

MULTICULTURAL ISSUES IN THE CLINICAL INTERVIEW AND DIAGNOSTIC PROCESS

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In 2003, the American Psychological Association (APA) published the *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists*, which marked APA's first formal statement on the substantive influence of cultural and contextual factors in clinical, research, school, consulting, organizational, teaching, and training settings. The guidelines, developed in response to the demographic shifts of the 20th century, outlined the great need for cultural sensitivity and culture-centered adaptations in psychology while encouraging greater awareness and incorporation of sociocultural factors across research and applied settings. Yet, the guidelines provided little instruction on how to use multicultural sensitivity, multicultural interventions, or multicultural competence. As a result, the guidelines remain largely aspirational (Hwang, Myers, Abe-Kim, & Ting, 2008).

Furthermore, unlike its briefer and less elaborate predecessor 10 years prior (APA, 1993), these guidelines provided fewer illustrative examples in the psychological services domain. For instance, in reference to clinical practice, Guideline 5 states, "Psychologists are encouraged to apply culturally appropriate skills in clinical and other applied psychological practices" (APA, 2003, p. 390). However, concrete suggestions for cultivating and using culturally appropriate skills were not presented. Indeed, most of the theoretical and empirical work on how to recognize and address cross-cultural influences in the clinical interview and diagnostic process was printed after the publication of the first multicultural guidelines for psychological services and its reprint in the

American Psychologist in 1993. To illustrate, more than 90% of articles and chapters written on clinical interview and culture and more than 66% of the literature on culture and diagnosis have been published since 1990, as documented in a PsycINFO database search. The majority of the instructional literature about how to conduct a culturally sensitive clinical interview and diagnostic formulation has largely appeared in select book chapters and articles. Although there is wide consensus that sociocultural context is important to psychological processes, empirical research on effective applications or characteristics of cultural competence is sparse (Sue, 1998).

In this chapter, we review the extant literature on the cultural factors that bear on the clinical interview and diagnostic process with racial/ethnic minorities. First, we review those factors that affect the clinical interview, such as the sociolinguistic factors involved in patient-provider communication, stigma of mental illness, perceived mistrust, and bias in clinical decision making. Second, we discuss cross-cultural issues in psychiatric nosology and the use of the Cultural Formulation as a method to use in culturally informed diagnostic interviewing. We limit our review to material covered in book chapters or peer-reviewed journal articles that have explicitly discussed the clinical interview or diagnostic formulation with racial/ethnic minority groups living in the United States. We exclude research and clinical literature that emphasizes specific disorders or assessment tools as a means to limit the potential for dual coverage of material discussed in other chapters of this volume. Our intention is to provide practitioners

and researchers with a brief overview of cultural factors that may emerge in the clinical interview and diagnostic process with racial/ethnic minorities in the United States.

CLINICAL INTERVIEW

Racial/ethnic minorities have been shown to have high premature termination rates in mental health care relative to their White counterparts, with most terminating care after one session (Armistead et al., 2004; Gallagher-Thompson, Solano, Coon, & Areán, 2003; Murry et al., 2004; Sue, 1977, 1998). The clinical interview, which typically occurs in the first session, may subsequently be exceedingly important in the retention of racial/ethnic minority patients in mental health care. The clinical interview is regarded as the initial and most common assessment tool used for clinical diagnosis and formulation (for a comprehensive review of clinical interviewing, see Aklin & Turner, 2006). The clinical interview can range in format from an unstructured to a fully structured assessment of an individual's presenting problem and relevant psychosocial history.

In what follows, we discuss the ways in which patient-provider communication, notions of stigma and mistrust, and clinical judgment can affect the therapeutic relationship and the types of diagnostic inferences made during the clinical interview. We draw attention primarily to factors beyond patient-provider ethnic match because of its small effect on treatment retention and attendance after the first session (Maramba & Hall, 2002). We underscore that our review does not focus on the step-by-step processes involved in conducting a basic diagnostic assessment (for information on structuring the interview and general guidelines, see Ivey & Matthews, 1984; Mezzich, Caracci, Fabrega, & Kirmayer, 2009; Shea, 1998) but rather on cross-cultural sources of variation that may result in patient-provider misunderstanding in the clinical interview and the types of diagnostic outcomes observed.

