particular culture that is important, not what has been generally said or written about his group.

Clinicians should be aware that psychiatry has its own cultural views, including a strong conviction that medication and psychotherapy have a positive effect on specific psychiatric disorders, and that, on the contrary, native healers do not have this effect. In treatment centres for refugees, commonly-used therapies are derived from interventions meant to treat posttraumatic stress disorder (PTSD). However, according to some researchers, PTSD is a cultural construct, which may medicalize normal human experiences (Summerfield, 2001; Young, 1995). Clinicians should keep an open mind for the explanatory models used by their refugee patients, rather than restricting themselves to the terms employed in psychiatry. It would be useful to mention such distinctions in the second cluster, "Cultural explanations of the illness."

In the same cluster, some remarks should be made about (cultural) thresholds for psychiatric treatment. Stigmatization can play an important role here. Patients from countries where psychiatry plays a marginal role in medicine, mostly in the treatment of patients with schizophrenia, will often try to avoid psychiatric treatment and seek help from general health practitioners. Other patients may have a preference for biomedical treatment modules such as medication and may refuse psychotherapy. In turn, therapists may have a preference for medication or psychotherapy, according to their own professional training.

Another related topic that should be included in this cluster of the OCF is the secondary gain of psychiatric treatment. Kleinman (1995) described how trauma stories were important for refugees to obtain entrance to medical care and for acquiring political refugee status. In our clinical work we sometimes have the same experience (Rohlof, 2007). If the possibility of secondary gain emerges as a result of a specific demand for treatment, this should be mentioned in the OCF item on "Help-seeking experience and plans."

Discrimination in Health Care

Patients' experience of discrimination in health care is an important issue. Often, refugees are referred to our specialized national centre Centrum '45 because they are not accepted as patients in other mental health centres. Often this is because clinicians at these centres view these refugees' illnesses to be "too complicated" or because they "do not speak Dutch." True as this may be, it can also be considered a means of avoiding clinical work with foreign patients, who take more time than those with more culturally normative mental health symptoms. In addition, in the Netherlands a smaller number of refugees is treated in mental health care than in other spheres of medical care (Laban, Gernaat, Komproe, & De Jong 2007). It appears that general practitioners tend to refer refugees more frequently to non-psychiatric specialists because they consider refugees to not be suited for psychotherapy. The prevalence of this misperception is supported by qualitative research which shows that asylum seekers complain about the difficulties in finding proper medical care (Van Dijk, Bala, Öry, & Kramer, 2001). For refugees it would be good to include questions in the OCF about the perceived non-accessibility of health care, and of perceived discrimination and signs of racism in contacts with health care professionals. This could be part of the section on "help-seeking experience" in the second cluster of the OCF.

Gender Issues

In many of the societies of origin for refugees in the Netherlands, such as Iraq, Iran, and Afghanistan, gender role differences are much greater than in western societies. As a result, refugees in the Netherlands often have preferences for male or female clinicians, since they are resistant to talking to a person of the opposite sex. They may also have preference for a gender-specific therapy, either in the form of individual treatment with a therapist of the same sex or a gender-specific group. Gender-specific groups for refugees with gender-matched therapists often have more cohesion because there is less sexual tension, as we have found in qualitative research (Rohlof & Haans, 2004). Sexual tension and sexual attraction can be quite uncomfortable topics for many non-western refugees. Although mixed gender groups are desirable from a western clinical perspective, because they allow members to learn from the ideas and behaviour of the opposite sex, such arrangements may be very difficult for refugees from cultures where a high degree of gender-segregation takes place. This is also true for individual therapy, especially when the subject of therapy is rape or some other kind of sexual violation. Western psychiatric literature reveals limited evidence for differential outcomes of depression from psychiatric treatment provided by male or female therapists (Zlotnick, Ekin, & Shea, 1998). However, our clinical impression is that this would apply less to patients from cultures with more marked gender role differences. Moreover, it would be unwise to ignore the wishes of the patient, when the choice of a male or female therapist is possible.

In the Cultural Formulation, we suggest that the clinician enquires about past experiences with or current preferences for male or female clinicians. It would also be useful to ask whether the patient would have objections against a mixed gender group. In the OCF, this can be incorporated under the item: "Help-seeking experience and plans".

Differentiation between Reference Culture and Host Culture

There is a need for greater differentiation between the influences of the reference culture and the host culture on refugees. The cultural formulation has possibilities for making this differentiation, but only for clinicians who are knowledgeable enough to ask more specific questions. Subcultures should be better specified, and individual patients should be asked to describe their own subculture. For example, most countries that refugees originate from are characterized by a major divide between urban and rural environments. While this difference is much less distinct in Europe and North America, in terms of the availability of facilities for work, education and health care, cultural differences between urban and rural settings can still be substantial. The most important question is: To which cultural group does the refugee see him or herself belonging at the moment? What do they see as their potential host culture? A multicultural neighbourhood in a big city differs greatly from that of an environment with little cultural diversity. For example, a homosexual Iranian refugee arriving in the Netherlands would find it more difficult to live in a village in the so-called "bible belt" than in the gay community of Amsterdam. It is therefore quite important to clarify what each patient sees as his or her most important culture of origin, as well as host culture or subculture. For refugees this is particularly important because they tend either to overadapt to the host culture or to isolate themselves from both the host culture and their own cultural group. Clear descriptions in the cluster on "cultural identity" are needed for refugees.

Conclusions

The OCF is useful method in mental health care and produces information that challenges the stereotypes of both clinicians and patients. Working with the OCF stimulates clinicians to ask questions beyond than those included in the usual assessment procedures. Compared to standard assessment questions, the questions raised in the Cultural Formulation Interview lead the clinician toward greater understanding of the patient in terms of his or her sociocultural setting, which, in turn, will have a positive influence on the clinician–patient relationship. Thus it is essential to apply the OCF at the beginning of the therapeutic encounter.

When working with refugees, use of OCF is more important than it is with migrants, patients from ethnic minorities or native patients. Refugees have a particularly complicated background, in terms of cultural identity and diverse surroundings in the host country. In addition, they often have explanations of their illnesses which are unfamiliar to clinicians in the host country. Moreover, social stressors and support systems for refugees are quite different than for other migrants, as they often do not live in cultural groups, or in neighbourhoods populated by people of the same cultural background. The OCF is thus vital to the psychiatric assessment of refugees. However, the OCF could be further enriched by addressing the arguments raised in this article and codified in the proposed Cultural Formulation Interview. Specifically, greater attention should be paid to:

- the presence of an interpreter, her influence and helpfulness, and whether the patient has a preference regarding working with interpreters or a particular kind of interpreter;
- the attitudes of the clinician towards the culture and the explanatory models of the patient and towards the culture of his own profession and institution;
- the patient’s previous experiences of inaccessibility and discrimination in health care;
- the patient’s possible preferences for male or female therapists, or gender-specific therapy groups;
- the relevance of subcultures, and patients’ conceptualization of their own culture and the host culture.

With these modifications, the OCF can remain a highly relevant and useful tool for providing adequate mental health care for refugees.

Notification

The case examples included in this article are composites of patients seen by the first author.

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Supplement

The Cultural Formulation interview

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Summary and case history

Filled in using the dossier before the interview

1. Biography (personal and social details)
2. History of current symptoms
3. Earlier treatments
4. Psychiatric illness within the family
5. Course of illness

Introduction

Aim: explaining the interview and setting the tone

“People from all over the world come to our clinic. Every country and every culture has its own way of life.

You only really notice when you leave your own country and go to live in a foreign country. People look different, speak another language, behave and express themselves in different ways. We can sometimes get the feeling that we are not understood.

Have you ever had that feeling? [If yes, listen briefly to explanation – “we will deal with this later on in the interview”. If no, “Maybe you will understand what I mean when we discuss it later.”]

Problems in communication are sometimes partly the result of a lack of knowledge of cultural differences. Since we would like to help you as best we can, it is important for us to understand something of your country and your culture. By this we mean your way of life, which days you celebrate, what it means for you to be ill etc.

I will now ask you a few questions about your culture and your symptoms”.

A. Cultural identity of the individual

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

- How well do you speak Dutch? How does it feel to always have to speak Dutch? Does it sometimes cause problems?
- To which ethnic group do you *officially* belong? Do you feel that you do belong to this ethnic group, or to another one? Does this ever change? (E.g. do you always feel that you are ..... or sometimes something else?)
- Do you miss other people having the same cultural background as yourself? (If yes:) Explain/ Why?
- What aspects of your culture are most important to you. (E.g. family structures, norms and values, feast days, faith...)
- Do you have children?
- (If they have children) Do you bring up your children in the same way that you were brought up? Explain.
- (If no children:) Would you bring up your children in the same way? Explain.
- To what extent can you follow your culture's way of life here in the Netherlands?
- Are their aspects of your culture that bother you are that you find less attractive?
- Do you feel involved with Dutch culture (E.g. do you interact much with Dutch people, do you go to Dutch social events, do you read Dutch literature, are you interested in how thing work in Dutch society, are there things in the Dutch culture which you are adopting.....)?
- If so, what aspects of Dutch culture do you like, and what aspects bother you?

B. Cultural explanations of the individual's illness

(Record explanation in individual's native language)

Now, about your symptoms,

- What are your worst symptoms? What do you call them in your own language?
- How do you think your symptoms started? (If only single answer: do you think that there are alternative/more explanations for your symptoms?)
- How do your friends, family and those around you explain your symptoms?
- How would people of your culture explain your symptoms?
- Do you feel understood by your friends, family and those around you?
- Have you felt up to now that the staff here understand you? Would you expect them to?
- If someone in your home community was sick, or had roughly the same symptoms as you, how would those around them try to help (e.g. pray for them, leave them to rest, care for them)?
- Are you being cared for in that way now?

- Do people where you come from sometimes make use of alternative, native or faith healers, or do people go to a normal doctor or hospital?
- What kind of help have you had up to now for your symptoms (both normal and alternative)? What helped most?
- What kind of treatment would you like to receive now? What would you personally prefer?
- (Examples: Talking about events in the past, adapting to the present, make plans for the future,talking about your emotions, receive advice, exercises, medicines,...)

C. Cultural factors in psychosocial surroundings and in functioning

- Now, let's discuss your daily life here rather than your daily life in your native country
- What is your current situation – are you married, do you have a family here?
- What is your position in your family? Is this different to the situation in your country of
- origin? Explain.
- Is there someone in your family who people go to for advice?
- If married: How is your relationship with your wife? Is this different to what it was in your country of origin? Explain.
- If has a family? How is your relationship with your family? Is this different to what it was in your country of origin? Explain.
- Have there been important changes in your social position in recent years? If yes: what does this mean for you?
- 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?
- If you had (emotional) difficulties in your own country, what did you do? To whom did you go?
- Is there someone in the Netherlands from whom you receive (emotional) support (e.g. when you are sad)? Is this person family of yours? How often do you make use of this opportunity?
- Is there someone in the Netherlands with whom you talk about your symptoms and traumatic experiences? If yes: Why him/her? Is there someone you would *like* to talk to? Explain.

Some people are greatly strengthened by their faith

- Are you religious?
- Do you pray? How often?
- Do you feel that prayer helps you? In what way?
- Has your faith changed since the experiences you had?
- Do you still pray as often as you did?
- Do your prayers help you as much as they did?
- Do you go to a place of worship (church, mosque etc) in the Netherlands? Do you always go to the same one? How often do you go?
- Do you know the people there?
- Do those people help you? Is there someone in particular who helps you? In what way do they do that?

D. Cultural elements in the relationship between the individual and the carer

- 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?
- Some people consider clinical staff to be their equals, sometimes even their friends. Others feel that the staff are above them, or beneath them. How do you see this? Do you that the medical staff and social workers are equal to you, beneath you or above you? When they advise something or prescribe medicines do you feel that you <u>must</u> take the advice or use the medicines?
- If you had a free choice in selecting the personnel treating you, would you prefer male or female personnel? (As a choice:) Why? (trust, shame, more likely to understand, easier to express yourself...)
- 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? (As a choice:) Why? (trust, shame, more likely to understand, easier to express yourself...)
- 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

This is the end of the interview. Thank you very much indeed, I personally found it very interesting to learn about how these things work outside the Netherlands and I hope that we can use what you have told me to understand and help you better.

Is there anything else that has not been mentioned in this discussion an which you would like to tell me about?

To be completed by interviewer after interview (optional, some matters will only become clear during the course of the treatment):

- Communication problems experienced within the patient's own language (use of terms/concepts and motivation/interest
- Extent to which symptoms have a cultural meaning for the patient
- To what extent is the patient prepared to engage in a working relationship with the therapist?
- Degree of closeness (personal contact)
- Pathology or otherwise of behaviour.

E. Observations during the interview

What was the contact with the client like? What kind of impression did he/she make? Record other notable issues from the conversation

F. Summary

Summary of the most important issues raised during the interview

G. Advice for further treatment

Possible problems in the area of cultures which could be an obstacle communicating with patiënt and specifying the diagnosis and the treatment. At the same time things can be noted which can be looked at in treatment.

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Chapter 3

Cultural formulation of diagnosis: state of the art. Literature review of a culturally-sensitive tool

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Abstract

In 1994, the Outline for Cultural Formulation (OCF) was included as a supplement to the DSM-IV. The OCF was developed as a tool to help care providers gain more insight in cultural factors which might be relevant while diagnosing mental problems of patients with cultural backgrounds that differ from the care provider´s. More than twenty years after publication, the query is justified whether the OCF actually serves the purpose it was intended for, and whether any adjustments are needed. By means of a literature search an answer is sought to these questions. The main conclusion is that reactions of professionals to the cultural formulation were positive and that it has managed to find its way into education, and, to a lesser extent, into clinical practice. However, evaluative and effect studies have been mostly lacking in the first period. Recent research has shown more favourable effects.

Key words
• mental health care • diagnosis • cultural formulation • cultural interview

Introduction

The Outline for Cultural Formulation (OCF) is a tool intended to improve diagnostic validity as well as to help align clinicians' recommendations of patients in mental health care (Lewis-Fernández, 1996). The tool was created by transcultural psychiatrists and medical anthropologists and added as a supplement to the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 1994).

In the OCF four components to be discussed with each individual patient are specified. The OCF is based on an idiographic and narrative approach of illness derived from psychiatric and medical anthropological views such as described by, among others, Kleinman (1980). In the four components these views are prominent:

- cultural identity: the identity of the individual is strongly influenced by the ethnic or social groups in which he is participating and the cultural repertoires which are shared. Knowledge of the cultural identity helps clinicians to understand the influence of culture in everyday life of the patient. Identification is an on-going process, which often yields multiple identities linked to participation in different ethnic or social groups.
- illness explanations: the way in which the individual gives meaning to and explains his illness has impact on his or her help seeking behaviour, and on the choices the clinician should make for the treatment he proposes to the individual patient.
- psychosocial environment and levels of functioning: often, social support, from family members, friends or religious groups is poorly recognized when there is a cultural distinction between the patient and the clinician. This is the same for levels of functioning: i.e., functioning in a household, family and community is mediated by cultural norms.
- cultural elements in the patient-clinician relationship: similarities and differences between the patient and the clinician; the more the cultural background between these two differs, the more the likelihood that errors will be made in diagnosis and the following treatment.

In The Netherlands, the relevance of the OCF has been discussed by Borra and others (Borra, Van Dijk, & Rohlof 2002). The power of the OCF lies in the description of a contextual perspective of the mental health problems of the patient. The individual giving of significance of the inner world of the patient is elicited. An individually evaluated OCF is a snapshot that during treatment needs to be checked and updated. It can serve as a check list for the culturally experienced clinician and a searching tool for the less experienced clinician. The OCF has been used in the Netherlands for about fifteen years. In the first years, the OCF was mainly used as a way to present cases of migrants in a culture sensitive way, such as in the book by Borra and others. Recently, more attention has been given in using the OCF in all kinds of patients by means of a Cultural Interview (CI) , a questionnaire based on the OCF. This CI, originally developed for refugees by Rohlof and colleagues (2002), was further developed for other populations, and used in these populations (Beijers & Tempelman, 2009; Groen 2009; Van Dijk, Beijers, & Groen, 2012). In DSM-5 (American Psychiatric Association, 2013), the OCF has been elaborated into a Cultural Formulation Interview (CFI): this is the coexisting with the CI, and needs more clinical testing (Lewis-Fernández et al., 2015).

Since the OCF has been slightly adapted in the DSM-5 some nineteen years after its introduction in DSM-IV, questions arise again about its role in clinical practice. The question at stake since its introduction in 1994 is whether the OCF has made a significant contribution in describing the cultural aspects of the diagnostic process in psychiatry. The OCF has been developed to make diagnostic processes more culturally validated, and to broaden the scope of a mostly western diagnostic system to psychopathology as existing in other parts of the world, in communities that are culturally different from the western. Was the OCF helpful in these processes, or should it be seen as a new and original instrument but with limited or no clinical use?

Methods

With the questions above in mind, a literature search was performed. With *cultural formulation, cultural assessment, cultural consultation,* and *cultural interview* as key phrases in combination with *mental,* articles in the English language about mental health (care) were searched in Ovid Medline (1994-present) and PsycINFO (1994-2013 and an additional search in 2017). Articles in the Dutch language with the same key words, but in Dutch, were also investigated, about mental health care and other care sectors such as general medical care. The literature search was supplemented with experiences of clinicians in the Netherlands involved with the implementation of the OCF and the cultural interview in clinical practice, mental health care and medical schools.

After a description of the outcomes of the literature search, we examined the amount of experience that has been acquired since the introduction of the OCF. The OCF has been operationalized in various forms in models and questionnaires for clinical interviews. Because the DSM-5 is operationalized in the Netherlands since

January, 2017, we did not include the CFI in our analysis. We describe the various models, on which components of the OCF they are focused, and how they have been applied.
Next, we address questions as:

- stretches the applicability of the OCF further than diagnosis and treatment of migrant patients?
- are adjustments required in the OCF for specific target groups such as refugees, who differ from other migrants because of their forced migration and, for many of them, traumatic experiences? And what about the effects of the OCF, does an OCF lead to more effective diagnosis and more efficient care?
- can it be used to work more cost efficient?

Finally, we consider the question whether adjustments to the OCF should or could be made based on research results and clinical experience, without damaging its value as a narrative tool.

Results of the literature search

General

The literature search yielded 28 articles describing the application of the OCF in various clinical populations. In most cases, these populations are from ethnic minority groups: migrants, refugees and American minority groups. Three articles deal with patients from other groups: one is about applying the OCF specifically to female psychiatric patients, two are about children in treatment.

The publications are mainly descriptive and discuss the application of the OCF in clinical practice. So far, little comparative research seems to be carried out and hardly any controlled effect research is available. A couple of articles discuss the OCF in education. Since these articles do not add much to the already written descriptive articles on the OCF, they are not discussed in length here.

A description of articles with qualitative and quantitative research is given below.

Publications in Dutch and experiences in the Netherlands indicate that the OCF does not only play a role in clinical practice, but also in schooling and training of care providers. Education experiences appear to be positive. Health-care psychologists in training report that obtaining contextual information about patients by means of the OCF has a positive effect on the relationship between patient and care provider. Patients appreciate this narrative approach and it helps GPs, psychiatrists or psychologists to understand what is really at stake more quickly. Above that, applying the OCF requires in the end less time to formulate treatment hypotheses and helps in finding more tools for treatment (Bruggeman & Busser, 2012; Beijers & Van Dijk, 2012).

Models For Clinical Interviews

So far, the model of the OCF as presented in the DSM-IV did not lead to a uniform format and application. The procedure as described in the DSM-IV supplement is too broad and there are no generally accepted instructions. In this literature search we focus on attempts that have been made to bring about uniformity in the method of gathering background information and setting up the OCF.

Six interviews models are described in literature for interviewing patients about their cultural backgrounds and for evaluating the impact of cultural aspects on the therapeutic process. They address one or more components of the OCF.

Weiss (1992) compiled, prior to the introduction of the OCF, the Explanatory Model Interview Catalogue (EMIC) as a socio-cultural formulation. This tool is primarily intended for comparative research as to the way in which patients from different cultures react to illness. It focuses on only one aspect of the OCF, i.e. the second part about illness explanation.

An extensive instruction for mainly residents was entered in the Clinical Manual of Cultural Psychiatry (Lim, 2006). It is an enumeration of many questions and points of attention which may be relevant to various parts of the OCF. Lim encourages residents to use the OCF. He makes this easier in offering mnemonics, like ETHNIC (explanation, treatment, healers, negotiation, intervention, and collaboration) for illness explanations and 'who, what, where, when, why, how' for migration history.

Groleau, Young and Kirmayer (2006) developed the McGill Illness Narrative Interview (MINI). This is a semi-structured interview which is developed to elicit illness narratives. The interview is mostly used in health research, also in the case of somatic diseases. The interview contains sections on illness narratives, on prototypes, i.e. similar problems in others, on explanatory models, on services and responses to treatment, and on the impact on life. The MINI does not contain sections on cultural identity, only two questions on stressors and support (except two questions in the 5th section), and no questions about clinician-patient relationship. In fact, comparable to the EMIC, the MINI is focussed on the second theme of the OCF: illness explanation.

In Sweden, Bäärnhielm, Scarpinati Rosso and Pattyi (2007) published an interview manual for the OCF. They offer 89 questions, sometimes with supplementary questions added. They do not describe experiences with the interview manual, neither feasibility, acceptability, or length. They do stress the importance of conducting the interview. In a later article, they present two clinical vignettes, showing this importance (Bäärnhielm & Scarpinati Rosso, 2009).

Mezzich and colleagues (2009) presented guidelines on how to collect cultural information according to the OCF. The authors regard the OCF as part of the first encounter between a psychiatric patient and a clinician. They gave general guidelines on how to conduct a basic diagnostic assessment. Moreover, they presented guidelines on how to introduce an OCF. The authors suggested 67 questions (in some cases with supplementary questions) for the clinician. Mezzich et al. did not write about experiences with the questions, about feasibility and acceptability of their questions and about the length and the relevance of the interview. No further report was found in the literature.

Clinical interviews in the Netherlands

In the Netherlands, the Cultural Interview (CI) was developed in Centrum '45, a clinic that offers trauma treatment for refugees (Rohlof, Loevy et al., 2002; Rohlof, 2008; Rohlof, Knipscheer, & Kleber, 2009; Rohlof & Groen, 2010). This structured interview consists of forty questions that provide information about all the components of the OCF. Research among thirty patients, all of whom were refugees, indicated that the cultural interview was feasible, that patients particularly appreciated questions about positive aspects of culture and that the interview could be conducted in about ninety minutes by undergraduate psychology students (Rohlof & Ghane, 2003).

Groen (2008) constructed a brief version of this cultural interview (BCI) and investigated its feasibility, acceptability, and clinical utility at De Evenaar, a center specialized in the treatment of refugees, asylum seekers, and other migrants (Groen et al., 2017). This shortened version is less work-intensive, both in the length of the interview and in compiling the report, and it gives enough information to formulate a culturally sensitive diagnosis and to write a treatment plan (Groen et al., 2017; Groen & Laban, 2011).

By now, based on clinical practice and the original draft of the CI, versions have been developed for forensic psychiatry, child- and adolescent psychiatry. The former is focused on criminal offence, the latter on aspects of upbringing and parent-child relationship. There is also an adapted version for GPs and for the care of the mentally retarded. These versions can be obtained from the first author. Thus, in the Netherlands, we can speak of a tendency of standardization within specific fields or sectors of psychiatry.

Piksen (2012) conducted a qualitative study on the administration of the CI in The Netherlands. She concluded that in some cases the questionnaire is used as a whole, in other cases partly. The questions are not always used literally, but serve as guidelines to enhance the dialogue interaction between patient and clinician. The feasibility of the CI is reasonable, but a clear explanation to the patient of the interview remains important. As valuable outcomes she noticed the augmentation of the contact between clinician and patient, the building of trust, and improvement of diagnostic and thus therapeutic quality. She recommended to add questions about discrimination and to incorporate the interview in the electronic patient file.

The development of interview models and questionnaires for operationalization of the OCF also gave rise to some critical sounds. Experts point out the risk that care providers might see taking the cultural interview and composing an OCF as a tool, to be used just once at the start of the treatment process (Van Dijk, 2002; Van Dijk, 2010; Rohlof & Groen, 2010; Van Dijk, Beijers, & Groen, 2012a, 2012b). They emphasize that the CI is more than just one of the many assessment tools and indicators which are relevant for diagnosis and medical indication. The CI comprises the patient's point of view towards his problems, complaints and suffering, thereby attaching particular importance to remaining sensitive to cultural and contextual aspects, from assessment and diagnosis, and during the course of treatment. In this sense, the CI is work in progress and can contribute to a more open-minded attitude and a more comprehensive and culturally sensitive way of diagnosing and treatment.

Applicability In Providing Care To Indigenous Patients

Kortmann (2006) postulates that all psychiatry is transcultural psychiatry. This postulation is concurrent with the emphasis in the field of migrant mental health that care for migrants leads to perceptions that are relevant for all mental health care, regardless the cultural background of the patient. Others state that there is a cultural encounter in every clinical setting, because of the co-occurrence of lay and medical cultural repertoires (Boutin-Foster et al., 2008). The literature search provides no information regarding possible added value of the OCF for the treatment of indigenous patients. Borra et al. (2002) do present a couple of case histories of patients from originally Dutch religious minority groups. In these cases, subcultural differences between care providers and patients keep cropping up, and it becomes clear that here, composing an OCF would result in better understanding of the nature and implications of the patient's mental health problems. More is needed, however, to prove the added value of the OCF in providing care to all patients.

Application of the OCF for refugees

So far, only few publications were retrieved on the applicability about the applicability of the OCF for refugees.

We only found three publications. Acharya (2009) used the OCF with Bhutanese refugees in the United States, but gave no comment on the OCF or its value for this group, nor did she suggest any adjustments. She does state that for this population, cultural factors such as concepts of self, ascribing mental complaints to stress factors, stigmatizing mental disease and language concepts influence the way in which symptoms are conceived, constructed, and expressed. She also stresses the relevance to discover the social perception of mental health problems and help-seeking, so that the therapist can take this into account in his treatment and thus achieve a better therapeutic result for patients. She recommends using the OCF for every patient.

Rohlof et al. (2009) commented on the use of the OCF for refugees from various backgrounds. They advised collecting specific information on working with interpreters, on the therapist's relationship to his own culture and the patient's culture, on the patient's previous experiences with discrimination and inaccessibility of care, on gender topics and on specific cultures and subcultures. For that matter, the authors consider these aspects to be just as important for refugees as for other migrants.

Groen (2008) showed that information obtained from the cultural interview results in more accurate diagnosis and treatment of refugees and asylum seekers. Elsewhere, he exemplifies the use of the OCF and the cultural interview by means of a case history of a Somali refugee (Groen, 2009).

In short, the OCF can certainly be used for refugees and what has been written on the topic gives no reason to see differences in its application to refugees compared to other migrants.

Effects On Diagnosis And Treatment

Does using the OCF lead, directly or indirectly, to better care, because of a more accurate diagnosis and/or more fitting treatment? So far, only few studies have focused on the effects of utilization of the OCF. The OCF is generally part and parcel of interventions and has rarely been investigated as a separate variable. Thus, literature mostly offers findings on culturally sensitive interventions in general, whereof the OCF is just one. So far, this kind of research has mainly been of a qualitatively descriptive nature.

There are many publications on culturally sensitive interventions. We will discuss three reviews.

In a comparative survey of 76 case studies with culturally adapted interventions, Griner and Smith (2006) concluded that the effect size of these interventions had an average of .45. This indicates a moderate strong benefit of the culturally adapted interventions. They found that interventions targeted to a specific cultural group were four times more effective than interventions provided to groups consisting of clients from different cultural backgrounds. Moreover, interventions in the native language of the client were twice as effective as interventions conducted in English.

Bhui et al. (2007) uttered a slightly different opinion. They reviewed descriptions of 109 mental health programs with cultural competent care in the field of psychiatry and they found that only 9 of these programs included an evaluation, all of them in Northern America. None of these studies were mentioned by Griner and Smith (2006). Only three studies used quantitative measures. They concluded that the programs showed evidence of significant satisfaction by the clinicians, but that there was no report of service user experiences or outcomes. One showed that practitioners changed their behaviour towards the patient and treated him more effectively after being trained in cultural competence. They recommended a further evaluation of those programs, both from the clinician as from the patient's perspective. In sum, there is some disagreement in review studies whether cultural competent services are proved to be effective.

Van Loon et al. (2013) performed another review of nine studies on culturally adapted treatment of depression and anxiety, none of which were included in Bhui's review. They concluded that culturally adapted treatment for depression and anxiety was effective in U.S.A. minority patients. The pooled difference of the nine studies with general treatment was 1.06.

Part of cultural competent services are cultural competent assessment procedures. Is adding the OCF, in the form of an interview or in another form, effective in enhancing the cultural competence of the whole treatment process?

We found four comparative studies in which the OCF as part of the diagnostic process was compared with standard diagnostics.

Neighbors et al. (2003) showed that Afro-Americans are far more frequently diagnosed as being schizophrenic than white Americans, but that using the OCF reduced this over-diagnosis. In other words, the OCF contributed to formulating a more accurate diagnosis.

In a study of 29 patients in Morocco, Zandi et al. (2008) ascertained that the Comprehensive Assessment of Symptoms and History (CASH) as diagnostic tool matches badly with the clinical diagnosis, whereas adding elements of the OCF results in a significant improvement of this match. There were more patients diagnosed with an affective disorder than with a psychotic disorder.

In a survey in which the effect of the OCF on treatment result was investigated, Lopez-Appelo (2000) compared two groups of patients of Latin-American origin (n=1003). The first group received culturally sensitive treatment, including the OCF, and the second group received regular treatment. A significantly better treatment result was found in the first group.

One small-scale evaluation research showed that the introduction of the CI in interpersonal therapy in an outpatient clinic specialised in treating patients diagnosed with depression reduced the drop out among patients with a non-western background significantly (Gumbs, 2012).

