# CALD 9 Pre-Course Reading

Supplementary Resources

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**Pre-Course Reading for the "CALD 9: Working in a Mental Health Context for CALD Clients Course."**

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***The scope of the resource***

This resource is written from the perspective of the New Zealand health system. It is aimed at practitioners who have knowledge and orientation in the New Zealand Health System, are working with culturally and linguistically diverse (CALD) clients from migrant and refugee backgrounds, and who are required to be culturally competent as part of health professional competency requirements.

We acknowledge that the wider context of cultural diversity is inclusive of Maori and Pasifika cultures. We also acknowledge that Maori people are the tangata whenua (the people of the land) in Aotearoa/New Zealand. The Auckland region has the largest Pacific population in the world. Cultural competence resources are available for working specifically with Maori and Pasifika clients and whanau and are therefore not covered in this resource.

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# Welcome

## An introduction to this resource

### Who is this resource for?

This is a pre-course reading for both the online or face-to-face learners who have enrolled into the **CALD 9: Working in a Mental Health Context with CALD Clients** course.

### Why do you need to read this prior to the course?

It is highly recommended that learners familiarise themselves with the topics in this Pre Course Reading. The course will not repeat or explain all the information in this resource however the course will briefly refer to the materials in this pre-course reading.

### Aim

The aim of the resource is to give you awareness of:

- the rationale for cultural competency
- cross-cultural challenges in assessment and diagnosis in mental health when working with CALD clients
- how to use questions from the CALD Assessment Tool towards developing a cultural formulation

### What topics are covered in this resource?

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## Why is Cultural Competency Important?

*"The fundamental nature of human potential is the ability to acquire learned habits throughout life, persistently modifying behaviour in response to environmental influences." (Ratner, 2006).*

With growing ethnic diversity in New Zealand, clinicians are increasingly faced with the challenges of culturally complex presentations in mental health. Conducting culturally appropriate assessments, diagnoses and interventions relies on an understanding of how cultural practices and beliefs affect presentations, engagement and interventions. Regardless of the professional discipline or the type of service, clinicians need to determine whether or not a person is suffering from a mental illness, and if so, to ensure effective treatment. Approaching mental health in the context of the client's culture is critical to this outcome.

**Why is cultural competency important?**

- Cultural competency improves patient care.
- Ethnicity and language have a substantial impact on practitioner-client relationships.
- A poor diagnosis due to lack of cultural understanding can have significant consequences for clients/families.
- Misunderstandings and a lack of knowledge about traditional cultural perspectives on mental health may leave CALD clients socially isolated and without appropriate support.
- Traditional cultures regard mental health in varied ways. In many, cultural and religious perspectives and practices differ significantly from Western biomedical and biopsychosocial models.

- The Health Practitioners Competence Assurance (HPCA) Act 2003, includes a requirement for registration bodies to develop standards of cultural competence and for practitioners to meet those standards.

Clinicians play a critical role in facilitating appropriate access, services and support for their CALD clients. Cultural awareness, knowledge and sensitivity will improve the practitioner's effectiveness in working in this field.

## Rationale for a Culturally Oriented Approach

*"Without cultural sanction, most or all our religious beliefs and rituals would fall into the domain of mental disturbance." John Schumaker*

Evidence informs us that a culturally oriented approach will:

**Improve patient engagement**

A number of studies report premature termination of treatment in mental health services among ethnic minority clients (Barrett et al., 2008; Leong & Kalibatseva, 2011; Swift & Greenberg, 2012).

**Improve patient satisfaction**

Culturally and Linguistically Diverse (CALD) clients are dissatisfied when their care is not culturally competent (Meyer & Zane, 2013).

**Improve health outcomes**

Evidence suggests that providing practitioners with cultural knowledge and skills results in more tailored and appropriate therapeutic techniques and in turn, increases culturally competent interventions (Berger et al., 2014). For example, clinicians working with Asian clients should become aware of and understand the significant heterogeneity among Asian groups. It is also important to understand the differences between the migrant and refugee journey and experience. Knowledge of these differences and an awareness of other culture-specific factors can help clinicians tailor treatment plans to the specific needs of their clients.

Cultural competence in mental health care is critical for culturally appropriate assessment, diagnoses and care in understanding the nature of distress, working with families and communities, and in general for improving the health outcomes for your client.

## Mental Health as a Western Discipline


Health professionals trained in Western biomedical and biopsychosocial models need training and practice in cultural competency to meet the needs of clients and families from a diverse range of cultural backgrounds. Mental health practitioners face an additional challenge in that their discipline and tools are steeped in Western values and perspectives. Despite increasing recognition of the critical importance of cultural factors in mental illness, the assumptions of psychiatric universalism continue to dominate and to view culture-specific disorders as simply minor deviations of prototypic disorders (Marsella & Yamada, 2000).

Post-modern perspectives have led us to the recognition that much of our reality is socially and culturally constructed. We have also become aware of the power of the dominant culture in determining what is acceptable and what is considered deviant.

**The differences in approach can contribute to the challenges we face when working with CALD clients.**

**Think about the system you're working in and the Western framework you're using to work with CALD clients. Is the system or the framework you are using creating some of the barriers/challenges you have listed in the earlier section?**

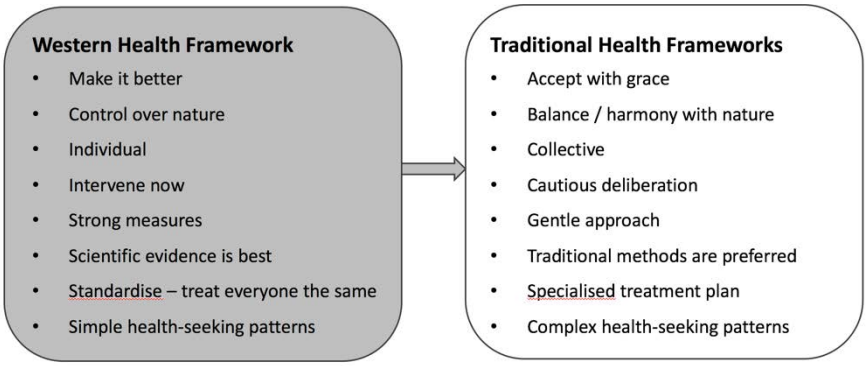
**System challenges such as:**

- No available interpreter to match the client's language
- No available translated information
- No language-matched cultural workers to support complex cases

**Framework challenges such as:**

- Western recovery concepts do not align with client's concept eg using individualistic Western competency indicators to evaluate client's recovery status
- Expectation that client's will meet Western oriented recovery goals eg self-efficacy, making own decisions, making own choices, independence.
- Biomedical and biopsychosocial systems versus traditional remedies or methods

**The following diagram outlines some of the differences between the Western Health Framework and Traditional Health Frameworks:**




## Cross-cultural Meta-skills

Meta-skills are critical to working with CALD clients in a mental health context. These are therapeutic skills over and above the basic skills of active listening, tone, paraphrasing, open-ended questioning etc. The use of meta-skills draws on the universal qualities of compassion, empathy, respect, the ability to remain neutral detached from a specific outcome, and honest and sincerity in relating.

- Sincerity – do you mean what you are saying?
- Respect – how are you treating this person?
- Empathy and compassion – this person is another human being, work from the heart.
- Neutrality – no bias.
- Detachment – from a particular outcome.

# Cross-cultural Issues in Assessment

Regardless of the professional discipline or the type of service, clinicians need to assess whether or not a person is suffering from a mental illness. If they are either formulate a diagnosis, recommend or provide treatment, or make a referral.

When engaging with a CALD client it is important to have awareness and knowledge of the potential areas of difficulty that often arise during a cross-cultural assessment.

## Western Frameworks

Western-trained practitioners assess clients and make mental health diagnoses from the perspective of Western diagnostic frameworks which are based on the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) or the International Statistical Classification of Diseases and Related Health Problems (ICD-10) (American Psychiatric Association (APA), 2013a; WHO, 1992). The DSM-V is the reference manual used in New Zealand in mental health services, providing a common language for clinicians and for referral purposes.

Clinicians who are not required to make a formal diagnosis often carry an internalised diagnostic template based on these commonly used systems.

**The implication is that all behaviour and symptoms are evaluated against a Western conception of mental health and illness which splits mental and physical illnesses. This has serious implications for cross-cultural psychiatry.**

## Concept of Self Differs


The concept of self differs across cultures. Whether a culture has collective or individualist values has a significant bearing on how people conceive of themselves. In collective cultures, the concept of self or 'I' is more inclusive than that of Western cultures – there is an interdependent experience of being. The Western or individualist sense of self is more associated with an independent and bounded experience.

In most collective cultures, when people refer to 'I', they usually mean 'we', with the 'self' encompassing a variety of significant others leading to the collateral or unindividuated self. In many cultures, the collective self takes priority and is superior to the individual self. In some cultures (such as Japanese) a sense of 'I-ness' or 'I want' seldom exists. For example, Japanese and Korean peoples depend on each other to sense what the other person needs or wants (Mehraby, 2004). Social and situational issues are likely to play a more important role in mental illness for a person from a collective culture, whilst internal attributes will play a greater role for those from more individualistically-oriented cultures.