Patient-Provider Communication

Research in medical anthropology and sociology has contributed largely to psychologists' understanding of the sociolinguistic factors that result in

miscommunication and misunderstanding in the clinical dyad. Few studies have focused on the mental health clinical encounter; thus, we draw largely on research on intercultural communication in the health care context. Sociolinguistics research on patient-provider communication in health care has found that misunderstandings arise from differences in language, communication styles, assumptions about patient and provider roles, health beliefs, and limited resources to negotiate understanding (Roberts, 2010). Notwithstanding, differential norms for nonverbal forms of communication such as eye contact, interpersonal distance, and physical touching may be misinterpreted in the absence of cultural context (Mezzich et al., 2009). For example, perception of prolonged gaze among African Americans may be misinterpreted as indicative of psychopathology in the absence of information about the cultural context from which the nonverbal information is derived (as discussed in Aklin & Turner, 2006). Our discussion focuses mostly on variation in patient-provider verbal communication.

At the most basic level of verbal comprehension, differential language preferences and language competencies between patient and provider are likely to result in misunderstanding, possible misdiagnosis, or both (Aklin & Turner, 2006). In these circumstances, language interpreters and cultural brokers are often used to facilitate communication between patient and provider. In fact, U.S. federal law mandates that adequate language assistance be provided to those with limited English proficiency seeking services in settings that receive funds from the U.S. Department of Health and Human Services (Alcalde & Morse, 2000). Yet, very little is known about how these language assistance policies are implemented and their effectiveness in treatment retention (Snowden, Masland, & Guerrero, 2007; Snowden, Masland, Peng, Lou, & Wallace, 2011). On one hand, communication may be enhanced when language assistance is provided; on the other hand, use of language intermediaries can limit patient-provider understanding and diminish rapport. For example, language interpreters and cultural brokers may intentionally or unintentionally edit utterances that alter the patient's intended meaning rather than provide direct linguistic translation (Roberts, 2010),

which may in turn affect clinical decision making. Issues outside of the translation itself may also affect patient narratives and diagnostic inferences, such as the structure of the interview (e.g., semistructured or unstructured; Csordas, Dole, Tran, Strickland, & Storck, 2010) and the extent to which the questions used in the clinical interview have been vetted for conceptual, semantic, and cultural equivalence (Matias-Carrelo et al., 2003).

At a higher level of verbal comprehension, symptom expression and experience are shaped by language, culture, and social context (Kirmayer, 2005; Kleinman, 1987). Thus, culturally patterned variation is expected in the idioms, metaphors, health beliefs, illness narratives, and communication styles used by patients and providers. During instances in which incongruence exists between patient and provider in these areas, misunderstanding may occur that affects diagnostic accuracy and treatment planning (Roberts, 2010). Misunderstanding can also arise when collaboration between patient and provider in the medical encounter is low and can be heightened when patient and provider race are discordant. For example, evidence has suggested that African Americans perceive visits with their medical providers as less participatory than do Whites, although participation in and satisfaction with the medical encounter improves for both races when patient and provider race are concordant (Cooper-Patrick et al., 1999). Incongruence may also harm the patient-provider relationship and result in tenuous rapport, limited agreement about the medical problem and treatment goals, and poor medication adherence and treatment retention, which in turn serve as sources of provider frustration (Levinson, Stiles, Inui, & Engle, 1993). In fact, research has shown that in cases of a cognitive match between patient and provider or congruence in treatment goals, better psychotherapy treatment outcomes are observed (Zane et al., 2005).

Stigma and Mistrust

Perceived stigma of mental illness among racial/ethnic minorities and Whites has been shown to affect patient engagement and retention in treatment (Snowden & Yamada, 2005). For racial/ethnic minorities, however, stigma concerning mental

illness and mistrust of health care providers may affect ethnic minorities' behavioral decisions to seek treatment and the types of symptoms endorsed in the clinical interview (U.S. Department of Health and Human Services, 2001). Research on the effect of stigma on service utilization is sparse. One recent study found that perceived stigma of mental illness was not related to treatment engagement among African Americans; however, stigma or other concerns about psychotherapy significantly predicted participation in treatment (Alvidrez, Snowden, & Patel, 2010). More research is needed to assess the dimensions of perceived stigma that influence treatment initiation, retention, and presentation in the clinical interview. The perceived stigma of mental illness may also influence how symptoms are experienced and expressed to others. For example, among Asians and Latina/os, experiencing distress in somatic terms is a culturally sanctioned method of communicating affliction and distress that does not pose a threat to social or familial standing (Angel & Guarnaccia, 1989; Chun, Enomoto, & Sue, 1996; Kirmayer & Young, 1998). Therefore, racial/ethnic minorities may articulate their psychological distress using more physical references, which may not align neatly with established diagnostic categories that prioritize affective states over somatic states.