A few comparative surveys are also focussed on increasing practitioners' cultural competence. Cultural competence refers to the capacity of practitioners to work effectively in cross cultural situations. The OCF is often used to this end. In a survey with self-assessment questionnaires, Harris et al. (2008) showed that after a nine-week course during which knowledge and application of the OCF were discussed, residents' multicultural knowledge, skills and attitude improved significantly and clinical application of the OCF increased. Incidentally, the effect subsided in a follow-up after nine months. Kirmayer et al. (2008a, 2008b) also noticed increased cultural competence in physicians and other practitioners of a cultural health clinic after a course on the OCF. The researchers did remark that applying the OCF insufficiently informs the clinician on relevant migration experience and religious and spiritual aspects, since these items are not well mentioned in the text of the OCF.

Ton et al. (2005) researched cultural health clinics in the United States. They concluded that one-to-one treatment of patients by practitioners belonging to the same cultural group (so-called *ethnic matching*) was hardly feasible, but that using the OCF was important in bridging differences in culture when no ethnic match proved possible. Moreover, ethnic matching is no must (Cabral & Smith, 2011).

In the case of the Netherlands, Borra et al. (2002) illustrated the significance of the OCF for the diagnostic process by means of an extensive description of seventeen case studies. They point out the risk of using the OCF as a tool without simultaneously investing in the therapist's cultural sensitivity. In other words, the OCF cannot only be used as a simple checklist regardless of the practitioner's underlying cultural skills and attitude. Moreover, they remark that by emphasizing cultural differences in the OCF, sociological and socio-economic aspects may be lost. They mention that there is also the risk that gender issues can be neglected. In the description of the OCF there is a section on clinician-patient relationship, but not on the interference of interpreters. Borra et al. (2002) point at this omission. Working with interpreters should be added to the problems patients and clinicians possibly meet when they do not share the same language. An interpreter obviously enables communication, but in some cases may also be a barrier because of shame and fear for gossip.

In a general practice in The Hague, Starmans (2005) used the OCF in the form of an adjusted cultural interview to investigate disease explanatory models of three different migrant populations with chronic complaints. He demonstrated differences in illness explanation between Hindu-Surinamese and Moroccan patients and their physicians, but not between Turkish patients and their doctors. The Moroccan patients were illiterate and offered no explanation at all for their chronic complaints, whereas the Hindu-Surinamese patients often referred to circumstances from a long time ago to explain their disorder. According to Starmans, this has consequences for the tackling of complaints. There were no further indications that asking the patient to explain his illness affected the physician's authority as regards his decisions for treatment.

Contrary to Ton et al. (2005), on this issue, Beijers and Tempelman (2009), using their experience with the education of mental health care workers in the use of the OCF and the CI, have the opinion that therapist and patient understand each other better thanks to the cultural interview, which in turn improves their treatment relationship.

Apart from the study of Lopez-Appelo (2008) no studies are available which prove that patients are cured more quickly or have fewer complaints after having been diagnosed and treated with the aid of the OCF. Neither have any studies been carried out so far that indicate that using the OCF leads to reduced cost.

An unpublished study in the Netherlands showed however some poor results (Nivel, 2015). An adapted CI was used in 43 non-western patients in some general practices. Outcome results of these group in physical and mental health, as well as care use and trust in care were compared with a group of 22 patients with the same demographic features. No statistical significant differences were found. However, the follow up period of 4 months was probably too short to show any results.

And the participators in the research regarded the interview as a valuable tool for exploration apart from the psychiatric complaints. The questions, they expressed, enlarged the understanding of the patient's view and improved the relationship.

Adjustments to the cultural formulation

The literature review indicates that some items should be added to the OCF, such as the use of interpreters and explicit questions about the patient's migration history. In our opinion, other relevant adjustments to the OCF are writing a more systematic summary (cluster V) and condensing or reducing the number of components of the OCF.

In the last part of the OCF the practical consequences of the acquired understanding for diagnosis, indication and treatment are laid out in the form of a summary. This part constitutes the connection between the OCF and the clinical practice. When the OCF is written by a different professional than the therapist, this part constitutes an important guideline for the therapist. When the writer of the OCF and the therapist are the same person, this part is a memory aid for the patient's culture-specific points of attention. Several suggestions have been made to systemize this part of the OCF and some general comments concerning the lay-out of the OCF are also relevant. So far, however, these ideas have not resulted in a widely supported proposal for adjustment.

Mezzich (2008) suggests developing standards for cultural assimilation and quality of life. If these concepts are measurable, comparing groups of patients will become possible.

Rohlof (2008) argues for describing cultural elements rather in terms of problems and possibilities in communication, diagnosis and treatment than in terms of cultural differences. Others have the opinion that cultural elements should be described as a process rather than a static situation (Van Dijk et al., 2002).

An essential part of the summary is a description of the manner in which the patient's individual behaviour relates to the group with which the patient identifies. The point is to understand how the patient deals with available cultural repertoires. After all, it is always about an individualized experience of culture (Lakes et al., 2006), and not an established cultural standard. If the OCF is to contribute to reducing stereotyping and culturalizing, it is important to find out why patients (and care providers) describe certain matters or processes as being cultural, how the patient deals with cultural repertoires in concrete situations and how cultural meanings relate to (inter)personal and social meanings (Kleinman, 1998; Van Dijk, 2010).

Is it possible to shorten the OCF, and to reduce the number of themes or components? This implies possible friction between the OCF's effectiveness and its value as a narrative tool. It goes without saying that an assessment according to the OCF takes more time than a traditional questionnaire and thus requires a larger investment of time and money. Seen from this point of view, a shortened version of the CI could stimulate its use in clinical practice. In this respect, experiences of De Evenaar, regional health care Drenthe, where the cultural interview has been held as standard procedure with each patient, are interesting (Groen, 2009; Groen & Laban, 2011). At the clinical practice there, it has appeared that explanations of illness have more influence on the cultural identity than the other way round. In other words, the way patients think about their disease is of prime importance, for example that their life was more or less at a standstill because of mental complaints. This has a greater influence on their daily functioning and their self-perception than their cultural identity. For more evidence of the importance of explanatory models on treatment effect above cultural identity (among other things), see also Benish, Quintana and Wampold (2011).

These findings contradict the OCF's original aim. Lewis-Fernández (1996), one of the constructors of the OCF, takes the view that someone's cultural identity is a necessary step to gain insight in other than biomedical symptoms of disease. It is not clear whether this difference in focus has to do with the specific population of traumatized refugees.

Simultaneously, it emerges from the same clinical practice that the clusters cultural identity (I) and, though less so, psychosocial environment (III) appear to have a greater influence on practitioners' considerations while making a treatment plan than the other two clusters (explanation of disease, cluster II, and cultural elements between patient and clinician, cluster IV) do. Particularly relevant elements were thought to be: origin, ethnicity, assimilation to the new culture, course of life, perception of self and gender (cluster I); understanding illness, explanation of illness, and religious aspects (cluster II) and place of the family, contacts with relatives, social contacts, feelings of shame and stigmatizing (cluster III) (Groen, 2009).

These experiences indicate that the OCF could be limited to these aspects. The cultural aspects in the patient-practitioner relationship are dealt with in the first three clusters. The aim then is to constantly scrutinize the patient-practitioner relationship per cluster: what are the consequences of identity, explanation of illness and psychosocial environment for the work relationship?

In the discussion about shortening the OCF, its positive effect on the patient-practitioner relationship must not be ignored. This nonspecific effect is crucial for the clinical practice, because adherence to medication and treatment depend on the working relationship between practitioner and patient. We should beware of throwing out the baby with the bath water.

Conclusion

In 23 years, a considerable amount of research has been carried out into the use of the cultural formulation in the diagnosing process. Only few of these studies were evaluative. This could partly be explained by the fact that such research is hardly feasible because of the methodological complexity and high cost. This makes it difficult to draw far-reaching conclusions. It is impossible to ascertain from the information found in available literature if and how the OCF contributes to a more effective or efficient treatment. The available data do not irrevocably suggest that use of the OCF leads to more accurate diagnosis and treatment. Only Lopez-Appelo (2008) shows a significant difference in outcome of treatment in the case when more culturally sensitive treatment, including application of the OCF, is administered.

Nevertheless, many authors, practitioners themselves, evaluate the OCF and the use of OCF-inspired interview-models positive and consider it having a value for diagnosis and treatment in psychiatry, judging from their experience with the tool. Based on descriptive research and practical experience, they recommend applying the OCF to various populations of ethnic minorities and migrants. They pose that the OCF seems to have a positive influence on the quality of the diagnosis and the treatment and on the relationship between the patient and the care provider, and thus on the patient's adherence to his or her therapy.

There is research about the feasibility and applicability of the OCF in clinical practice. From this research it appears that the OCF might need to be adjusted. For example, more attention should be paid to the use of interpreters. Clinical practice also shows that it is necessary to understand the patient's personal and collective past (migration, escape) and his current living circumstances (socio-economic aspects, power relationships, social environment). The OCF does not exclude these elements, but because of the frequent coining of the word culture, there is a strong emphasis on cultural aspects, possibly at the expense of other relevant aspects. There may be a risk of culturalizing, of interpreting behaviour cultural, although it has little or nothing to do with a person's culture. Therefore, it would be better to speak of a Contextual Formulation and accordingly to extend the OCF with specific points of attention. Furthermore, one could argue that the dynamic culture concept underlying the OCF and the CI does not collide with the static culture concept practitioners often implicitly use.

Then the OCF would be comparable to personalized integrated diagnosis (Mezzich & Salloum, 2007), the psychiatry of, with and by the individual. Or it would be comparable with person-centered ethnography (Hollan, 1997). The strength of these approaches is that the practitioner is stimulated to look at the mental health problems and the disorder through the eyes of the, culturally different, patient.

The number of five components in the OCF could possibly be reduced. An option which needs to be investigated is whether the fourth cluster, the relationship between patient and care provider, can be integrated into the first three clusters. This would make the OCF more dynamic in nature, as the care provider would constantly have to wonder which cultural elements in the relationship between patient and therapist have influence on the patient's cultural identity, the cultural explanation for his disease and his cultural psycho-social environment. Whether this is profitable in the sense of better information and more efficiency, can only be judged by building experience with this approach (Groen & Laban, 2011). Assuming that the OCF is not a once-only operation, but a process during which hypotheses and assumptions about the patient are tested and adjusted throughout the treatment, the relevance of shortening the OCF is limited. Then, the only thing that would reduce time would be the initiative towards a first assessment according to the OCF.

In the current edition of the DSM, the DSM 5, the OCF is slightly adjusted, operationalized in the Cultural Formulation Interview applicable to all patient regardless their ethnicity or culture and put in a more prominent place, in order to encourage clinicians to stress the cultural and contextual aspect of the patient's problems and complaints. Recent research in a field trial showed that the use of, the Cultural Formulation Interview, was considered favourable: 318 patients and 75 clinicians regarded this interview as feasible, acceptable and potentially clinical useful (Lewis-Fernández et al., 2017). Through participation in the Cross-cultural issues subgroup of the DSM-5 Gender and Culture study group the Dutch experiences could be included in the development of the Cultural Formulation Interview.

The OCF has only been adopted in Dutch mental health care since the turn of the century. Systematic examination of the OCF, for example of its role in lowering no-show and drop-out has only been done very recently. Systematic descriptive research of experiences with the OCF over several years is new (Groen & Laban, 2011). Meanwhile, people are experimenting with the OCF and the cultural interview in several places in the world. We hope that it will be possible to give a more definitive answer to the questions about influence and effect of the OCF in a couple of years' time. The implementation of the Cultural Interview in some of the Dutch mental health institutions offers the opportunity for a more systematic and broader search into its effects on the quality of diagnosis and treatment.

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Chapter 4

How Do Clinicians Prefer Cultural Competence Training? Findings from the DSM-5 Cultural Formulation Interview Field Trial

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Abstract

Objective

This study's objective is to analyze training methods clinicians reported as most and least helpful during the DSM-5 Cultural Formulation Interview field trial, reasons why, and associations between demographic characteristics and method preferences.

Method

The authors used mixed methods to analyze interviews from 75 clinicians in five continents on their training preferences after a standardized training session and clinicians' first administration of the Cultural Formulation Interview. Content analysis identified most and least helpful educational methods by reason. Bivariate and logistic regression analysis compared clinician characteristics to method preferences.

Results

Most frequently, clinicians named case-based behavioral simulations as "most helpful" and video as "least helpful" training methods. Bivariate and logistic regression models, first unadjusted and then clustered by country, found that each additional year of a clinician's age was associated with a preference for behavioral simulations: OR=1.05 (95 % CI: 1.01–1.10; p=0.025).

Conclusions

Most clinicians preferred active behavioral simulations in cultural competence training, and this effect was most pronounced among older clinicians. Effective training may be best accomplished through a combination of reviewing written guidelines, video demonstration, and behavioral simulations. Future work can examine the impact of clinician training satisfaction on patient symptoms and quality of life.

Keywords

• Cultural psychiatry • Cultural formulation interview • DSM-5 • Academic training

Government and professional organizations contend that clinician cultural competence training can reduce racial and ethnic health disparities [1–3]. Cultural competence approaches, however, differ by provider discipline, training methods, and outcomes measured, with no indication of which methods clinicians find helpful [4–7]. Methods to train clinicians in mental health interventions can clarify cultural competence training. Research on intervention training is important in mental health since psychotherapy interventions lack regulated standards unlike medications [8]. Researchers have hypothesized that to ensure clinician adherence to and competence in verbal interventions, training must include a review of written guidelines, case-based behavioral simulations, and supervision of at least one case [9]. Passive methods such as reading guidelines or watching videos change clinician behavior less than active methods that engage participants such as behavioral simulation, clinician modeling with expert feedback, and question-and-answer sessions [10–13]. Studies of training methods typically present views of expert trainers, and to our knowledge, no study has yet presented data on clinicians' preferences for cultural competence training.

One cultural competence model with emerging evidence is the psychiatric cultural formulation. Published in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), the Outline for Cultural Formulation (OCF) describes topics identified by cultural mental health experts as relevant to diagnostic and treatment planning [14]. The OCF is guided by social science research and outlined four assessment domains: (1) cultural identity of the individual, (2) cultural explanations of illness, (3) cultural levels of psychosocial support and functioning, and (4) cultural elements of the patient-physician relationship; a fifth domain can be used to summarize clinically relevant information [15]. The OCF has been the most widely used framework for introducing cultural competence to psychiatric trainees, with publications in over ten languages from six clinics around the world developing practice guidelines [16, 17]. For DSM-5, the OCF was revised into the Cultural Formulation Interview (CFI) by an international consortium to create a standardized interview of 16 questions with guidelines [18]. An earlier draft of the CFI was tested in an international field trial for feasibility, acceptability, and clinical utility among patients and clinicians, and revised for DSM-5 based on their feedback [19]. A 2014 Lancet Commission on culture and health has advocated for CFI use throughout all medical subspecialties given its evidence base and focus on patient cultural views of illness and treatment relevant beyond psychiatry [20].

The Commission also called for more research on cultural competence training [20]. Clinicians were trained to use the CFI for the DSM-5 field trial through active and passive methods and then asked their opinions on various methods after assessing their first patient. This paper examines (1) which training methods clinicians reported as most and least helpful, (2) reasons for preferences, and (3) relationships of patient and clinician characteristics with educational method preference. While training can be studied at multiple levels [21], we focus on training methods and patient and clinician factors since these are most frequently addressed by clinicians, administrators, and educators. We analyze specific methods; clinician factors such as age, discipline, years of experience, hours of prior cross-cultural training, and ethnicity; and patient factors such as ethnicity and presence of a psychotic illness that have been hypothesized as correlating with training preferences [22]. We present clinician perspectives on training given the literature's tendency to report perspectives of researchers and administrators who are not ultimately responsible for implementing clinical interventions [23, 24]. Better understanding of clinician preferences can produce more effective and efficient training programs.

Methods

The field trial was designed by cultural psychiatry experts through the DSM-5 Cross-Cultural Issues Subgroup (DCCIS) [18]. The New York State Psychiatric Institute (NYSPI) and Columbia University Department of Psychiatry formed a single site and coordinated logistics for all sites. The study started in November 2011 and ended in September 2012. Each site aimed to enroll at least 30 patients and partnered with clinics for enrollment. The overall trial enrolled 75 clinicians in the USA, Peru, Canada, the Netherlands, Kenya, and India.

We enrolled new and extant patients. Research clinicians new to the patient administered the CFI and diagnostic interview; extant patients were referred by treating clinicians to research clinicians. We obtained informed consent from all patients and clinicians before enrollment. Sessions with the research clinician consisted of administering the CFI, designed to last 15–20 min, followed by a routine diagnostic assessment. All sessions were audio-taped. All participants completed questionnaires before and after the interview. The study was approved by each site's Institutional Review/Ethics Board and followed local informed consent regulations.

Eligible CFI research clinicians were required to have a terminal degree (i.e., MD, MSW, PhD, APRN) permitting them to see patients, consistent with each country's requirements. Clinicians were excluded if they could not attend the training. Clinicians did not interview their own patients to assess CFI training preferences in assessing new patients.

Eligible patients were 16 years or older, fluent in the language of research clinicians, and could have any psychiatric diagnosis. We included the language match requirement to avoid using interpreters who could introduce cultural information not obtained through the CFI. Patients were excluded if acutely suicidal or homicidal; intoxicated or in substance withdrawal; or with any condition that could interfere with the interview such as dementia, mental retardation, or florid psychosis. A sample of convenience was recruited and read a standard recruitment script. For this analysis, only patients interviewed by clinicians using the CFI for the first time were included since subsequent cases could introduce bias as clinicians gained experience [9].

CFI Training and Assessments

After being introduced to the field trial, clinicians attended a 2-h training session at their sites consisting of these methods: (1) reviewing CFI written guidelines, (2) a 24-min video of the CFI simulated between a patient and clinician, (3) interactive behavioral simulations pairing clinicians to practice the CFI through sample cases created by the authors or from clinical experience, (4) coaching and feedback from local principal investigators (PIs) who led the training session, and (5) a final period for questions and answers. The training featured two South Asian researchers from the UK. All PIs were affiliated with the DCCIS.

Before the interview, patients and research clinicians completed demographic surveys, with clinicians also reporting professional training and cultural competence experiences.

Research clinicians administered the CFI followed by a routine diagnostic assessment, with sessions audio-recorded with patient consent. A copy of the CFI was provided to clinicians before each session. After the interview, the research clinician recorded patient diagnosis and treatment recommendations.

Research clinicians were interviewed on training experiences after the first patient session, providing answers to two questions: (1) What did you find most helpful about the training? Why? (2) What did you find least helpful about the training? Why? The overall field trial collected other data, but only training data are reported here.

All instruments were reviewed by the DCCIS. Research staff translated (when not in English), summarized, and uploaded all interviews into a database managed centrally by the Center of Excellence for Cultural Competence at NYSPI.

Data Analysis

Service researchers have recommended mixed-methods data analysis in which qualitative methods explore a new phenomenon and quantitative methods correlate the phenomenon to sample traits [25]. We applied this approach, beginning with a qualitative analysis of clinician responses to training method preferences through deductive content analysis and quantifying these findings for statistical modeling [25].

Qualitative Data Analysis

Deductive content analysis tests extant theories through (1) selecting the textual unit of analysis, (2) developing a theory-based codebook of exclusive categories, (3) coding data, and (4) reporting data by category [24]. Each debriefing interview was the unit of analysis, and each meaning unit was the words or sentences expressing a single idea [24]. The first and third authors (NKA, EC), psychiatrists trained in mixed methods research, reviewed all 75 transcriptions together for data quality over 5 h. The first author created the codebook from Beidas and Kendall's framework of training methods as passive (didactic lectures, watching videos) or active (behavioral simulations, coaching, feedback through questions and answers), with "active" defined as a learning process requiring observable demonstrations of trainee interaction [21].

Both authors first applied the codebook (available upon request) to seven interviews (10 % of the total sample) over 6 h. Both team members coded all sample interviews independently in NVivo 10 (QSR International)—coding each meaning unit with a unique code and meeting once weekly—to compare results, reach consensus, and revise the codebook. After the third round of independently coding test interviews produced no new coding changes, both authors coded all 75 interviews together. Queries and reports were generated in NVivo to explore patterns and draft memos on themes, triangulate data, and audit debriefing sessions for rigor [26]. A list of categories for most and least helpful methods was produced.

Inductive content analysis was then used to organize method preferences by reason. The first and third authors independently undertook one complete round of open coding, category creation, and abstraction. Coding reports from the deductive content analysis were reviewed, coded by reasons for preference (when provided), and sorted into higher-order headings through abstraction [26, 27]. Similar codes were collapsed into inclusive categories, additional codes were integrated, and clusters of related codes were organized into hierarchies. For example, under the category behavioral simulation most helpful, the sub-codes positive learning from others and experiential learning were freely generated, collapsed into inclusive sub-code technique, and contrasted with sub-code knowledge. Both team members together re-coded all content by method with this final list.

Quantitative Data Analysis

To analyze associations among method choice and clinician characteristics, we transformed deductive codes for quantitative analysis [25]. Clinician interviews were categorized based on method choice. Answers not endorsing any method were excluded, as was one clinician who did not report age, leaving 64 clinicians for analysis. Four helpful methods were named: behavioral simulation, video, review of written guidelines, and multiple methods (Table 1). Based on deductive content analysis, method choices were grouped into preference for any active method, either exclusively or combined with a passive method (n=46), and an exclusive preference for passive methods (n=18) to reflect clinical training programs. Most clinical trainings use purely passive methods such as written guidelines or active with passive methods, not solely active methods [23, 24].

Clinician characteristics were coded as originally entered at each site, except for race and ethnicity variables. Though central in the USA as constructs of cultural difference, other countries have other markers of difference [28]; there is no standard method for reporting race and ethnicity in international trials, which typically report participants by country. To apply US constructs of race/ethnicity would impose a US-specific interpretation. For example, grouping Kenyans with African Americans or Indians with Asian Americans ignores local constructions of cultural difference. Instead, we looked at demographic factors identified by PIs as locally recognized by governments, creating a variable to indicate matching between clinicians and patients. For example, for the Kenya site, a clinician and patient from the same tribe were considered a match. Similarly, we created a matching variable for immigrant status, where both clinician and patient born inside or outside the site country were considered matches.

We examined five clinician characteristics for correlations with training preferences based on past studies [29–32]: (1) age (continuous variable), (2) years of clinical experience (continuous variable), (3) hours of prior cross-cultural training (median split at ≥25 h), (4) experience with patients from different cultures (daily vs. other frequency), and (5) discipline (medical vs. other degree, as 60 % of the sample were psychiatrists). Using LOGISTIC and SURVEYLOGISTIC procedures in SAS software, Version 9.4 (Cary, NC), logistic regression models were clustered by country to account for similarities in variance of sites within the same country. These were adjusted for clinician gender, presence of a DSM-IV psychotic disorder, patient-clinician immigration match, and patient-clinician ethnic match, factors found to affect cross-cultural communication [30, 31, 33]. Diagnoses were coded according to DSM-IV disorder cluster based on the first three digits in line with clinical epidemiology methods [34].

Results

The field trial enrolled 75 patients corresponding to each clinician's first case. The average age was 44.3 years (SD=14.4) with 57.3 % males and 42.7 % females; 62.7 % lived in their birth country. Forty percent were married and living with a partner, and 20 % were employed full time. The mean number of years of education was 11.1 (SD=4.5). A percentage of 30.7 of patients were enrolled in the USA, 28 % in India, 14.7 % in the Netherlands, 9.3 % in Canada, and 6.7 % each in Kenya and Peru. After the CFI, clinicians recorded diagnoses under these disorder clusters: 49.3 % with depression, 25.3 % with anxiety, 20 % with psychosis, 17.3 % with a substance disorder, 5.3% with bipolar disorder, and 17.3 % with an "other" primary diagnosis such as a personality disorder; comorbid diagnoses were counted for a total >100 %.

Seventy-five clinicians participated with 54.7 % females and 45.3 % males. Regarding age, 17.3 % were 28–30 years old, 48 % were 31–40, 21.3 % were 41–50, 12 % were over 50, and 1 clinician did not answer. Thirty-two percent were attending psychiatrists, 28 % psychiatry trainees, 17.3 % psychologists, 14.7 % social workers, and 8 % master's level trainee therapists. In terms of clinical experience, 44 % of clinicians had 5 years or less, 21.3 % had 6–10 years, 17.3 % had 11–15 years, 5.3 % had 16–20 years, 10.7 % had ≥21 years, and 1 clinician did not answer. Regarding lifetime cross-cultural training, 25.3 % had <10 h, 21.3 % had 10–25 h, 13.3 % had 26–50 h, 26.7 % had >75 h, and 5 clinicians did not answer. For frequency of contact with culturally different patients, 61.3 % answered daily, 20 % answered weekly, 4 % answered monthly, 12 % answered seldom, and 2.7 % answered never. A percentage of 34.7 of clinicians were from the USA, 28 % from India, 14.7 % from the Netherlands, 9.3 % from Canada, and 4 % each from Peru and Kenya. Seventy-six percent were practicing in their birth country compared to 24 % who were not. All clinicians were included and none met exclusion criteria.

Educational Methods Named Most and Least Helpful

Table 1 presents training methods reported as most and least helpful, coded as active, passive, or mixed [21]. For multiple methods, the combination is specified. We present results for the entire sample in Table 1 and representative quotations for method preferences named by 10 % or more of the sample (>7 clinicians) in the text.

Table 1. Educational methods named most/least helpful (n=75)

	Most helpful		Least helpful	
	n	%	n	%
Active methods				
Behavioral simulations	25	33.3	2	2.7
Expert coaching and feedback	0	0	0	0
Question/answer session	0	0	0	0
Passive methods				
Video	11	14.7	11	14.7
Reviewing written guidelines	4	5.3	0	0
Multiple methods named				
Video demonstration and behavioral simulation (mixed)	12	16	0	0
Overall training package (mixed)	5	6.7	9	12
Reviewing written guidelines and video (all passive)	3	4	0	0
Reviewing written guidelines and question/answer session (mixed)	2	2.7	0	0
Behavioral simulation and coaching (all active)	1	1.3	0	0
Behavioral simulation and question/answer session (all active)	1	1.3	0	0
Video demonstration and coaching (mixed)	1	1.3	0	0
Answer irrelevant (questions about field trial procedures)	8	10.7	15	20
Nothing named	0	0	38	50.7
Missing data	2	2.7	0	0

Note: “Mixed” denotes a combination of active and passive methods

Most Helpful

Twenty-five clinicians (33.3 %) named behavioral simulations as the most helpful method. During inductive coding, 16 % of clinicians reported that behavioral simulations improved their practice with CFI implementation. For example, a US psychologist with 13 years of clinical experience, 5 h of prior training in cross-cultural issues, and no self-reported contact with culturally different patients said, “The role-play mock session was most helpful because it provided valuable insights as to how to conduct the actual interview.” A percentage of 5.3 clinicians believed that simulations clarified theoretical knowledge. A Canadian social worker, also with 13 years of clinical experience and 5 h of training in cross-cultural issues, but with daily contact with culturally different patients stated, “The training in group sessions was most helpful due to the opportunity to clarify questions and issues.” Finally, 2.7 % explained that the behavioral simulations helped change attitudes. A psychiatrist from India with 1 year of clinical experience, 1 h of training in cross-cultural issues, and weekly contact with culturally different patients said, “Most helpful was the role-play since it brought up and solved a number of doubts about the CFI that were not acknowledged just by reading it alone." A percentage of 10.7 of clinicians did not report reasons.

The second single method named by 14.7 % of clinicians as most helpful was the video demonstration. Twelve percent believed that the video helped to understand interviewing techniques. One US psychologist with 6 years of clinical experience, 5 h of training in cross-cultural issues, and daily contact with culturally different patients emphasized, "The training video provided a good example of how to administer the CFI." Another clinician believed that the video responded to his distinct learning style as a "visual learner," and one clinician did not name a reason.

Finally, 33.3 % of clinicians reported multiple methods as most helpful. The largest group of 16 % endorsed the combination of behavioral simulations and video. A social worker from the Netherlands with 17 years of clinical experience, 1 h of training in cross-cultural issues, and daily contact with culturally different patients typified these responses: "The video was helpful because it showed how to bring the CFI into practice. Practicing with my colleagues in role-play was helpful because it gave me an idea of how to handle the questions."

Least Helpful

In the largest set of responses, 50.7 % of clinicians (n=38) did not name any method as least helpful. Of individual methods, 14.7 % reported that the video demonstration was least helpful. A percentage of 9.3 did not think that the video case represented their practice settings. A US psychologist with 11 years of clinical experience, 5 h of training in cross-cultural issues, and weekly contact with culturally different patients said, "The video does not illustrate enough what needs to be done when the client does not cooperate." A psychologist from the Netherlands with 10 years of clinical experience and weekly contact with culturally different patients echoed this concern: "The training video was of a model client. Maybe it would be good to show a different client." Two other clinicians mentioned casting as a reason, with one Peruvian clinician explaining, "The background of the people in the examples is not similar to our backgrounds," in reference to their ethnicities. One research clinician wanted more than one case shown, and one clinician offered no reason.

Of multiple methods, 12 % of clinicians named the overall training package to be least helpful. This was the only multiple method named compared to a variety of combinations considered most helpful and may reflect general dissatisfaction with the entire training. Three clinicians felt that it was not practical enough. For example, a social worker from the Netherlands with 12 years of providing care and daily contact with patients who are culturally different stated: "What was least helpful was the lack of experience with this new method. You can give structured guidelines, but you will have to learn to actually work with it (get experienced) to achieve more quality." Two other clinicians wanted more time for training.

The Relationship Among Clinician Characteristics and Educational Methods

In the logistic regression analyses, clinician age was the only significant finding: OR=1.05 (95 % CI: 1.01–1.10; p=0.025). With each additional year of age, the odds of a clinician preferring an active method increased by 5.4 %.