The example of depression demonstrates well how a sense of "self" impacts on expressions of mental health. In non-Western cultures, being depressed does not involve the existential elements of personal meaninglessness, worthlessness or suicidal ideation. The collective identity tends to shape and limit the experience to somatic or interpersonal domains (Marsella & Yamada, 2000). Andary et al. (2003) give an example of an Indian 'Ayurvedic' practitioner's response to the news of a youth suicide when visiting Australia. He was

surprised that a young person had committed suicide because of feelings of alienation and low self-esteem. He commented that he would expect an unmarried woman who became pregnant to commit suicide because of the shame it brought to her family but not a young person who was blameless. This example illustrates the impact of culture on suicidal behaviour across cultures.

**As a person moves into a new culture their values and concepts may change in order to fit into the new environment. However, the core values such as the concept of self does not change so easily. It is therefore important that clinicians do not assume a client has the same values as the host culture.**

## Aetiology


Cultural factors are often seen as having a causative role in psychiatric disorders and addictions. Acculturation for migrants and refugees is a stressor in itself due to the rapid and demanding adaptation this requires. For some, the demands may be too high, especially when combined with other factors common to migrants and refugees. Racism, discrimination, social isolation and intergenerational conflict in the family can also contribute to the onset of mental disorders. For refugees, other factors may include loss, torture, trauma and settlement challenges.

Some cultural and religious practices or beliefs can provide psychological support and a source of strength for newcomers for example belief in:

- Inshallah – it is the will of God/as God wills it.
- Karma – a circumstance determined by previous actions.

**The absence of familiar cultural supports after migration, along with changes in the standards of normality and abnormality, can also be implicated in the aetiology of mental disorders. Differences in the conception of self also contribute to how an individual experiences reality (as alone or connected) and may influence symptoms that lead to mental disorders.**

## Ethno-cultural Variations in Expressing Distress

**Communication**

**Understanding the cultural context of communication is critical in mental health as there is so much variation in the way different cultures express and communicate distress.**

Understanding the expression of emotion is particularly complex. Surveys indicate that clinicians rate their skills in accurately recognising emotions and emotional syndromes more poorly when their clients are from cultures different from their own (Andary et al., 2003).

Western cultures tend to rely heavily on verbal communication, while collective cultures tend to use more non-verbal communication. Understanding or interpreting non-verbal communication in any culture brings its own challenges since much of a message can be physical or internalised and requires some sensitivity and skill on the part of the listener to read or even recognise the cues. However when it comes to cross-cultural communication in a mental health context, a clinician is faced not only with differences in individual expression but also with verbal and non-verbal expression and then with the cultural variations of these. For example, clinicians in an Australian survey expressed concerns about whether they were misinterpreting South-East Asians' reticence to display emotion as showing signs of a depressive disorder (Andary et al.,2003). In the same study, clinicians were concerned as well about interpreting Mediterranean clients' more 'expansive' expression of emotion (as compared to Australians) as indicative of the elevated mood associated with bipolar disorders. Similarly, clients expressed concern about being appropriately understood by clinicians of a different culture.

**Interpretation of expression**

**The interpretation of emotional expression, and the conclusions that clinicians draw about the affective state of the client, impacts on diagnostic and treatment considerations.**

Understanding that some mental distress may have unique presentations that are cultural in origin can assist with mental health screening and help avoid misdiagnosis. Cultural understanding of these symptoms can help build a therapeutic alliance with a client.

Just as standard screening instruments can sometimes be of limited use with culturally diverse populations, so too are standard diagnoses. Expressions of psychological problems are, in part, culturally specific, and behaviour that is aberrant in one culture can be standard in another. For example, seemingly paranoid thoughts are to be expected in clients who have migrated from countries with oppressive governments. It's important to consider that

behavioural phenomena that may be defined as mental illness in a Western context may be cultural in origin and understood differently in this context.

Culturally rooted groups of symptoms previously referred to as "culture-bound syndromes," are called "cultural concepts of distress" in DSM V (Kohrt et al., 2014). These cultural concepts of distress may or may not be linked to particular DSM V diagnostic criteria (APA 2013a). DSM V lists some cultural concepts of distress but other concepts exist that are not recognized in DSM V (APA 2013d). Cultural concepts of distress comprise three areas (APA, 2013a, p.758):

- **Cultural syndromes:** Clusters of symptoms that tend to co-occur in certain cultural groups, communities, or contexts.
- **Cultural idioms of distress:** Ways of communicating emotional suffering that do not refer to specific disorders or symptoms, yet provide a way to talk about personal or social concerns. Frequently these manifest as physical symptoms (somatisation).
- **Cultural explanations:** Symptoms, illness, or distress are perceived by a culture as having specific, local origins or causes.

Depression is an example of a cultural concept. For Western clinicians, major depressive disorder (MDD) can be considered a "syndrome," or cluster of symptoms that appear to "hang together". But depression can also be considered an "idiom of distress," in the sense that Westerners commonly talk of feeling depressed in everyday life. The label "depression" can imbue a set of behaviours with a particular meaning. No single concept maps onto a specific psychiatric disorder, and conversely, no single psychiatric disorder (eg MDD) maps onto a cultural concept (eg Shenjing shuairuo-neurasthenia). Each illness has to be assessed in its own right. Clinicians must not only draw from diagnostic experience, available categories of illness, and the various dimensions along which aspects of the illness may range, but also recognise and try to understand the client's cultural understanding of the illness. The information provided throughout DSM V and particularly in the cultural formulation chapter, can help practitioners avoid misdiagnosis, obtain clinically useful information, improve clinical rapport and promote therapeutic efficacy (APA, 2013a).

**Examples of APA (2013d) defined cultural concepts of distress are:**

- **Shenjing shuairuo (neurasthenia) - Chinese**

  A condition characterised by physical and mental fatigue, headaches, difficulty concentrating, dizziness, sleep disturbance, and memory loss. Other symptoms include gastrointestinal problems, sexual dysfunction, irritability, excitability, and autonomic nervous system disturbances.

- **Taijin kyofusho - Japanese**

  Avoiding interpersonal situations due to intense fear that one's appearance or actions give offense to others. "Sensitive type" relates to anxiety about interpersonal

interactions, while "offensive type" relates to concern about offending others. Related DSM disorder: Social anxiety disorder and obsessive-compulsive disorder

- **Kufungisisa-Shona - Zimbabwe**

  Kufungisisa ("thinking too much") is an idiom of distress and a cultural explanation among the Shona of Zimbabwe. As an explanation it is considered to be causative of anxiety, depression and somatic problems (eg "my heart is painful because I think too much"). As an idiom of psychosocial distress it is indicative of interpersonal and social difficulties (eg marital problems, having no money to take care of children). Kufungisisa involves ruminating on upsetting thoughts, particularly worries. Kufungisisa is associated with a range of psychopathology including anxiety symptoms, excessive worry, panic attacks, depressive symptoms and irritability.

**Non-universality of emotional concepts**

**Another incorrect assumption is that emotional concepts are universal. Both the manifestations as well as the meanings of emotions are culturally determined, and the language constructs used to express these differ enormously across cultures. Some cultures have no equivalent concepts or terminology for those used in another culture. For example, there is no word in the Chinese language to express what Westerners refer to as anxiety.**

Some cultures may have many descriptions for a concept expressed by only one or two words in another. A relatively well known example is that of the many words in French used to express 'love'. Another example is of the Aboriginal Pintupi translations for sad (Andary et al., 2003). There are at least five words used to express concern and feeling of sadness – for worry about the land, worry and concern about relatives, sadness at their absence and in sympathy for them. One of these translations (Yulatjarra) might involve self-wounding as 'sorry-cuts', which is seen as normal. This example illustrates how concepts themselves may differ and there may be culturally sanctioned behaviours associated with these concepts which are different to Western norms.

In addition to cultural differences in expression there are also differences in the value of emotions. Some cultures emphasise different emotions because they have specific values. There is also a difference across cultures regarding the conditions that elicit emotions. For example, being told what to do can elicit anger in some cultures and deference in others.

## Somatisation

Another way distress can be expressed is through somatisation.

**Somatisation generally refers to the presence of physical symptoms where there is no physical pathology evident – the body becomes the vehicle for the expression of the social or emotional distress (Kirmayer et al., 2003; Kirmayer & Young, 1998).**

Somatisation of psychological or psychiatric symptoms is reported to occur more often in those from collective cultures. However the term may be a misnomer since the concept of somatisation derives from the distinction Western cultures make between mind and body. Many cultures do not make the distinctions between the physical and non-physical aspects of self in the way Westerners do.

**Western psychiatry tends to categorise thoughts and emotions as the domain of the individual. Collective cultures usually do not see the emotions as internal to the individual, but rather as inter-personal experiences. This has particular bearing on the diagnosis of depression.**

When the term 'somatisation' is used clinically (within a Western framework), it infers various underlying processes:

- A group of psychiatric disorders (somatic symptoms and related disorders in DSM V) (APA, 2013a).
- The conversion of psychological conflict into physical symptoms.
- The externalisation of cognitive responses to stress.
- A pattern of behaviour in which emotional or social problems become obscured or denied (in some psychodynamic views, an immature defence).
- A coping mechanism in anthropological and cultural psychiatry.
- A means to describe feelings of sadness or distress in the absence of words or concepts.

These distinctive concepts tend to be operationalised in research as medically unexplained somatic symptoms as hypochondriacal pre-occupations and somatic presentations of anxiety or other psychiatric disorders (Kirmayer & Young, 1998).