Beyond stigma, perceived mistrust of health care providers has been shown to affect attitudes toward mental health care providers and treatment, which may likely surface in the clinical interview. *Cultural mistrust* refers to a mild set of paranoid behaviors that facilitate coping with historical and contemporary experiences of racial injustice and discrimination among African Americans (Whaley, 1997, 2001c, 2001d). In particular, the troubled and complicated history of medical experimentation with African Americans undergirds what has been referred to as the "medical apartheid," or medical divide, that creates and perpetuates health care disparities and a continued fear of medicine and distrust of the medical profession (as discussed in Washington, 2006, p. 23). In regard to mental health care, research has shown that high ratings of cultural mistrust are associated with negative attitudes among African Americans toward White clinicians. This mistrusting stance is also held by other racial/ethnic groups. For example, perceived cultural mistrust is associated

with negative perceptions of mental health services among American Indians/Alaska Natives (Whaley, 2001d). Cultural mistrust may present a significant barrier to rapport building in the clinical dyad and confer a negative effect on treatment outcomes, especially for African American and American Indian/Alaska Native patients because of the potential differences in cognitive match between patient and provider. However, these associations have not been empirically tested.

Cultural mistrust may also confound diagnostic estimates of psychiatric conditions among African Americans. Research on the differential rates of schizophrenia found among African Americans and White Americans has demonstrated that African American psychiatric patients receive a diagnosis of schizophrenia at a disproportionately higher rate than do White Americans (Neighbors, Trierweiler, Ford, & Muroff, 2003; Whaley, 2001b). Explanations for these race-related differences include differential manifestation of schizophrenia pathology among African Americans (e.g., cultural mistrust) and clinician biases that result in differential interpretations of patients' symptom profile (Trierweiler et al., 2006). The link between cultural mistrust and schizophrenia, however, has not been well substantiated. For example, in one set of studies African Americans who scored high on a measure of cultural mistrust and a related concept of interpersonal distrust had higher odds of receiving a diagnosis of probable depression, not schizophrenia, relative to Whites (Whaley, 1997). Yet, in another set of studies the extent to which cultural mistrust predicted a diagnosis of schizophrenia varied by type of interview (Whaley, 2001b), which suggests a lack of reliable findings. To illustrate the inconsistencies further, African Americans with high levels of interpersonal distrust or mild paranoia were less likely to be hospitalized relative to White men with equal levels of distrust (Whaley, 2004).

Despite the mixed research evidence, the concept of cultural mistrust does highlight the difficult task of distinguishing between normative and nonnormative experience, such as differentiating between a normative experience of mistrust stemming from historical or contemporary experiences of racism, discrimination, colonization, unfair treatment, and

exploitation in medical settings, and a nonnormative experience of mistrust caused by the presence of clinical paranoia. To this end, use of psychometric measures of cultural mistrust in clinical assessment and direct discussion of cultural mistrust in the clinical dyad and its impact on rapport building may prove beneficial for treatment retention and patient engagement (Whaley, 2001a).

Clinical Judgment and Decision Making

Multiple sources of difference, including variation in the data obtained (information variance), inferences made about severity of symptoms (criterion variance), and the information offered by patients (patient variance), have been shown to affect diagnostic inferences made during the clinical interview (Aklin & Turner, 2006). The reliability and validity of clinical inferences improve with the use of semistructured or structured diagnostic interviews by decreasing information variance (Whaley, 1997). Yet, information variance remains largely accountable for race-related differences in diagnostic inferences made using structured and unstructured clinical interviews (Strakowski et al., 1997).