Discussion

This paper examined clinician preferences for training methods from the DSM-5 CFI field trial. A majority of clinicians named active behavioral simulations as most helpful, either alone or with other methods. Passive methods such as watching a video or reviewing written guidelines were preferred only by one in seven and one in twenty clinicians, respectively. Clinicians appear to value experiential learning with the CFI, as with the DSM-IV OCF [35]. Moreover, this preference increased with clinician age.

Our findings suggest both active and passive training programs could be created for learners based on preferred method. Some studies report clinician preferences for passive training methods [36, 37], but older clinicians with established practice styles appreciate case-based simulations that promote peer interactive learning and skills uptake [38]. Older trainees such as those in continuing medical education programs (CME) may favor more active approaches compared to younger trainees. CME participants may more closely resemble our sample of convenience since CME clinicians can choose CME topics for self-assessment. Older trainees in CME programs may therefore benefit from case-based simulations in addition to passive training.

Least-helpful responses also indicate clinical applications for CFI training. Over half of clinicians named nothing as least helpful, suggesting broad acceptability of the overall training package. Of 11 clinicians naming video demonstration as least helpful, 7 stated that the case did not reflect their environment. Training materials may therefore need local tailoring to reflect clinician caseloads such as patient diagnoses. Even though the content of the cases may demonstrate limited generalizability, clinicians across countries preferred case-based behavioral simulations that future work can examine as a generalizable method.

This study has several limitations. First, we present data on a sample of convenience. This sampling strategy is standard in DSM-5 field trials. A different sample with greater variation in cross-cultural experiences could have led to different results. Second, we attempted to standardize training. While reviewing written guidelines and video demonstration could be the same across all sites, there may be inter-site variations in the quality of behavioral simulations, expert coaching, and question-and-answer sessions. A training package implemented in multiple sites could be reasonably expected to exhibit changes. Third, we examined associations among patient, clinician, and training factors through quantitative analyses. Organizational factors such as heavy patient volume could have also affected clinician perceptions. These are not factors typically addressed within cultural competence training, and future work can examine relationships between organizational factors and clinician perceptions. Fourth, we collected training data after the first CFI session, but perceptions may have changed based on time between training and the first interview. Assessments of cultural competence training typically occur once rather than longitudinally, pointing to the need for more research [6]. Our study design advances this scholarship by assessing clinician perceptions after an actual case rather than immediately following training to clarify practical relevance. Fifth, we trained clinicians in a draft of the CFI, not the final DSM-5 version. Their responses may have been influenced by parts of the original draft changed for DSM-5 as well as instructions to use the CFI strictly as written rather than recommendations in DSM-5 for clinicians to use the CFI flexibly. The CFI toolkit also consists of an informant interview when patients cannot provide consent and twelve supplementary interviews exploring cultural topics in greater depth than the core 16-item CFI [39]; studies are needed on whether training method preferences are similar or different with these interviews. Finally, this study has relied on clinician self-report rather than objective evidence of clinician behavioral change, a focus for future work.

Nonetheless, our work contributes to research on cultural competence training in mental health. Cultural factors affect information exchange and processing throughout every clinical encounter, even in those in which patients and clinicians share similar demographic traits [17]. Our findings establish initial evidence for CFI training. Videos and case-based simulations are being developed with the American Psychiatric Association [39] and the New York State Office of Mental Health, allowing assessments of clinician preferences for combined active and passive methods. In addition, academic and community administrators can examine CFI adoption, cost, and long-term sustainability as implementation outcomes after training [40, 41]. Most importantly, research is needed linking training to clinical outcomes such as patient improvements in symptoms and quality of life.

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Chapter 5

The Cultural Formulation Interview: Dutch experiences

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Abstract

The American Psychiatric Association's DSM-5 Cross-Cultural Issues Subgroup developed the Cultural Formulation Interview (CFI) for routine use in the clinical assessment of any patient. The aim of this study is to determine whether the CFI was perceived as feasible, acceptable, and clinically useful by patients (n=30) and clinicians (n=11) in the Netherlands. The study was conducted as part of an international field trial in five countries. Earlier studies have revealed that the ethnic diversity of the Dutch psychiatric population tends to limit communication in mental health and reduce the accuracy of psychiatric diagnoses. Semi-structured interviews have been developed in the Netherlands to identify cultural issues in diagnostic assessment. In the Netherlands, 11 clinicians were trained in a structured program to administer the CFI. They conducted 30 interviews among patients of foreign and Dutch origin. The clinicians and patients used quantitative and qualitative questionnaires before and after the administration of the CFI. Patients as well as clinicians were positive about the feasibility, acceptability, and perceived utility of the CFI. Patients were slightly more positive than clinicians about its clinical utility. The CFI did not lead to diagnostic changes, possibly due to the characteristics of the mental health institutes. The CFI is a feasible, acceptable, and potentially clinically useful instrument in psychiatric practice. Its value may be greatest for patients among whom communication and diagnostic problems are expected.

Keywords
• cultural formulation interview • cultural interview • DSM-5 • cultural competence
• the Netherlands

Introduction

In the Netherlands, the proportion of migrants (defined as having one or both parents born in another country) in the population has increased since the 1980s. This number is expected to increase further from 22.6% in 2017 to 31.1% in 2060 (Stoeldraijer & Garssen, 2011). The largest group of migrants is non-Western, almost 2,2 million on a population of about 17 million (CBS, 2017). The largest non-Western groups are from Turkey (400,000), Morocco (391,000), Surinam (341,0000) and the Netherlands Antilles (153,000). Migrants from Syria are a fast growing group, from 22,000 in 2015 to 72,000 in 2017. In the major cities such as Amsterdam and Rotterdam, almost half of the population is not of Dutch origin. Soon, the original Dutch population will be the largest minority group in the cities, one of dozens of other groups.

There has also been a substantial increase in the number of migrants who use mental health services. In Rotterdam, the second largest city, the number of migrant patients in mental health care increased significantly between 1990 and 2004 (Dieperink et al., 2007). Before, accessibility and utilization of mental health services were major problems, but currently the provision of culturally sensitive and effective, high-quality care is the key issue. In order to achieve this goal a thorough understanding of the patient and adequate communication in mental health care are crucial. Without these, treatment participation is difficult to achieve, as has been found in studies on depression (Blom et al., 2010; Fassaert et al., 2010). Clinicians' lack of understanding and inadequate communication could also lead to earlier treatment discontinuation and more missed appointments (Korrelboom et al., 2007).

Moreover, high-quality mental health care for migrants depends on an accurate diagnostic process. A common opinion in psychiatry is that psychiatric disorders share many characteristics all over the world, but that the expression of these disorders may vary in different cultures (see discussion in Kleinman, 2008). As a consequence, research has revealed difficulties in the diagnostic process across cultural population groups (Zandi et al., 2007; Lu, 2004). These difficulties are related to the diversity of collective understandings individuals have of themselves and their sociocultural environment, and to their views and expectations about mental health, including illness explanations, symptom presentations, and help-seeking behaviours. The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) acknowledges the influence of culture on mental health: it states, "all forms of distress are locally shaped, including DSM disorders" (American Psychiatric Association, 2013: p. 758).

Transcultural psychiatrists and medical anthropologists agree that greater attention should be paid to the impact of culture and other contextual factors in the assessment of psychiatric disorders. They claim that clinicians should be aware of disparities in locally shaped cultural notions between themselves and their patients, the individual interpretations of collective concepts and behaviour patterns that patients hold, as well as the cultural relativity or embeddedness of mental health concepts, methods, and interventions. Ignoring these claims may lead the clinician to neglect the individual's cultural experiences (Lakes et al., 2006). Neglecting these experiences may lead to an oversimplification in the clinical encounter. According to Arthur Kleinman (2005) the first commandment in clinical practice is: "Do no harm by stereotyping."

Historical background: Outline for Cultural Formulation of Diagnosis

In the 1980s and 1990s, the claim of the Diagnostic and Statistical Manual-III (1980) and III-R (1987) to be a classification system that was valid worldwide was criticized. A study group of the United States' National Institute of Mental Health consisting of psychiatrists and anthropologists proposed a number of adjustments (Lewis-Fernández, 1996; Mezzich et al., 1999). As a result, the Outline for Cultural Formulation (OCF) was introduced in DSM-IV (American Psychiatric Association, 1994). In DSM-5, the OCF is described as a framework clinicians use during a clinical evaluation to assess how culture influences the illness process, the social context, and the clinical history of the illness. In the Netherlands, the OCF was introduced with clinical vignettes and theoretical explanations (Borra et al., 2002).

Cultural interview

The DSM-IV OCF did not include a standardized method to guide clinicians on how to develop questions to gather information from patients to construct an OCF, or how to implement the OCF in clinical practice (Lewis-Fernández, 2009). In the Netherlands, the Cultural Interview (CI) was developed as a tool to help clinicians construct an individual OCF (Rohlof et al., 2002). The CI is a semi-structured questionnaire with 40 questions that allow the user to obtain information on the cultural background of the patient and its influence on the individual's psychopathology. A less time-consuming version has been developed which has been tested in a comparative study. This version (Brief Cultural Interview, BCI) has been shown to be better understood and appreciated by patients than the original CI and yields results that are comparable(Groen et al., 2017).

Over time, specific versions were introduced for specific domains and groups, including forensic psychiatry, child psychiatry, patients with schizophrenia, patients with intellectual disability, and general practitioners. These versions and their utilization possibilities are extensively described in a Dutch publication (Van Dijk et al., 2012), and are available online (www.cultureelinterview.nl). According to clinicians, the CI contributes to the quality of the therapeutic relationship (Piksen, 2010). A first smal research project showed that the use of the CI in interpersonal therapy with patients from developing countries reduced treatment discontinuation while retaining treatment efficacy (Gumbs, 2012).

Cultural Formulation Interview

During the development of DSM-5, the Cross-Cultural Subgroup of the Study Group on Gender and Culture Issues reviewed existing operationalisations of the OCF worldwide and created the Cultural Formulation Interview (CFI). This Cross-Cultural Issues Subgroup consisted mainly of North American transcultural psychiatrists, but also of experts from Great Britain, Sweden, and the Netherlands (including the first author).

Part of this process involved a literature review on the use of the OCF. Its conclusion was that the OCF was being used in education and, to a lesser extent, in clinical practice, but that evaluative and efficacy studies were largely lacking (Lewis-Fernández et al., 2014; Rohlof et al., 2017).

Similar to the Dutch CI, the CFI is an operationalization of the OCF as a semi-structured interview. The CFI provides topics and guidelines for assessing the impact of a patient's cultural background and context on mental health problems and can be regarded as an invitation to patients to share their health-related views with their clinician. The thread of the interview is the patient's story about his or her illness experience and its meaning, as understood by the patient and his or her community. The CFI is constructed following four core themes of the OCF (American Psychiatric Publishing, 2013:749):

1. Cultural definition of the problem (questions 1-3);
2. Cultural perceptions of cause, context and support (questions 4-10);
3. Cultural factors affecting self-coping and past help seeking (questions 11-13)
4. Cultural factors affecting current help seeking (questions 14-16).

The CFI has patient and informant versions, which obtain the same information from the patient directly or from an accompanying person.

In addition twelve supplementary modules may be used to obtain in-depth information during the initial assessment or later in therapy (see Figure 1). All of these components of the CFI are available online (www.psychiatry.org/dsm5).

Figure 1. Cultural Formulation Interview and the supplementary modules

Cultural Formulation Interview
14 questions (field trial version), 16 questions (definitive version)

Supplementary modules

Name of the module	Number of questions
Explanatory model	14
Level of functioning	8
Social network	15
Psychosocial stressors	7
Spirituality, religion and moral traditions	16
Cultural identity	34
Coping and help-seeking	13
Patient-clinician relationship	5 + 7[1]
School-age children and adolescents	20 + 8[2]
Older adults	17
Immigrants and refugees	18
Caregivers	14

The CFI is intended for use at the beginning of the initial evaluation, can be integrated in a standard assessment interview, and may be administered to all patients regardless of the clinical setting, culture or ethnicity.

Field trial

An international field trial was part of the CFI development process. A field trial version of the CFI consisting of 14 questions was tested in clinical sites in the United States, Canada, Peru, Kenya, India, and the Netherlands.

The overall results of the international trial consisted of interviews with 318 patients by 75 clinicians (Lewis-Fernández et al., 2017). The CFI was found to be feasible, acceptable, and useful. Clinician feasibility ratings were significantly lower than clinician acceptability and utility ratings and also than patient ratings. Acceptability and utility ratings were not significant different between clinicians and patients. In the case clinicians performed more than one interview, their feasibility ratings improved significantly, and the subsequent interviews required less time.

Site-specific results of the field trial from Pune, India were reported from 36 patients and 8 clinicians (Paralikar et al., 2015). Their study results showed no significant difference between clinicians, patients, and their relatives in the evaluation of the CFI. The presence of serious mental disorders was associated with

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[1] 5 questions to the patient, 7 questions the clinician has to ask to himself..

[2] 20 questions to the child, 8 issues for the parents.

lower overall ratings among patients. Overall value of the CFI (a composite score of feasibility, acceptability, and utility) was lower for patients and clinicians when relatives were present. Clinicians experienced in treating culturally diverse patients rated the CFI more positively than less experienced clinicians.

In the Netherlands, three institutes took part in the trial: Centrum ’45 (Oegstgeest), a national centre of expertise offering clinical treatment of patients with complex posttraumatic stress disorders including traumatized refugees; De Evenaar Centre for Transcultural Psychiatry North Netherlands, part of GGZ Drenthe Mental Health Care (Beilen), offering clinical treatment to refugees, asylum seekers, and migrants; and PsyQ Depression Ambulant, part of the Parnassia Psychiatric Institute (the Hague), offering outpatient treatment of depression to an ethnically diverse patient population. The first three authors were responsible for the field trial in the Netherlands.

The research questions were the following:

- Is the CFI feasible in clinical practice?
- Is the CFI acceptable for patients and clinicians?
- Is the CFI potentially useful in clinical practice?

In this article, data from the Dutch site of the international field trial are presented. First the methodology is described, followed by the quantitative and qualitative data. That will enable us to answer the three research questions. In the discussion we will compare our findings to those of the overall international field trial and to the Indian site, and compare the CFI with the CI. We will end by noting some limitations.

Methods

As in all sites, the Dutch clinicians followed a strict protocol to enable comparison to the other field trial sites. The Dutch researchers recruited clinicians from their institutes. After being introduced to the field trial, clinicians attended a 2-hour training session consisting of:

(1) review of CFI written guidelines,
(2) a 24-minute video of a CFI simulation between a patient and a clinician,
(3) interactive behavioural simulations pairing clinicians to practice the CFI through sample cases created by the authors or based on their own clinical experience,
(4) coaching and feedback by local principal investigators who led the training session,
(5) a final period for questions and answers.

The training video featured a clinician and an actor from the United Kingdom playing the roles of clinician and patient. Data on clinician perceptions of the field trial training have been published elsewhere (Aggarwal et al., 2016).

The CFI assessment was conducted in English or in the local language(s) at each site of the trial. The Dutch researchers translated the CFI into Dutch, following the method of three translations independent of one another; these three versions were discussed by the translators, resulting in one consensus translation.

Clinicians were asked to administer the CFI in Dutch or English at the beginning of the assessment phase of a newly admitted patient. They were instructed to follow the sequence and exact wording of the CFI questions and to refrain from responding to the patients' answers with new questions that took the interview beyond the scope of the CFI. They could ask the patient to explain details, but not probe any further.

All sites were provided with a standard set of debriefing questionnaires for patients and clinicians[3] [4]. These questionnaires were composed of closed questions that were answered using a four-point Likert scale, and of open-ended questions[5]. The researchers translated the patient questionnaires into Dutch. The questionnaires for clinicians were not translated, since all the selected Dutch clinicians were fluent in English.

Patients were recruited between January and April, 2012.

The referral coordinator or the research assistant reviewed the inclusion/exclusion criteria for each patient referred. Patients were enrolled sequentially as recruited. All patients who came for a first assessment at one of the cooperating clinicians were included. These were new patients not seen before by the clinicians of the institute. Exclusion criteria were insufficient fluency in Dutch or English, intellectual disability, and poor reality testing (florid psychosis). One of the aims of the Dutch field trial was to include a representation of the patient population at

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[3] Clinicians used the following questionnaires:
- Clinician demographic form
- Patient referral form
- Debriefing instrument for clinicians after every encounter
- Debriefing instrument for clinicians after first and third encounter
- Open-ended questions for debriefing clinicians

Patients used the following questionnaires:
- Patient demographic form
- Debriefing instrument for patients
- Open-ended questions for debriefing

[4] Examples of questions to the patient (closed)
These questions helped me to explain what kind of help I would like to have (clinical utility)
These questions were easy to answer (feasibility).
These questions should be asked by every clinician (acceptability).

[5] Options: strongly disagree (-2), disagree (-1), agree (1), strongly agree (2).

each institute. Therefore, all ethnic groups were included, patients from foreign and Dutch origin. Patients were referred for enrolment in the study if they suffered from depressive disorder or posttraumatic stress disorder.

Before the assessment phase started, all patients received an explanation of the trial, were asked for permission to participate and, after agreeing, provided written informed consent. Patients were told that refusal to participate would not have any influence on their treatment. After completion of the socio-demographic questionnaires, participating patients completed the debriefing questionnaires.

Clinicians filled in information about their own demographic and cultural background, education, and experience with culturally diverse patients. They also completed the debriefing questionnaires after each CFI and a separate questionnaire after the first and the third CFI.

All CFIs were audiotaped to register their duration and to examine clinicians' administration of the CFI, including sequence and proper use of the questions. Other parts of the assessment, such as the general psychiatric assessment, were not audiotaped. Quantitative and qualitative data were analyzed separately from the data collected at the other international field trial sites. Audiotaped interviews were checked for consistency and compliance with the CFI questions.

Ethical approval

Before the field trial, ethical approval was verified by the medical ethical committee of GGZ Drenthe Mental Health Care. Because of the non-invasive character of the study, it was decided that no approval was required, in accordance with the Medical Research with Human Subjects Act (Dutch: WMO).

Results

At the Dutch field trial site, the CFI was administered by 11 clinicians who interviewed 30 patients; each of the three institutes contributed 10 patients. In practice, patients were only excluded because of poor Dutch or English fluency. All patients who were asked to participate in the trial agreed; there were no refusals. There were 21 male patients and 9 females in the age range of 21-77 years (median 41,2 years). Of these, 13 patients were Dutch natives, and 17 were migrants (first and second generation), originating from 12 countries: 3 from Surinam, 2 from Morocco, Turkey, and Sierra Leone, and 1 from Afghanistan, Azerbaijan, Bosnia, Burundi, Guinea, Ingushetia, Iraq, and Ruanda. They were referred for outpatient (n=10) or day clinical or inpatient treatment (n=20), before the CFI-enhanced interview.

The eleven clinicians were psychiatrists (n=2), psychologists or psychotherapists (n=6) and social psychiatric nurses (n=3). Three of them had more than 50 hours of cultural training, 3 had fewer than 10 hours, and these data were missing for 5 clinicians. Six were males and 5 were females; 7 were natives and 4 migrants. Two clinicians administered the CFI with 1 patient, one with 2 patients, 6 with 3 patients, and two with 4 patients.
Patients' and Clinicians' characteristics are shown in table 1.

Table 1. Patients and clinicians characteristics of the Dutch CFI field trial

Patients (*n*=30)	
Age, mean (SD)	41.87 (15.33)
Years of education, mean (SD)	12.08 (4.97)
Female, *n* (%)	9 (30.00)
Foreign-born	17 (56.57)
New to CFI clinic, *n* (%)	20 (66.67)
Axis 1 diagnoses, *n* (%)	
0	1 (3.33)
1	12 (40.00)
2	9 (30.00)
3 or more	8 (26.67)
Clinicians (*n*=11)	
Age, mean (SD)	43.64 (11.46)
Years providing healthcare, mean (SD)	15.55 (12.64)
Female, *n* (%)	5 (45.45)
Professional discipline, *n* (%)	
Psychiatrist/ psychiatry trainee	2 (18.18)
Psychologist	6 (54.55)
Social worker	3 (27.27)
Other mental health clinician	0 (0)
Foreign-born, n (%)	2 (18.18)
Frequency of contact with patients of different cultures, n (%)	
Daily	10 (90.91)
Weekly or monthly	1 (9.09)
Seldom or never	0 (0)
Hours of cultural training	
< 10 h	3 (50.00)[6]
h	0 (0)
>50 h	3 (50.00)

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[6] Data unavailable for five participants.

Range of the CFI duration was 8 to 40 minutes (mean 18.8 minutes, SD=8.8). The CFI plus the general psychiatric assessment had a total mean duration of 87.5 minutes (SD=28.7). From the audiotapes it was clear that clinicians generally adhered to the CFI instructions, although some asked additional questions.

Table 2. Mean evaluation by clinicians and patients in the Netherlands of the feasibility, acceptability, and perceived clinical utility of the field trial version of the CFI[7]

	Clinicians (*n*=11) Mean (SD)	Patients (*n* = 30) Mean (SD)
Feasibility	1.0 (0.6)	0.9 (0.4)
Acceptability	1.0 (0.4)	1.0 (0.4)
Perceived Clinical Utility	0.9 (0.3)	1.1 (0.4)

Table 2 shows the mean clinician and patient evaluation scores on the feasibility, acceptability, and perceived clinical utility of the CFI. Like the method used in the international field trial, we assigned positive values for agreement (+1 for *agree* and +2 for *strongly agree*) and negative values for disagreement (−1 for *disagree* and −2 for *strongly disagree*).

Clinicians were positive about the three implementation-relevant aspects of the CFI. However, clinicians seemed less certain than patients about the CFI's utility; the clinician overall mean utility score (0.9) was slightly lower than the patients' score (1.1). Some specific utility items showed low scores among clinicians. For instance, clinicians were not entirely sure that the CFI increases their confidence in the diagnosis (mean= 0.00, SD= 0.86 on a scale from -2 to +2) or that it contributes to treatment planning (mean=0.21, SD=0.98). They were more satisfied about the general utility of the CFI, for instance in terms of facilitating rapport with the patient (mean=0.62, SD=0.72). Clinicians were generally satisfied with respect to feasibility and acceptability. Accumulating experience with the CFI did not lead to more satisfaction among clinicians. Only 1 out of 11 clinicians scored less than 0.5 on acceptability, only 2 out of 11 scored less than 0.5 on clinical utility, and no clinician scored less than 0.5 on feasibility.

Participating patients were generally positive about the CFI, similar to the clinicians' scores. Patients scored high on certain feasibility items such as how easy the CFI questions were to understand (mean=1.00, SD=0.65), duration of the CFI (mean=0.52, SD=0.99), and the flow of the interview (mean=0.93, SD=0.94).

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[7] Scale -2 till +2

Patients were also satisfied with the acceptability and potential utility of the CFI. Out of thirty patients, six were less satisfied about the feasibility, three were less satisfied about acceptability, and two were less satisfied about clinical utility than clinicians.

In sum, patients and clinicians in the Netherlands provide similar evaluations of the feasibility and acceptability of the CFI, but patients score slightly higher on utility.

Findings from the debriefing interviews with the research assistants were that that patients' Dutch fluency was sometimes overestimated, that patients sometimes had difficulty completing Likert scales, and that they often required clarification such as on the evaluation categories and questions. Difficulties administering the CFI were related to some patients' limited Dutch fluency, given the exclusion of a professional interpreter from the trial so as to limit the cultural information obtained from sources other than the CFI.

Responses to the open-ended debriefing questions revealed that the CFI afforded clinicians a better understanding of the patient's context. However, clinicians did not comment on changes to the diagnosis brought about by the CFI. Some clinicians felt constrained by what they perceived as the strict guidelines of the interview protocol, the wording and sequence of the questions, and the instruction not to depart from the field trial instruction to pursue the patient's answers, expressed emotion, and non-verbal reactions.

Due to the small groups of patients from the different countries it was not possible to perform a further analysis of the data. A comparison between native Dutch and migrants was also considered as less valid, since the group of migrants came from very different countries, and three of them were also second generation migrants. This would have made an analysis very tentative.

Conclusions and discussion

Patients and clinicians in the Netherlands found the CFI to be feasible, acceptable, and clinically useful; overall scores were similar in both groups, with the exception of clinical utility, which was slightly lower among clinicians than patients.

Compared to the Pune, India site of the international study (Paralikar et al., 2015), both patients and clinicians in the Netherlands evaluated the CFI as slightly less valuable. Compared to the international field trial (Lewis-Fernández et al., 2017), participating clinicians in the Netherlands were more positive about the feasibility of the CFI, but had scored similarly on acceptability and clinical utility. By contrast, participating patients in the Netherlands reported lower ratings than in the full field trial: 0.9 versus 1.33 on feasibility, 1.0 versus 1.27 on acceptability, and 1.1 versus 1.26 on clinical utility. These are substantial differences, which might be due to the larger number of migrants in the Dutch study: 56% of the Dutch sample was foreign-born, compared to 35% of the overall sample. One possibility is that migrants may have faced language difficulties participating in the interviews.

In the Dutch field trial, clinicians did not report finding the CFI useful in clarifying the patient's diagnosis on open-ended questions. This may be due to the restriction of the disorders in the policy of the three Dutch institutes. Only patients with presumed depressive disorder or posttraumatic stress disorder were allowed. Additionally, the high professional standard in the institutes may have had a ceiling effect with respect to the diagnostic process.

Clinicians were the oldest group of the international field trial, with the most years providing mental healthcare. Patients' characteristics were comparable to the mean of the international field trial. There was a significant difference between patients from developed counties and from developing countries in being born outside the country: in the developing counties this was almost non-existent. These factors may also have influenced the difference between the results in the Netherlands compared to the results of the complete field trial.

The DSM-5 CFI international field trial led to several changes in the CFI: the number of questions was increased from 14 to 16 and questions (or parts thereof) that were not well understood were reformulated. The DSM-5 guidelines still include the instruction to formulate questions as proposed and in the order listed. Incorporating the CFI questions in a naturally progressing conversation is recommended. The questions now are introduced as examples, which can be reformulated depending on the situation. Furthermore, additional and probing questions are allowed.

In the DSM-5, the CFI is considered especially useful in certain cases, such as when:

- There are considerable cultural, religious or socio-economic differences between the clinician and the patient which can make diagnostics more difficult;
- The clinician is uncertain of the relationship between symptoms and diagnostic categories;
- There are problems with regard to assessing the gravity of the illness or the level of impairment;
- There are problems with engaging the patient in the treatment.

It is important to note that only the core CFI was part of the field trial. The supplementary modules were not included for logistical reasons despite being considered an integral part of the CFI. Further research is needed on when and how to use the supplementary modules. Moreover, additional work is required to assess whether the core CFI obtained enough information to construct an overall cultural assessment for diagnosis and care of a particular patient; this was not a goal of this study. This field trial assessed the field trial version of the CFI. Follow-up research in clinical practice is needed that focuses on the final DSM-5 version of the CFI including the supplementary modules.

The field trial did not compare the usefulness of the CFI with the CI in clinical practice. A comparative study would be needed. The CFI has the practical advantage of being shorter, so that it is easier to implement in a regular assessment interview than the CI. By contrast, it is unclear whether the CFI yields enough cultural and contextual information, in comparison to the CI. The CI tackles most of the relevant themes of the OCF, but takes longer than the CFI. For example, the CI contains more questions about the cultural identity of the patient, which can be relevant for medication treatment or psychotherapy. Additional questions on cultural identity are included in the CFI supplementary module on this topic, but this additional module may not be accessed by busy clinicians. In general, it is unclear whether any of the additional CFI supplementary modules will be used by most clinicians because of time pressure and workload.

One solution is to choose the cultural assessment instrument depending on the circumstances. For example, the CI could be used selectively, while the CFI can be used prior to every initial assessment, due to its short duration.

The existing CI and the new CFI are both an operationalization of the OCF. They address individual experiences and contexts of clinical problems. They share the same focus on narrative, idiographic description, and themes. Both interviews are thus not completely interchangeable.

In assessing patients from different cultures, the clinician's attitude and the treatment negotiation efforts are important, not only the diagnostic process. These require culturally sensitive and competent clinicians, methods, guidelines, protocols, and organisational structures (Kirmayer, 2012). Attention to the cultural aspects of mental health care also calls for reflection on the clinician's own clinical reality or medical culture, and therefore demands a culturally critical attitude.

Limitations

The results of the study should be interpreted with some caution.

First, the participating clinicians, mental health institutions, and patients were not representative of the Dutch mental health system. For instance, patients not fluent in Dutch or English were excluded.

Second, the CFI was not translated using back-and-forward translation methods, as is usually recommended.

Third, not all relevant clinician-related variables were included in the field trial. Although all participating clinicians were experienced professionals, their cultural competence was not fully assessed prior to the use of the CFI. Only 6 out of 11 clinicians revealed their cultural training: 3 had many hours of training, 3 had few. The clinician's level of cultural competence could have influenced their evaluation of the CFI.

Fourth, research conditions proved not to be optimal. Some patients were not acquainted with the general use of research instruments or had difficulty understanding the questions or completing Likert scales. Some patients were included despite some limited fluency in Dutch or English, which was only shown during the scoring on the questionnaire. However, this limited fluency did not have results on the final data, since the research clinicians succeeded in clarifying all the different topics of the instruments.

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Chapter 6

Feasibility, acceptability and clinical utility of the Cultural Formulation Interview: mixed-methods results from the DSM-5 international field trial

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Abstract

Background
There is a need for clinical tools to identify cultural issues in diagnostic assessment.

Aims
To assess the feasibility, acceptability and clinical utility of the DSM-5 Cultural Formulation Interview (CFI) in routine clinical practice.