Additionally we have the following issues:

- **Western psychiatry asserting psychological expression over that of somatisation**

Western psychiatry asserts the superiority of psychological expression over that of somatisation. However, as there is no conclusive empirical evidence to support this position the primacy given to psychological processes over physical expression has little use in understanding non-Western cultures.

- **Many collective cultures de-emphasising the psychosocial aspects to avoid the stigmatisation of mental illness**

  The cultural context is pre-eminent. Somatising is often a socially sanctioned expression. Some migrants may come from countries with limited health services where mental illness is associated with extreme states and where there may be no familiarity with psychiatric diagnoses. Many collective cultures avoid the stigmatisation of mental illness by de-emphasising the psychosocial aspects of their distress. This does not imply that they do not experience emotional or psychological symptoms, but rather that they choose not to make them the focus of their distress nor of the clinical consultation. In some cultures, an emotional state may be conceptualised as an interpersonal phenomenon rather than an intrapersonal experience. Ultimately, if we are to accept a systemic model all human experience impacts every level of the system – physically, cognitively, emotionally, socially, spiritually and environmentally.

  How people express the experience or distress (somatically, psychologically or spiritually), the meaning this has for them (individually and culturally) and the forms that the expression takes (contained or expanded). This is what differs across cultures.

**It is the task of the clinician to decipher the cues, to contextualise these and then to discern how best to facilitate healing.**

## Ethno-cultural Identity


Individuals may differ in the extent to which they identify with and endorse their own cultural traditions.

Cultural identity holds great meaning to a person. If the clinician is to develop a sound cultural formulation of the client's presenting complaints, the depth of their cultural identity needs to be ascertained.

**The implication is that ethnicity is not as important when understanding perspectives and explanations as the degree to which a person identifies with the beliefs and practices of a group.**

For migrants and groups that are subject to additional (and sometimes multiple) cultural influences, there can be significant variation in the extent to which they identify with traditional cultural values. Some migrant clients may be bicultural in their degree of acculturation, others may be fully acculturated and some may maintain a strong traditional identification. It is particularly important to ascertain cultural identity when evaluating cultural aspects of mental illness and when using Western standards for assessment, diagnosis and treatment. The DSM V gives cultural identity priority in the guidelines for cultural formulation (APA, 2013b; 2013c).

Ton and Lim (2006) also note how advantageous it is to establish cultural identity in a clinical assessment. It not only identifies sources of strength and support that are useful in treatment but also identifies potential sources of cultural conflict.

**By enquiring about the whole person (and not just about the illness), a deeper understanding of the client's world view can be gained and thereby a greater rapport can be developed.**

## Explanatory Models

Different cultures have different ways of understanding illness and will attribute different causes for the origin and symptoms of their illness. Explanations of illness are explained strongly influenced by cultural values. To a large degree, these values also define the acceptable symptoms of the illness as well as the behaviour, expression and role of the sick person. Explanatory models also contain elements of prognosis, the general course the illness is likely to take and some ideas about treatment.

**Why we need to understand the client's explanatory model**

- Beliefs about the illness might determine whether or not a client seeks help at all
- Clients from ethnic communities often only present once the illness has progressed to an acute stage
- Culturally appropriate beliefs can be misunderstood as psychopathology
- The severity of a disorder can be misjudged
- Cultural explanations will often reveal culture-bound syndromes
- Appropriate treatment depends on accurate diagnosis

**It is critical that a clinician takes time to understand the client's explanation for their illness as well as to share some of their own perspectives with the client. The chances of misdiagnosis are higher if the clinician is unclear about the client's understanding of their illness. The success of intervention and adherence will depend to a significant degree on the formation of a collaborative model that is acceptable to both client and clinician.**

**Explanatory models of mental illness outlined by Ton and Lim (2006) and Kirmayer et al. (2003) include:**

- **Biomedical (scientific) model**

  Biological causes are seen to be the basis for illness. This model is characteristically used in Western allopathic medicine.

- **Humoral/balance model**

  Based on the theory that the human body is filled with four basic substances called humors and that all diseases, illness and disabilities result from an excess or deficit of one of these humors. Treatments could include Traditional Chinese Medicine (TCM), Ayurvedic medicine and various herbal medicine traditions.

- **Moral model**

  This model involves the belief that the condition is caused by a moral defect such as laziness, weak will or selfishness. Families sometimes use this model as well as the client.

- **Spiritual/religious model**

  This holds that illness results from spiritual or religious transgressions or from unmet religious obligations. Offended spirits, gods or God bring punishment. Religious leaders may be involved in treatment.

- **Supernatural model**

  Sorcery, witchcraft or other supernatural elements are seen to cause illness. Treatments vary across cultures and may involve either finding the person who placed the curse or a shaman to lift or counteract the spell.

- **Psychosocial stress model**

  This model attributes illness to overwhelming psychosocial stressors. Treatment would include addressing the stressors.

- **Combined models**

  Individuals often have explanatory models based on one or more of the above, and many combine traditional and biomedical models.

  Some people's models are fixed, while others' models might be ill-defined and not necessarily easily articulated to a practitioner. Kirmayer et al. (2003) note in a report on a cultural consultation service that explanatory models were not central to case formulations because most clients used pluralistic explanations. What created difficulties were the conflicts that arose between clinicians' and clients' explanations when clinicians were too attached to their own perspectives. They point out the possibility that clients who used traditional explanations exclusively may be less likely to consult mainstream health care services. Therefore it is essential that clinicians remain open to other explanations of illness and are able to integrate these with their own explanations in order to maintain adequate trust and rapport for assessment and treatment to continue.

  Kleinman (1980) identifies three overlapping cultural sectors that influence people's explanations of health and illness:

  - The most influential originates in the 'popular sector' and consists of information from friends, family and community, and common wisdom and knowledge.
  - The second is from the professional sector and is based on Western biomedical knowledge and technology.
  - The third originates in the folk sector, consisting of spiritual and secular healing systems.

## Help-seeking patterns

Less acculturated migrants often perceive their health problems in relation to their own health belief model. As a result they may communicate their understanding of their health issues in a manner that does not coincide with modern Western scientific history gathering. Depression or anxiety disorders are not seen as mental health issues and therefore they can be somatised as not sleeping well, feeling lethargic or having increasing heart palpitations etc. Less acculturated migrants may seek help from traditional health practitioners for these symptoms.

**It is important to ask your migrant clients about their understanding of their illness, health issues, and previous or current alternative treatment methods of practice.**

This pattern applies to migrants who value traditional therapies or treaments over more western biomedical models.

Health Seeking Migrant

Migrants often label illness according to their social and cultural knowledge. They often seek help from traditional therapists/doctors/healers/ religious leaders (if available) before seeking help from a NZ health practitioner or service.

No, migrant may reassess problem

Patients may self-medicate with herbal or traditional medicines; practice meditation, yoga, spiritual divination; or undergo traditional cleansing, cupping, scraping, acupuncture etc.

Is the health problem solved?

No. Migrant seeks help from GP, Emergency Department or other health service.

If traditional solutions are not successful, migrants expect the NZ health system to provide:
1) Prescriptions or injections (even IV drip for fever).
2) Practical and immediate solutions to alleviate symptoms – especially if they are paying money for the service. They are less interested in receiving health advice or talking through the problem.

Yes

Migrant continues with traditional intervention and does not seek help from the GP or other western health service (eg. mental health service).

Migrant often presents with more advanced stage of illness or acute symptoms. If not asked directly, migrant may not disclose any information about previous treatments or traditional healing interventions.

Can the NZ practitioner find out, consider and accommodate different health beliefs or practices?

Yes

Culturally competent health practitioners are aware of the coexistence of difference health models and will take time to enquire about the patient's practice of such techniques.
They take time to explain the western biomedical model and see if both practices conflict or can accommodate each other.

A NZ practitioner who is culturally competent will: ask about the patient's background; reframe illness in relation to the patient's understanding; ask about the patient's beliefs and treatment practices and explain any conflicts or risks to ensure successful care of the patient.

No

Migrants who find the western biomedical models of treatment do not meet their expectations may agree with the practitioner during the sessions, but may not comply and may even terminate treatment or engagement. They may either return to traditional methods or seek out a practitioner who will fulfill their expectations of a practical solution or a prescription. This may lead to the patient becoming critically ill and presenting with even more acute issues later on if the traditional methods are not effective.

## Culture-bound syndromes

The Diagnostic and Statistical Manual of Mental Disorders (DSM V) or the International Statistical Classification of Diseases and Related Health Problems (ICD-10) (American Psychiatric Association (APA), 2013a; WHO, 1992) includes information on cultural concepts in order to improve the accuracy of diagnosis and the comprehensiveness of clinical assessment. Clinical assessment of clients presenting with these cultural concepts should determine whether they meet DSM V criteria for a specified disorder or another specified or unspecified diagnosis. Once the disorder is diagnosed the cultural terms and explanations should be included in case formulations; they may help clarify symptoms and aetiological attributions that could otherwise be confusing. Clients whose symptoms do not meet DSM criteria for a specific mental disorder may still expect and require treatment; this should be assessed on a case-by-case basis. In addition to the Cultural Formulation Interview (CFI) and its supplementary modules, DSM V contains the following information and tools that may be useful when integrating cultural information in clinical practice (APA 2013a; 2013b; 2013c; 2013d):

- **Data in DSM V criteria and text for specific disorders:** The text includes information on cultural variations in prevalence, symptomatology, associated cultural concepts and other clinical aspects. It is important to emphasize that there is no one-to-one correlation at the categorical level between DSM disorders and cultural concepts. Differential diagnosis for individuals must therefore incorporate information on cultural variation with information elicited by the CFI.
- **Other Conditions That May Be a Focus of Clinical Attention:** Some of the clinical concerns identified by the CFI may correspond to V codes or Z codes—for example, acculturation problems, parent-child relational problems, or religious or spiritual problems.
- **Glossary of Cultural Concepts of Distress:** Located in the Appendix and this glossary provides examples of well-studied cultural concepts of distress that illustrate the relevance of cultural information for clinical diagnosis and some of the interrelationships among cultural syndromes, idioms of distress and causal explanations.