Information variance can stem from clinician biases related to levels of training and experience and race (see Garb, 2005; Neighbors et al., 2003; Trierweiler et al., 2006). For example, expert clinicians tend to more frequently rely on idiosyncratic theories or pattern heuristics, ask essential questions, and exhibit greater recall for disconfirmatory information, relative to novice or less experienced clinicians (Brailley, Vasterling, & Franks, 2001; Garb, 2005), which suggests that novice or less experienced clinicians are more likely to search for information that confirms their preexisting hypotheses or stereotypes during the clinical interview (Garb, 1996). Biases in the implicit or explicit search for information that confirms a stereotype about a racial/ethnic minority patient may hamper clinical judgment and affect diagnostic impressions (Abreu, 1999). These biases may be accentuated in psychiatric emergency care contexts when clinicians are under greater time and efficiency pressures (Muroff, Jackson, Mowbray, & Himle, 2007).

Furthermore, clinician race is an independent predictor of the types of symptom attributions made

and diagnoses assigned to patients in treatment settings. For example, Trierweiler et al. (2006) found that African American clinicians were more likely than non-African American clinicians to assign a diagnosis of schizophrenia to African American patients when positive symptoms such as hallucinations were identified, whereas non-African American clinicians more frequently used presence of negative symptoms such as blunted or constricted affect to assign a schizophrenia diagnosis. More research is needed that systematically examines errors in the cognitive process of decision making that result in differential diagnostic outcomes (Whaley & Geller, 2007).

Summary

Patient-provider communication and clinical judgments are influenced by a set of observable and unobservable factors including sociolinguistic, non-verbal, patient (e.g., perceived stigma of mental illness, mistrust of health care providers), and clinician factors (e.g., search for confirmatory information, level of experience, race). We have illustrated how these factors are shaped by cultural and social context and how their interaction might affect diagnostic accuracy as well as retention and engagement of racial/ethnic minorities in psychotherapy. Further research is needed on the mediating role of socioeconomic position in patient-provider communication, perceived mistrust, and stigma of mental illness and its implications for diagnostic inference. In the section that follows, we underscore key cross-cultural issues in psychiatric nosology. We also discuss the Cultural Formulation as an exemplar for eliciting sociocultural information that can be used in diagnostic formulation and treatment planning.

DIAGNOSTIC PROCESS

Despite the growing attention to the influence of context on mental health, consensus is minimal regarding the extent to which psychiatric disorders are universal and the extent to which symptom patterns are shaped according to sociocultural factors (Canino & Alegria, 2008; López & Guarnaccia, 2000). The gaps in knowledge about the cross-cultural applicability of psychiatric disorders are evident in

the leading psychiatric text, the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed. [DSM-IV; American Psychiatric Association, 1994] and 4th ed., text rev. [DSM-IV-TR; American Psychiatric Association, 2000]). To illustrate, the DSM-IV and DSM-IV-TR have been critiqued for the absence of explicit guidelines by which to assign diagnoses across cultural contexts, oversimplification of the influence of sociocultural processes on mental disorders, overreliance on limited epidemiological data, and prioritization of descriptive symptom sets that may miss alternative phenotypes (Aderibigbe & Pandurangi, 1995; Alarcón et al., 2009; Lewis-Fernández et al., 2010; Mezzich et al., 1999; Rogler, 1993a). Other related critiques have involved the emphasis on similarity over cultural difference and prioritization of biological dimensions over cultural facets of psychopathology (Kleinman, 1987, 1996).

These cultural shortcomings may engender overidentification or underidentification of psychiatric disorders across cultural groups (Alegria & McGuire, 2003) or inadvertently promote stereotypes that impair clinical decision making (Alarcón et al., 2009). In the absence of more substantive sociocultural contextualization, clinicians may also commit a category fallacy or impose Western psychiatric categories on other cultural groups without evidence of their cross-cultural validity (Kleinman, 1977).

Systematic research on the role of culture in the diagnostic process is sparse despite calls dating back to the early 1990s for research-based theories on how culture structures and mediates the diagnostic process (Rogler, 1992, 1993b). The absence of programmatic research is due in part to ideological tensions within cross-cultural psychiatry about whether and how to prioritize sociocultural context within clinical research and practice (Fabrega, 2002; Malgady, 1996). Further, empirical testing on the clinical costs and benefits of using the prevailing universalistic nosology or a more culturally relativistic nosology is sorely needed (Alegria & McGuire, 2003).