Method
Mixed-methods evaluation of field trial data from six countries. The CFI was administered to diagnostically diverse psychiatric out-patients during a diagnostic interview. In post-evaluation sessions, patients and clinicians completed debriefing qualitative interviews and Likert-scale questionnaires. The duration of CFI administration and the full diagnostic session were monitored.

Results
Mixed-methods data from 318 patients and 75 clinicians found the CFI feasible, acceptable and useful. Clinician feasibility ratings were significantly lower than patient ratings and other clinician-assessed outcomes. After administering one CFI, however, clinician feasibility ratings improved significantly and subsequent interviews required less time.

Conclusions
The CFI was included in DSM-5 as a feasible, acceptable and useful cultural assessment tool.

Declaration of interest
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Unexamined cultural differences in how patients and clinicians frame illness and care may distort diagnosis and assessments of severity, impose communication barriers, compromise engagement, adherence and response, and unnecessarily prolong patients' suffering (1,2). Patient–clinician differences in age, gender, sexual orientation, socioeconomic status, race/ethnicity, religion, language, and/or national origin can contribute to cultural differences in all clinical interactions(3,4). The DSM-IV Outline for Cultural Formulation (OCF) is a conceptual framework that helps clinicians identify the impact of culture on illness and care during a clinical evaluation (5,6). The OCF is widely used in clinical training and cultural competence initiatives(7–10). However, its implementation in routine care has proved challenging (11): clinicians had to improvise questions to collect the information, received limited guidance on which patients would benefit most, and faced uncertainty about whether to implement the OCF as a separate assessment or embed it in a standard clinical evaluation (12–14). The lack of a structured instrument also impeded research on cultural assessment and inclusion of cultural information in clinical trials (15,16). In response, the American Psychiatric Association's DSM-5 Cross-Cultural Issues Subgroup (DCCIS) developed the Cultural Formulation Interview (CFI) (17) to operationalise the OCF for routine use in the clinical assessment of any patient, based on a literature review and consensus-building discussions with designers of OCF-based interviews (18). The CFI instruments comprise an initial assessment interview (core CFI), an informant interview for collateral information and 12 supplementary modules that expand on these basic assessments. The core CFI consists of an introduction, open-ended questions for patients and instructions to clinicians for each question. Acknowledging the need for global relevance and recognising international work on the OCF, sites in six countries participated in the field trial. This report presents findings from the international field trial that tested the 14-item pilot version of the core CFI (online supplement DS1) in three service domains based on patient and clinician feedback. Together with other field trial data not reported here, this process resulted in the final 16-item version in DSM-5 (19). We assessed several factors related to successful implementation of clinical innovations in service settings,20 including patient and clinician perceptions of the CFI's feasibility ('Can it be done in clinical settings?'), acceptability ('Do patients and clinicians like it?'), and potential clinical utility ('Is it helpful?'). We also considered whether closed- and open-ended assessments yielded similar results, and whether outcomes showed a practice effect, improving with experience. Our study is the first to examine these service domains for a tool to enhance cultural competence in multiple international settings.

Method

Study design and settings The CFI field trial was designed by the DSM-5 DCCIS via regular teleconferences (19,21). The study was conducted from November 2011 to September 2012; the New York site coordinated logistics for all sites. The study design purposively included samples of diverse patients, clinician disciplines and types of out-patient services, because a goal of the DSM-5 trials was to test the feasibility, acceptability and utility of proposed diagnoses and assessments under varied clinical conditions to determine inclusion in DSM-5 (22,23). Each site aimed to enrol at least 30 patients from affiliated psychiatric out-patient clinics in Canada (one site), India (two), Kenya (one), The Netherlands (one), Peru (one) and the USA (five). Sites were chosen based on involvement of a principal investigator in the DCCIS and aimed to include diverse cultural populations and types of out-patient services (general community, immigrant/refugee and ethnic-focus clinics). An opportunity sample of new and existing patients at each site was enrolled using a standard recruitment script. Clinicians who had no prior contact with their study patient conducted the interviews ('study clinicians'). Clinicians did not interview their own patients because prior knowledge and a pre-existing relationship would confound study aims focusing on an initial assessment. Current patients were referred by treating clinicians to local study clinicians. Each study clinician was expected to interview 3–6 patients during the trial to assess practice effects. Each patient participated only once. Patients and clinicians could also invite companions (for example relatives) to participate in the interview and subsequent assessments (24). All study clinicians participated in a 2h CFI training session at their site consisting of (a) reviewing the core CFI's written guidelines; (b) a 24min video demonstration; (c) interactive behavioural simulations with coaching and feedback from local principal investigators; and (d) a question-and-answer period. The study clinician administered the CFI followed by a routine diagnostic assessment. Topics of the CFI comprise four cultural domains: (a) definition of the problem; (b) perceptions of cause, context and support; (c) factors affecting self-coping and past help-seeking; and (d) factors affecting current help-seeking. All sessions were audiotaped with patient consent. The study was approved by each site's institutional review/ethics board and followed local informed consent regulations. All patients completed their locally approved consent process.

Participants

Eligible patients were aged 16 or older and fluent in the language of the local clinicians. We required the language match to avoid using interpreters who might introduce cultural information not obtained through the CFI. Patients were excluded if they were acutely suicidal or homicidal, intoxicated or in substance withdrawal, or if their condition seriously limited the assessment (such as dementia). Eligible study clinicians had a clinical degree permitting them to see patients, consistent with each country's requirements.

Assessments

Pre-interview, patients and clinicians completed demographic surveys. Clinicians also indicated their professional training and cultural competence experiences. Local principal investigators identified demographic factors recognised by their governments as indicators of social differences, avoiding a USA-based characterization (19,25). After every session, study clinicians provided patients' DSM-IV diagnoses and patients and clinicians completed follow-up questionnaires and semi-structured qualitative interviews. All assessments were translated into the local languages at each site and reviewed by a bilingual committee of mental health professionals for consensus (26).

Quantitative

Participants completed two brief questionnaires: the Debriefing Instrument for Patients (DIP) and the Debriefing Instrument for Clinicians (DIC), which comprise self-administered, Likertscale items assessing feasibility, acceptability and clinical utility (online supplement DS2) coded as 'Strongly disagree', 'Disagree', 'Agree' and 'Strongly Agree'. As with other DSM-5 trials, (22) these instruments were created for use in the CFI field trial. Items were selected for measurement by the DCCIS with reference to three domains (feasibility, acceptability and clinical utility) likely to affect the implementation of assessments such as the CFI (20,22). The same content was included in each instrument, with wording adapted for each stakeholder group. As a measure of feasibility independent of self-report, we assessed the duration of the CFI and the total diagnostic interview (including the CFI), based on session audio files.

Qualitative

Separate semi-structured qualitative interviews (8–9 questions, previously reported (19)) with patients and clinicians conducted by research assistants at each site provided more detailed accounts of the impact of the CFI on the initial evaluation. These interviews assessed participants' perceptions of the most and least helpful aspects of the CFI, its impact on interview quality and outcomes, and its role in clinical practice, including diagnosis and treatment planning. Each site provided written English summaries of the interviews to the coordinating site.

Analysis

Quantitative

SAS version 9.4 (Cary, NC) was used for all analyses.

Descriptive information. Patient and clinician characteristics were compared cross-nationally using ANOVA for continuous variables and Chi-square (or Fisher's exact test) for categorical variables; the Kruskal–Wallis test was used for ordinal or continuous variables with skewed distributions.

DIC/DIP. Negative DIC/DIP responses were coded as 72 (strongly disagree) or 71 (disagree) and positive responses as +1 (agree) or +2 (strongly agree) (24,27). Missing responses were imputed using the mean of the non-missing items within the assessment domain for the individual. Mean proportion of missing responses was 4.5% (s.d.= 1.4) for the DIP (range 2.8–7.6% for a single item) and 2.2% (s.d.=1.0) for the DIC (range 0.9–4.1%). Cronbach's alpha was used to assess the internal consistency of the three DIC/DIP domains. For domains with as50.70, inter-item correlation matrices, item correlation with total and changes to alpha by item were examined to detect problematic items; these items were excluded from subsequent analyses.

Mean DIC/DIP scores for feasibility, acceptability and utility were compared within patient and clinician cohorts, crossnationally and overall. We also compared the overall patient and clinician mean scores for each assessment domain; remaining items in domains with excluded items were also compared individually. To account for site-specific effects, clinicians seeing several patients and the inclusion of new and existing patients to the clinic, we used generalised linear mixed-effects models (PROC GLIMMIX in SAS), with random intercepts for site and clinician and a fixed effect for new patient status. Tukey–Kramer post hoc tests that adjust for multiple comparisons were used to identify significant patient–clinician differences (28).

Duration. Durations of the CFI and the full diagnostic interview (including the CFI) were compared separately cross-nationally using PROC GLIMMIX to adjust for new patient status and clinician effects. The proportion of total interview time devoted to the CFI was also calculated.

Practice effect. To determine whether clinicians' accumulated experience with the CFI affected their perceptions of the outcomes, we analysed changes in DIC scores over subsequent CFI interviews; we also analysed interview duration and the proportion of time devoted to the CFI in the full interview for each clinician. A mixed-effects model adjusted for clinician and site effects (but not patient newness, since patients were always new to study clinicians). Separate mixed-effects models and Tukey–Kramer post hoc tests contrasted DIC assessment domains between and within each administration, respectively.

Qualitative

Qualitative analyses were conducted by a three-person multidisciplinary team (public health, sociology and psychiatry) using deductive content analysis and working independently of the quantitative analysis team. Deductive content analysis codes qualitative data using pre-established categories based on theoretical frameworks (29,30). Each debriefing interview was coded for feasibility, acceptability and utility according to a codebook (developed by N.K.A.): feasibility and acceptability were defined as per Proctor et al. (20) and their definition for appropriateness was used to define utility, consistent with the terminology of the DSM-5 trials (25). Coder training consisted of two 1h sessions. Each coder labelled each interview phrase with one unique code for feasibility, acceptability or utility to minimise bias (31). Interrater reliability of 80% was achieved using a random 10% selection of transcripts. Iterative revision of the codebook was conducted over 5 weeks by reviewing concordance among codes and concepts, developing new subcodes, memoing, specifying code definitions with parameters (appropriate and inappropriate use), and reviewing data examples until new information produced no change to coding categories. All debriefing interviews were uploaded into NVivo (QSR International 2012) and randomly assigned for coding. NVivo reports were generated for codes, exploring patterns and drafting analytical memos by theme. Qualitative codes were counted by individual respondent and by number of mentions per text to analyse data by session and for the total sample.

Results

Patient characteristics

The field trial enrolled 321 patients; 3 were under 16 and were excluded, leaving 318 for analysis, of whom 189 were new and 129 existing patients. They had a mean age of 41.4 and 10.6 years of education; half were female (Table 1 and Table DS6). Most countries had an even distribution of employed, unemployed and participants who were out-of-the-labour-force (for example retired), except for the USA where nearly half were disabled. Marital status differed by country. Proportion of foreign-born individuals ranged widely, from 0% in Peru to 97% in Canada. Patients' primary language varied by site. Significant cross-national differences were observed for all sociodemographic variables (gender: P50.05; all others: P50.001). Clinically, 70% of patients received one DSM-IV Axis I diagnosis, 20% received two, 7% three or

Table 1. Patient sample characteristics (N=318)

Patients	Canada (n=33)		India (n=101)		Kenya (n=29)		Netherlands (n=30)		Peru (n=34)		US (n=91)		Total (n=318)		Test Statistic (df)	p-value
	Mean (SD)		Mean (SD)		Mean (SD)		Mean (SD)		Mean (SD)		Mean (SD)		Mean (SD)			
Age	51.12 (15.85)		35.42 (12.85)^{b}		31.97 (10.77)		41.87 (15.33)		36.50 (10.47)^{b}		49.25 (13.62)^{b}		41.44 (14.95)		F(5,306) = 17.56	**<0.001*****
Years of Education	7.53 (4.94)^{a}		11.37 (4.21)		9.83 (3.37)		12.03 (4.97)		12.56 (2.83)		9.94 (4.78)^{c}		10.64 (4.52)		F(5,101) = 6.92	**<0.001*****
	N	%	N	%	N	%	N	%	N	%	N	%	N	%		
Female	21	63.64	42	41.58	14	48.28	9	30.00	20	58.82	50	54.95	156	49.06	Fisher's Exact Test	**0.011***
Foreign-born	32	96.97	1	0.99	1	3.45	17	56.67	0	0	61	67.03	112	35.22	$\chi^2(5) = 187.75$	**<0.001*****
New to CFI clinic	33	100	101	100	0	0	20	66.67	34	100	1	1.10	189	59.43	$\chi^2(5) = 286.25$	**<0.001*****
Number of Axis I diagnoses																
0	2	6.06	3	2.97	0	0	1	3.33	0	0	1	1.10	7	2.20	$\chi^2(5) = 55.97$	**<0.001*****
1	25	75.76	91	90.10	26	89.66	12	40.00	20	58.82	49	53.85	233	70.13		
2	5	15.15	6	5.94	3	10.34	9	30.00	10	29.41	32	35.16	65	20.44		
3 or more	1	3.03	1	0.99	0	0	8	26.67	4	11.76	9	9.89	23	7.23		

a. Data unavailable for 1 participant.
b. Data unavailable for 2 participants.
c. Data unavailable for 10 participants.
*$p<0.05$; **$p<0.01$, ***$p<0.001$.

more, and 2% none (Table 1); this proportion varied significantly across countries (P50.001). Depressive disorders were diagnosed most frequently, followed by anxiety disorders.

Clinician characteristics

In total, 75 clinicians were enrolled, with an average age of 38.4; over 50% were female, except in The Netherlands and Peru (Table 2). Nearly 50% were psychiatrists or psychiatric trainees, 28% psychologists, and 15% social workers. Countries differed substantially on several indices. Kenyan clinicians had a mean of 3 years of practice, had seldom/never treated patients of different cultures, and all had 510 h of cultural training. By contrast Dutch clinicians had 15.6 years of practice, 91% had daily cross-cultural contacts, and half had 450 h of cultural training. The proportion of foreign-born clinicians ranged from 0% in India and Peru to 57% in Canada. All variables differed significantly across countries, except for age and gender.

Self-report outcome ratings

Cronbach's alphas for the DIC were high: 0.78 (feasibility), 0.80 (acceptability) and 0.89 (utility). DIP internal consistency was high for utility (0.82) but minimal for feasibility (0.18) and acceptability (0.17). Item-based analyses identified one problematic item under feasibility ('Took more time to share my perspective then I wanted') and acceptability ('Were too personal'); both items were negatively worded. Removing these items increased Cronbach's alpha for feasibility (0.45) and acceptability (0.48) (online supplement DS2), these domains each now containing two items. Prior research on cross-cultural variation with negatively worded survey items supports this approach (32).

Patient and clinician ratings of feasibility, acceptability and clinical utility were positive, but varied significantly cross-nationally (online Table DS7). Once adjusted for site effects, mean overall results for all three outcomes (Table 3) were positive among patients – scoring 1.26–1.33 on a scale from 72 to +2 – but evaluations were less positive among clinicians, with scores of 0.93–0.98 on utility and acceptability and 0.75 on feasibility. Overall, feasibility was significantly lower than the other indices among clinicians, and significantly lower than patients' feasibility rating. Clinicians also rated acceptability and utility lower than patients, but not significantly. By contrast, patient scores across assessment domains were nearly identical.

After excluding the two problematic DIP items, comparison of remaining single-item ratings of feasibility (easy to understand, t(10)= 5.27, P50.001; improved flow, t(10) =2.32, P= 0.043) and acceptability (encourage clinician use, t(10) =2.17, P=

Table 2. Clinician sample characteristics (N=75)

Clinicians	Canada (n=7)		India (n=21)		Kenya (n=5)		Netherlands (n=11)		Peru (n=5)		US (n=26)		Total (N=75)		Test Statistic (df)	p-value
	Mean (SD)		Mean (SD)		Mean (SD)		Mean (SD)		Mean (SD)		Mean (SD)		Mean (SD)			
Age	37.57 (7.76)		34.67 (7.48)		33.40 (4.39)		43.64 (11.46)		39.60 (8.26)		40.08 (10.26)^{a}		38.35 (9.12)		$\chi^2(5) = 10.39$	0.065
Years providing mental health care	10.14 (5.24)		7.48 (7.09)		3.00 (1.22)		15.55 (12.64)		6.60 (4.34)		10.16 (8.61)^{a}		9.47 (8.58)		$\chi^2(5) = 13.12$	**0.022***
	N	%	N	%	N	%	N	%	N	%	N	%	N	%		
Female	6	85.71	12	57.14	3	60.00	5	45.45	1	20.00	14	53.85	41	54.67	Fisher's Exact Test	0.377
Professional Discipline																
Psychiatrist/ Psychiatry Trainee	2	28.57	15	71.43	5	100	2	18.18	5	100	8	30.77	37	49.33	Fisher's Exact Test	<0.001***
Psychologist	1	14.29	2	9.52	0	0	6	54.55	0	0	12	46.15	21	28.00		
Social Worker	1	14.29	4	19.05	0	0	3	27.27	0	0	3	11.54	11	14.67		
Other Mental Health Clinician[1]	3	42.86	0	0	0	0	0	0	0	0	3	11.54	6	8.00		
Foreign-born	4	57.14	0	0	1	20.00	2	18.18	0	0	11	42.31	18	24.00	Fisher's Exact Test	<0.001***
Frequency of contact with patients of different cultures																
Daily	4	57.14	12	57.14	0	0	10	90.91	1	20.00	19	73.08	46	61.33	Fisher's Exact Test	<0.001***
Weekly or Monthly	0	0	9	42.86	0	0	1	9.09	4	80.00	4	15.38	18	24.00		
Seldom or Never	3	42.86	0	0	5	100	0	0	0	0	3	11.54	11	14.67		
Hours of cultural training																
< 10 hours	2	28.57	6	28.57	5	100	3	50.00^{b}	0	0	3	11.54	19	27.14	$\chi^2(5) = 14.05$	**0.015***
10 – 50 hours	1	14.29	11	52.38	0	0	0	0^{b}	3	60.00	11	42.31	26	37.14		
>50 hours	4	57.14	4	19.05	0	0	3	50.00^{b}	2	40.00	12	46.15	25	34.71		

a. Data unavailable for 1 participant.

b. Data unavailable for 5 participants.

1. Other clinicians: Licensed Marriage and Family Therapist (1 person), Social Work intern (1), Rehabilitation Counselor (1), Psychology trainee (2), Unspecified clinician (1).

*p<0.05; **p<0.01, ***p<0.001.

Table 3. Comparing feasibility, acceptability and clinical utility of the CFI from Likert-scale debriefing interviews with clinicians and patients (N=315)

	Domain				
	Feasibility M (SD)	Acceptability M (SD)	Clinical Utility M (SD)	Test Statistic (df)	p-value
Patients	1.33 (0.57)	1.27 (0.71)	1.26 (0.53)	F(2,833) = 1.41	0.246
Clinicians	0.75 (0.90) ^{a,b}	0.98 (0.75) ^{a}	0.93 (0.70) ^{b}	F(2,864) = 13.37	<0.001***
Test Statistic (df)	t(10) = 3.53	t(10) = 1.65	t(10) = 2.14		
p-value	**0.005****	0.131	0.058		

Mixed-effect models compared domain score differences within groups as well as between groups; comparisons control for clinicians seeing multiple patients, multiple clinicians within a site, and whether the patient seen was new to the clinic.
Data unavailable for the following participants: n=16 (patient acceptability), n=13 (patient feasibility), n=5 (patient utility), and n=3 (clinician acceptability).
a,b. Values with paired superscripts in the same row differ significantly (p< 0.05) after adjusting for multiple comparisons, Tukey-Kramer test.
*p<0.05; **p<0.01, ***p<0.001.

0.055; felt at ease, t(10)= 21.3, P= 0.059) across patient and clinician assessments revealed the same pattern as the analysis of means. DIC single-item results (online supplement DS2) identified clinician concerns about CFI comprehensibility and interview flow (feasibility) and about CFI impact on clarification of diagnosis, cultural background, severity, and patient–clinician differences (utility). DIP single-item results did not indicate specific concerns, although identification of barriers to care (utility) scored somewhat lower than other items.

Duration

Average CFI duration ranged from 18.8min in The Netherlands to 29.2 in Kenya (P50.001) and total interview duration ranged from 37.6min in Kenya to 88.2 in The Netherlands (P50.001). Average overall CFI duration was 23.4min, within a 54.1 min intake. Cross-nationally, the proportion of the interview devoted to the CFI varied significantly (online Table DS7).

Practice effects

Clinician (DIC) feasibility ratings improved significantly with practice, from an average of 0.59 at first use to 0.96 at the sixth or subsequent administration (Table 4). Acceptability and utility scores, by contrast, were stable and positive over time. Feasibility differed significantly from acceptability and utility ratings only for the first administration. Mean CFI duration decreased significantly, by over

Table 4. Practice effects on feasibility, acceptability and clinical utility, and duration of interviews in successive clinician interviews using the CFI (N=316)

Number of CFI administrations	First (n=74) Mean (SD)	Second (n=68) Mean (SD)	Third (n=67) Mean (SD)	Fourth (n=42) Mean (SD)	Fifth (n=26) Mean (SD)	Sixth^{1} (n=39) Mean (SD)	Beta (95% CI)	p-value
Feasibility	0.59 (1.02) †‡	0.81 (0.95)	0.72 (0.92)	0.84 (0.66)	0.72 (0.94)	0.96 (0.67)^{a}	0.053 (0.003, 0.103)	**0.039***
Acceptability	1.01 (0.72) †	0.98 (0.78)	0.97 (0.76)^{a}	0.98 (0.79)^{b}	0.87 (0.74)	0.98 (0.70)^{a}	-0.011 (-0.051, 0.029)	0.591
Clinical Utility	0.96 (0.65) ‡	0.92 (0.82)	0.84 (0.66)	0.91 (0.74)	0.98 (0.66)	1.06 (0.66)^{a}	-0.013 (-0.046, 0.021)	0.458
Duration of CFI in minutes	26.44 (10.40)^{c}	22.23 (9.64)^{e}	22.87 (9.38)^{b}	22.16 (8.77)^{a}	23.42 (9.57)^{a}	22.28 (8.39)	-1.017 (-1.616, -0.418)	**0.001****
Duration of full diagnostic interview in minutes	62.70 (27.41)^{d}	54.26 (25.95)^{f}	53.67 (23.58)^{g}	48.21 (21.49)^{g}	47.92 (22.55)	50.43 (28.61)^{b}	-1.609 (-2.708, -0.510)	**0.004****
CFI proportion of total diagnostic interview	47.49% (21.95)^{d}	47.62% (22.47)^{f}	48.91% (22.72)^{g}	51.67% (21.62)^{g}	54.07% (17.69)^{a}	51.94% (18.61)^{b}	0.046% (-0.753, 0.845)	0.910

Mixed-effect model comparisons control for clinicians seeing multiple patients and multiple clinicians within a site.
1. Combines the sixth administration or greater into one group. 6th=18 individuals, 7th=9, 8th=5, 9th=4, 10th=3.
a. Data unavailable for 1 participant.
b. Data unavailable for 2 participants.
c. Data unavailable for 6 participants.
d. Data unavailable for 10 participants.
e. Data unavailable for 4 participants.
f. Data unavailable for 5 participants.
g. Data unavailable for 3 participants.
†‡. Values with paired superscripts in the first-administration column differ significantly ($p < 0.05$) after adjusting for multiple comparisons, Tukey-Kramer test. No other values differed significantly within administrations
*$p<0.05$; **$p<0.01$, ***$p<0.001$.

4 min, consistent with clinicians' reports of increasing confidence in feasibility. This effect on CFI duration was evident by clinicians' second CFI administration, and remained stable at 22–23min thereafter. Mean total diagnostic interview duration also decreased significantly but gradually, by over 12 min from first to last administration. CFI proportion of the total interview time increased slightly with practice.

Qualitative interviews

Qualitative coding of the post-CFI open-ended debriefing interviews identified a pattern similar to the closed-ended quantitative DIC/DIP analysis (online Table DS8). Clinicians had a more negative perception of CFI feasibility than patients: 107 of 318 clinician interviews included negative feasibility comments about the CFI as a tool, and 39 negative feasibility comments concerning prospects for clinical implementation, compared with only 26 and 7 negative comments, respectively, among 318 patients. By contrast, patients made 81 positive feasibility comments about the CFI and 14 positive feasibility comments about its implementation prospects, whereas clinicians only made 30 and 9 positive comments, respectively. Clinicians' concerns focused on feasibility; acceptability and utility elicited more positive views. By contrast, patients' comments were largely positive across all assessment domains. These patterns were identical whether views were coded by participant or by total number of utterances.

Clinicians were concerned about the CFI's feasibility as a tool, faulting its organisation ('jumbled') and its placement early in the clinical interview. They also worried about implementation related issues, such as time burden and whether the format was overly structured. Patients were more positive about feasibility, praising the CFI structure ('from basic questions to more complex . . . in the sense of how you feel') and clinicians' non-'pressured' administration. However, some patients found 'all the details' confusing; they also worried the CFI might be too time-consuming for busy clinicians. Regarding acceptability, clinicians praised the CFI's ability to generate empathy but found some questions difficult to administer (for example on the clinician–patient relationship). Patients liked the flow and person-centeredness of the CFI questions ('I felt like I was talking to someone I knew'), although some became upset by the life content elicited. The views on CFI utility were the most positive. Generally, both groups of participants found the CFI useful with respect to diagnosis, treatment planning and understanding the patient's situation, including the role of culture in mental illness (for example 'will help me get better treatment;' 'will help me understand the patient's problem extensively on the basis of cultural, religious things').

Discussion

Main findings

The DSM-5 Cultural Formulation Interview field trial was the first international study to examine clinician and patient perceptions of the feasibility, acceptability and clinical utility of a cultural assessment interview designed for use in routine clinical practice in diverse cross-national settings. The international trial included 318 patients and 75 clinicians over 11 sites in six countries. Mixed-methods analyses showed that both patients and clinicians found the CFI to be feasible, acceptable and clinically useful and these findings supported its inclusion in DSM-5. The diversity of the samples and sites – and the fact that both closed-ended and open-ended assessments yielded similar results when analyzed masked to one another – enhance the clarity, robustness and generalizability of our findings.

The strategy for our quantitative analysis was developed at one of the study sites in India and used here with minor modifications (27). Site-specific analyses of the field trial data have also found positive perceptions of implementation-related outcomes (19,24,27). In the full sample, patients assessed the CFI more positively than clinicians, and the difference was significant for feasibility. Clinicians were more concerned about feasibility than about acceptability or utility. The qualitative data, based on post-CFI open-ended interviews, likewise showed greater clinician concern about feasibility, compared with patient views and other clinician-rated outcomes.

To be successfully implemented, a new assessment should address the concerns of all stakeholders (33), our design enabled us to examine views of both clinicians and patients. Differing views of feasibility among stakeholders probably reflect practical concerns and limited time of busy clinicians (34), relevant for effective allocation of health system resources that must balance clinical values and practical constraints (35). Although stakeholders' perceived acceptability and utility of an assessment or intervention may conceivably differ (20,36), we found no significant differences in our field trial.

Our mixed-methods design identified barriers to implementation of the CFI field trial version. DIC single-item analysis and qualitative data largely converged. They also confirm a previously published sub-analysis of New York-site qualitative data, which had identified lack of differentiation of the CFI from routine clinical assessments, question clarity and ordering, and the time required for the interview as main concerns (19). The consistency of these concerns in our cross-national analysis is striking, given the cultural and clinical diversity among study participants. Many of these issues were addressed in the revised version of the CFI published in DSM-5. Based on the field trial results, the revision clarified confusing wording, improved the flow of questions and distinguished the intent of the CFI from other aspects of clinical management. Four questions were condensed into two, and one question on cultural identity and three on the views of the patient's social network were added. Future research should examine the impact of implementing the CFI on clinical practice and outcomes, and in cultural competence training.

The practice effect identified from self-report and interview-duration data has important implications for questions about feasibility. Findings suggest that 2h of training followed by experience administering a few interviews may be sufficient to address clinicians' concerns about feasible use of the instrument, even in a diverse sample of provider disciplines and of cultural competence experience across sites (25). Consideration of the practice effect may facilitate uptake of the CFI, mindful that implementing any new tool may initially evoke resistance (27), which may lessen over time if its relative advantage becomes clear in routine practice (37). Indeed, by the second CFI administration, clinician feasibility scores increased substantially and no longer differed significantly from clinician acceptability and utility scores. Duration of the CFI interview, an objective indicator of feasibility, showed a similar practice effect, decreasing by 4min by the second administration and remaining stable thereafter.

Duration of the full diagnostic interview also decreased significantly albeit more gradually. By the last administration, the duration of the full intake assessment, including 22 min for the CFI, was 50 minutes. This is comparable to the time required for an initial assessment in many mental health settings. In the USA, for example, average duration of community-based psychiatric visits (initial and follow-up combined) was 32– 38 min in 1989–2006 (38-40), intakes are often 45–50 min. Our study found substantial international variation in intake duration. Some of this variation may derive not only from resource constraints – few clinicians for many patients – but also from clinic characteristics. The sites with the longest intakes (Canada and The Netherlands) included specialized programs for immigrants and refugees, whereas most other sites operated in general community clinics. Sites also differed significantly in the proportion of total interview time devoted to the CFI, yet all were able to integrate the CFI into routine intake procedures. The proportion of the interview devoted to the CFI increased slightly with experience, suggesting clinicians continued to find it useful and that the information it yielded was relevant to other aspects of the diagnostic interview, inasmuch as less time was required for the overall interview as a practice effect.