Understanding the cultural context of illness experience is essential for effective diagnostic assessment and clinical management. Cultures are open, dynamic systems that undergo continuous change over time. In the contemporary world most individuals and groups are exposed to multiple cultures which they use to fashion their own identities and make sense of experience. These features of culture make it crucial not to overgeneralise cultural information or stereotype groups in terms of fixed cultural traits (DSM V, 2013a).

**Please refer to Appendix 2 for the Table of Culture-Bound Syndromes which list syndromes that occur in African, Asian and Middle Eastern cultures.**

## CALD Assessment Tool

**In this section, we discuss the Guidelines for Formulation from the DSM V:**

A. Cultural identity of the individual – we look at how to explore the cultural identity of the individual.

B. Cultural explanations of the individual's Illness – we look at how important the client's explanation of their illness is, how to establish this and common models of explanation.

C. Cultural factors related to the psychosocial environment and levels of functioning – we look at cultural social stressors, supports and levels of functioning and the roles of religion and family networks.

D. Cultural elements of the relationship between client and clinician – we explore the difference in culture and status between the client and clinician, and the challenges that these differences may have in diagnosis and treatment. This includes being aware of issues such as transference, counter-transference, the common factors framework and the clinician's own cultural background and preferences.

E. Overall cultural assessment for diagnosis and care – we discuss how cultural considerations influence comprehensive diagnosis and care. This includes therapeutic intervention and a holistic treatment plan.

### Rationale for Cross-cultural Assessment

Cross-cultural assessment is a complex and challenging aspect of mental health. Most of the difficulties are generated by using predominantly Western-oriented concepts, tools and standards for CALD clients. As a guide to assessment and diagnosis the DSM V provides an outline for developing a Cultural Formulation.

The following information offers an assessment tool (CALD Assessment Tool) and additional information for working with DSM V guidelines to help practitioners avoid misdiagnosis, obtain clinically useful information and improve clinical rapport and therapeutic efficacy with their clients (Andary et al., 2003; Ton & Lim, 2006).

The five criteria for Cultural Formulation are as follows (APA, 2013a, p. 749-750):

A. Cultural identity of the individual.

B. Cultural explanations of the individual's illness.

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

D. Cultural elements of the relationship.

E. Overall cultural assessment for diagnosis and care.

**The CALD Assessment Tool provides questions that can be used to elicit information in three of the DSM stages of the cultural formulation – A, B and C. The questions are adapted from Dr Sanu Pal (2008), a transcultural psychiatrist, and Benson and Thistlethwaite (2009). A complete copy of these is provided in Appendix 1.**

## About the CALD Assessment Tool

The CALD Assessment Tool comprises a series of questions designed to help you to elicit cultural information for assessment and eventual diagnosis and treatment. The tool aligns with parts A, B and C of the DSM V "Outline for Cultural Formulation -1" (APA, 2013, p. 749-750). This tool is divided into the three corresponding sections for Part 1 of the APA (2013a) cultural formulation tool.

**It will be important to begin your assessment with a preamble about the service, an explanation of the clinician's role and some social conversation in order to set the client at ease. The order of the CALD Assessment Tool questions can change in each section and not all the questions will be necessary with each client. Also adjust your questioning style to suit the client or family, their age, education levels and language proficiency.**

### Cultural Identity

**This part refers to Part A of the DSM-V Cultural Formulation Tool – Cultural Identity of the Individual** (APA, 2013a).

As well as establishing the cultural identity of the client, it is also necessary to know their ethnic identity. While people may have a clear ethnic/cultural identity (an embedded internalised individual core identity), they may also subjectively identify with a different group or different values. Some people will have had multicultural exposure and either identify with a group that differs from the one expected or with different aspects of different cultures. Sensitive enquiry will reveal subtle differences. Take care not to assume that the client was born overseas.

To ascertain cultural identity it is important to ask questions about migration, language, gender issues, age, sexuality issues, religious/spiritual beliefs, socioeconomic class and education and the acculturation process.

## Migration

**This part refers to Part A of the DSM V Cultural Formulation Tool – Cultural Identity of the Individual (APA, 2013a).**

Knowing something about the history of the client's culture and of any tribal or ethnic conflicts may help avoid making assumptions or comments that are inappropriate or offensive. It may also help avoid engaging an interpreter of an ethnicity unacceptable to the client or family. For example, a Chinese person from Hong Kong would usually prefer not to be regarded as a Chinese person from China and vice versa.

Suggested questions to help to establish how your client came to this country:

- How did you (and your family) come to New Zealand?
- Why did you leave your home country and who made the decision? (Explore duration, with whom they migrated, any significant family member(s) left behind).
- Was anything left behind?
- What was your journey like? (This can bring up sensitive issues of trauma. Explore past trauma and grief – don't avoid these issues).
- How did you leave? (This can bring up sensitive issues of immigration status. You could say: "Is your legal status a source of stress for you? I know that many people are afraid to get the services they need because they do not have legal status. This can put them in a stressful situation that affects their health. It is helpful for me to understand the challenges you are facing"?).

It is important to realise that identities develop in different contexts relative to conditions and that migration may influence this. For example, a migrant may have become part of an 'ethnic minority' although they may never have heard the term before they arrived here. People also often identify more (or less) strongly with their cultural group after migration.

Elements of the client's migration history can be useful in understanding cultural identity. This history may provide information about the reasons for migration, the time and circumstances of the journey as well as loss and trauma pre- and post-migration (Kirmayer et al., 2011). This will be especially important for refugees whose circumstances have often involved violence and war. It's also important to understand levels of acculturation and whether the desire/need for acculturation is externally or internally driven. This could help identify potential areas of strengths and supports.

## Language

**This part refers to Part A of the DSM-V Cultural Formulation Tool – Cultural Identity of the Individual** (APA, 2013a).

Questions about language will indicate something about acculturation, education levels and language preferences.

Suggested questions to ask to establish your client's language proficiency:

- What language do you speak at home? With elders? With children Or with sisters and brothers? With your friends?
- Did you learn any foreign language or second language in your home country?
- In what language did you have your education (primary/ secondary/tertiary)?
- What language do you prefer your children to learn?
- Do you think children should learn their mother tongue as well?
- What language (mother tongue or host language) do you prefer to use when socialising with friends or relatives?

These questions ascertain how comfortable the client is in speaking the host language. While they may be comfortable speaking English for an official or professional visit, they may not be able to express themselves as well when discussing issues that cause them distress or that may not have a direct translation into English. They might find it easier to express themselves in their own language.

Note that one of the first decisions a practitioner needs to make in conducting an assessment is what language this should take place in. If the client and clinician do not speak the same language or the client does not have proficient English language skills an interpreter needs to be engaged. A culture-appropriate and language-appropriate interpreter should be engaged if necessary. The "CALD 4 Working with Interpreters course" is recommended to health practitioners to enhance essential knowledge and skills to work effectively with interpreters.

**Allow extra time in the session if an interpreter is booked.**

## Cultural Practices

**This part refers to Part A of the DSM V Cultural Formulation Tool – Cultural Identity of the Individual** (APA, 2013a).

Suggested questions to ask to establish your client's cultural practices:

- These days, how much are you able to practise your traditional way of life? (This could include socialisation with own people, dress codes, greetings, participation in festivals, practising ethnically oriented family roles, restrictions imposed by traditions.)
- Explore ethnically shaped developmental experiences: Can you remember some of your childhood experiences and tell us some of them? Did you feel any change when you reached adolescence or adulthood? (Explain in regard to your cultural norms or practices.) Is there any special activity, ritual or social function you have gone through that you can remember? (Enquire about special rituals or rites of passage.)
- How are you adjusting or maintaining conventional family roles in the new environment? (Enquire about ethnically prescribed family roles.)
- Do you maintain traditional dress codes at work? At home? At any family functions or festivals? (Enquire about traditional dress codes, special greetings.)

Establishing your client's cultural practices will highlight the traditions that are most important to them. We all tend to turn to our core cultural practices in times of stress or distress – understanding your client's traditions and practices may shed light on how they understand their disorder and how they would like to manage it. It can also give further insight into their level of acculturation.

## Gender

**This part refers to Part A of the DSM V Cultural Formulation Tool – Cultural Identity of the Individual** (APA, 2013a).

Suggested questions to ask to establish your client's attitudes about gender roles:

- Do you think men and women should have different roles? Can you describe or give examples of some of the roles?
- Who in the family should be making key decisions (eg managing finances, buying a house)?
- Is there any hierarchy maintained in the family? (That means some family members have preference to others for certain things or activities.)