Those who uphold the notion that sociocultural context plays a prevailing role in mental health have been the chief architects behind the development of the Cultural Formulation. The outline for the Cultural Formulation first appeared in DSM-IV as part of Appendix I and was intended to complement

the standardized multiaxial assessment (American Psychiatric Association, 1994). Herein, we chose to provide an overview of the Cultural Formulation as a tool that may enhance patient-provider understanding and limit biases in clinical decision making.

Cultural Formulation

Research has shown that diagnostic errors can occur as a function of the assumptions made by clinicians about the systematic linkages between symptom manifestation, expression, and course (Aklin & Turner, 2006; Alegria & McGuire, 2003). To this end, the Cultural Formulation was developed to promote systematic evaluation of an individual's socio-cultural context across five domains hypothesized to have an impact on clinical care. These domains are (a) cultural identity of the individual, (b) cultural explanations of the individual's illness, (c) cultural factors related to psychosocial environment and levels of functioning, (d) cultural elements of the relationship between the individual and the clinician, and (e) overall cultural assessment for diagnosis and care (American Psychiatric Association, 2000, pp. 897–898). Clinicians are tasked with developing a diagnostic formulation that draws on a patient's metaphors, models, and concepts of illness, help seeking, and coping (Mezzich et al., 2009).

The majority of the literature on the Cultural Formulation has appeared in edited books or peer-reviewed journal articles. Readers are encouraged to consult Mezzich et al. (2009) for a how-to guide on using and preparing the Cultural Formulation and the edited book by Mezzich and Caracci (2008) on the history, characteristics, and illustrations of the Cultural Formulation. Other models for incorporating sociocultural information into the diagnostic process are available elsewhere (see Canino & Alegria, 2008; P. A. Hays, 2008; Hwang et al., 2008). We note that the *ethnocultural assessment*, an early precursor to the Cultural Formulation, also encouraged the exploration and incorporation of ethnocultural context, identity, migration and adjustment history, and therapists' cultural background in clinical assessment (readers are encouraged to consult Jacobsen, 1988). In the next section, we briefly review the five domains of the Cultural Formulation (for more detailed

information on the Cultural Formulation and examples, see Lewis-Fernández, 1996a, 1996b; Lim & Lin, 1996; Lu, Lim, & Mezzich, 1995; Mezzich, 1995; Mezzich & Caracci, 2008).

First, clinicians are encouraged to inquire about an individual's multiple categories of identity and identity development including race, ethnicity, country of origin, language, and acculturation. However, additional identity domains not mentioned in the initial formulation that should also be considered include gender, age, sexual orientation, religious and spiritual beliefs, geographic region, and socioeconomic position (D. G. Hays, Prosek, & McLeod, 2010; Lu et al., 1995). The intersection of these social identities should also be examined further, in particular the ways in which these identities shape behavioral decisions and emotional expressions (Mezzich et al., 2009). The use of cultural brokers, consultants, or informants is encouraged to facilitate understanding between patient and provider; however, as discussed earlier, the use of language intermediaries and cultural brokers is not without its limitations. To our knowledge, systematic empirical investigations on the impact of cultural brokers on diagnostic accuracy have not been conducted.

Second, clinicians are tasked with learning about an individual's explanation of illness or explanatory model of illness, which includes assessment of idioms of distress, culture-bound syndromes, perceived causes, and history of help-seeking behavior. Cultural syndromes often co-occur with anxiety, mood, and dissociative disorders (American Psychiatric Association, 1994; Lewis-Fernández, Guarnarcía, & Ruiz, 2009). Thus, this domain of the Cultural Formulation draws attention to the emic and etic concepts associated with DSM-IV categories and the challenges to arriving at discrete psychiatric diagnoses (Kirmayer, 1991). *Etic concepts* refer to externally defined (and potentially universal) phenomena, whereas *emic concepts* refer to locally emergent (and potentially distinctive) phenomena (Berry, 1969). In eliciting patients' explanatory models, clinicians invoke their emic illness concepts and terms. Evidence has suggested that incorporation of these emic concepts adds incremental validity to predictions of clinical status. For example, use of a cultural-idioms-of-anger scale added

incremental validity to predictions of clinical status above and beyond standard measures of depression and anxiety among a sample of Puerto Ricans living in New York City (Malgady, Rogler, & Cortés, 1996). Similarly, use of a brief assessment of lifetime history of suffering from a culture-bound syndrome (*nervios*) added incremental validity to predictions of current psychological distress among Mexican mothers (Alcántara, Abelson, & Gone, 2012).