Limitations

This study has several limitations. Participating clinics were recruited purposively and may pay higher-than-average attention to cultural issues; clinicians who were most interested may have done more interviews, potentially confounding the positive practice effect. However, clinicians' interest did not prevent them from stating their concerns candidly in the qualitative interviews. Second, we developed our own self-report measures of service outcomes because at the time of the field trial there were no psychometrically validated quantitative measures of implementation-related outcomes.[41] The DIP feasibility and acceptability domains of assessment had psychometric limitations. One-time use of these assessments is consistent with the DSM-5 field trial goal of testing proposed diagnostic criteria (or tools such as the CFI) for inclusion or revision in the final manual.[22] The congruence of the qualitative and quantitative results as a benefit of the mixed-methods design supports the robustness of the DIP data. Third, the study interview consisted of the CFI session followed by the routine diagnostic assessment. All clinicians were asked to inform patients when they transitioned from the CFI to the routine assessment. It is possible that some patients did not distinguish the CFI component of their evaluation from the routine diagnostic component when responding to questions in their debriefing interviews.

Implications

Despite these limitations, the DSM-5 international field trial results support the feasibility, acceptability and clinical utility of the CFI. The positive valuation by patients and clinicians suggests that it is worth investing about 20 min of an initial evaluation on a cultural assessment that holds promise for enhancing clinical communication, diagnostic accuracy, effective treatment planning, patient satisfaction, engagement and clinical response (19,21). The promise of such benefits argues for further study of CFI implementation effects on clinical and service outcomes (such as cost and sustainability) (20). As a practical matter, the field trial suggests an attractive learning curve, with clear benefits after 2h of training and a single interview. A 2014 Lancet commission on culture and health advocated use of the CFI in all medical subspecialties, not just psychiatry (42), highlighting its broad relevance. Although further studies of implementation outcomes are needed, our findings indicate good prospects for meeting these acknowledged needs.

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Chapter 7

Patient-Clinician Relationship

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To write prescriptions is easy, but to relate to people in other ways is difficult. Franz Kafka: A country doctor'. 1919

Abstract

The core CFI has one question on the patient-clinician relationship, and there is a supplementary module entirely devoted to it. In the first part of this chapter we describe the clinical utility of understanding cultural aspects of the patient-clinician relationship. In the second section we describe the supplementary module about the patient-clinician relationship and its clinical utility.

Keywords
• Patient-clinician relationship • outline for a cultural formulation • culture.

Clinical Utility of Assessing the Patient-Clinician Relationship

In psychiatry a good patient-clinician relationship is of immense value (Nussbaum, 2013). Without a basic trusting relationship patients will not be open and honest about their thoughts, feelings and behaviours and psychiatric diagnostics will be aggravated. They will not follow the advice of the clinician, change their behaviours, nor will they be compliant with medication and psychotherapy, and will eventually end up with no shows and early drop outs.

Creating a relationship with patients is more challenging if patients and clinicians differ culturally of experience cultural differences, There will be different idioms of distress, and different expectations about the clinical encounter, about the course of the treatment, and about the possible treatment effects; and there will eventually be lack of trust. Psychiatric treatment of patients with a different cultural background has shown to produce a less favourable outcome than with indigenous patients of the same cultural background (Fassaert et al.,2010).

Building Rapport

The patient-clinician relationship is an ongoing object of study of transcultural psychiatrists. Kleinman (1980) pointed at the necessity to develop strategy so the expectations of the patient and the possible solutions of the clinician may meet. If the so-called explanatory models of the patient and of the clinician are too apart treatment will fail. Kortmann (2010) added that different phases of treatment require different distances to the patient. He distinguishes:

1. an elementary-sympathetic stage, in which the clinician tries to establish a beneficent and confidential relationship with the patient that facilitates trust and treatment adherence.
2. a diagnostic-therapeutic stage, in which the clinician has to make a proper diagnosis and treatment plan, according to his professional standards.
3. a personal stage, in which the clinician tries to integrate his observations and analysis in a tailor made treatment so it makes sense for the patient.

The clinician should be aware that a smooth sequence of attitudes will be favourable for the course and the outcome of the treatment. If he stays too long in the first stage, the patient may feel trust, empathy and understanding, but will miss a professional judgment of the clinician. If the second phase is too long, the patient may admire the clinician in his professional role, but finally will miss a personal touch, that motivates him to be compliant and change behaviour. So, the relationship which is built during the first diagnostic and treatment sessions is of crucial importance for the ultimate outcome.

Cultural Aspects of Every Clinical Encounter

As in other situations and contexts of human interaction, patients and clinicians produce, reproduce and transform culture in the process of providing and receiving mental health care, in making contact, in diagnosis and treatment. In other words, medical knowledge is cultural too and mental health care can be seen as production of culture (Taylor, 2003). In addition, clinical interaction is influenced by differences in power between patient and clinician in the consultation room, and between the social and cultural groups they make part of. Notably, health care professionals have the power to define the worries and complaints of the patient and label them according to classification system as DSM-5 or ICD-10 in a way that gives the patient access to scarce social recourses.

Attention is often focused on lingual and cultural differences, generally seen as blocking communication and the health care process. But, in every clinical encounter medical culture and lay culture interact, even when patient and clinician share the same cultural or ethnic backgrounds or speak the same language (Boutin-Foster et al., 2008). Meanings of distress, complaints and symptoms are negotiated in a continuous process of interpreting, defining, communicating, and redefining, with as objective a shared understanding of the patient's mental health condition and agreement about diagnosis and treatment.

Lacking objective biomarkers of mental disorders, diagnosis and treatment depend on clinicians' interpretation of the patients' interpretation of bodily and mental sensations, and related social reactions by the patient. This two-fased process of interpretation is complicated in a dyadic therapeutic relationship, yet even more complex when a third party is involved, especially in situations where relatives or professional interpreters are present (Bot, 2005; Willen, 2011).

Culture and attitudes are co-constructed in interaction between patients and clinicians. Lewis-Fernández and Kleinman (1995) locate culture not in the minds of individuals, but between people, in the medium of intersubjective engagements. Patients' attitudes towards clinicians are affected by factors such as patients' prior experiences with health care, culture, transference and countertransference reactions, but also other social and individual factors.

This influences their views about what is seen as 'proper' to communicate, how to communicate, and expectations of care and interaction with the clinician.

Different Models of Clinical Encounters

Globally there is great variety in models of clinical encounters within health care systems, but the essence of all is that one person is in need of help and another is in a helping position. A range of factors such as social and cultural traditions, history, economy, ideologies, politics, and local contexts affects the organization of health care systems. In Western-industrialized societies clinical encounters shifted in half a century from rather authoritarian relations between clinician and patient towards a more egalitarian person-centered approach. The latter entails the clinician becoming more of a medical consultant and guide, while the patient gets more decision power. The focus shifts to self-management of the patient, and increases his responsibilities.

Clinicians, in both primary and psychiatric care in Western-industrialized societies, have several roles when carrying out a psychiatric assessment. They are medical expert, as well as helper, guide, pharmacologist, potential psychotherapist, and gatekeeper of health care. In multicultural environments these clinicians encounter patients who are socialized in different (mental) health care systems, which they use simultaneously. Migrant patients' expectations of the role of clinicians are diverse. as are their levels of trust in health care and providers. Especially patients with a refugee background may have experiences of mental health care being a part of a repressive state, and even of health professionals participating in torture.

Emotional Reactions between Patient and Clinician

Clinicians need to know that all kinds of emotions may occur during psychiatric treatment. Some speak of (transcultural) transference and countertransference, (Comas-Diaz & Jacobsen, 1991). The clinician should be aware of his own ethnocentric reflex at one hand, and of his feelings of discriminating, or of overidentification, which can become an obstacle in the diagnostic evaluation and in treatment. In the unequal relation of the clinician and the patient it is difficult to express these feelings, but denying is still worse. The clinician should try to identify her own emotional reactions already during the first encounter.

The Role of Reflection in Understanding Culture

A reflexive stance means trying to see oneself through the eyes of the other. Selfreflection, or reflexivity, is a prerequisite for anthropological comparative study of culture and society (Hylland Eriksen, 2004). It is a structured approach to try, to some extent, to take a step back from one's own cultural framework. Reflexivity can also be a useful approach in clinical work in multicultural environments when trying to understand more of the perspective of the other.

Reflecting in situations of on-going clinical activity may be difficult. To enhance one's capacity for effective actions in complex social situations, Rudolf et al., (2001) address the value of reflections or our thoughts, feelings and actions, after activity.

They take the view that off-line reflection gives distance in time and space to analyse and re-experience feelings, thoughts, actions and results that have been confusing. This approach can be helpful for identifying blind-spots in the assessment situation, possible misunderstandings, miscommunication and neglect of alternative diagnostic understandings. Self-reflection is additionally a way to identify reactions of (transcultural) countertransference, and raising cultural awareness.

The Supplementary Module

Why and when to Use the Supplementary Module

The Cultural Formulation Interview (CFI) facilitates exploration of cultural aspects of the clinician-patient interaction by looking at the present relation and context. In the CFI there is one question on the Patient-Clinician Relationship, namely, question 16. The supplementary module includes suggestions as to questions for a further and more comprehensive exploration. Addressing cultural aspects of the interaction in the assessment situation enables both the clinician and the patient to improve understanding of the communication and attribution of meaning.

The objective of the supplementary module ‘Patient-Clinician Relationship’ is to assess the role of culture in the therapeutic relationship. More specific, it about the way patient *and* clinician experience, interpret and shape their cultural toolkits or repertoires, and how this influences the development of the relation (Gregg & Saha, 2003). The module, therefor focusses on the *individual* experience of culture (Lakes et al., 2006). Culture as it is experienced and performed by their agents. Culture in this context is broadly referring to “all the ways the individual understands his or her identity and experience in terms of groups, communities or other collectivities, including national or geographic origin, ethnic community, racialized categories, gender, sexual orientation, social class, religion/spirituality, and language” (APA, 2013).

This supplementary module addresses the mentioned two-step process of interpretation in mental health care. The questions try to unveil the thoughts and beliefs framing interpretation and to assist the clinician reflecting on both interpretational processes. The module consists of two separate sets of questions. One set is to be used during the clinical encounter, and the other facilitates reflection by the clinician afterwards. The first set can be used in case the CFI question 16 gives rise to further exploration. It is recommended to keep the second set in mind in every phase of treatment.

An Overview of the Patient-Clinician Module

The supplementary module has twelve questions. Five are questions are for the patient, seven to support the clinician to have a self-reflexive stance. The first set of five questions evaluates four domains in the clinician-patient relationship: experiences, expectations, communication, and collaboration.

- They probe the thoughts and beliefs of the patient about (mental) health care in general, and (mental) health care professionals in particular, that may influence the therapeutic process in a positive of negative way.
- They bring to surface past experiences that may impede or can be helpful in establishing an effective therapeutic relationship.
- They elicit the patient thoughts about the present clinician and future relationship.

These questions furthermore implicitly strengthen the clinician's presentation as thoughtful and open, express his willingness to respect the patient, to listen to his experiences, and take them seriously, and underscore the relevance he attaches to the patients point of view.

The first two questions of the module intend to explore patient's experiences of health care. The presentation of complaints is contextual, depending on prior clinical experience, present needs and cultural traditions and expectations. Negative experiences in the past for instance may explain the patient's reluctance to inform the clinician in an open way.

Expectations which the clinician cannot meet, may be identified, for instance fast recovery of a chronic psychiatric illness, obtaining scarce social resources or assistance in a juridical affair, and can be addressed in an early phase of therapy. The other way around, the clinician can take into account in his treatment plan what the patients experienced as helpful of difficult in the past, culturally patterned expectations and sometimes discover unexpected cultural and contextual resources of the patient.

The following three questions focus on the present situation, and look for impediments in establishing an effective therapeutic relationship. The third question explores patient's preference for clinician. The golden rule is not assuming the patients preferences, but informing about them openly. If present, the patients´ preference concerning the interpreter has to be included. The influence of racial differences in therapeutic relationship is well known, but also differences in gender, age, ethnicity or religion may or may not play a role. It is important to keep in mind that matching is not always obvious or preferred. Differences, furthermore, are not facts, set once and for all. The initial preferences and the initially experienced differences may diminish as the therapeutic relationship unfolds in a positive way.

The forth question aims to open a dialog about patients' doubts about being understood in the diagnostic phase. For example talking about homosexuality may be blocked if patient and clinician share a religious background that does not approve a homosexual orientation. The fifth question aims to promote a discussion about further collaboration.

The second set of questions offers guidelines for the clinician to reflect on after the interview.

- They help the clinician raising cultural self-awareness and gain insight in the framing by medical culture.
- They help to gain insight in practices of stereotyping
- They help the clinician to become aware of effects of the context of treatment on the behaviour of patients.
- They illuminate the limitations of the routines that clinicians develop and use in clinical practice to assess patients and to plan treatment.
- They can be used in the clinical encounter, as well as in discussing the patient with colleagues.

The first two questions aim to promote a reflection over feelings that may occur in the patient-clinician relationship. Discrimination and social exclusion often play an important role in the narratives of patients from minority groups. Being part of the dominant social group, and not having personal experience with discrimination and social exclusion, may unintentionally hinder clinicians to assess adequately their impact on the live of the patient.

Furthermore, the clinician can easily misjudge a patient when only guided by his appearance. Wearing a head kerchief of being clad in an assumed 'traditional' way, may hide a surprisingly 'modern' worldview.

The third question explores the impact of the presence of an interpreter on the communication. The presence of an interpreter may cause the patient to be less open about his thoughts or the opposite, may improve trust and understanding. For instance, is the interpreter to be trusted, and how does he deal with confidential information? In small communities the fear of gossip is often present. And occasionally, especially in the case of refugees, the patient may wonder about the allegiance of the interpreter to conflicting parties in land of origin.

The fourth question aims to encourage the clinician to make an overall reflection about how the patient's cultural background may influence the diagnostic categorisation and evaluation. For example, this includes thoughts about uncertainty on diagnostic interpretation of signs and expressions of distress. The fifth question supports a reflexive stance towards one own suggestions for treatment, and routines. Like considering if treatment plan and recommendations were made with concern about the patient's conceptualisation of the problems. And checking sufficiently the assumptions about the patient and his cultural orientations in evaluating therapeutic possibilities. The sixth and seven questions promote thinking over one's own prejudice and stereotyping that may have been played in the encounter with the patient.

Obstacles and Caveats when Using the Module

The patient may wonder why the clinician is asking all these questions, who seemingly have little or nothing to do with his or her complaints. Patients may not be used to be asked these kind of questions, take a passive stance and expect the clinician to act. As stressed in the guideline, it is important to introduce the questions in a proper way.

Secondly, patients may not understand the question, or are not willingly to disclose their thoughts about therapy or about the clinician in a context of dependence. Sometimes, the patient discloses his thoughts easier by talking about past experiences than about the actual situation. Besides this strategy, the clinician can present examples from his or her clinical practice, in order to inform the patient that he or she is acquainted with the situation the patient is in. Thirdly, the 'culture' pitfall has to be mentioned. The culture pitfall refers to a focus on the culture of the group instead of on individual patient as cultural agent (Kleinman & Benson, 2006). It also refers to an operationalization of culture as a set of static properties of patients instead of as a fluid intersubjective system of meaning and practice (Kirmayer, 2012). Above all, patients usually do not like to be treated as a representative of an ethnic group instead of an individual (Feldman et al., 2007).

Patient *and* clinician may also use talking about culture as a defense mechanism. For the patient to avoid talking about personal affairs and to legitimate his choices; for the clinician, to argue that occurring problems in treatment are external caused, and not therapist-related. It is important to avoid talking about 'culture' in general, and using culture as an argument. Instead the clinician should focus on factual behaviour and beliefs of the patient and his social system in everyday life. Finally, there is the command every clinician always should in mind according to Arthur Kleinman (2005): "First, do not harm by stereotyping".

Conclusion

In this chapter, we have given a theoretical background to the study of patient-clinician relationship. We then described the supplementary module and showed ways how to use them, and ended by showing possible caveats. Even if not used, the clinician should keep in mind the module in every phase of psychiatric assessment and treatment in order to enhance reflexivity and raising cultural awareness.

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Module:

Patient–Clinician Relationship

Related Core CFI Question: 16 Some of the core CFI question are repeated below and are marked with an asterisk (*). The CFI question that is repeated is indicated in brackets.

Guide to interviewer: *The following questions address the role of culture in the patient–clinician relationship with respect to the individual's presenting concerns and to the clinician's evaluation of the individual's problem. We use the word* **culture** *broadly to refer to all the ways the individual understands his or her identity and experience in terms of groups, communities or other collectivities, including national or geographic origin, ethnic community, racialized categories, gender, sexual orientation, social class, religion/spirituality, and language.*
The first set of questions evaluates four domains in the clinician-patient relationship from the point of view of the patient: experiences, expectations, communication, and possibility of collaboration with the clinician. The second set of questions is directed to the clinician to guide reflection on the role of cultural factors in the clinical relationship, the assessment, and treatment planning.

Introduction for the patient: I would like to learn about how it has been for you to talk with me and other clinicians about your [PROBLEM] and your health more generally. I will ask some questions about your views, concerns, and expectations.

Questions for the patient:
1. What kind of experiences have you had with clinicians in the past? What was most helpful to you?
2. Have you had difficulties with clinicians in the past? What did you find difficult or unhelpful?
3. Now let's talk about the help that you would like to get here. Some people prefer clinicians of a similar background (for example, age, race, religion, or some other characteristic) because they think it may be easier to understand each other. Do you have any preference or ideas about what kind of clinician might understand you best?
4. *Sometimes differences among patients and clinicians make it difficult for them to understand each other. Do you have any concerns about this? If so, in what way? [RELATED TO CFI Q#16.]

Guide to interviewer: *Question #5 addresses the patient-clinician relationship moving forward in treatment. It elicits the patient's expectations of the clinician and may be used to start a discussion on how the two of them can collaborate in the individual's care.*

5. What patients expect from their clinicians is important. As we move forward in your care, how can we best work together?

Questions for the clinician after the interview:

1. How did you feel about your relationship with the patient? Did cultural similarities and differences influence your relationship? In what way?
2. What was the quality of communication with the patient? Did cultural similarities and differences influence your communication? In what way?
3. If you used an interpreter, how did the presence of an interpreter or his/her way of interpreting influence your relationship or your communication with the patient and the information you received?
4. How do the patient's cultural background or identity, life situation, and/or social context influence your understanding of his/her problem and your diagnostic assessment?
5. How do the patient's cultural background or identity, life situation, and/or social context influence your treatment plan or recommendations?
6. Did the clinical encounter confirm or call into question any of your prior ideas about the cultural background or identity of the patient? If so, in what way?
7. Are there aspects of your own identity that may influence your attitudes toward this patient?

Chapter 8

Somatization in Refugees

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Abstract

This article presents a review of the literature concerning medically unexplained physical symptoms in refugees. We outline a variety of definitions and explanations of somatization, as well as the role of culture in the concept of disease. In addition, we present a review of the epidemiological literature about somatization in traumatized refugees.

Refugees from non-Western countries exhibit more unexplained somatic complaints than the general Western population. Although different studies have employed different methodologies and therefore have obtained different results, it could be concluded that refugees form a particular population in which somatization is prominent. In addition, there is a connection between somatization and culturally specific idioms of distress, and stigmatization. Implications for assessment, treatment and research concerning refugees are discussed.

Keywords
• Refugees • Migrants • Somatization • Medically unexplained physical symptoms
• Traumatization

Introduction

Somatization poses a difficult problem in psychiatric practice. Both psychiatrists and patients can become frustrated, because they may both be under the impression that the other cannot understand their point of view: psychiatrists because they may see somatization as a reason why the patients reject their psychiatric and psychotherapeutic diagnoses and subsequent interventions; psychiatric patients because they have the feeling that their demands for further physical examination and physical therapies are not being met. This problem is especially present when there is contact between clinicians educated in the West and non-Western migrant patients (e.g. Baarnhielm & Ekblad, 2000; Borra, 2008; Ritsner et al., 2000; Van Moffaert, 1998). In our center for traumatized refugees[1], we see many patients who exhibit medically unexplained physical symptoms, probably more so than in the realm of psychiatric practice for non-migrants. Many of these patients expect to be predominantly treated for their somatic symptoms rather than for their mental problems. Often, this expectation results in misunderstandings and problems in the therapeutic process.

In this article, we present a review of the literature regarding medically unexplained physical symptoms in refugees. Our main research question is: do non-Western refugees have a greater tendency to somatize than other patient groups in clinical psychiatry? The second question is: is there a connection between somatization and traumatization?

We begin by formulating definitions, theories and explanations concerning the concept of somatization. We also discuss the role of culture in the context of somatization. In the second section, we present a review of the literature on the topic of somatization in general, and somatization in refugees in particular. We end with conclusions and recommendations for clinicians and suggestions for further research.

Theoretical considerations

Somatization, or the expression of one or more physical symptoms which cannot be explained by medical examination, is a rather complex phenomenon. There are various clinical manifestations and many possible causes. We will use the definition provided by Lipowski (1988), who stated that somatization is ‘a tendency to experience and communicate somatic distress and symptoms unaccounted for by

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[1] A branch of Foundation Centrum ‘45, the National Expert Center for the Treatment of Victims of Persecution, War and Violence, Rijnzichtweg 35, 2342 AX Oegstgeest

pathological findings, to attribute them to physical illness, and to seek medical help for them' (page 1359). This definition includes not only the psychological aspects of somatization, but also the relevant social dimensions and the aspects that are attributed to the medical system. However, this definition ignores the influences of the environment, cultural beliefs and the medical system on the patient. One could consider, for instance, the reinforcing effect of repeated medical investigation on somatization (e.g. 'If they have spent so much time examining me, I must have a serious disease'), or the effects of attention and care. In addition, secondary gain (e.g. receiving illness benefits in the form of financial compensation) could influence somatization. Stigma surrounding seeking psychiatric treatment can also enhance somatization; this is dependent on the culture of the individual (Raguram et al., 1996; Rao et al., 2007).

There are at least three different ways to approach somatization. According to Kirmayer and Robbins (1991), somatization can be considered as: (a) a syndrome of medically unexplained somatic symptoms; (b) hypochondriasis, or (c) somatic signs and symptoms of psychiatric disorders.

The first concept refers to medical conditions that are as of yet unknown. When a patient experiences pain, functional symptoms or functional deficits, he or she can assume that s/he has a somatic disease. However, when a physician cannot find any indication of organic pathology, then somatization or, depending on the symptoms, a somatoform disorder may be diagnosed. In fact, the diagnosis of somatization, in this case, is an 'exclusion' diagnosis, i.e. a diagnosis made by the exclusion of other diseases. In terms of the classification system of the Diagnostic and Statistical Manual- 4th edition (DSM-IV) (American Psychiatric Association (APA), 2000) this syndrome of somatization would be classified as an undifferentiated somatoform disorder (DSM-IV code: 300.81). In severe cases this would become classified as a somatization disorder (DSM-IV code: 300.82). The symptoms may derive from a permanent state of arousal in which the autonomous nervous system is activated, and in which, for instance, muscle contractions cause headaches and aches in the back and limbs. In refugees, this form of somatization can occur as a result of hyperarousal, a manifestation of anxiousness without the full diagnosis of an anxious disorder.

The second concept, hypochondriasis (DSM-IV code: 300.7) is a serious psychiatric disorder, in which the patient fears that they have, or is convinced that they have, a serious disease, with all the signs of this disease. This belief is grounded on a false interpretation of somatic signs. Patients with this syndrome have an almost delusional belief in their disease or are obsessed by their symptoms, and it is difficult to convince them of other interpretations of the signs. Refugees, mostly from non-Western societies, sometimes suffer from this condition as a culturally specific sign of distress: general distress is translated into a conviction that they have a specific disease.

The third approach to somatization is to regard it as coexisting with the psychological symptoms of mental disorders. Mental disorders are also, by definition, expressed in a somatic way. For instance, physical symptoms such as constipation, amenorrhea or a dry mouth can be present in cases of depression. In anxiety disorders, somatic expressions like diarrhea or hyperhidrosis can occur. In patients with a posttraumatic stress disorder, symptoms such as quick respiration, palpitations and hyperhidrosis are often seen when the disorder is triggered by an impulse which resembles the original traumatic experience. In the classification system of the DSM-IV (APA, 2000), all these somatic symptoms are included in the classification of a specific psychiatric disorder. Refugees often exhibit somatic symptoms; psychiatric disorders are more common among refugees, and they initially express these disorders as somatic symptoms (Laban et al., 2008).

Kirmayer and Young (1998) constructed another method of dividing patients with somatization. They identified three groups: the first group they called initial somatizers, who are patients who come for psychiatric treatment with somatic complaints, but who are easily convinced of the psychological nature and the need for psychological treatment of their complaint. The second group comprises facultative somatizers; patients who tend to make use of somatic symptoms at certain moments during their illness and in their treatment. The third group consists of the real somatizers: patients with a firm belief in the somatic origins of their pains and dysfunctions.

There are many possible explanations for the process of somatization. As a result, various theories or explanations for somatization in non-Western patients have been presented (Güzelcan et al., 2002; Kirmayer et al., 1998; Richters, 2002). However, it is important to bear in mind that many of the explanations are also valid for Western patients. Some of the explanations may be relevant simultaneously.

Somatic disease. At first, it is crucial to bear in mind that somatization or somatic complaints may be the result of a yet unknown somatic disease. A thorough somatic examination before commencing psychiatric treatment may show, in many but not all cases, the existence of such a disease. Somatic examination should be extensive and not be based on superficial stereotypes (e.g. 'Another psychiatric patient who thinks he has cancer'). We should also keep in mind that some diseases have a latency period and become visible and detectable at a later phase. In some cases, it is wise to opt for a re-examination. Refugees, especially those from a non-Western background, are in danger of being misdiagnosed, since communication with them may be difficult because of poor language abilities, and their poor knowledge of the medical system.

Psychological conflict. The second theory is that somatic complaints without a somatic disease are an expression of a psychological conflict. This is the main theory that psychiatrists and psychotherapists use; however, importantly, their patients do not. This could easily result in misunderstandings and even conflict in the treatment process. This theory is reminiscent of certain old psychodynamically grounded psychosomatic theories, especially the so-called specificity theory where certain somatic diseases like asthma and stomach ulcers were believed to result from certain unsolved conflicts (Alexander, 1950). This theoretical framework has been abandoned, and has been replaced by the general stress theory (Weiner, 1977).

Culture specific. The third explanation is that somatization is a culturally specific sign of distress. In some cultures, psychiatric diseases as defined by the Western nomenclature are unknown. Psychiatric diseases are then explained on a spiritual, supernatural or somatic level. Caribbean voodoo and Chinese neurasthenia are examples of this, as is French crise-de-foie, in which general exhaustion is thought to be caused by liver problems. Somatization can be seen as a way in which to express distress which is socially and culturally acceptable (Kirmayer & Young, 1998).

Alexithymia. Another explanation is alexithymia, which is the inability to express emotions. Emotions therefore seek a somatic form of expression. People with alexithymia have a greater sensibility in terms of somatic signals than emotional signals. In a large review of the relevant literature, an association between somatization and alexithymia has been established (De Gucht et al., 2003). However, there are still questions, because most of the studies that were reviewed used questionnaires in order to establish somatization, and not a physical examination. Alexithymia is more often encountered in non-Western cultures (De Ridder et al., 2008).

Stigma. The fifth explanation deals with the fear of stigmatization that patients may encounter when they express psychological problems. They consciously or unconsciously prefer to present somatic problems rather than psychological problems because of the fear of being called insane by their doctor, their family, or others. The health system is also oriented towards somatic problems. In many countries, having a somatic disease makes it easier to profit from illness benefits. Somatic diseases legitimize illness. The general opinion is that a doctor will listen more carefully when the complaint concerns somatic symptoms. In countries where people see psychiatry as a care system specifically for schizophrenics, patients have a greater fear of being stigmatized if they were to seek psychiatric treatment for depression or an anxiety disorder. In many non-Western countries, this is certainly the case (Raguram et al., 1996).

Trauma. In this subgroup, another phenomenon is evident. Patients who have been tortured often show chronic symptoms of pain and dysfunction in the parts of their body where they were tortured, without any objective signs of lesion. Due to the fact that their somatic symptoms are linked with feelings of hate, anger and sadness, they tend to become chronic (Van Ommeren et al., 2002). The same phenomenon is encountered in veterans who have been wounded or otherwise hurt. The Gulf War syndrome is said to be an example of this mix of somatic and psychological factors. Sometimes this is difficult to distinguish: chronic somatic diseases can of course also be responsible for psychological distress. It has been said that deep-rooted emotions prevent somatic symptoms from being cured (Hermannsson et al., 2002).

Prevalence of somatization and differences between Western and non-Western patients

In this review, we will look at the prevalence of somatization in the general population. We will present findings from a search using Pubmed and PsychINFO, with the search terms: somatization, somatization, medically unexplained psychical symptoms, and all these in combination with refugees.

First, we will present data in order to show the differences between Western and non-Western patients in medical care. Epidemiological studies on somatization have been performed using the general population and those in primary care. This provides a better insight than research using patients in the psychiatric services because of the selection of patients.

When we define somatization as someone having somatic complaints without an actual proven somatic disease, it can be argued that most people somatize once in a while. A large number of people present complaints to their general practitioner once, and do not come again after being reassured that they do not have any serious disease. According to a review at least 33% of somatic symptoms in primary care and population-based studies are 'medically unexplained' (Kroenke, 2003). The proportions range from 20% to 74%, depending on the method used for classifying a symptom as medically unexplained. Of the five large studies he reviewed (total N = 16, 116, all performed in the United States), three studies found a percentage of around 33%, while the other two studies found percentages of 74% and 20%, but used a different method of classification. In an older study in the Netherlands, it was estimated that 20% of somatic symptoms could not be medically explained (Huygen et al., 1984). Therefore, stating that one third of patients in primary care and in the general population has medically unexplained physical symptoms appears to be a reasonable estimate.

At this point, it would be interesting to know the frequency of somatization in developing countries and in ethnic minorities. In a study performed on patients in primary care in India, about 65% of all patients showed somatization of psychological problems and unexplained somatic complaints (Davar, 1999). In the United Kingdom, significantly higher levels of somatization were reported among Asian people than among native English people (Bal & Cochrane, 1990).