Understanding attitudes to gender differences can help clarify traditional roles or expectations.

## Family Roles

**This part refers to Part A of the DSM V Cultural Formulation Tool – Cultural Identity of the Individual** (APA, 2013a).

Suggested questions to ask to establish your client's attitudes about age:

- What do you think about elders' roles in the family? Do you think these are changing in your family after migration? If yes, can you give an idea how? What used to be the role in your home country?
- What do you think the role and responsibility of younger people in the family are now after migration? Have there been any changes? Can you tell us about these?

These questions help further understand how the client and their family have changed since migrating. Answers here could highlight key relationships, acculturation issues, change in status for the client or key members of their family.

## Sexuality Issues

**This part refers to Part A of the DSM V Cultural Formulation Tool – Cultural Identity of the Individual** (APA, 2013a).

Suggested questions to ask to establish your client's attitudes about sexual roles:

Ask the question relevant to the person. Sometimes the person may not wish to discuss these in the presence of an elder or younger person, so before you start give a hint, and if agreed, then continue.

- Do you have any sexual preference? (Heterosexual or same sex relationships.)
- What is the unmarried/married/divorced/separated person's status in your cultural community? Have you noticed any change since you migrated? In what way?
- What do you think about using contraceptives? Does this differ for married or unmarried people?
- What do you think about the relationship between men and women living together (de facto relationship)?
- What do you think about sexual relationships outside marriage? Do you think that any changes have happened in this regard to you or your family since migrating?

Remember that raising sexuality issues often needs to be handled with extra sensitivity. These issues may trigger trauma related to sexual assault during refugee flight for refugee men, women and children.

## Religious Beliefs/Socio-economic Class and Education

**This part refers to Part A of the DSM V – Cultural Formulation Tool – Cultural Identity of the Individual** (APA, 2013a).

Suggested questions to help to establish your client's religious and spiritual beliefs as well as socio-economic class and education:

- Do you have a faith or spiritual tradition?
- Did you practise this tradition in childhood?
- Have you changed your religion since then? If yes, can you tell me the reasons for change?
- Do you have any regular religious practices?
- Do you have any food preferences in relation to religious beliefs?
- Do you like to maintain your ethnic dress codes and greetings?
- Have you come across any difficulty with religious practices?
- Did you or your family belong to any social class before migration?
- What do you think of your or your family's social class (in home country) since you have migrated?
- Do you think there is a change in your social class now? If Yes, in what way?

Religious beliefs influence how clients perceive and manage their health. Religious leaders may become included in the treatment team and add additional community support. Note: the "CALD 7 Working with Religious Diversity" provides knowledge about a range of religious beliefs and practices from Islam, Sikhism, Hinduism and Buddhism. It will enhance learners' understanding of the influence of religious beliefs of clients and their families' health, behaviour, and wellness as well as interventions.

## Level of Acculturation

**This part refers to Part A of the DSM V Cultural Formulation Tool – Cultural Identity of the Individual** (APA, 2013a).

Suggested questions to ask to establish your client's level of acculturation:

Assess the acculturation process.

- At what age did you migrate to New Zealand?
- How many years you have been in New Zealand?
- Do you have a job related to your skills? Are you satisfied with your job or what you are doing? If not, what may be the reason?

- Are you comfortable using English for work? If not, what do you think might be the reason?
- Do you attend parties or functions such as birthdays, weddings or going to a friend's place not belonging to your community or culture if you are invited? (Participation in host culture social network.)

Look for major sources of stress in settlement experience in relation to culture.

- Did you have to change the kind of work you did when you arrived in New Zealand?
- Do you think you have had any major changes in relationship with any important person in your life due to this migration?

Ask about stressors in the acculturation and adjustment process.

- Have you experienced any discrimination in regards to education, employment or accessing any service? (Offer the opportunity to give examples.)
- The settlement and acculturation process happens in different ways. What group do you think you belong to now – traditional, transitional, bicultural, host culture (Kiwi)? Could you tell me why?

Acculturation can alter clients' health-seeking patterns, their expectations of treatment and the health system and the number and quality of support networks. However acculturation does not usually change core values, so during highly stressful periods clients may hold strongly to certain traditional ideas and beliefs despite having been settled for many years.

## Cultural Explanations of Illness

**This part refers to Part B of the DSM-V Cultural Formulation Tool – Cultural Explanations of the Individual's Illness** (APA, 2013a).

The client's understanding of their body, mind and illness is likely to differ from that of the clinician, so the clinician needs to work within the client's framework. Explanatory models of illness are particularly important in mental health because beliefs about the illness may determine whether or not a client seeks help and if they do, with whom. For example, if a client or their family does not conceptualise the symptoms as mental illness, they may instead delay seeking treatment or consult a religious leader or traditional practitioner.

Suggested questions to ask to ascertain the clients' explanatory model of illness:

- What do you think caused your problem?
- Why do you think it started when it did?
- What do you think your illness does to you?
- What are the chief problems it has caused for you?

- How severe is your illness?
- What do you most fear about it?
- What kind of treatment/help do you think you should receive?
- Within your own culture, how would your illness be treated?
- How are your family and community helping you?
- What have you been doing so far?
- What are the most important results you hope to get from the treatment?
- When would you like to come back?

Understanding explanatory models can also help prevent misdiagnosis. Culturally appropriate beliefs can be misunderstood as psychopathology. This is important in determining what information should be taken into account when making judgements about what is normal or abnormal in a culture and can avert any differences in beliefs being regarded as psychopathological. For example, in some cultures, it is normal for a person to hear the voice of a loved deceased person; this could be diagnosed as auditory hallucinations.

**An example from clinical practice is of a man presenting in a Buddhist robe carrying Buddhist literature and answering questions in a philosophical way. The clinician assumed he was a monk and assessed him as being depressed. However in a subsequent interview his family expressed concern about his strange dress and behaviour. It turned out that he saw himself as a reincarnation of Buddha with a mission to save the world. It is easy to jump to conclusions based on cultural stereotypes and using cross-cultural assessment guidelines can help prevent making these assumptions (Andary et al., 2003).**

Sometimes the severity of a disorder can be misjudged. In one example, a woman was diagnosed with an acute episode of paranoid schizophrenia and her symptoms remitted quickly (Andary et al., 2003). At the end of her treatment, the client wanted to sacrifice a chicken to repel the curse that she saw as a cause of her illness and this was seen as a further symptom of her delusion. Subsequent consultation revealed that this was a normal cultural practice for treating curses; this information could have avoided her being unnecessarily hospitalised for a longer period.

Appropriate treatment rests primarily on accurate diagnosis; understanding the client's explanatory model is essential for making treatment plans that will be effective.

## Psychosocial Environment

**This part refers to Part C of the DSM V Cultural Formulation Tool – Cultural Factors Related to Psychosocial Environment and Levels of Functioning** (APA, 2013a).

Racial or ethnic discrimination towards your client's community can contribute to relocation stressors and the client's ethnic identification. It is therefore important to explore such discrimination as well as acculturation issues.

Where possible take time to become familiar with what is going on in your client's community and also identify supports and stressors. It is important to ascertain cultural support as well as the common stressors experienced by the cultural or ethnic group such as traditional role reversals in families or between genders.

Suggested questions to ask, to identify your client's supports and stressors:

- What are the major sources of support in your life?
- What are the major stressors in your life?

If there is an indication of possible family violence/abuse, follow with:

- Is your partner a source of support for you?
- Does your partner make you feel bad about yourself?
- Have you (or your children) been hit, kicked, punched or otherwise hurt by someone in the past year? If so, by whom?

If no family violence, continue with:

- Are family members a source of support for you?
- What are some of the family problems that affect you?
- Is it important for you to find a community that fits with your cultural background?
- Have you or your family felt accepted by this community (host or ethnic, as relevant)? Why or why not?
- How respected are your values by the mainstream culture?
- Do you participate in any community religious activity? (If not already answered under spiritual beliefs.) Is there anything stopping you from practising your faith here? Do you think your spiritual or religious influences have hurt you or contributed to your problem? (This may be a major source of guilt or stress.)
- Are there any religious or spiritual resources that could help you overcome your problem?
- Would it be helpful if a religious leader or traditional healer was consulted in your treatment?

Include family members in the assessment. Be aware that sometimes other members will offer information that the client is too shy or unwilling to relate to. Use non-verbal cues and observe family interactions, including in the waiting room, for an understanding of relevant dynamics.

Enquire about individual strengths (faith, skills, cultural knowledge and commitment to own cultural wisdom), family and community-based support (extended family, religious and traditional celebrations and rituals, recreational activities, involvement in political or social groups) and environment-based culturally-related strengths (space and time dedicated to prayer and ritual, dietary preferences, outdoor interests, and access to outdoors for recreation). It is important that psychosocial functioning be assessed across various settings including home, family and the ethnic community as well as the mainstream community.

It may be preferable with some cultural groups or some clients to conduct assessments at home. Mental health issues are commonly stigmatised in CALD communities and this may prevent the client/family from accessing services. Home visits are also useful to assess the client context and family dynamics.