Third, a thorough evaluation of a patient's interpretation of the relevant psychosocial stressors and levels of functioning makes up the next domain of the Cultural Formulation. Clinicians are encouraged to obtain an understanding of a patient's social stressors, social supports, impairment, functioning, and use of kin networks and religion to cope with distress. This understanding is in addition to an assessment of the patient's developmental, family, and psychosocial history (Lu et al., 1995). Clinicians are encouraged to consult with relatives and informants in a patient's social network to garner a better understanding of the impact of illness across the individual's life domains and across the life span (Mezzich et al., 2009).

Fourth, clinicians must explore the cultural and social factors that affect the clinical dyad and the therapeutic relationship. Assessment of these factors includes evaluation of the cultural and social status differences that may affect the diagnostic process and hamper communication, understanding, and eventual diagnostic inferences. Clinicians are advised to consider possible interethnic and intraethnic transferences and countertransferences that may evoke a range of emotional reactions ranging from hostility and mistrust to overcompliance and ambivalence (Comas-Díaz & Jacobsen, 1991). For clinicians and patients to identify the assumptions and biases that may have an impact on the therapeutic relationship, they must adopt a self-reflective stance.

Fifth, the Cultural Formulation concludes with a statement concerning the implications for diagnostic assessment and clinical care or a synopsis of the prevailing cultural themes across the four domains. The goal is to provide a succinct summary of the cultural factors and values that can enhance clinical care and promote treatment adherence and retention (Mezzich et al., 2009).

Summary

Despite the publication of the Cultural Formulation in 1994, it has been used infrequently because of the limited information in the *DSM-IV* about how to use it and the lack of case examples demonstrating its utility (Mezzich et al., 2009). Indeed, much of the work on the Cultural Formulation remains largely theoretical, leaving a dearth of empirical research on how the diagnostic process would be improved through its use (Escobar & Vega, 2006). In sum, the Cultural Formulation provides a template for diagnostic interviewing that is intended to uncover differences in patient-provider communication styles, beliefs, assumptions, and reactions that may affect treatment engagement and retention and clinical decision making.

CONCLUSION

In this chapter, we reviewed the available literature on the cultural factors that influence the clinical interview and the diagnostic process with racial/ethnic minority patients living in the United States. We focused on the sociolinguistic factors that may hamper effective patient-provider communication such as differences in language competencies, communication styles, and health beliefs. We also discussed how the perceived stigma of mental illness and mistrust of health care providers can affect the formation of a therapeutic relationship. In addition, we discussed how biases in clinician judgment impair clinical decision making and the extent to which these biases may account for race-based differences in diagnostic inferences. Our review ended with an overview of the Cultural Formulation as a tool that simultaneously draws attention to biases and assumptions that negatively affect rapport, diagnostic accuracy, and patient retention and encourages evaluation and incorporation of patient health concepts and terms.

Recent population estimates have indicated that U.S. racial/ethnic minority populations are growing at disproportionately higher rates than their White American counterparts (U.S. Census Bureau, 2011). These demographic changes underscore the diversification of the entire U.S. population and the expected diversification of the mental health care patient

population in the 21st century. Now more than ever, empirical investigations are needed into the factors that will enhance racial/ethnic minority patient engagement and retention in treatment while limiting potential provider biases in the clinical encounter (see Alegria et al., 2008, for a model of an intervention designed to increase patient participation, retention, and attendance among Latinos). This is especially true given that race-based differences in diagnostic inferences and treatment disposition are observable as early as childhood (Muroff, Edelson, Joe, & Ford, 2008). Furthermore, we need research that addresses issues of sociocultural context and mental health not just for racial/ethnic minorities, but for majority groups as well (Alarcón et al., 2009). To address the mental health needs of the patient population in the 21st century, the cultural competency research and practice agenda will need to move toward the production of actionable instead of aspirational deliverables.

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