However, in a large study conducted by the World Health Organisation (WHO) about somatization in primary care, Gureje et al. (1997) found no substantial differences in the prevalence rates of somatization in 14 different catchment areas around the world: the overall prevalence was approximately 0.9%. Only in Rio de Janeiro and in Santiago de Chile were significantly more somatization disorders present. They also examined a less restrictively defined form of somatization, as assessed by the Somatic Symptom Index (SSI) (Escobar et al., 1989). The SSI was said to have a positive outcome when four or more unexplained somatic symptoms for men and six or more unexplained somatic symptoms for women were determined. The overall frequency estimated using the SSI was 19.7%, and the estimates in 10 of the 15 catchment areas were close to or even greater than this value. Again, the rates in the two South American areas were much higher than the overall rate.

However, this study was heavily criticized, since it was conducted in large cities and not in more rural regions where people are less Westernized. Kebede and Alem (1999) found that the prevalence rate of somatization among the general population in Addis Abeba, Ethiopia was 3.1%.

Prevalence among refugees in the general population

A literature search concerning the frequencies of somatic complaints in refugees revealed six studies on refugees in Western countries. These studies are community studies. The frequencies are shown together in Table 1.

A three-year follow-up study of 240 refugees in a community in Norway was performed by Lie (2002). The focus of the study was to look at the development of psychological symptoms, but she looked also at general health. About half (47 %) of the group considered their general health to be either good or very good, on a self-perception scale. Nevertheless, more than half of the group had heart complaints (57 %) and 40 % had bodily aches and pain.

Table 1. Research on somatic complaints in refugees in the general population

Author	Method	% with somatic complaints	Types of complaints
Weine et al. (2000)	MOS-SF 36	6.9 versus 5.3* average physical role	
Lie (2000)	Self perceptions of general health, perceptions of life and health situation on a 1-10 scale, list of 7 somatic complaints	50% poor or bad health. Perception of general life and health situation 4.8/10	- Heart symptoms (56%) -Bodily pains (40%)
Westermeyer et al. (1989)	Population survey with SCL-90 somatic scale	44% borderline or abnormal scores	
Beiser et al. (1994)	List of 16 somatic items	5.0 % of refugees showed somatization vs. 4.8 % of the general population (non significant)	
Gerritsen et al. (2005)	MOS- SF 36	42 % of refugees, 59% of asylum seekers poor health	-Neck/shoulder (33%) -Back (32%) -Migraine/headache (32%)
Laban et al. (2008)	Self-developed questionnaire, WhoQoL	A longer period of asylum causes poorer physical health	

** On a scale of 10, showing a significant difference between refugees who sought psychiatric treatment and refugees who did not*

Somatization in a non-patient population of 97 Hmong refugees was studied by Westermeyer et al. (1989). Four different measures of somatization were employed, including a 12 item self-rating scale, a single-item global rating based on interviews, and somatic subscales of the two Hamilton interview-rating scales. Next to this, demographic variables were collected, medical problems were scored, and medical treatment-seeking, psychiatric problems and symptoms were described, and a rating for psychosocial adaptation and acculturation.. For about 44% of the refugees, an abnormal or borderline score on the somatization scales were found. Regression analysis revealed some interesting correlations. There was no connection between somatization and current somatic disorders or with a history of war wounds. Somatization was associated with psychiatric disorders. There was a strong correlation with depressive symptoms, thus not supporting the contention that somatization may be an alternative for depression. More education was associated with less somatization. And, interesting enough, those subjects who were fluent in English with considerable psychopathology, may be more apt to somatize than those with comparable psychopathology but less skill in English. The authors concluded that somatization is associated with a failure to acculturate. For them, somatization indicates a certain help seeking behavior which is acceptable to others and therefore does not cause stigma.

Beiser et al. (1994) performed a study among 1348 south-east Asian refugees, whom they compared to 319 residents of Vancouver using different measures. The authors did not find significant differences in terms of the measure of somatization: the rates were 5.0% for refugees versus 4.8% for the Vancouver residents. Their conclusion was that after resettling in British Columbia, south-east Asian refugees did not show more psychopathology or somatization than local residents.

Gerritsen et al. (2006) explored the physical and mental health of Afghan, Iranian and Somali asylum seekers (N = 232) and refugees (N = 178) living in the Netherlands. They used the Medical Outcome Study (MOS) 36-item list to measure physical health. More asylum seekers considered their physical health to be poor than refugees did (59.1% versus 42.0%). Approximately half of all of the respondents suffered from more than one chronic condition. The mean number of chronic conditions was 2.0 for the entire study population. The conditions that were most frequently reported were severe neck/shoulder problems (33.4%), severe/chronic back complaints (32.7%), and migraines/severe headaches (32.6%). Although the authors did not speak of somatization, their descriptions point to complaints connected with high muscle tension (which was probably caused by enduring distress) and not at medical illness according to a narrower definition.

The physical health and quality of life of Iraqi asylum seekers in the Netherlands was studied by Laban et al. (2008). They compared two groups of asylum seekers: one group who had lived for a short period in the Netherlands (N = 143) and another group who had lived there for more than two years (N = 151). They used among other scales a 22-item scale, dealing with perceived physical health and chronic physical health problems and physical handicaps. The physical health problems were divided in two categories: physical complaints and physical diseases. The physical health was rated at a mean 55 on a scale from 1-100 for the short period group and 47 for the long period group. The difference is significant. It was found that respondents with a long asylum procedure reported a significantly lower quality of life, higher functional disability and more physical complaints. Multivariate regression showed that the length of stay was the strongest predictor for a low overall quality of life, and for physical health. No comparison was made with the general population on these scales. Thus, this last research shows a significant difference between two groups of asylum seekers, but did not show a difference with the general population.

Prevalence among refugees in primary health care

Next, we looked at research findings on somatic complaints in refugees in primary care (see Table 2). Lin et al. (1985) conducted an investigation using 261 Asian refugees and 265 Chinese and Filipino migrants in primary care in the United States, and compared the two groups. Somatization accounted for 35% of visits to doctors. The percentage of somatization in the immigrants was 27%, and in the refugees it was 42%. The most common complaints were headaches, abdominal pains, and lower back pains. The authors concluded that somatization is an important health problem among both immigrants and refugees, but that it is a greater problem for refugees.

Table 2. Research on somatic complaints in refugees in primary care

Author	Method	% with somatic complaints	Mean number of complaints	Types of complaints
Lin et al. (1985)	Medical files, ICD-9, reason for visit classifications	42% of refugees 27% of migrants		-Headache (7.5%) -Stomach ache (6.6%) -Lower back pain (5.8%)
Holtz (1998)	HSCL-25, 8 somatic items		1.75	-Stomach ache (19%) -headache (16%) -muscle, bone and joint problems (49%)
Crescenzi et al. (2002)	HSCL-25, list of 8 somatic complaints		3.45	-Headache, bellyache, pains over the whole body, panic attacks, unexplained signs of paralysis, heart complaints, insomnia
Van Ommeren (2002)	Checklist of 25 somatic complaints	84% in tortured refugees	2.5 of tortured subjects 1.8 of non tortured subjects	
Thijs & Van Willigen (1989)	Questionnaires of somatic complaints and anamnesis	85% questionnaire 66% anamnesis		-Weakness/loss of weight (50%) -Gynecological complaints (35%) -Complaints of movement system (25%) -Headache
Hondius et al. (1992)	Prospective study with one interview	75%	2.5	-Stomach ache (19%) -Headache (16%) -Muscle, bone and joint problems (49%)

A study of 70 Tibetan refugees in India, 35 who had been tortured and 35 who had not been tortured (80% of this sample were nuns), was conducted by Holtz (1998). Although there was a difference in the anxiety scores (tortured refugees scored higher on anxiety) there were no differences in terms of scores for depression and somatic symptoms. The subjects had a mean score of 1.75 out of 5 in the somatic subscales of the Hopkins Symptom Checklist, which is higher than the cut-off point for somatization.

Refugees from Tibet (N = 150) were also studied: 74 of the subjects of this study had never been imprisoned and 76 had been previously imprisoned (Crescenzi et al., 2002). In the total study population there was a high rate of depression and somatic symptoms and the two research groups did not differ in terms of these measures. The two groups had the same number of somatic complaints. However, the formerly imprisoned group had significantly higher anxiety scores.

Van Ommeren et al. (2002) looked at refugees from Bhutan in Nepal, 526 who had been tortured and 526 who had not. They found a significantly higher amount of non-specific somatic complaints in the tortured group: 84% of them had somatic complaints. Using regression analysis, they found posttraumatic stress disorder (PTSD) to be a predictor of somatic outcomes, and depression a predictor of the number of somatic complaints. In other words, there is a strong connection between physical complaints and psychopathology. They advised screening for PTSD when survivors of extreme stress present non-specific somatic complaints.

Refugees living in the Netherlands who came from different countries and presented themselves for primary care were studied by Thijs and Van Willigen (1989). They found that 85% of them had somatic complaints, but that for 66% of them, a somatic diagnosis could not be made. The most common complaints were general weakness, gynecological complaints, headaches and complaints about their movements.

A prospective study among 156 refugees from Turkey and Iran living in the Netherlands was conducted by Hondius et al. (1992). They found that 75% of the patients had somatic complaints, and that 70% did not have a somatic diagnosis. They also looked retrospectively at refugees from the Middle East and Latin America. Of these refugees, 84% showed somatic complaints, and in 73% of the cases a somatic diagnosis could not be made. Furthermore, refugees attributed their somatic and psychological complaints to illness and torture, while psychological complaints were attributed to worries relating to the post migration situation.

Comparison between refugees and non-refugees

In Table 3, a comparison between the general population and refugees in terms of the total numbers of somatic complaints can be seen. The numbers are derived from the studies that we reviewed earlier in this article. The numbers of somatic complaints among refugees is generally higher than among non-refugees. Unfortunately, the different studies are not comparable. Different somatization questionnaires were used, with different cut-off points for somatization. In addition, most research does not look at coexisting somatic disorders; a thorough somatic examination is rarely included. Thus, we can only speak of a trend in the literature. The trend is that, generally speaking, high levels of somatic complaints occur in refugees. Whether this high level of somatic complaints has something to do with somatization is not totally clear. Serious comparative epidemiological studies should not only include comparable groups in terms of age and gender, but also look at the amount of somatic diseases in both groups. In addition, the same questionnaires should be administered, and, when translated, there should be a back-and-forward translation, and after that a validation of the questionnaire.

Table 3. Somatization and unexplained physical symptoms in the general population and in refugees

Setting	% pop. with physical symptoms, % with no somatic diagnosis	% pop. with physical symptoms, % with no somatic diagnosis	Mean number of complaints	Mean number of complaints
	General pop.	Refugees	General pop.	Refugees
Population studies	5% (North America)	(+/- 50%)	min. 1 (80%)	?
Primary care	min. 10-30% & 6-36.8% (WHO)	75-85 % 42-73% (27% migrants)	2-4	1.75-3.45
Secondary care	30-50%	?	? (6.0-12.6)	?

Discussion

The research questions central to this paper concerned the postulated tendency of non-Western refugees to exhibit somatization, and the existence of a connection between somatization and traumatization. Two general conclusions can be drawn:

(1) Refugees have more unexplained somatic complaints than the general (Western) population. Although different studies have used different methodologies and obtained different results, the conclusion can be drawn

that refugees form a special population in which somatic complaints are more prominent than in other groups;

(2) Unexplained somatic complaints can be found in populations all over the world.

Somatization in refugees is strongly connected with psychopathology and possibly also with traumatization. A large review of the literature concerning the prevalence of psychopathology in refugees showed that refugees are 10 times more likely to have PTSD than age-matched individuals from the general population. The prevalence of depression and generalized anxiety disorder appears to be the same in refugees as in the general population (Fazel et al., 2005).

Somatization in refugees might be perceived as a specific idiom of distress (Kirmayer & Young, 1998), which accompanies PTSD. This does not mean that somatization does not exist: every clinician working with refugees can tell about his or her own problems in the treatment process, when a patient seeks help for somatic complaints and the clinician cannot find a disease to cure. In addition, it seems that stigmatization prevents refugees from receiving psychiatric care. Refugees prefer to be referred to medical services, rather than to psychiatric institutions, as they fear that they will be considered mad by their compatriots (Laban et al., 2008). This fear of stigmatization influences both the symptom expression of the patients and the referral strategy of the general practitioner.

There has been a heated debate about the exclusion of somatoform disorders in the DSM-classification system (Mayou, Kirmayer, Simon, Kroenke, & Sharpe, 2005; Sharpe & Mayou, 2004). Somatoform disorders can be perceived as a combination of a personality disorder, anxiety and depression, hypochondriasis as a form of anxiety, and the physical symptoms included in undifferentiated somatoform disorder or pain as 'functional somatic symptoms' on Axis III of the DSM. This interpretation ignores a multitude of well-documented clinical findings and might discourage further research on the diagnosis and treatment of somatoform disorder (Rief, Henningsen, & Hiller, 2006; Rief & Isaac, 2007). The discussion around this topic will continue until the publication of the DSM-5 in 2013. It is too easy to suggest a removal of somatoform disorder from the medical literature because it means nothing and it is an effect of the Cartesian dualism between body and mind in medical theory. For this reason, the problems surrounding the interaction between clinician and patient are far too great: different clinicians have different explanatory models for complaints, and therefore different treatment models. Patients ask for a somatic based treatment, like medication or surgery. Primary care physicians try to refer patients with unexplained somatic symptoms to a psychiatrist. The solution to this could be that clinicians must make a choice regarding treatments which will enhance the capability of the patient to cope with pain and malfunction. Relaxation techniques, psychomotor therapy and active training programs are examples of such strategies. Whether this kind of therapy is situated in somatic health care, or in psychiatry, has to be decided. To lower the risk of stigma, basing the treatment in somatic medicine would be preferable.

At first, a clear diagnosis of unexplained somatic symptoms should be made. Whether the diagnosis somatoform disorder should be abandoned should be decided by further academic debate.

Future research

More research will need to be conducted in order to compare somatization between groups of refugees and other population groups, and in the community as well as in the health care system. In this research it would be advisable to use the same instruments, with the same cut-off points for somatization for the comparison groups. Of course, the groups should be matched in terms of demographic variables. A somatic examination of individuals from both groups should be performed, with additional elementary laboratory examinations. It is clear that a comparison of the results of questionnaires is not enough.

In addition, a special treatment program for refugees with unexplained somatic complaints should be constructed. This is the best solution with which to combat stigmatization and somatic fixation, and to resolve the problem of too many wrong and senseless referrals to somatic specialists, as described earlier. Medical services and psychiatric institutions should work together in this program. By combining medical and psychiatric assessments and treatments, the program could result in better outcomes. Of course, the outcomes of programs like the one being suggested should be scientifically evaluated.

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Chapter 9

Pain symptoms in tortured refugees. A clinical survey.

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Submitted

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Abstract

Torture may be associated with long-lasting somatic symptoms, partly explained by physical injuries. Physical pain as a result of torture, may seriously complicate the diagnostics and treatment of posttraumatic pathology in refugees. The question whether a relation exists between the experience of torture and the extent of reported somatic complaints, is therefore highly relevant. With the data set of a large clinical population of refugees (N=940), we examined specific pain items of a somatic complaints questionnaire (PILL), of a general symptom check list (HSCL-25), and of a trauma questionnaire (HTQ) in relation to torture reports. Pain scores on one item level were significantly higher in tortured refugees than in non-tortured refugees, on the other items not. In addition, gender moderated the relationship between reported torture and pain, with women reporting more physical symptoms than men. Region of origin had no influence on this relationship. Torture as traumatization has a connection with somatic symptoms, which means that this can enhance the unnecessary use of somatic treatment modalities. Enlarging motivation for psychological trauma treatment is a tool, which can be used for refugees with torture experiences and somatic symptoms without physical origin.

Keywords:
• Refugees • Torture • Pain • Somatisation • PTSS

Introduction

According to a systematic review of empirical studies [1], the prevalence of somatization among refugees from non-Western countries living in the Western world is high compared to the general Western population. Although included studies employed different methodologies which make results difficult to compare, there appears to be substantial evidence that refugees form a population in which somatization is prominent. Explanations for this high prevalence refer to different factors, such as pre-existing psychopathology, an accumulation of traumatic events, in particular torture, the stresses and strains of being a migrant, and stigmatisation in psychiatric care [2].

Somatization may form a significant obstacle in the treatment process, not only in mental health care but also in health care in general. It has been shown that refugees tend to emphasize their somatic health problems in symptom presentation. For instance, in a study among Iraqi refugees, women reported somatisation complaints in about one third of the population [3]. Also, these refugees were more inclined to seek medical help for their problems in general hospitals than in mental health institutions [4]. As a result, somatization problems may hamper the access of refugees to proper mental health care. This is particularly relevant as meta-analytic reviews on psychotherapeutic treatment effects among traumatised refugees showed positive outcomes, especially with regard to cognitive behaviour therapy and narrative exposure therapy, although there were no specific efficacy studies included on refugees with torture experiences [5-7]. Explaining that there may be a direct link between torture and unexplained pain symptoms could persuade refugees to enter treatment in mental health programs, rather than in general health hospitals.

In this article, we focus on the connection between torture and somatization in refugees who sought treatment in a large mental health clinic, located in the Netherlands.

Torture

There are several definitions of torture. The most widely accepted definition of torture is described in Article 1 of the United Nations Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (8, page 1):

“... ‘torture’ means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity..”

Torture is an act meant to keep the victim alive, and pressing him or her to give information or confessions, by means of heavy physical or psychological pressure. There are more physical methods of torture than one can imagine, but the most common methods are beating and physical violence, hanging, electrical shocks, raping and other sexual assaults, heavy noises, and drowning or waterboarding. Psychological torture methods include isolation, mock execution, blackmailing with torture of others, and humiliation. A strict difference between these two categories is not possible since most often both are used together.

Torture has direct, and long-lasting effects on individuals. Direct effects are provoked by the perpetrators, with the intention to mentally break the person, so that he or she will cooperate with the perpetrator. Remarkably, in clinical and research literature there has been more attention to psychological long-term effects than to somatic or somatoform effects. Quiroga and Jaranson [9] performed a review on studies about effects of torture. They mentioned psychological symptoms (anxiety, depression, irritability/aggressiveness, emotional liability, isolation, withdrawal); cognitive symptoms (confusion/disorientation; memory and concentration impairments); and somatic symptoms of the neurovegetative system (lack of energy, insomnia, nightmares, sexual dysfunction). Reported mental disorders as effect of torture were posttraumatic stress disorder (PTSD) and depression, and in less frequent cases other anxiety disorders and substance abuse. The most important physical consequence of torture was chronic pain experienced in multiple parts of the body. Torture survivors also reported diverse physical symptoms: acute injuries, sometimes temporary, such as bruises, hematomas, lacerations, cuts, burns, and fractures of teeth or bones. One study showed that after ten years pain was still highly prevalent [10]. Other more specific impairments are dependent on the nature of the torture.

In a large meta-analysis 48 epidemiological studies were reviewed of individuals who underwent war traumas and torture and who developed PTSD [11]. All the studies were about civilians, mostly of non-Western countries. There was some proof of a ‘dose-response relation’: the more severe the torture, the more PTSD symptoms in the aftermath. Female gender and old age were risk factors. Post migration effects like problems with asylum procedures, lack of employment and lack of social support also worsened psychiatric complaints. However, being prepared for the torture appeared to be a protective factor. Higher resilience levels, meaning greater ability to exercise control over the torture stressors, were associated with less perceived distress during torture and less PTSD subsequently [12-13].

In order to improve mental health care for tortured refugees, we studied the relationship between having experienced one or more torture incident(s) and reporting somatic and pain symptoms. We firstly hypothesized that refugees who underwent torture will report more physical complaints, as operationalized by experienced pain, than refugees without a history of torture.

Secondly, we hypothesized gender and region of origin to be significant risk factors. Particularly, tortured refugees from Southeast Europe have more somatic symptoms than subjects from Central Africa, and tortured women have in general more post traumatic, depressive and pain related symptoms, as previous research has shown [14]. Although region of origin and gender could have a large influence on the occurrence on pain symptoms in refugees, we hypothesised that the former experience of torture is the most substantial factor in subsequent pain symptoms, larger than gender and region of origin.

Method

Setting

Centrum '45 is the national Dutch institute for the psychotherapeutical and psychiatric treatment of victims of war, persecution and violence. To this institute an increasing number of refugees from Western and non-Western countries are referred for diagnosis and treatment. Treatment programs for this population include outpatient, day-clinical and inpatient settings.

Data of 940 refugee patients, all the refugee patients who were referred to the institute between the 8th of February 2002 and the 24th of April 2014, were gathered. These refugees were referred because of enduring posttraumatic and depressive symptoms, mainly by other mental health institutes and sometimes by general practitioners. In the sample more male patients than female are represented, the mean age is 40.9 years (SD 10.5). The most frequently reported regions of origin are the Middle East, Sub-Saharan Africa and South-East Europe (Table 1 presents the details).

Table 1. Characteristics of the sample.

	Frequency	Percentage
Middle East	542	57,7
Sub-Saharan Africa	141	15,0
South East Europe	168	17,9
male	671	71,4
female	269	28,6
	940	

Instruments

During the assessment phase, a clinical intake interview and different questionnaires were used. The questionnaires were the Harvard Trauma Questionnaire (HTQ), the Hopkins Symptom Check List 25 (HSCL-25), and the Pennebaker Inventory of Limbic Languidness (PILL). These three questionnaires have generally been used for refugees in many empirical studies and they have been validated for different groups of refugees. Moreover, there have been validated different language versions, which increases the use of these questionnaires for refugees who are not fluent in English or Dutch.

The HTQ assesses traumatic experiences and symptoms of posttraumatic stress disorder [15]. It is a self-report questionnaire consisting of three sections: a section on the range of traumatic experiences with four categories of response ('experienced', 'witnessed', 'heard about', and 'no') , a section with open-ended questions on subjective descriptions of the traumatic events, and a 30-item section on the symptoms of PTSD, with four categories of response, ranging from 'not at all' till 'extremely'. The HTQ has been validated for refugees from different origin and in different languages [16-18]. The instrument was also validated in our clinic in different language versions (Arabic, Farsi, Serbo-Croatian, Russian, and English bilingual adaptations). The psychometric properties were adequate to good across different cultures [19]. Moreover, recent research established measurement invariance for these instruments across different refugee cultures [20].

The HSCL-25 is a part of the 90-item original SCL, which was originally constructed for all psychiatric patients to measure symptoms of anxiety and depression [21]. Mollica et al. [22-23] constructed a 25-item version especially for refugees. It uses 10 items from the anxiety cluster of the HSCL, 13 items from the depression cluster, and two additional somatic symptoms ('poor appetite' and 'difficulty falling asleep or staying asleep'). Respondents can choose between 4 answer categories: symptoms bothered or stressed you in the past week not at all, a little, quite a bit, or extremely. The HSCL was also examined in our institute and showed good reliability and validity among refugee patients [19].

The PILL was constructed by Pennebaker to examine the level of somatization of a patient [24]. It is a self-report Likert scale with 5 answer categories: burden in the last year of the specific symptom seldom or never (once a year or never), sometimes (twice a year), regularly (once a month), often (once a week), or almost always (several times a week). Construct validity of the PILL has been demonstrated by significant correlations between the PILL and other measures of physical health complaints, including the somatization subscale of the SCL-90-R (r =.55, p <.05), which consists of items describing physical symptoms and the SMU Health Questionnaire (r =.49, p <.05), a 63-item checklist of complaints, minor illnesses, and more serious and chronic health problems. The PILL has a high internal consistency, with a Cronbach's alpha of .91 (25-26).

Procedure

Patients were asked if they were able to complete the questionnaires by themselves in a quiet room in the clinic. If the answer was positive, they were left alone with the questionnaires, but these were checked afterwards in the presence of the patient by a psychometrical assistant on missing values. The questionnaires could thus be made complete in the case of missing answers. If a patient was unable to complete the questionnaires, an assistant would ask the questions, in most cases in the presence of an interpreter. Some patients were illiterate, or were not able to fully understand the questions. Although a major effort was made by the assistants and the interpreters in completing all the values, there were in some cases missing values.

Assessment of torture

For the determination of 'being tortured', two items in the HTQ were used: item 16, Physical torture, and item 19, Threatened to be executed. We considered these two items as the most prominent items of torture, although this is not fully in concordance with the broad definition of UNCAT (see before). Grouping the two items together, we created a group of tortured refugees, and compared this group with the remainder of the population, the non-tortured refugees.

Data analysis

Because of missing items, data analysis was limited to 781 refugee patients. Table 3 presents means and standard deviations of the current pain symptoms in tortured and in non-tortured refugees. The sample was limited to three different regions of origin: Middle East, Sub-Saharan Africa and South-East Europe, as rates for persons from other parts of the world were too low represented for a valid comparison (N = 705).

Statistical tests were performed using SPSS-24. First, we computed the variable 'pain symptoms' by combining scores of the items PILL#15 (chest pains), PILL#51 (sore throat) and HSCL#8 (headaches). Differences between tortured and non-tortured patients were tested by means of a t-test of between-subject effects on the dependent variables (somatic and pain symptoms) and torture as the independent variable.

After the univariate analyses, we performed an ANOVA to study the influence of region of origin and gender on the report of pain symptoms in relationship to the report of torture experience.

Results

Torture

According to our definition 703 (74.9%) patients of the total sample of 940 subjects were tortured. Although torture was more common in men (78.1 %) than in women (66.5 %), the difference was not significant (see Table 2).

Torture and reported pain

Table 2. Frequency of torture and gender division in the total sample.

	Torture	No torture	total
males	524	147	671
females	179	90	269
total	703	237	940

Tortured refugees reported more chest pains than non-tortured participants ($t = -2.32$, $p < 0.05$), but not more headaches ($t=-1.54$, n.s.) and sore throat ($t= 0.19$, n.s.). Table 3 shows mean and standard deviations of the dependent variables.

Our hypothesis that refugees reported torture experiences will report more physical complaints (as operationalized by experienced pain) than refugees without a history of torture was thus only partly confirmed.

Table 3. Means and SD's of different pain complaints in non-tortured vs tortured refugees
(HSCL: scale 1-4, PILL: scale 1-5). Headaches t= -1.54, n.s., Chest pains t=-2.32, p<0.05, Sore throat t=0.19, n.s..

item	Torture No/Yes	Mean	Std. Deviation	N
HSCL 8: Headaches	N	2.98	0.997	188
	Y	3.12	0.943	593
total		3.09	0.958	781
PILL 15: Chest pains	N	2.42	1.395	188
	Y	2.76	1.423	593
total		2.68	1.423	781
PILL 51: Sore throat	N	2.16	1.183	188
	Y	2.17	1.216	593
total		2.17	1.207	781

Regions of origin, torture and reported pain

Torture appeared to be more common in refugees coming from Africa and the Middle East: persons from Sub-Saharan Africa reported the experience of torture in 0.86 of all cases, and persons from the Middle East in 0.75 of all cases, persons from Eastern Europe reported having been physically tortured in 0.57 of the cases (p< 0.001). See Table 4.

Table 4. Means of tortured persons from different regions of origin. P< 0.000

Region of origin	Mean	Std Deviation	N
Middle East	0.75	0.42	542
Sub-Saharan Africa	0.86	0.34	141
South East Europe	0.57	0.49	168
Total	0.73	0.43	851

The occurrence of the pain symptoms headaches (F (2,724) =.065, n.s.) and sore throat (F (2,729)= 0.769) in patients from different regions of the world did not differ significantly; only chest pains showed a tendency to differ (F (2,732) = 2.38, p<0.10): partly in line with our hypothesis, patients from South East Europe reported the most chest pains, patients from Sub-Saharan Africa the least (see Table 5).

Table 5. Means and SD's of different pain complaints in refugees from different regions of origin. Headache p= 0.919. Chest pains p= 0.055. Sore throat p= 0.475

	Region of origin	Mean	Std. Deviation	N
HSCL 8: Headaches	Middle East	3.08	0.973	450
	Sub-Saharan Africa	3.05	1.011	126
	South East Europe	3.10	0.883	129
total		3.08	0.963	705
PILL 15: Chest pains	Middle East	2.64	1.431	450
	Sub-Saharan Africa	2.47	1.384	126
	South East Europe	2.85	1.404	129
total		2.65	1.421	705
PILL 51: Sore throat	Middle East	2.20	1.236	450
	Sub-Saharan Africa	2.09	1.180	126
	South East	2.14	1.109	129
total		2.17	1.203	705

Gender

In line with our hypothesis, women reported more pain symptoms then men: females reported more chest pain (t= -2.14, p=0.05), more sore throat (t=-2.59, p<0.05), and more headaches (t=-2.84, p<0.01) than males, see Table 6.

Table 6. Means and SD's of different pain complaints in male and female refugee patients.

	gender	Mean	Std. Deviation	N
HSCL 8 Headaches	male	3.02	.967	555
	female	3.26	.917	226
	total	3.09	.958	781
PILL 15: Chest pains	male	2.58	1.381	555
	female	2.92	1.498	226
	total	2.68	1.423	781
PILL 51: Sore throat	male	2.08	1.154	555
	female	2.40	1.304	226
	total	2.17	1.207	781

Multivariate analysis

As predicted, torture was the only significant factor regarding reported pain symptoms (chest pain) in the multivariate analysis with region of origin and gender as fixed factors (R = .031, p <0.05) See Table 7.