**See Appendix 1 CALD Assessment Tool for a summary of the questions discussed above.**

## Cultural Elements 1

**This part refers to Part D of the DSM V – Cultural Elements of the Relationship Between Client and Clinician.**

Researchers commonly relate low compliance and premature termination of treatment when reporting on challenges in interventions with CALD clients. For many ethno-cultural groups, symptoms relating to depression and anxiety are not seen as psychological or psychiatric problems and so interventions in these domains are often dissonant with cultural perceptions – it is not surprising that some CALD clients do not remain in treatment or follow the plans. The metaphor for compliance is a telling one since it implies the client needs to subject themselves or acquiesce to the clinician's or system's model and does not suggest a collaborative approach (Kirmayer, 2001).

Kirmayer (2001) suggests that collaboration is the key, as well as working with cultural advisors and colleagues from other cultures. Collaboration will not only make it possible to "better identify their patients' problems, but also will uncover cultural resources that can complement and, at times, supplement conventional psychiatric treatment". The relationship between client and clinician, particularly in mental health, will often determine whether a client remains in a treatment process or not.

- In particular, negotiating the differences between explanatory models is critical in maintaining client follow-through. After eliciting the client's explanatory model the clinician needs to find common ground with their own model. Being able to enter into

the world of the client through a common framework will enhance the understanding of the psychological problem and the client's distress as well as assist the acceptance of diagnosis and treatment (Cross & Bloomer, 2010).

- The clinician must also be able to explain the Western model in plain language and be concise about the seven key concerns – name, cause, reason for time of onset, pathology, severity, course and outcome, and treatment (Andary et al., 2003). Metaphors and examples may help explain incomprehensible names, bearing in mind a concept/terminology in one language/culture is not always directly translatable.
- Communicating respect and understanding of the client's explanatory model will go a long way towards their accepting and adapting to a new way of perceiving their situation. Making explicit comparisons and pointing out similarities and differences in the client and clinician models will convey understanding of and interest in the client's culture. The clinician should encourage questioning from the client as this will help in assessing the client's or family's understanding.
- As part of acknowledging and valuing the client's model, working with a religious leader or traditional healer may need to be incorporated into treatment in ways that do not conflict with the clinical treatment.
- It is important to make a distinction between accommodating the client's treatment expectations and adopting the client's model. Andary et al. (2003) point out that a clinician trying to accept a model that they don't believe in is not authentic and can discredit them. Credibility is an important aspect of the relationship, more so for some groups than others. Although credibility is generally enhanced when there is more similarity between the parties, if the person is honest in their communications it is possible to convey respect and acceptance while holding a different approach. For example: "In New Zealand culture, we don't … but I understand that this is important to you and your family and so we can try to include this by …." Respect, credibility and provision of benefit are the important factors in contributing to successful negotiation (Andary et al., 2003).
- Cultural influences on transference and counter-transference in a clinical setting require awareness and management throughout the relationship.

Cross and Bloomer (2010) emphasise the importance of dialogue in a mental health or psychiatric interview. Language problems need to be clearly differentiated from mental health problems and working with an interpreter who is bilingual and bicultural will be essential for some clients. Working with an interpreter and/or cultural case worker can also enhance the therapeutic relationship if the clinician manages the relationship so that a good therapeutic triad is established. Providing an interpreter who speaks the preferred language of the client, who is ethnically appropriate and is competent to work in mental health and maintain confidentiality are important. These principles are covered in the "CALD 4: Working with Interpreters" course particularly the three distinct phases of the session with an interpreter – pre-briefing, structuring the session and post-briefing.

## Cultural Elements 2

**This part refers to Part D of the DSM V – Cultural Elements of the Relationship Between Client and Clinician.**

The clinician should:

- Have awareness of their own cultural background, values and preferences.
- Be self-reflective about their attitudes to the cultural group of the client and the potential areas of bias or prejudice.
- Maintain awareness of transference and counter-transference, and whether these are inter-ethnic, throughout the process.
- Have awareness of potential areas for misunderstanding and ultimately misdiagnosis (ethno-cultural identity of client, differences in Western and non-Western values, differences in conceptions of normality and self, differences in cultural expressions of distress and coping strategies, differences in the professional service delivery models (especially for substance abuse/dependence treatment services), explanatory models of illness, multicultural exposure and the possibility of culture-bound syndromes).
- Have some knowledge of the client's culture. Build rapport by talking or asking about the client's country/culture. (A quick internet search will usually reveal enough information to start a conversation).
- Seek consultation if difficulties with engagement, follow-up or adherence are experienced or if there are negative transference and counter-transference issues. If there are any cultural factors that could adversely affect the therapeutic relationship and the treatment phase, these MUST be addressed or an alternative referral for the client made.
- Have a dialogue with the client about their treatment experience and needs:
    - What is their motivation for seeking treatment? (Have they come under pressure from someone else?)
    - What do they expect from the clinician? Do they feel they can speak freely? Do they feel able to make their own decisions in collaboration with the clinician?

      Is there a preference/need for a particular gender of practitioner or for a practitioner of a similar cultural background?
    - Are they comfortable with the clinician/therapist?

## Skills

**Pointers for engaging in therapeutic interventions:**

- Take time to establish trust and rapport (using principles offered throughout this course).
- Maintain authority and credibility (particularly with Asian and Middle Eastern cultures) but be modest and able to disclose appropriately.
- Discuss cultural differences (Paniagua, 2005).
- Avoid confrontation or questions that may be too direct.
- Maintain unconditional regard for the individual and the family, and communicate this regard verbally or through actions, for example, by arranging a home visit.
- Be sure to understand the client's explanatory model of illness and treatment expectations.
- Collaborate with the client to reduce shame, to manage the fear of seeking help (especially for substance abuse/dependence clients) and achieve goals.
- Check with the client and/or the family that the therapeutic relationship is working and that expectations are being met.
- Understand how the client's culture views symptoms and approach these appropriately. (If it is not usual for them to identify feelings, work with the behaviour and thoughts that are associated with somatic expressions.)
- Use euphemisms or culturally appropriate analogies, phrases and stories. (Also find myths or common stories from the client's culture to illustrate.)
- Use cultural assets to lower risk (family as support, sense of responsibility to family if person is suicidal).
- Encourage culturally endorsed coping skills (going to temple, rituals and activities).
- Provide appropriate cultural escape routes.

## Transference Issues

When working with mental health clients it is important to be alert to and to manage transference issues. Transference happens when the client transfers feelings towards the clinician. It can also take place amongst the triad (clinician-interpreter-client) when working with an interpreter.

**Counter-transference**

Counter-transference happens when the clinician transfers feelings onto the client. When there is an ethno-cultural difference between client and clinician, counter-transference may

result in either a denial of cultural factors, or an inordinate attention to the client's cultural background. This may lead to the exclusion of other clinical issues, and guilt, pity or aggression towards the client.

**Inter-ethnic Transference**

Inter-ethnic transference is the client's response to a clinician from a different ethnicity. Inter-ethnic transference may result in over-compliance, denial of culture and ethnicity, mistrust or hostility, and ambivalence.

**Auto-racism**

Where the ethnicity of the client and clinician is matched, transference can take the form of auto-racism. This is where the client identifies their group as inferior and believes they are therefore receiving inferior treatment, or they over-idealise the clinician because of the shared cultural background.

Alternatively, the clinician may distance themselves in an attempt not to over-identify, or develop cultural myopia, by framing the problem in cultural terms to the exclusion of clinical factors.

Triggering of issues for the clinician – the clinician can develop anger, guilt and ambivalence if the client's experiences trigger similar and unresolved ones of their own.

## Overall Cultural Assessment for Diagnosis and Care

**This part refers to Part E of the DSM-V Cultural Formulation – Overall Cultural Assessment for Diagnosis and Care.**

The overall assessment needs to be integrated to present the key issues from the previous sections. It is important to identify what cultural or ethnic factors might predispose the client to their current problem.

Making a cross-cultural diagnosis is challenging given the complex variables involved – in particular, the possibility of culture-bound syndromes. However a rigorous cultural formulation will assist clinicians and clinical teams to establish a competent differential diagnosis, and a culturally congruent treatment plan.

The treatment plan may involve culturally specific elements (such as a traditional healer, family involvement), appropriate application of ethno-pharmacological principles, the engagement of interpreters and/or cultural advisors, and the use of culturally appropriate services or cultural consultants/culturally competent teams.

**Issues to consider in developing the formulation:**

- What is psychopathological and what is cultural?
- Many psychiatric disorders such as mood, anxiety, conduct, adjustment, somatoform, dissociative and personality disorders can present differently across cultures.
- Presentation of psychotic, bipolar and substance abuse disorders may vary less so.
- Delusions must be incongruent with culturally held beliefs and values.

**Issues to consider when integrating the information:**

- The narrative of cultural factors needs to reflect the client's worldview, their explanatory model of the illness/disorder and their expectations.
- How the cultural formulation will affect management.
- Whether the type of treatment recommended is congruent with, and appropriate to, the client's cultural experience.
- Whether to include psychopharmacological interventions as well as psychotherapeutic frameworks, the family (or not), the participation of religious and community elders and the engagement of an interpreter or a cultural case worker.

**Inattention to any of these factors can result in non-adherence or premature termination of treatment as well as client dissatisfaction.**

## Applicability of Therapeutic Treatments

**Selecting ethical treatment choices**

In Western medicine it is a common practice to treat psychological and psychiatric problems with pharmacotherapy, individual psychotherapy and/or psychoeducation. However these modalities are not suited to all cultures' worldviews, values or practices, and finding the best approaches within and outside of these modalities is necessary. The practice of medicine is increasingly culturally pluralistic in nature requiring that governing bodies sanction the incorporation of complementary and alternative therapies.

