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The Clinical Ethnographic Interview: A user-friendly guide to the cultural formulation of distress and help seeking

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Abstract

Transcultural nursing, psychiatry, and medical anthropology have theorized that practitioners and researchers need more flexible instruments to gather culturally relevant illness experience, meaning, and help seeking. The state of the science is sufficiently developed to allow standardized yet ethnographically sound protocols for assessment. However, vigorous calls for culturally adapted assessment models have yielded little real change in routine practice. This paper describes the conversion of the Diagnostic and Statistical Manual IV, Appendix I Outline for Cultural Formulation into a user-friendly Clinical Ethnographic Interview (CEI), and provides clinical examples of its use in a sample of highly distressed Japanese women.

Keywords

cross-cultural assessment; clinical ethnography; women's health; Japanese culture

Transcultural nursing, psychiatry, and medical anthropology have theorized that practitioners and researchers need more flexible instruments to gather culturally relevant illness experience, meaning, and help seeking. However, vigorous calls for culturally adapted and culturally relevant assessment procedures have yielded little real change in routine clinical practice despite the fact that the state of the science is sufficiently developed to allow standardized yet ethnographically sound protocols for assessing people from all cultures. The Diagnostic and Statistical Manual IV (DSM-IV) created the DSM-IV-TR Appendix I: Outline for Cultural Formulation (CF) in 1991 that promised to change this problem by creating standard assessment topics (American Psychiatric Association, 2000; Mezzich, 1995; Mezzich, Caracci, Fabrega, & Kirmayer, 2009; Mezzich et al., 1999). The topics in this assessment are relevant for all clinical problems. It has been available for over 15 years, but it is still underutilized by clinicians. A recent issue of *Transcultural Psychiatry* that presents several articles on the CF concluded that the lack of a structured and systematic format has hampered its widespread use (Mezzich et al., 2009).

We believe that the reasons for this neglect are threefold. First, published reports on the use of the CF outline have focused on documenting the detailed intricacies of patients' idioms of distress and causal models. This may leave the clinician who is not trained in anthropology or ethnography overwhelmed and reluctant to apply the CF. Second, the complex nature of many of the questioning sequences required to understand culture and health are too in-depth for initial assessments. Third, the face-to-face, question-and-answer style of the

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typical clinical evaluation can be intimidating for people who are from other countries or who belong to minority groups in the USA. We believe that the full and subtle exploration of the social, emotional, and physical experiences of people from vastly different cultures requires methods that do not rely on abstractions and verbal analysis. In addition, for people from many cultures, physical, social and emotional experiences of distress are so intertwined that it is inappropriate to assess them as if they were distinct. This article describes the conversion of the DSM-IV, Appendix I Outline for Cultural Formulation into a clinical interview, and provides examples of interview responses from a sample of 24 highly distressed Japanese women as part of a larger study on the relationship between culture, distress, and help seeking. The Clinical Ethnographic Interview (CEI) was developed to provide a user-friendly, engaging, ethnographically sound and thorough exploration of distress and help seeking across the life course. While this assessment was designed for mental distress, the questions could be used for any distressful condition.

Background

Research and clinical practice with diverse populations has been challenged by the need to measure phenomena precisely and uniformly despite recognition that existing tools are generally not culturally relevant. In the area of mental health, most studies have used western-derived instruments to measure mental health in diverse populations. However, assessment tools do not always assess all of the relevant symptoms and indicators necessary to accurately and adequately capture the phenomena of interest. While a few studies have incorporated culturally unique symptoms into structured clinical interviews, such as the Structured Clinical Interview for Diagnostic and Statistical Manual (SCID) (Hinton, Ba, Peou, & Um, 2000; Hinton et al., 2001; Hinton, Um, & Ba, 2001; Lewis-Fernandez et al., 2002; Park & Hinton, 2002), this method requires the practitioner to be familiar with the specific culturally prescribed symptoms of the population. Strategies to develop alternative assessment protocols for use with culturally diverse patients have included the McGill Illness Narrative Interview (MINI) (Groleau, Young, & Kirmayer, 2006). This interview is a semistructured, qualitative interview protocol that elicits a basic temporal narrative of symptom and illness experience, previous experiences with similar symptoms and illness events for the interviewee and other close persons, and the explanatory models held by the interviewee related to the illness and its treatment. While this comprehensive tool is well suited for research on diverse causal models, it may be too cumbersome for the average clinician to use for routine practice.