Table 7. Tests of Between-Subject Effects

	Type III Sum of Squares	df	Mean Square	F	Sig.
Region*Gender	2.577	2	1.289	.657	.519
Region*Torture	1.474	2	.737	.376	.687
Gender*Torture	.025	1	.025	.013	.909
Region*Gender*Torture	2.234	2	1.117	.570	.566

Discussion

This study partly confirms the relation between earlier torture experiences and pain symptoms later in life. In our sample of refugee patients who were referred to our trauma clinic the experience of torture was omnipresent. Even with our restricted definition of torture, being only physical torture and the threat of being executed, the sample reported torture in almost 3 out of 4 patients (more in males than in females). These percentages are also higher than percentages mentioned in the literature, where clinical samples of refugee patients showed percentages of 6.6 % till 70 % in males and 31 % in females [9]. In a systematic review [27] the percentage of torture in population samples of refugees was estimated at 21 %, so our sample reported much more torture related experiences than may be expected in the population of refugees in the Netherlands. Torture also accounted for the highest inter-survey variance of PTSD and depression [27]. Since torture in the past is hard to prove, we are dependent on self-reports in which scores could be different than actual experienced torture. In the already mentioned systematic review self-reports of depression were higher than reports derived from clinical interviews: 36.7 % vs 23.2 %. This may point at higher scoring if we only use self-reports.

Pain symptoms were surprisingly not highly present in our patient population. Furthermore, this patient population showed in general far more somatic complaints (75 %), than the general refugee population which was studied earlier in the Netherlands, showing pain problems in 11 % of all cases [4]. However, our hypothesis that the pain symptoms were more severe in tortured refugee patients than in non-tortured patients, even when this torture has been committed long ago, was only partly confirmed. Only the symptom of chest pain showed a significant difference between tortured and non-tortured patients. Non-cardiac chest pain (NCCP) is not uncommon in health care: it is the complaint of more than 7 million emergency department (ED) visits and as many as 27 million office visits in the United States each year [28]. It has been identified as connected with anxiety disorders, such as panic disorder. The association with depressive disorders is more complex and bidirectional. A link with the symptoms of refugee patients is obvious.

Since anxiety disorders are omnipresent in refugees, NCCP could be considered as the somatic manifestation of these disorders. Torture as a main cause for anxiety will have a large influence on NCCP, too.

Our other hypotheses that the region of origin and gender have effects on the occurrence of pain symptoms after torture, were partly confirmed. Region of origin was not related to the reporting of pain symptoms after torture. This may refute an indication of cultural influences on reporting pain symptoms, at least after being tortured and between these three refugee population groups coming from Eastern Europe, the Middle East and Africa. Pain after torture appeared to exceed cultural differences, as a common language of traumatic experiences. Pain perception in general includes sensory experiences but also emotional and cognitive factors. As such it is also influenced by culture, as shown in many studies, mainly about Western Caucasian patients compared to non-Western patients [29]. Cognitive factors can imply catastrophizing ideas about what pain could indicate in terms of physical deficits. NCCP can thus be interpreted as a signal of a supposed heart failure, or of other somatic diseases. This could evolve in interethnic differences in pain perception. However, in our sample of tortured patients from three different regions it did not. We conclude that the influence of torture and other traumatic experiences are more prominent in the aetiology of pain than differences of culture between these studied three groups.

Whether torture could produce a different cognitive appraisal of pain and thus influence pain perception has been studied [30]. Tortured prisoners of war (POW) were studied with regard the relation between chronic pain with a so-called personification of torture: when pain is related to the image of the torture and the person of the torturer. The tortured POW's were compared with matched control POW's. The researchers found a difference in torturing personification between tortured and non-tortured individuals. But there was no difference between the two groups in the concrete description of pain.

Gender however, did make a difference in our study: females reported more chest pains and sore throat complaints after being tortured in the past than men. This is in concordance with a recent meta-analysis on chronic widespread pain in the general population, where females reported more pain complaints than men, in a ratio range of the different studies from 1.06 till 4.80 [31]. So, in the general population, females show more pain symptoms than men, independent of traumatization or other causal factors. In our research we found the same with seriously traumatised and tortured patients: females show more pain. This is also concordant with earlier research as described in the introduction [2-3]. An explanation for this could be that men manifest stress symptoms more in anger and alcohol abuse, while women show stress symptoms more in somatic complaints and depression [32].

Implications for clinical practice

Pain symptoms in refugees could be indicative of torture experiences, and torture experiences can be treated by psychotherapeutical modules for posttraumatic stress disorder (PTSD) [5-7]. Our findings have implications for the treatment of refugees. Asking about torture experiences in the first assessment interviews in mental health care is something most clinicians find quite difficult, because of the confrontation with the painful memories and the resulting emotions. Yet, this is a necessary issue in the psychiatric and general health assessment of refugees. Next to this, in general health care there should be more attention to the long-lasting effects of torture in refugees, since a long tract in somatic care could undermine efforts in psychiatry and psychotherapy, and would also be time and money consuming and less effective. Medically unexplained physical symptoms could be indicative of at unprocessed memories of torture and other traumatic experiences [30].

Of course, there should be a physical examination of the patient, since pain could be the consequence of tissue lesions or other somatic illnesses. This should not only been performed in general medicine, but should also be part of the normal assessment procedure in mental health care of refugees. If no direct causes of pain can be found, the protocol for unexplained pain has to be added to the psychological treatment of the refugee patient, since remaining symptoms can further handicap the patient [33]. Programs including physiotherapy and psychomotor therapy has been used for this, till now however with mixed results [34].

Strengths and limitations

There are strengths in this research. The studied population is a very large group of traumatised refugee patients, larger than in any study in literature. A large sample has a high power. Clear connections between torture, gender, region of origin and pain symptoms have thus been shown. So, the finding that torture does not create a large difference in pain symptoms is well evidenced.

Next to this, we used cross-cultural validated questionnaires in many languages which were translated back and forth.

Also, we did not exclude any patients. All patients who were referred to our institute in the given time period, were included.

There are also limitations in this study. The study is based on self-report questionnaires, as well as for the pre-existent torture experience as for the symptoms. There may be a risk of over-scoring or under-scoring of the symptoms, and of the traumatic experiences including torture.

Since we studied the results of refugees who were referred to our institute, we were not able to look at stigmatization, as the patients already took the step to be referred to our institute, widely known as a psychiatric clinic. Also, we could not look at the effect of lack of traumatization, because this is a condition for referral to our institute.

Final statement

Even in a very large sample of refugees, it is hard to prove a strong relation between experienced torture and physical complaints later on in life. This does not take away the need to find adequate treatment protocols for traumatized patients with a combination of psychological and physical complaints.

Ethical statement

All patients have declared by writing a statement, that the data derived from the self-report questionnaires can be used, anonymously, for scientific purpose. This procedure is approved by the ethical committee of the institute.

Conflict of interest

The authors declare that there is no conflict of interest, connected to this paper.

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Chapter 10

General discussion

Clinical vignette 1, part 3

The Ethiopian man mentioned in the introduction of this thesis, has shared his history with us. But we do not yet consider that as a valid start for a treatment procedure. We decided to use the cultural interview in order to get a concrete and insightful perspective on his questions and wishes. This patient was completely new to the range of treatments and supports available such as psychiatric help and psychotherapy. According to him, psychiatrists deal with severely disturbed people, and hold them in a lunatic's asylum. He told us that his complaints were mainly physical in nature and he could only accept a psychological aetiology as a less probable explanation. He further explained that if his complaints turned out to be psychological, he would rather prefer seeking help from a native healer than a psychiatrist. In our centre, he wanted to be treated like a physically-ill patient, and preferred medication over psychotherapy. Also, in case of medication, he was able to share about this with his family; whereas he would have to defend his case for taking treatment from a psychiatric hospital as being forced by his general practitioner because of a somatic disease. On further assessment, following the outcomes of the initial cultural interview: when asked about his main problem, he reported only physical complaints, and about the desired medical help he preferred for this 'physical treatment'. He also mentioned considering going to a native healer. The initial diagnosis, depression, was followed by a second diagnosis-somatization disorder, to regard his somatic complaints.

So, we started the treatment by prescribing medication, and offering psychotherapeutic sessions in which we tried to build a more trusting relationship.

Research questions

In this thesis I attempted to study two research questions with regard to the diagnostic methods used to assess mental difficulties among refugees:

Could the Cultural Interview and the Cultural Formulation Interview be considered as feasible, acceptable and potential clinically useful instruments in the diagnostic procedure of traumatised refugees?

What is the role of somatic articulation in the symptom presentation by refugees: is somatization a common phenomenon among refugees, and where does somatisation originate within this population?

Focus of the thesis

The focus of this thesis was the search for a better start of treatment in refugees. It became clear in the last decade of the twentieth century that clinicians and refugees may have different views on psychopathology and healing, leading to ineffective health care. A search for alternate assessment procedures in mental health care was therefore considered useful and urgent. The Outline for a Cultural Formulation of Diagnosis (OCF), as published in Diagnostic and Statistical Manual of Disorders (DSM), part IV, appeared to be a more suitable way to diagnose the problems of refugees (American Psychiatric Association, 2000). Since the OCF during those years was not yet operationalised in a standardized interview or questionnaire, clinicians in our clinic decided to construct a semi-structured interview. The interview and the experiences with this initial so-called cultural interview have been described in chapter 2. The promising clinical results helped recognizing the prominent position of the cultural interview in the assessment phase.

In the initial years, most publications on the OCF (as reported in chapter 3) consisted of descriptive articles and recommendations for its use in psychiatry. Scientific reports on the advantages and disadvantages of its use as well as its effects on diagnosis and treatment were quite scarce (Griner & Smith, 2006; Lopez-Appelo, 2008). So, the author joined an international research group headed by the American Psychiatric Association's DSM-5 Study Group on Gender and Cross-Cultural issues. In the preparation of DSM-5 (A.P.A., 2013) the group of transcultural psychiatrists who developed the original OCF had the intention to further operationalize the OCF (Lewis-Fernández et al., 2014). After discussing with the entire group, a new interview was constructed: the Cultural Formulation Interview (CFI). An important suggestion during the development of the interview was to make the interview usable not only for the refugee and migrant population, but broaden the relevance to all psychiatric patients. The idea that the OCF should deserve a deemed position in the process of assessment began to spread because of its use as an instrument to provide mental health care to each individual. So, transcultural psychiatry modified instruments for the use among the population of psychiatric patients.

In order to conduct effective research to study the new interview, clinical professionals were trained to use the CFI. The investigators assured that all the professionals who participated in the research had similar level of minimal training in using the CFI. This was called cultural competence training, as the use of the CFI enhances cultural competence. To enhance cultural competence different methods have been used, like behavioural simulations, written guidelines, and video instruction. Some of these methods have been better evaluated than others (see chapter 4). We will discuss these findings in the further paragraphs.

The research findings on the utility of CFI were reported in chapter 5 and 6 of this thesis. It became evident that the CFI is a potentially powerful instrument in optimizing the psychodiagnostic assessment. Although it does not focus on the classification of mental diseases, it does pay emphasis on the complex relationship between the patient and clinician, and the quality of the therapeutic alliance, which need clarification at the beginning of treatment in mental health.

The nature of a relationship between clinician and patient was described in greater details in chapter 7. Diagnosis and treatment in mental health depend on the clinician's interpretation of the patient's perception of physical and mental sensations. During their interaction, cultural attitudes are co-constructed (Lewis-Fernández & Kleinman, 1995).

During our quest to build an effective assessment for refugees, and an understanding of the limitations in making a diagnosis, we frequently encountered the problem of somatization. This motivated us to conduct research on such this theme.

Chapter 8 provides a detailed literature review, whereas chapter 9 reports on empirical data on the possible connection of torture with traumatization among a clinical sample of refugees. As we have described in the clinical vignette at the beginning of this discussion, somatization has many identities: prevention of stigmatization, alexithymia, overemphasis on minor somatic symptoms, lack of trust in psychological treatment.

In this discussion chapter, we will explore deeper into the subject of psychodiagnostic assessment and diagnosis among refugees. We will relate this with our empirical findings. We will also describe the clinical implications of the findings.

Cultural interviews: critical considerations

Refugees often have a cultural background which is different from that of the health care professional. Initial research, as well as our own clinical experience, showed that a standard assessment procedure may not function very well with the refugee population (Bäärnhielm et al., 2015). We postulated that the use of a so-called cultural interview would be a way to get a more adequate assessment of a refugee patient in mental health care. Such a culturally adapted strategy would work better in order to build a stronger rapport and connection with them, and would ease treatment strategies later on. The original cultural interview was constructed by our team based on the viewpoints that form the different sections of the CFI. In the next paragraphs, these issues will be discussed and compared with our empirical findings.

Cultural identity

In interviews, identity is a rather complex subject to discuss about. Patients find it often difficult to describe what should be regarded as their cultural identity. We observed this already while using our original cultural interview. In the CFI, the questions about cultural identity precede with an explanation: '*sometimes, aspects of people's background or identity can make the [problem] better or worse. By background or identity, I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, and your faith or religion*'. This makes it quite clear that talking about cultural identity: is not easy for patients. After this, three questions are asked about background or identity, whether these aspects make the problem worse or better, and whether the background or identity alone is causing these concerns or difficulties. According to the qualitative data of the research on the CFI, it seems that some refugees do not talk about their background or identity, and rather show themselves as world citizens. In those cases more has to be done to get knowledge about their cultural identity. So, a supplementary cultural identity module was added, where questions about national, ethnic, racial background, language and migration were put together (Groen et al., 2016). It is important to know more about cultural identity: it provides information on feelings of belongingness within a group, perceived discrimination, and feeling aloof or distant from other groups. Examples of this are ubiquitous: to originate from Iraq provides only very limited information, if you do not know whether the person is a Kurd, or a Yezidi, or a Mandean (see below in Clinical Vignette 2). Cultural identity in these cases may also mean discrimination, or being set apart, in the country of origin. In most of these cases there is a long history of exclusion, inclusion, persecution and discrimination. It is reported in research related to discrimination and (lack of) connection to a group, that there is a higher risk of psychotic disorders in persons who feel discriminated and do not have a connection with members of the same ethnic group (Veling et al., 2010; Veling, 2013).

Symptom presentation and treatment seeking

As mentioned in the introduction, the refugee population may show idioms of illness that are different from the native (often western) population. In a literature review of local responses on trauma, Hinton and Kirmayer (2013) showed that local responses can differ in many ways: exposure to trauma may lead to a general hyperreactivity to stressors and to distressful emotional states; for example, a slight upset, worry, anger, or fright may induce intensive arousal and quite specific somatic symptoms, which may be characteristic for the specific cultural group, such as shortage of breath and awareness of wind blowing through the body.

Next to this, there are changes in treatment seeking behavior. Laban et al. (2007) showed that refugees rather tend to ask for treatment in somatic health care than in mental health care, even when their problems are purely psychological. Also, Fassaert et al. (2009) found that Muslim immigrants perceived less need for mental health care than the native Dutch with the same problems. In case of carrying the similar mental morbidity, refugees may possess similar coping mechanisms as the Muslim patients; they both tend to solve their problems on their own, or seek help from a medical doctor. When using the CFI, the clinician gets significant information on these two factors. In the first five questions the clinician enquires the patients about problems instead of symptoms, how are their problems otherwise described, what troubles them most about their problems, why is this happening, what are the underlying causes, and what is the perception of important others about their problems. There is also a specific question about help-seeking (number 12). So, with refugees this section of symptom presentation and treatment seeking is not neglected, and may provide sufficient information to identify the potential problems in this field: preferences for medical treatments, stopping mental health treatment because of seeking help from the traditional healers only (providing a combination of mental health treatment along with traditional help could be successful), explanations of having difficulty in understanding somatic symptoms.

Stressors and support

The number of stressors and amount of support is difficult to determine among refugees. Since refugees often come from interdependent (or collectivistic) cultures, within which individuals are inevitably a firm part of the family system, receiving lack of support from family members may be more vital for them than for persons who belong to independent (or individualistic) cultures, wherein persons are encouraged to grow and develop as an independent individual. Also within interdependent cultures, the individual’s role in his or her life is more likely to be ascribed rather than be chosen, and the determined social role stays central to the individual’s well-being (Chun et al., 2006; Qureshi et al., 2016).

The CFI does not explicitly take these factors in consideration. Seemingly, the CFI rather presumes that the clinician already possesses this knowledge and is culturally competent. Only basic questions about stressors and supports are posed in the CFI, with inquiries about support from family, friends, or others, and problems with family or money. More detailed questions were constructed and added to a supplementary module developed especially for immigrants and refugees, which is to be used in cases of uncertainty regarding the nature of the stressors present (Boehnlein et al., 2016). Also, however, in the supplementary module there are no extensive questions enquiring about stressors and supports in case of refugees. And the module on psychosocial stressors, another enquiry, is quite superficial. So, complicated cases have to be clarified beyond the CFI and its modules, as mentioned in the next clinical vignette. You might argue that since the CFI is considered to be valid for all patients, it is less appropriate to use it with cases wherein culture has a strong impact on stressors and support. For clinicians who are poorly culturally competent, this will be a prominent point to note. So, next to the use of the CFI training in cultural competence will remain vital.

Clinical Vignette 2

Meryam A. is a 22 year old girl from Iraq. She lives with her mother and younger sister. Her father and older sister are living separately. She comes from a small Christian minority, the Mandeans, and had to flee because of increasing difficulties with fanatic fighters from the Muslim majority. Her major complaint was that she is too nervous about her upcoming exams, and she thinks it will not be possible to achieve success in it. Contact with her church is almost lost, since all of the members live in exile now, far apart from each other. Her main concern was that she was hardly able to study because of language barriers, and a completely new study system, wherein she had to study by herself, instead of repeated instructions of the teacher which she was habitual to back in her home country. The stress about this was substantial, because she had promised to finish her studies so that she could financially support her mother.

All questions about her past were answered shortly. She was upset, because we postulated that she would be traumatized again by the experiences in Iraq. According to self-questionnaires, she did not report any traumatic experiences, but later on her mother reported some instances which have occurred in the past. Finally, we decided to focus on stress regulation through exercises and some medication, instead of trauma treatment.

So, if the core CFI and the modules do not provide sufficient information about these aspects, a thorough examination by a culturally competent mental health worker will be beneficial. This is particularly true for refugees. Or: the CFI should provide more examples about stressors and support in other, maybe highly interdependent cultures. These examples could help the clinician discover highly complex interpersonal support systems, and culturally based stressors, such as difficult family dynamics and structures, fear of being excluded because of one's sexual orientation, or stringent religious and moral norms and rules. At the moment, the core CFI unfortunately gives only slight support to un-experienced and cultural incompetent clinicians on this cultural aspect: more knowledge is crucial.

Patient-clinician relationship

The importance and the nature of the patient and clinician relationship are described in chapter 7. This relationship is based on mutual trust and respect, and is a platform that promotes patients to willingly express and discuss about their thoughts, emotions and behaviors. Lack of a healthy relationship will result in challenges to formulate an accurate diagnosis, and clinicians may also encounter problems in compliance and effect of treatment. Chapter 7 illustrates the different factors that help build the relationship between patient and service provider with relevant literature review.

This relationship highlights differences between cultures, especially because of a difference in attachment style. Attachment is an important vehicle in the relationship between clinicians and patients, especially in psychotherapy. Research showed that specifically patients with an avoidant attachment style, as many refugees may carry, show considerable progress in psychotherapy when a safe relation is established with the therapist (Koelen & Rohlof, 2017; Mallinckrodt et al., 2016; Petrowski et al., 2013). This style helps them to grow and become independent of the therapist, at the end.

Nevertheless, not always do excellent relationships between patients and clinicians predict a good outcome in therapy. Cultural factors play a role here too. In collectivistic cultures, satisfaction within relationships is a stronger predictor for subjective well-being than in individualistic cultures (Galinha et al., 2016). This indicates that persons coming from collectivistic cultures, like many refugees, experience more distress while becoming independent of their clinician during treatment. In accordance with this, it has been reported that a decrease of alliance in therapy with patients who have a low quality of interpersonal relationships enlarges the effect of therapy. Patients tend to repeat their typical pattern of interpersonal behavior in therapy sessions (Piper et al., 2004). While providing therapy to the refugees, one must be aware of the fact that refugees from a collectivistic culture can remain dependent on their therapist: if one notices this pattern, a timely effort to prevent it is advisable, like paying less attention, maintain longer gaps between their sessions et cetera. This is not interpreted from the information mentioned in this chapter, but from my personal observations made during the clinical practice. Research on this is not available, and is advised. Of course, creating long-term inter-session periods should not be the case in short-term therapies with a fixed end date, where a frequent contact with the therapist is a part of the protocol, like short-term trauma treatments.

It is difficult to describe the patient-clinician relationship at the beginning of treatment. But the Core CFI has one question regarding this, presuming opinions of the patient about this developing relationship. The question is: '*Sometimes doctors and patient misunderstand each other because they come from different backgrounds or have different expectations. Have you been concerned about this and is there anything that we can do to provide you with the care you need?'* (A.P.A., 2013, p. 757). We should recognize that patients will not have fully articulated answers for a question like this at the beginning of treatment. Asking this question with few modifications further during the treatment would be more advisable.

Cultural Interview and Cultural Formulation Interview

Despite the remarks we have made, we recommend the use of the Cultural Interview for refugees and of the Cultural Formulation Interview for every patient. The CFI, if used for assessment among refugees, should have more relevant examples to help the culturally incompetent clinician.

The following arguments to use a cultural interview are relevant:

The Cultural Interview is meant as a complimentary in-depth interview which explores the role of cultural factors, and is used as a first assessment interview with refugees in mental health care. Also, it was received well by patients, as the authors mentioned in a qualitative evaluation of the interview (Rohlof & Ghane, 2003). Later on, it was modified for refugees by Groen, who found that this modified version of the interview was better evaluated, better understood, and crisper than our initial interview (Groen et al., 2017).

The second interview, the CFI, is meant for every psychiatric patient, as mentioned earlier. This interview has been evaluated extensively, using both qualitative and quantitative methods, as mentioned in chapters 5 and 6. The international field trial has shown that patients as well as clinicians evaluate the interview as a feasible, acceptable and clinically useful instrument for psychiatric patients of all kinds.

Our first research question (Could the Cultural Interview and the Cultural Formulation Interview be considered as feasible, acceptable and potential clinically useful instruments in the diagnostic process for traumatised refugees?) therefore is answered positively.

The CFI was not only measured in refugees, but also in other groups of patients (see Chapter 6). Among the patients studied in the international field trial, 35 % were foreign born, but they were not all refugees. The answers of refugees were not measured separately in the research, so we have to understand their attitude to the CFI from the answers of the total population.

However, refugees in general show differences from native patients in self-understanding, memory and identity. Giving positive answers to evaluative questions in assessment questionnaires has been proven to be difficult for them because of a general negative inclination on questions, resulting in poor positive scores (Bäärnhielm et al., 2017).

Cultural Competency

Gathering information about cultural related topics utilised in psycho-diagnostic assessment is one task; applying the obtained knowledge in effective treatment is another task altogether. Along with the development of the CFI and research about it, we also looked at ways to apply that knowledge in treatment. In this context, the phenomenon of cultural competency is relevant.

One important finding, which was reported in the international field trial about the CFI, was regarding the best possible way to educate professionals about cultural competence. In Chapter 4, we have discussed about this challenge. It is an analysis and description about the preferred elements by clinicians to start training in using the CFI for psychodiagnostic assessment of the patients.

Cultural competence is the capacity to communicate and effectively treat persons from a different cultural background. In the United States, there has been much interest in enhancing this competence, given the inequality in care for ethnic minorities compared to the Caucasian population (Institute of medicine, 2003). In the Netherlands, it is still a minor component of the training provided in mental health care sector: residents in psychiatry receive only 8 hours of training in transcultural psychiatry, which includes basic knowledge about ethnic minorities and refugees; for other mental health professionals this is negligible.

The systemic manner in which the research on the CFI was designed provided us with the opportunity to perform research studying the preferences of clinicians regarding their cultural competence training and using the CFI with patients. As described in chapter 4, behavioural simulations (e.g., role playing with the course members as actors), were evaluated as the most helpful method. And the second best method evaluated was the video demonstration. But this demonstration was also evaluated as least helpful by other clinicians, mostly because the patient in the video was not representative of the entire patient population.

Training in cultural competence should have a major prominent role in education of psychiatry residents and health care psychologists and psychotherapists, as well as in continued medical education for psychiatrists and other mental health professionals. There is sufficient evidence that there is a positive correlation between training in cultural competency and improved patient outcomes in health care, as reported in a systematic review (Lie et al., 2011). There is another study which reported some nuances in these findings (Huey et al., 2014): they state that evidence for cultural competence is mixed, because ethnicity and minority-focused treatments frequently incorporate culturally tailored strategies, and these tailored treatments are mostly efficacious; yet it supports cultural competence as an useful and complimentary asset to the standard treatment, which remains equivocal as the best. In psychiatry this would more often be the case than in any general health care practice. This may be because higher level verbal communication style is used in psychiatry; however, this has not been extensively studied yet.

Experts have different views on the concept of cultural competence. While some focus on the knowledge one should have about different concepts of illness, background and history of patients (Kirmayer et al., 2014), others conceive this concept more as an attitude (Bäärnhielm, 2009). An example of the latter is noted in the following expression: '*a matter of learning to cope with being in the position of not knowing, daring not to know, and of wanting to know; a position often in contradiction to feeling competent.*'

In fact, cultural competence is a mix of both elements. One should know of the family structure of the individual patient's culture, specific cultural beliefs, norms and values (like the belief in djinns, and how to cope with them), specific history including war and struggle in the country where the patient originate from. And next to this, it is necessary to have respectable curiosity about how he or she perceives all this aspects, what are the actual individual beliefs, norms and values, and what are the individual's past experiences (Kirmayer et al., 2014) – but isn't this, evidently, essential for every bona fide psychotherapist?

This kind of cultural competence demands a cultural interview as is shown in cultural consultation services (Kirmayer et al., 2014). Using the person-centred method of interviewing, one remains curious about the information the patient is giving about his own background. And it is possible to interpose within the interview's specific questions about concrete concepts like the ones mentioned earlier.

Concepts such as cultural differences, different explanatory models, value orientation, acculturation, family history, and race and racial identity, are important to acknowledge (Pena et al., 2016). But adapting the attitude of the 'not knowing and curious clinician' is also quite important, and even highly important among patients from other cultures than that of the clinicians.

Somatization

The last aspect in assessment and diagnostics among refugees that was studied was somatization. As we discussed in Chapter 8 and 9, refugees usually report many complaints having a somatic nature, while there is no evident somatic disease responsible for the complaints.

Somatization is a complex concept. As we mentioned in chapter 8, it can be explained in different ways: (a) a syndrome of medically unexplained somatic symptoms; (b) hypochondriasis, or (c) somatic signs and symptoms of psychiatric disorders. Also, the etiology may be different in different persons, as described. In refugees it is always possible that complaints of experiencing pain have their origin in somatic tissue lesions caused by torture and other rough management made by the policemen, soldiers or prison guards (Defrin et al., 2014).

Yet, somatization without a somatic disease, turned out to be prevalent among refugees as compared to other migrant groups, and the native population, as discussed in chapter 8. Refugees form an extraordinary population in which the problem of somatization occurs more feverously.

In chapter 9, we have explained this matter because of a history of torture. Somatic complaints turned out to be omnipresent in our clinical sample of refugees. But the relationship with experienced torture in the past was weaker. In fact, only one complaint, of chest pain, indicated a high correlation with torture. A causal relation could not be proved, as this was not possible in this study design.

Somatic symptoms in refugees should be taken seriously. A thorough physical examination by a physician is the first treatment of choice. More detailed somatic investigations should follow. Sometimes a somatic cause underlying the complaints will be uncovered. However, tissue lesions are difficult to diagnose.

If after thorough investigation no somatic disease could be diagnosed, then the possibility of a psychological origin underlying the complaints should be discussed with the patient. Only if the patient agrees, a referral to a psychology or psychiatry professional should be suggested. Refugees come from countries where mental health care is provided to severely ill patients, such as persons with schizophrenia and bipolar disorder. They tend to deny their problems as being mental problems, and further seek treatment in general health care rather in mental health care (Laban et al., 2007). Hence, motivation and psycho-education of the patient is essential and a priority when a referral is made to the mental health care provider.

Clinical implications and limitations

Using the CFI to assess the mental health and provide similar care for refugees will direct the mental health professional to gather more information about the nature of the complaints, coping and resilience, the background of the patient, his or her ideas about the treatment and mental health care, and previous treatments taken, compared to the care commonly provided. Next to this, questions about cultural identity can be necessary to make certain complaints and problems more comprehensible for the clinician and for the patient as well. These are important issues in the assessment of the patient. The remainder of the issues in the assessment process, like family history, possible genetic factors, social history, and traumatic experiences, could be studied in the second half of the assessment process. So, the CFI is not an extra effort, but covers crucial issues in the mental health assessment process. It is therefore not time consuming, but time saving. As mentioned in chapter 5 and 6, we found that patients are even more enthusiastic about the CFI than the professionals. In this respect, using the CFI may enhance the patient-clinician relationship which may predict effective and successful treatment.

One could say that the CFI is rather equivalent to the commonly used psycho-diagnostic assessment process. But this is only partially true. Some questions are the same, whereas, others are more focused on the cultural and social context relevant to the patient. Also, in general psychiatry and mental health care, clinicians are much more tended to enquire about specific psychiatric symptoms, and their history (Hengeveld & Schudel, 2003). Clinicians will use this information to arrive at a quick diagnosis of a mental disorder as per the criteria of DSM-5. Yet, the CFI is highly focused on the patient in the context relevant to him or her, and his or her culture, and on his or her own concept of illness and healing. Because of this, the clinician will get more information on the patient, his wishes and his surroundings. In certain fields within the mental health care, this could be of less value: for instance in the acute psychiatry room. But in psychotherapeutic context, it has a greater value to learn about this. It is assumed that it will be beneficial since it enhances the patient-and clinician relationship, although this is more complicated (see above).

Using the OCF in clinical consultation has advantages for the diagnostic process, as has been reported. Bäärnhielm and her colleagues found that applying the OCF in a psychiatric outpatient clinic resulted in changes of the primary diagnosis, mostly from psychotic disorders in depressions, among 56.5 % of the cases (Bäärnhielm et al., 2015).