Within a Western psychotherapeutically-oriented environment, the following frameworks may be more useful than traditional psychodynamic approaches:

- Story-telling and narrative therapy is a culturally responsive framework for many CALD groups, particularly those who have strong oral traditions (some collective cultures).
- More directive counselling styles (such as cognitive behavioural therapy – CBT) may suit clients from collective cultures where there is high power distance (such as Asian and Middle Eastern clients). In these approaches the therapist is seen as the expert and is expected to direct the treatment. However, other therapeutic approaches can be

integrated into treatment as long as the therapist meets the primary expectations of the client. The clinician needs to be aware that not all cultures are familiar with goal-setting and homework, and the structure of CBT may need adapting.

- Family therapy may be appropriate for clients from collective cultures, however if the issues are stigmatised in the family's culture, there may be hesitancy (Stade et al., 2015).
- Group therapy can be successful when the facilitator speaks the same language as the participants or an interpreter is provided; and the group is homogenous (ie a group of Syrian men or a group of Iraqi women). It is important that participants are not acutely or severely unwell (Sijbrandij et al., 2017; Silove et al., 2017; Stade et al., 2015).
- Narrative exposure therapy (NET) is an effective short-term culturally universal intervention for trauma victims, particularly those with severe PTSD symptoms (both children and adults).
- Motivational Interviewing (MI) is a client-centred, directive therapeutic style that enhances readiness for change by helping clients explore and resolve ambivalence. Research shows its efficacy for addiction treatments, especially in reducing alcohol and other substance abuse (Miller & Rollnick 2002).

Clients who have been through torture and trauma can find support groups helpful once they feel stabilised through therapeutic support.

There are a number of intervention options – thought needs to be given to what will be most appropriate for each client and/or the family. Remember that each client needs to be assessed individually. Unique circumstances and differences in acculturation render generalisations ineffective or inappropriate or can result in stereotyping. Generalisations need to be used for points of consideration ONLY.

Caraballo et al (2006) offer the following pointers for selecting ethical treatment choices:

- Can the expectations and cultural preferences (eg authoritative or co-operative figure) of the client be met?
- Is there adequate flexibility to incorporate the client's illness explanatory model and treatment needs?
- It is important to explain and clarify misconceptions about mental health and that seeking help for mental health issues does not equate to being 'crazy'.

  Has the client's 'health literacy' been taken into account?

**Please note that treatment modalities will be addressed in the two additional resources that supplement this training.**

## Summary

Culture influences the way people understand and experience their mental health and the way they present this in a clinical setting. No presentation is accultural.

The DSM V provides an outline for developing a cultural formulation and based on this we offer an assessment tool for gathering the relevant and required information. Assessing cultural identity, the client's explanatory model of their illness, determining what psychosocial factors affect their health, as well as identifying the cultural elements that influence the relationship between the client and the clinician are all vital to developing an appropriate cultural diagnosis and intervention.

Other issues that affect assessment, including Western bias in testing and screening procedures, are highlighted in this section. Screening tools and tests that have some validation on a cross-cultural population in New Zealand are presented (or linked to the Resources), as well as cautions about making diagnoses based on these alone. Using cultural competency skills when conducting mental health assessments for CALD clients is critical in establishing a good rapport and achieving engagement in mental health treatment.

Grieger (2008, p.137) notes that when conducting mental health assessments it is never appropriate to ask if culture is relevant to a client, but rather to ask "how is culture relevant to understanding [my] client?"

To achieve effective cross-cultural intervention and treatment outcomes, you need to continue to gain some practical examples and skills from the **CALD 9 Working in a Mental Health Context with CALD Clients** course, for example, gaining understanding or skills on how to:

- develop rapport
- identify supports and stressors
- provide culturally appropriate screening
- improve on under- and over-diagnosis of depression, psychosis, stress related disorders
- work with a collaborative approach
- improve outcomes taking into consideration of ethnopharmacology
- create an appropriate treatment plan
- make referrals appropriately
- seek professional consultation
- continue your cultural competency development

## Resources

The following two supplementary resources are available to learners who have completed the CALD 9 course:

- Working with Asian Mental Health Clients [supplement]
- Working with Middle Eastern and African Mental Health Clients [supplement]

These resources offer additional and culture-specific information that applies to mental health assessment and intervention is provided in the resources. Topics include the following:

- Cultural demographics
- Re-cap on aspects of religious issues that impact on mental health
- Traditional cultural and family values
- Assessment guidelines for working with adults
- Assessment guidelines for working with children and the elderly
- Explanatory models of illness as relevant to the cultural groups
- Appropriate and applicable treatment modalities and Interventions
- Special issues when working with the respective cultures in mental health
- Refugee issues with specific groups eg children

**You can access these resources from your eCALD user account.**

Additional supplementary resources can be downloaded from www.ecald.com.

- CALD Family Violence Resource for Health Practitioners Working with Asian, Middle Eastern and African clients [Supplement] - Pre-requisite CALD 1
- CALD Older People Resource for Health Providers Working with Asian, Middle Eastern and African older people [Supplement] - Pre-requisite CALD 1
- Maternal Health for CALD Women Resource for Health Providers Working with Asian, Middle Eastern and African women [Supplement] - Pre-requisite CALD 1
- CALD Child and Adolescent Mental Health Resource for Health Providers Working with Asian, Middle Eastern and African families [Supplement] - Pre-requisite CALD 1

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# Appendix 1: CALD Assessment Tool

The following provides a summary of suggested questions discussed in PART B of this resource:

**A. Questions to establish Cultural and Ethnic Identity**

(adapted from Dr. Sanu Pal, 2008)

1. How did you (and your family) come to New Zealand? (reasons for leaving home country and who made the decision?). Explore duration, with whom migrated, any significant family members left?

2. Are you able to practise your way of life in New Zealand?

   (This includes socialisation with own people, dress codes, greetings, participation in festivals, practising ethnically oriented family roles, restrictions imposed by traditions).

   Explore ethnically-shaped developmental experiences such as:

   a. Childhood experiences: Can you remember some of your childhood experiences?
   b. Was there any change when you reached adolescence or adulthood? (Explain it in regard to cultural norms or practices).
   c. Is there any special activity, ritual or social function you have gone through which you can remember? (Enquire about special rituals or rites of passage.)
   d. Do you still have traditional family roles in New Zealand? (Enquire about ethnically prescribed family roles.)
   e. Do you maintain traditional dress codes at your work place? At home? Or in any family function or festival? (Enquire about traditional dress codes, special greetings.)

3. Language:
   a. What language do you speak at home? With elders? With children Or with sisters and brothers? With your friends?
   b. Have you learned any foreign language or second language in your home country?
   c. In what language did you have your education? (primary/secondary/tertiary education).
   d. What languages would you like your children to learn now? Do you think children should learn their mother tongue as well?
   e. What language do you prefer to use in social gatherings such as with friends, relatives? Do you prefer your own language or host language?

4. Gender issues related to culture:
    a. What do you think about the different roles of men and women? Can you describe or give examples of some the roles?
    b. Who in the family do you think should be making key decisions? Decisions such as managing finances, buying a house.
    c. Is there any hierarchy maintained in the family? (That means some family members have preference for others for certain things or activities).
5. Age :
    (a) What do you think about the elder's role in the family? Do you think it is changing in your family after migration? If yes, can you explain what has changed? What used to be their role in your home country?
    (b) What do you think the role and responsibility of younger persons are in the family now after migration? Have there been any changes? Can you describe the changes?

6. Sexual issues: Before you start, explore whether it is appropriate to ask these in the presence of another family member, and adapt as needed.
    a. What is the unmarried/married/divorced/separated person's status in the community? Have you noticed any changes since you migrated? In what way?
    b. What do you think of using contraceptive practice? Married or unmarried persons?
    c. What do you think about the relationship between men and women living together (De facto relationship)
    d. What do you think about sexual relationships outside marriage?
    e. What do you think about relationships where the couple is the same sex?

7. Religious and spiritual beliefs:
    a. Do you have a faith or religion that you have practised since childhood?
    b. Have you changed your religion or faith since then? If yes, can you tell me the reasons for change?
    c. Do you have any regular religious activity? Where does this occur - at home, a religious place? somewhere else? in some other form of community religious activity?
    d. Do you have any food preferences in relation to religious beliefs?
    e. Do you like to maintain your ethnic dress codes and greetings?
    f. Have you come across any difficulty in practising your faith?

8. Socio-economic class and education:

a. Before migration, what impressions did you and your family have of your social class?
b. What was your impression of social class in your home country after your migration?
c. Do you think there is any change of your status now? In what way?

9. Acculturation process can be assessed by asking:
   a. At what age did you migrate to New Zealand?
   b. How many years have you been in New Zealand?
   c. The acculturation process has a few stages. How would you describe yourself?
      - Do you follow traditional ways most of the time?
      - Do you follow traditional ways as well as some Kiwi ways?
      - Do you think it's about half and half?
      - Do you feel like a Kiwi? Would you call yourself a Kiwi? Could you tell me why?

**B. Questions to explore the Cultural Explanatory Model of Illness** (adapted from Benson & Thistlethwaite, 2009).

a. What do you think caused your problem?
b. Why do you think it started when it did?
c. What do you think your illness does to you?
d. What are the chief problems it has caused for you?
e. How severe is your illness?
f. What do you most fear about it?
g. What kind of treatment/help do you think you should receive?
h. Within your own culture how would your illness be treated?

**C. Cultural factors related to psychosocial environment and levels of functioning** (adapted from Dr Sanu Pal, 2008).

a. Do you have a job? If so, is it similar to what you were doing before you migrated?
b. Is your job related to your skill? Are you satisfied with your job or what you are doing? If not what is the reason?
c. Have you experienced any discrimination in regard to education, employment or accessing any service? Can you give an example?
d. Do you have enough support from family and friends?

e. Do you have any groups or communities that you belong to?

f. Do you feel that you have had a major change in relationship with any significant person due to your migration?

g. Are you required to speak English at work? If Yes, are you comfortable using English as your language at work? If not, then what do you think the reason is?

h. Do you get invited to the activities of friends and colleagues?

i. Do you get invitations to homes and special events such as parties, birthdays and weddings from people outside your culture? If so, do you attend and participate? (Participation in host culture social network).

## Appendix 2: Table of culture-bound syndromes

For reference purposes, we have listed syndromes that occur in African, Asian and Middle Eastern cultures.

| Syndrome<br>Country of Origin | Description |
|---|---|
| **Amok**<br><br>(Malaysia, Indonesia, Laos, Polynesia and Philippines) | Amok (Malaysia) also known as Cafard or Cathard (Laos, Polynesia and the Philippines) is a dissociative episode featuring a period of brooding followed by an outburst of aggressive, violent or homicidal behaviour aimed at people and objects.<br><br>Amok typically occurs in males aged between 20 and 45 years who have experienced a loss of social status or a major life change. The episode is often precipitated by a perceived slight or insult and is generally accompanied by persecutory ideas, automatism, amnesia or exhaustion. After the episode has occurred, the individual returns to their premorbid state.<br><br>Episodes of amok are now rare and generally confined to individuals living in rural areas. |
| **Brain fag**<br><br>(West Africa and many sub-Saharan areas) | Brain fag or brain fog describes a syndrome typically affecting high school or college students pursuing a Western-style education. Symptoms often begin after an intensive period of intellectual activity and include watery or dry eyes, dizziness, blurring of vision, difficulty concentrating or remembering, pain or feelings of pressure in the head or neck, fatigue and difficulty sleeping, shaking hands, rapid heartbeat, crawling sensations under the skin, feelings of weakness and |

| Syndrome<br>Country of Origin | Description |
|---|---|
| | depression.<br><br>DSM V categorises brain fag as an affective, somatoform disorder. The term and syndrome occur in many sub-Saharan areas. |
| **Dhat**<br><br>(India, Sri Lanka) | Dhat, also known as Jiryan (India) or Sukra Prameha (Sri Lanka) is defined as, vague somatic symptoms of fatigue, weakness, anxiety, loss of appetite, guilt and sexual dysfunction attributed by the client to loss of semen in nocturnal emissions, through urine and masturbation.<br><br>Although it is rare, women have experienced similar symptoms to dhat, related to whitish vaginal discharge. The general psychosomatic symptoms are very similar. |
| **Shen-k'uei**<br><br>(China, Taiwan) | Shen-k'uei, a Chinese syndrome, has similar symptoms to dhat. Shen-k'uei is described as, a form of sexual neurosis associated with excessive semen loss due to frequent intercourse, masturbation, nocturnal emission or passing of white turbid urine which is believed to contain semen. Young people who think they might be suffering from it become anxious and panicky and complain of somatic symptoms (with no organic cause) such as dizziness, backache, fatigue, weakness, insomnia, frequent dreams and physical thinness. Some believe that women can steal a man's vital energy through sexual intercourse and this loss of semen leads to the disease. Furthermore, it is also believed that semen loss has the potential to lead to an imbalance in chi, promoting weakness.<br><br>Semen-loss anxiety is also known in the West although it is largely considered to be a thing of the past, possibly as a consequence of increased industrialisation and urbanisation. The Victorians were well known for being almost obsessive about masturbation and nocturnal emissions, blaming these behaviours for wasting away, paleness, cold sweats, hairy palms, tremors, exhaustion, muscle weakness, pimples, and a variety of other symptoms. |
| **Hwa-byung**<br><br>(Korea) | Hwa-byung also known as ul-hwa-byeong or wool-hwa-byung literally translates to "fire illness", and is believed to be caused by a build-up of unresolved anger (known as haan or "everlasting woe") that disturbs the balance of the five bodily elements. This anger is often experienced as a heavy mass that pushes up from the abdomen into the chest.<br><br>Hwa-byung typically occurs in middle-aged Korean women with limited |

| Syndrome<br>Country of Origin | Description |
|---|---|
| | education from low socio-economic rural areas. Affected individuals generally operate in a traditional family structure and the triggering cause is generally a family-related event, such as spousal infidelity or conflict with in-laws.<br><br>Symptoms include anxiety, pervasive depression, obsessions and compulsions, anorexia and feelings of hatred, shame, paranoia, fearfulness, destructive impulses, irritability, anxiety and absent mindedness. Sufferers also complain of sleeplessness, dizziness, headaches, indigestion, sexual dysfunction, intolerance to heat, dry mouth, hot and cold flushes, weakness, heart palpitations and blurred vision.<br><br>Western diagnoses include major depression, anxiety disorders such as phobias, generalised anxiety and obsessive-compulsive disorder, and somatisation disorders. |
| **Koro**<br><br>(Malaysia, China, Assam, Thailand, India) | Koro (Malaysia), also known as Shuk yang or shook yong or suo yang (China); or Jinjinia bemar (Assam); or Rok-joo (Thailand); or Suudu (Tamil, India) is one of the better known culture-bound disorders in which the affected individual has the overwhelming belief that their genitalia is receding into their body, possibly causing death. Afflicted persons may resort to clamps, ties, pegs or hooks to keep the genitals from fully receding, sometimes resulting in damage to the organs.<br><br>Koro more commonly affects males and is sometimes believed to be caused by sexual behaviours such as masturbation or sex outside of marriage that are thought to result in an imbalance of the male/female principle (yin and yang). Epidemics of koro have been also reported and may be a kind of mass hysteria.<br><br>Similar syndromes have been reported in other culture. For example, in the Guangdong region in China it is believed that a fox spirit can steal penises, while perceptions of genital shrinkage are often ascribed to sorcerers or black magic in regions of Africa. |
| **Saora**<br><br>(South-eastern India, China) | Saora (Southeastern India), also known as Shenjing Shuairuo (Chinese), is used to describe a syndrome experienced by young men and women in India's Saora tribe. It has features of a dissociative or conversion disorder and includes elements of depression and anxiety disorders, such as physical and mental fatigue, dizziness, headaches, |

| Syndrome<br>Country of Origin | Description |
|---|---|
| | gastrointestinal problems, difficulty concentrating, sleep disturbance, memory loss, sexual dysfunction, irritability and excitability. Affected individuals exhibit memory loss, fainting and inappropriate crying or laughing. In addition, sufferers claim to experience repeated insect bites when no insects are present.<br><br>Tribe members often attribute these behaviours to the actions of supernatural beings who want to marry the afflicted persons; however, this syndrome may occur in response to social pressure to conform to a certain way of life. |
| **Qi-gong**<br><br>(China) | Qi-gong Psychotic Reaction also known as Qi-gong Deviation Syndrome is a time-limited episode lasting between two and four weeks that is characterised by dissociative, paranoid and other psychotic and non-psychotic symptoms that occur after participation in the Chinese method of meditation known as Qi-gong.<br><br>Symptoms may include headaches, dizziness or disorientation, strange sensations in the lower abdomen (the Dan-Tian point), hypochondriasis, anxiety, sadness, feelings of being out of control and visual and auditory hallucinations. |
| **Shin-byung**<br><br>(Korea) | Shin-byung is characterised by anxiety and somatic complaints such as general weakness, dizziness, fear, loss of appetite, insomnia and gastrointestinal problems. It is attributed to possession by ancestral spirits. |
| **Zar**<br><br>(North Africa, Middle Eastern Societies) | Zar is a syndrome where an individual believes they have been possessed by a spirit. It is characterised by dissociative episodes when the affected individual shouts, laughs, weeps, sings or hits their head on the wall. They may also become apathetic, withdrawn and unable to carry out daily tasks. |
| **Old Hag Syndrome**<br><br>(A number of cultures) | Old Hag Syndrome is relatively common across a number of cultures. It is believed that a “hag” (witch or supernatural being) has sat on the affected person's chest as they slept. The person experiences an inability to move, feelings of pressure on the chest and difficulty breathing. They may see red eyes or feel feet or fingers. They may also |

| Syndrome<br>Country of Origin | Description |
|---|---|
| | hear the hag breathing. Visitations from the hag tend to cross multiple generations in a family.<br><br>A modern version of the Old Hag Syndrome may be found in some alien abduction stories which feature the same general themes. |
| **P'a Leng**<br><br>(China, Singapore) | P'a Leng (Wind Illness) (China), also known as Wei Han Zheng (Singapore) is a fear that wind or cold will result in a loss of yang and imbalance of the body. The affected person becomes obsessed with being warm and may wear winter clothing in the middle of summer. |

Ref: https://en.wikipedia.org/wiki/Culture-bound_syndrome#DSM-5_list