Till now, however, a definitive proof that the administration of a cultural interview has improved the treatment process, or, to a lesser degree, the long-term relationship between clinician and patient, has not been reported. The important question is, whether a cultural interview is essential for a modern mental health examination, will be only answered by two findings mentioned as follows:

1. The patients, when asked independently about the interview, state that it is feasible, acceptable and of potential clinical use.
2. A thorough research initiative should be made wherein the CFI would be compared to a standard assessment. An empirical international study among refugees on this topic is needed. This could be developed under the various connected research centres.

Based on the findings presented in this thesis as well as our own clinical expertise, this interview leads to better relationships and, as a consequence, better treatment choices and outcomes (as was illustrated in the case).

Giving attention to somatic symptoms is a more complicated part of mental health care. Openly denying it to the patient as a clinician that there may be an underlying physical cause for the pain or other somatic symptoms is contra-productive. Applying, next to psychiatric care and psychotherapy, more somatic oriented treatment modules like psychomotor therapy and physiotherapy would be an adequate and beneficial option.

In 2013, a day clinical program for refugees with traumatic experiences and medically unexplained somatic symptoms was constructed in our clinic (Verdoorn-Strijk & van Bokkem, 2014). The program contained individual and group therapy sessions. Exposure therapy, biofeedback, relaxation techniques, mindfulness, fitness, and psychiatric consultation were part of this one day program conducted per week. This program was carried out by a clinical psychologist, a nurse practitioner, a psychosomatic physiotherapist, and a clinical psychiatrist (the author of this thesis). A small group of patients who finished the program was followed by distributing questionnaires among the group. So, this was no double blind research but an open

pilot study. The patients did not show improvement according to evaluation of the questionnaires (see also chapter 9) : Pennebaker Inventory of Limbic Languidness (somatic symptoms questionnaire), Harvard Trauma Questionnaire, Brief Symptom Inventory, and the World Health Organisation Quality of Life questionnaire.
But patients mentioned in their last interview that they had less burden of the symptoms, they developed a more healthy style of living, and were fitter than before. They experienced much support, they had better rapport with their children, they visited their general practitioner less frequently and took less medication., They also reported that they were highly motivated to have trauma oriented psychotherapy. The patients also expressed becoming enthusiastic about the person-centric treatment during the program.

A program like this, maybe more individualized, should further be continued, with addition of more stronger research based on it. There is sufficient evidence regarding the benefit of such programs for refugees with somatization complaints in literature. A randomized control study where 36 refugees with pain symptoms and PTSD received cognitive behaviour therapy (CBT) with or without physical activity (PA), or were put on a waiting list, showed significant improvement of coping strategies, pain and mental health status in the CBT-PA group (Liedl et al., 2011). Another study on 15 refugees with persistent pain and PTSD, who received a combination of biofeedback and narrative exposure therapy showed a significant reduction in pain and PTSD symptoms, as well as an increase in life satisfaction (Morina et al., 2012).

In conclusion we could say that the CFI, with complimentary questions, should be used in the psycho-diagnostic assessment among the refugee population. Also, we should use more differentiated treatment programs for somatising refugee patients.

Future research implications

As already mentioned earlier, research on adequate and effective diagnostic systems for refugees and individuals from various ethnic minorities as well as the common population is necessary. Noting the rise of refugees in the world, this is a serious issue and of higher priority. Whether culturally sensitive interviews, or elements of them lead to more diagnostic accuracy has been investigated only in fewer studies up till now (Zandi et al., 2008; Zandi et al., 2016).

The influence of cultural interviewing on compliance in treatment and on the effect of treatment is still an open field and scope in research. Attempts to conduct research on this matter did not provide many notable results, probably also due to a poor methodology and research design (Devillé et al., 2016). More resources should be invested in that area, considering with optimism that a cultural interview would enhance the relationship between patient and clinician, and further enhancing treatment compliance and a positive effect of treatment, independent of the technique used in providing the treatment.

In the case of somatisation among refugee patients, there is shortage of studies in combining treatments with psychotherapy or psychiatric treatment and more somatic oriented treatments (Liedl et al., 2011; Morina et al., 2012). Sophisticated programs with elements of trauma treatment and body exercises or physiotherapeutic approaches should be developed, used and evaluated by patients in a study wherein such a program is compared with another active treatment, such as trauma treatment and support respectively.

Concluding remarks

Refugees are a heterogeneous group of people in terms of ethnicity, religious affiliation and linguistics. But they have some aspects in common too: being migrants, they have to adapt to another culture, hence, they are often traumatised, or even tortured, and they live in a marginal position within the society. Nevertheless, it is difficult to bring them together on one ground, which is why a person-centred approach is more effective than an 'one-size-fits-all' approach.

The cultural interview and the cultural formulation interview were developed to use in this person-centric approach. Positive experience with the original cultural interview is well described in this thesis. The cultural formulation interview, which was developed later, was the subject of a large international field trial, and appeared to be feasible, acceptable and of potential clinical utility. As a spin off from this study came the conclusion that clinicians prefer behaviour simulations in their cultural competence training, as well as training in attitudes and skills.

The occurrence of somatization was studied in a review of literature, and among a clinical study involving 940 refugees. A connection with traumatization, and a slight connection with torture, was reported.

There are multiple implications. Use of the CFI among refugees should be encouraged. Attention to the patient-clinician relationship in transcultural mental health has to be increased. Cultural competence training should consist of more behavioural simulations with patient-actors. Somatization problems, and specially pain symptoms, should be encountered as such, although they are a part of the large PTSD complex among refugees.

What we know is that refugees will continue to constitute an important and ever-growing part of the population in mental health outpatient and inpatient services. Research on effective and relevant programs in psycho-diagnostic assessment and treatment with refugees remains a matter of vision: therefore, it will be seen as highly significant in the next approaching decades.

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Summary

This thesis is about the construction of the cultural interviews, and about the evaluation of the latest interview. In addition, the challenge of building a good patient-clinician relationship is described here.

Another important issue is the syndrome of somatization. It is a complex construct, and in refugees it has a connection with traumatization. Of traumatic experiences, being tortured is studied here. Suggestions on how to cope with somatization are mentioned.

In **chapter 1**, the two central research questions are described.

Is the cultural interview, and the new Cultural Formulation Interview accepted by patients and clinicians.

In what frequency somatization is present in refugees, and is there a connection with experienced torture.

By the end of 2015, officially there were about 88,000 refugees in the Netherlands, and 28,000 asylum seekers. But a lot more former refugees could be counted. Studies showed that from this group almost one-third have posttraumatic stress disorder, and one-third have depression. Quite often these diagnoses are seen together in one person. Refugees experience different stressors which result in different psychopathological disorders. Migration and loss can lead to depressive states. Acculturation problems can result in depersonalization and derealization. Traumatic experiences can be relived during flashbacks, nightmares and other intrusions. Social marginalization can led to social defeat and isolation. Communication with refugees and diagnostics in refugees has to improve.

In **chapter 2,** the application of the so-called Outline for a Cultural Formulation (OCF) is described, in the case of refugees patients in mental health care.

The chapter discusses the experiences of mental health professionals who applied the OCF for assessment of psychopathology and treatment needs of refugees in the Netherlands. The OCF approach proved to be a useful tool in the assessment and diagnostic phase of clinical treatment. However, patients reported problems with defining their own culture and providing explanations of illness and therapists had difficulty identifying culturally-based difficulties in the clinical relationship. Additional information was needed about working with interpreters, therapists' attitudes towards the culture of the patient and towards their own culture, patients' previous experiences with discrimination and inaccessibility of care, gender issues, and specific cultures and subcultures. A more structured approach to conducting the OCF is recommended. We developed the "Cultural Interview" for this purpose. The adaptations are aimed at improving the OCF for use with refugee populations, as well as for more general use in transcultural psychiatry.

In **chapter 3,** a literature review is presented on the world wide publications of the content and the use of the OCF till 2016.

More than twenty years after publication, the query is justified whether the OCF actually serves the purpose it was intended for, and whether any adjustments are needed. By means of a literature search an answer is sought to these questions. The main conclusion is that reactions of professionals to the cultural formulation were positive and that it has managed to find its way into education, and, to a lesser extent, into clinical practice. However, evaluative and effect studies have been lacking in the first period. Recent research has shown more favorable effects.

Chapter 4 is the first article of our international study group on the OCF, and its operationalization: the newly constructed Cultural Formulation Interview.

This study's objective is to analyze training methods clinicians reported as most and least helpful during the DSM-5 Cultural Formulation Interview field trial, reasons why, and associations between demographic characteristics and method preferences. We used mixed methods to analyze interviews from 75 clinicians in five continents on their training preferences after a standardized training session and clinicians' first administration of the Cultural Formulation Interview. Content analysis identified most and least helpful educational methods by reason. Bivariate and logistic regression analysis compared clinician characteristics to method preferences. Most frequently, clinicians named case-based behavioral simulations as "most helpful" and video as "least helpful" training methods. Bivariate and logistic regression models, first unadjusted and then clustered by country, found that each additional year of a clinician's age was associated with a preference for behavioral simulations. Most clinicians preferred active behavioral simulations in cultural competence training, and this effect was most pronounced among older clinicians. Effective training may be best accomplished through a combination of reviewing written guidelines, video demonstration, and behavioral simulations.

In **chapter 5** the Dutch outcomes are described of the international field study.

During the development of DSM-5 a new interview has been developed, the Cultural Formulation Interview (CFI). As part of an international field trial among twelve countries the CFI has also been tested in the Netherlands. The aim of the study was to determine whether the CFI is feasible, perceived clinical useful and acceptable for patients as well as for clinicians. In the Dutch part of the research eleven clinicians were trained in a structured program to administer the CFI. They conducted thirty interviews among patients from Dutch and foreign origin. The participating clinicians and patients used quantitative and qualitative questionnaires before and after the administration of the CFI.

Patients and clinicians in the Netherlands are positive about the feasibility, the perceived utility and the acceptance of the CFI. Patients are more positive about the clinical utility. The CFI did not change diagnostics: this has probably to do with the character of the research institutions. The CFI is a practical, acceptable and potentially clinical useful instrument in psychiatric practice, for every patient and particularly for patients among whom communication and diagnostic problems are expected.

Chapter 6 contains the results of the total international field study on the CFI.

The field study was set up to assess the feasibility, acceptability and clinical utility of the CFI in routine clinical practice. There has been performed a mixed-methods evaluation of field trial data from six countries. The CFI was administered to diagnostically diverse psychiatric out-patients during a diagnostic interview. In post-evaluation sessions, patients and clinicians completed debriefing qualitative interviews and Likert-scale questionnaires. The duration of CFI administration and the full diagnostic session were monitored.

The mixed-methods data from 318 patients and 75 clinicians found the CFI feasible, acceptable and useful. Clinician feasibility ratings were significantly lower than patient ratings and other clinician-assessed outcomes. After administering one CFI, however, clinician feasibility ratings improved significantly and subsequent interviews required less time. The CFI was included in DSM-5 as a feasible, acceptable and useful cultural assessment tool.

Chapter 7 shows a description of the patient-clinician relationship. Purpose of this is the improvement of this relationship.

The core CFI contains only one question on the patient-client relationship, but the Patient-Clinician Relationship supplementary module is devoted entirely to this topic. In this chapter, we first describe why it is useful for clinicians to assess the cultural aspects of the patient-clinician relationship. We then describe the supplementary module and provide guidelines for its use. We provide a theoretical background to the evaluation of the patient-clinician relationship. We describe the supplementary module on this topic, show how to implement it, and end by describing possible obstacles and caveats to its use. Even if the clinician does not ask the questions verbatim, he or she should keep the topics of the module in mind during every phase of mental health assessment and treatment to enhance his or her reflexivity and cultural awareness.

A meta review on somatization in refugees is described in **chapter 8.**

The purpose of the chapter is to present a review of the literature concerning medically unexplained physical symptoms in refugees. We outline a variety of definitions and explanations of somatization, as well as the role of culture in the concept of disease. In addition, we present a review of the epidemiological literature about somatization in refugees. Refugees from non-Western countries exhibit more unexplained somatic symptoms than the general Western population. Although different studies have employed different methodologies and are therefore difficult to compare, it can be concluded that refugees form a particular population in which somatization is prominent. Potential, not mutually exclusive, explanations of the high number of somatic symptoms in the refugee population include general psychopathology, specifically traumatization, results of torture, and stigmatization of psychiatric care. There are implications for assessment, clinical treatment and further research concerning somatization in refugees.

Research about the connection between the experience of torture and pain symptoms later on in life in refugees is the subject of **chapter 9.**

Torture may be associated with long-lasting somatic symptoms, partly explained by physical injuries. Physical pain as a result of torture, may seriously complicate the diagnostics and treatment of posttraumatic pathology in refugees. The question whether a relation exists between the experience of torture and the extent of reported somatic complaints, is therefore highly relevant. With the data set of a large clinical population of refugees (N=940), we examined specific pain items of a somatic complaints questionnaire (PILL), of a general symptom check list (HSCL-25), and of a trauma questionnaire (HTQ) in relation to torture reports. Pain scores on one item level were significantly higher in tortured refugees than in non-tortured refugees. In addition, women reporting more physical symptoms than men. Region of origin had no influence on this relationship. Torture as traumatization has a connection with somatic symptoms, which means that this can enhance the unnecessary use of somatic treatment modalities. Enlarging motivation for psychological trauma treatment is a tool, which can be used for refugees with torture experiences and somatic symptoms without physical origin.

Chapter 10 contains the general discussion of the central findings of this thesis, and elaborates on the clinical implications. Next to this the limitations of the studies are highlighted, and indications for further research.

The use of a cultural interview can improve the relationship with the patient, especially with a refugee, en will improve diagnostics, because the interview is regarded as feasible, acceptable and of clinical utility. This produces also a positive effect on treatment results, although this is not exactly proven.

Giving attention to somatic symptoms is a more complicated part of mental health care. Denying as clinician that there is a physical cause for the pain or other somatic symptoms is contra-productive. Applying, next to psychiatric care and psychotherapy, more somatic oriented treatment modules like psychomotor therapy and physiotherapy would be a possibility.

Samenvatting

(Summary in Dutch)

Dit proefschrift gaat over het ontwikkelen van culturele interviews, en over de evaluatie van het meest recente interview. Daarnaast wordt de uitdaging van het opbouwen van een goede cliënt-hulpverlener relatie beschreven. Een ander belangrijk onderwerp is het somatisatie-syndroom. Dat is een complex onderwerp, en bij vluchtelingen heeft het een connectie met traumatisering. De ervaring van marteling, als een traumatische ervaring, wordt in dit proefschrift onderzocht. Verder worden suggesties gegeven hoe om te gaan met somatisatie.

In **hoofdstuk 1** komen de twee centrale onderzoeksvragen aan de orde:

(1) wordt het culturele interview, en de vernieuwde variant, het zogenaamde culturele-formulering-interview, geaccepteerd door patiënten en door behandelaren.

(2) hoeveel komt somatisatie bij vluchtelingen voor, en is er een connectie met eerder ervaren marteling.

Op het einde van 2015 zijn er officieel ongeveer 88.000 vluchtelingen in Nederland, en 28.000 asielzoekers. Maar er kunnen veel meer voormalige vluchtelingen bij worden geteld. Onderzoek heeft aangetoond dat ongeveer één derde van deze groep een posttraumatische stress stoornis heeft, en één derde een depressie, heel vaak gelijktijdig. Vaak worden deze diagnoses in één persoon samen gezien. Vluchtelingen ervaren meerdere stressoren hetgeen resulteert in verschillende psychiatrische stoornissen. Migratie en verlies kunnen leiden tot depressieve toestanden. Acculturatieproblemen kunnen resulteren in depersonalisatie en derealisatie. Traumatische ervaringen kunnen herbeleefd worden gedurende flashbacks, nachtmerries en andere intrusieve beelden. Sociale marginalisatie kan leiden tot sociale achteruitgang en isolering.

Vanwege bovengeschetste problematiek is optimalisering van het proces van assessment en diagnostiek bij GGz patiënten met een vluchtelingachtergrond essentieel. Twee thema’s spelen daarbij een belangrijke rol: aansluiting bij de belevingswereld van vluchteling-patiënten en de vaak somatisch georiënteerde klachtenpresentatie. Om hier meer inzicht in te krijgen is het zogenaamde cultureel interview ontwikkeld.

In **hoofdstuk 2** wordt de toepassing van de zogenaamde Outline for a Cultural Formulation (OCF) beschreven, in het geval van vluchtelingen-patiënten in de geestelijke gezondheidszorg.

Het hoofdstuk bediscussieert de ervaringen van professionals in de geestelijke gezondheidszorg die de OCF hebben gebruikt voor het vaststellen van psychopathologie en van behandelbehoefte van vluchtelingen in Nederland. De OCF benadering bleek een nuttig onderdeel te zijn bij de diagnostische fase van behandeling. Patiënten rapporteerden echter problemen met het definiëren van nu eigen cultuur en van het geven van verklaringen van hun ziekte, en behandelaren hadden moeite met het identificeren van op cultuur gebaseerde problemen in de relatie van behandelaar met patiënt. Er was aanvullende informatie nodig over het werken met tolken, over de houding van behandelaren tot de cultuur van de patiënt, en tot hun eigen cultuur, over de eerdere ervaringen van de patiënt met discriminatie en met ontoegankelijkheid van zorg, over gender, en over specifieke culturen en subculturen. Een meer gestructureerde toepassing van de OCF wordt aanbevolen. We ontwikkelden het 'Cultureel Interview' voor dit doel. De aanpassingen zijn bedoeld om de OCF te verbeteren bij het gebruik bij vluchtelingen, en ook in het algemeen in de transculturele psychiatrie.

In **hoofdstuk 3** wordt een literatuuroverzicht gepresenteerd over de internationale publicaties over de inhoud en het gebruik van de OCF tot aan 2016.

Meer dan twintig jaar na de publicatie van de OCF is de zoektocht gerechtvaardigd naar de vraag of de OCF het doel diende waar het voor bedoeld was, en of er aanpassingen nodig zouden zijn. Door middel van een literatuuronderzoek wordt een antwoord gezocht op deze vragen. De belangrijkste conclusie is dat reacties van professionals op de OCF positief waren, en dat de OCF zijn weg gevonden heeft naar het onderwijs, en, in mindere mate, ook naar de praktijk. Evaluatieve studies en effectstudies zijn in deze periode echter afwezig. Recent onderzoek heeft wel gunstig effect laten zien.

Hoofdstuk 4 is het eerste artikel van onze internationale studiegroep over de OCF, en zijn operationalisatie: het nieuw geconstrueerde Cultural Formulation Interview (culturele-formulering-interview).

Het doel van deze studie is om de oefenmethodes te analyseren die behandelaren rapporteren als meest en minst behulpzaam tijdens de veldstudie van het DSM-5-CFI, alsmede de redenen waarom, en associaties tussen demografische eigenschappen en voorkeur voor methode. We gebruikten gemengde methoden om interviews te analyseren van 75 behandelaren op vijf continenten, die aangaven wat hun voorkeur had bij de training na een gestandaardiseerde trainingssessie en na de eerste toepassing van het CFI door de behandelaar. Een inhoudsanalyse liet de meest en minst behulpzame oefenmethode zien, en de reden ervan. Bivariate en logistische regressie analyse vergeleken de eigenschappen van de behandelaren met de voorkeuren voor een methode. Meestal noemden de behandelaren de rollenspellen het meest behulpzaam en de video als het minst behulpzaam. Bivariate en logistische regressie modellen, die eerst onaangepast waren en later geclusterd per land, lieten zien dat elk toenemend leeftijdsjaar van de behandelaar geassocieerd was met een voorkeur voor rollenspellen. De meeste behandelaren gaven de voorkeur aan rollenspellen bij de training van culturele competentie, en dit effect was meer uitgesproken bij oudere behandelaren. Een effectieve training kan het best bereikt worden door een combinatie van het lezen van geschreven richtlijnen, video demonstraties, en rollenspellen.

In **hoofdstuk 5** worden de Nederlandse uitkomsten beschreven van de internationale veldstudie.

In de ontwikkeling van de DSM-5 is een nieuw interview ontwikkeld, het Cultural Formulation Interview (CFI). Als onderdeel van een internationale veldstudie in twaalf landen is het CFI ook getest in Nederland. Het doel van de studie was om te bepalen of de CFI toepasbaar, potentieel klinisch bruikbaar, en acceptabel is voor patiënten en voor behandelaren. In het Nederlandse gedeelte van de studie waren elf behandelaren getraind in een gestructureerd programma om de CFI toe te passen. Ze hielden dertig interviews bij patiënten van Nederlandse en buitenlandse afkomst. De participerende behandelaren en patiënten gebruikten kwantitatieve en kwalitatieve vragenlijsten vóór en na het gebruik van het CFI.

Patiënten en behandelaren in Nederland zijn positief over de toepasbaarheid, de potentiele bruikbaarheid en de acceptatie van het CFI. Patiënten zijn positiever over de klinische bruikbaarheid. Het CFI veranderde de diagnostiek niet: dit had waarschijnlijk te maken met de aard van de onderzoeksinstellingen. De CFI is een praktisch, acceptabel en potentieel bruikbaar instrument in de psychiatrische praktijk, voor elke patiënt en in het bijzonder voor patiënten bij wie communicatieproblemen en diagnostische moeilijkheden worden verwacht.

Hoofdstuk 6 bevat de resultaten van de gehele internationale veldstudie betreffende het CFI.

De veldstudie was opgezet om de toepasbaarheid, de acceptatie en de klinische bruikbaarheid van de CFI te bepalen in de routine van de psychiatrische praktijk. Met gemengde (kwalitatieve en kwantitatieve) methoden is er een evaluatie verricht van de data uit zes landen. De CFI is toegepast bij poliklinische psychiatrische patiënten met verschillende diagnosen gedurende een diagnostisch interview. In de evaluatie vulden patiënten en behandelaren complete kwalitatieve interviews in en vragenlijsten met Likert-schalen. De duur van de toepassing van het CFI en de volledige diagnostische sessie werden bijgehouden.

De data van het gemengde methoden onderzoek met 318 patiënten en 75 behandelaren vonden het CFI toepasbaar, acceptabel en bruikbaar. De toepasbaarheid werd door behandelaren significant lager ingeschat dan door patiënten en was ook lager dan andere beoordelingen door behandelaren. Echter, na het toepassen van één CFI, waren de beoordelingen van behandelaren significant beter, en de volgende interviews vereisten minder tijd. Het CFI werd opgenomen in de DSM-5 als een toepasbaar, acceptabel en bruikbaar cultureel intake interview.

Hoofdstuk 7 beschrijft de patiënt-behandelaar relatie, ten einde die te verbeteren.

Het basis-CFI bevat slechts één vraag over de patiënt-behandelaar relatie, maar de Patiënt-Behandelaar-Relatie supplementaire module is geheel gewijd aan dit onderwerp. In dit hoofdstuk beschrijven we eerst waarom het bruikbaar is voor behandelaren om de culturele aspecten van de patiënt-behandelaar-relatie vast te stellen. We beschrijven dan de supplementaire module en geven richtlijnen aan voor het gebruik ervan. We bieden een theoretische achtergrond voor de evaluatie van de patiënt-behandelaar-relatie. We beschrijven de supplementaire module hierover, laten zien hoe hij toegepast moet worden, en eindigen met het beschrijven van mogelijke obstakels en valkuilen. Zelfs als de behandelaar niet de vragen letterlijk stelt, zou hij de onderwerpen van de module moeten onthouden gedurende elke fase van de psychiatrische intake en behandeling teneinde zijn of haar bewustheid erover te verbeteren, en het culturele bewustzijn.

Een metareview over somatisatie bij vluchtelingen wordt beschreven in **hoofdstuk 8.**

Het doel van het hoofdstuk is om een overzicht te geven van de literatuur betreffende somatisch onverklaarde lichamelijke klachten bij vluchtelingen. We geven een variëteit van definities en verklaringen aan van somatisatie, alsmede de rol van cultuur in het begrip van ziekte. Daarnaast presenteren we een overzicht van de epidemiologische literatuur over somatisatie bij vluchtelingen. Vluchtelingen uit niet-westerse landen vertonen meer onverklaarde somatische symptomen dan de Westerse populatie. Hoewel verschillende studies verschillende methodologie hebben gebruikt en daarvoor moeilijk te vergelijken zijn, kan geconcludeerd worden dat vluchtelingen een specifieke populatie vormen waarin somatisatie veel voorkomt. Mogelijke, niet wederzijds uitsluitende, verklaringen van het hoge aantal somatische symptomen in de populatie van vluchtelingen zijn algemene psychopathologie, specifiek traumatisatie, gevolgen van marteling, en stigmatisatie van psychiatrische zorg. Er zijn implicaties voor de diagnostiek, behandeling en het verder onderzoek betreffende somatisatie bij vluchtelingen.

Onderzoek over het verband tussen de ervaring van marteling en pijnsymptomen later in het leven bij vluchtelingen is het onderwerp van **hoofdstuk 9.**

Marteling kan verbonden zijn met langdurende somatische symptomen, die voor een gedeelte verklaard worden door fysieke verwondingen. Lichamelijke pijn als gevolg van marteling kan de diagnose en behandeling van posttraumatische pathologie bij vluchtelingen ernstig compliceren. De vraag of er een relatie bestaat tussen de ervaring van marteling en de mate van gerapporteerde lichamelijke klachten is daarom hoogst relevant. Met behulp van een dataset van een grote klinische populatie vluchtelingen (n=940) onderzochten we specifieke pijnsymptomen van een somatische klachten vragenlijst (PILL), van een algehele symptomenlijst (HSCL-25) en van een trauma-vragenlijst (HTQ) in relatie tot rapportage van marteling. Pijnscores op itemniveau waren significant hoger bij gemartelde vluchtelingen dan bij niet-gemartelde vluchtelingen. Vrouwen rapporteerden meer lichamelijke symptomen dan mannen. Regio van oorsprong had geen invloed op deze relatie. Marteling als traumatisering heeft een connectie met lichamelijke symptomen, hetgeen betekent dat dit kan leiden tot onnodig gebruik van somatische behandelingsmethoden. Het vergroten van de motivatie voor psychologische traumabehandeling is een methode die gebruikt kan worden voor vluchtelingen met ervaringen van marteling en somatische symptomen zonder lichamelijke oorzaak.

Hoofdstuk 10 bevat de algehele discussie over de centrale bevindingen van dit proefschrift en gaat in op de klinische implicaties, daarnaast worden de beperkingen van de besproken studies geschetst en biedt het aanwijzingen voor verder onderzoek.

Toepassing van een cultureel interview kan de relatie met een patiënt, zeker met een vluchteling, positief beïnvloeden, en het zal de diagnostiek ook verbeteren, omdat het interview als positief wordt ervaren qua toepasbaarheid, bruikbaarheid, en klinisch nut. Dat heeft ook positief effect op het behandelresultaat, hoewel dit nog niet hard is aangetoond in een dubbelblind onderzoek.

Aandacht geven aan somatische symptomen is een gecompliceerder gedeelte van de geestelijke gezondheidszorg. Ontkennen als behandelaar dat er een lichamelijke oorzaak is voor pijn of andere somatische symptomen is contraproductief. Het toepassen, naast psychiatrische behandeling en psychotherapie, van meer somatisch georiënteerde behandelmodules zoals psychomotore therapie en fysiotherapie kan een mogelijkheid zijn.

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About the author

Hans (Johannes George Boudewijn Maria) Rohlof was born on the 12th of August 1950 in Hilvarenbeek, the Netherlands. After a secondary education in Tilburg he finished Medical School at Leiden University in 1976. He was board certified as a psychiatrist in the University Psychiatric Clinic in Leiden/Oegstgeest in 1982. After that he was appointed as clinical psychiatrist and manager in different inpatient and outpatient services in the Leiden region.

From 1999 till November 2015 he was affiliated to 'Centrum '45' in Oegstgeest, the Netherlands: this is the National Institute for Psychotrauma Treatment and Research.

From 1982 till present, he has a private practice for psychiatry and psychotherapy in Leiden, the Netherlands, in cooperation with other psychiatrists and psychotherapists, in recent years in the group practice 'Transparant Mental Health'. Next to this, he is connected as consultant psychiatrist to 'GGZ Integraal', a psychiatric outpatient service for migrant patients. He is also connected as consultant psychiatrist to 'Silver Psychology'.

He started his career in Transcultural Psychiatry around 1988, with clinical practice and an education and clinical appointment in 1992 at the National Institute for Refugee Care 'Pharos' in Amsterdam and Utrecht. In 2001, he was one of the founders of the Section on Transcultural Psychiatry of the Netherlands Association of Psychiatry, and for eight years he was Board Member and Secretary. Since 2007, he is a Board Member and later Treasurer, of the Division on Psychotherapy of the Netherlands Association of Psychiatry. Since August, 2008, till September, 2014, he was a Board Member and later Chair of the Transcultural Section of the World Psychiatric Association. In 2014, he was appointed as Honorary Advisor of this Section. In the same year he was granted a Honorary Membership of the World Psychiatric Association because of his merits for the field of psychiatry. Since 2014, he is Board Member of the World Association of Cultural Psychiatry. In 2015, he became Treasurer of this Association, and in that function he is one of the three executive officers.

He is a member of the Editorial Board of the peer reviewed scientific journals 'Transcultural Psychiatry' and 'World Cultural Psychiatry Research Review'. He is also editor of the Dutch journal for psychotherapy 'PsyXpert'. He is a peer reviewer for different scientific journals, among which the 'British Journal of Psychiatry' and 'European Psychiatry'. He is occupied with the national education of residents in Transcultural Psychiatry, and with several other education programs, nationwide and abroad.

He is the Secretary of the ‘Johannes Wier Foundation for Human Rights and Health Care’, based in Amsterdam, since 2015.
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