The DSM has addressed cultural diversity in psychiatry by adding the Outline for Cultural Formulation in Appendix I of the current version of the DSM-IV-TR (American Psychiatric Association, 1994; Lewis-Fernandez & Diez, 2002; Mezzich et al., 1999). The National Institute of Mental Health (NIMH) sponsored the development of this appendix through a culture and diagnosis workgroup in 1991 (Mezzich et al., 1999). The CF contains a list of interview topic areas for the clinician to consider when assessing the mental health of people from diverse cultural groups. These topical areas include predominant symptom patterns used in the culture; the meaning and severity of symptoms in relation to cultural norms; the perceived causes of the illness; and help-seeking experiences. Despite published case studies demonstrating how the topics in the outline can be used to understand clients' specific symptom presentation, understanding of their illness, and help-seeking patterns, few papers have considered how this topic list can be converted into a structured clinical interview that can be widely implemented in general practice (Mezzich et al., 2009).

The use of the cultural formulation has received some systematic evaluation. The Patient–Provider Encounter Study (PPES) examined the actual use of culture in the formulation of psychiatric diagnoses among ethnic minorities (Alegria et al., 2008; Fortuna, Porche, &

Alegría, 2009). This study found that while most of the clinicians considered culture and social context important, they did not use the entire cultural formulation systematically. Another study attempted to provide structured guidelines to clinicians who were not trained in anthropological methods. In this study, clinicians were encouraged to engage in a dialogue with the client about the clinical problems and their meaning in the context of the client's life (Bäärnhielm & Rosso, 2009). While this begins to meet the need for a structured clinical interview, it does not systematically guide the clinician in the integration of the cultural formulation material for the care of the client.

This paper presents an adaptation of the DSM-IV cultural formulation into a clinical interview. The authors developed this clinical interview for use in a NIMH funded research study (MH071307). The presentation begins with the theoretical concepts used in the adaptation. Next, we provide a detailed guide to the interview itself, along with qualitative data from the research study to help the reader evaluate the merits of its use in a given population.

Theoretical foundations for the development of the Clinical Ethnographic Interview

The cultural formulation advanced by the NIMH working group was based on theoretical propositions that are rooted in medical and psychological anthropology. This review of literature informs the choice of the concepts and questions we used in our research study to adapt the cultural formulation into the CEI. These theoretical concepts, how they relate to the cultural formulation topics, and the specific questions of the CEI are presented in Table 1.

Cultural models and symptom experience

Culture is a group-level phenomenon that includes the beliefs, values, practices, and institutions within a given social collective. These expectation patterns can be conceptualized as cultural models (Holland & Quinn, 1987; Markus, Kitayama, & Heiman, 1996; Moscovici, 1988). Cultural models are internalized cognitive– affective schemas derived from cultural macrolevel system information, and perception of relevant internal physical and emotional sensations, as well as emotions and actions. Cultural models direct individual perception and sensation (Holland & Quinn, 1987; Markus et al., 1996; Moscovici, 1988). *Cultural models* tell people what to attend to, what to ignore, what things mean and what should be done about them. Understanding how a given cultural model might direct attention is the starting point in making predictions about how the body, emotions, and social situations may be perceived, and therefore how health is maintained or distress experienced. All physical and emotional experiences, interpretations and evaluations, as well as the dynamics within the social structure, are “filtered through” cultural models.

Once a sensation is noticed, it is labeled and interpreted in terms of its normalcy and severity. A physical sensation or emotion is labeled a “symptom” when it is a sign of an abnormal state, disturbance, illness, or pathology. Because of the influence of cultural models on the development of perception and interpretation, all of these analyses are cultural interpretations, and are based on experience by the self and others within one's family and reference group. Along with symptom labeling, individuals evaluate levels of normalcy. Individuals will examine their social network and other referents to decide if these symptoms have occurred in others (normalcy for people in society) and will examine their own memory for whether and under what circumstances they have experienced these symptoms before (normal for themselves). Finally, people will evaluate these symptoms in

terms of their impact on their level of comfort and level of functioning (severity). Cross-cultural assessments must therefore assess symptoms using the most open-ended methods possible, and allow their patients to group those symptoms in patterns that are meaningful for their cultural reference group. The patient can then describe these symptom groupings in terms of their severity and normalcy.

The challenge in creating the CEI was to provide the participant with opportunities to describe their bodily and emotional sensations *in their own terms*. Therefore, we developed interview questions that ask about specific sensations, how the respondent understands these sensations, and their attributions of their causes. These questions correspond to the broad categories of “Cultural explanations of the individual’s illness” in the cultural formulation.

Meaning interpretation and social evaluation

Cultural models influence group-level beliefs about distress and illness, defining both health and deviations from health. Cultural models provide templates that are used to interpret both the cause and the social significance of symptoms and illness (Kleinman, 1988, 1995). These cultural explanations allow societies to develop meaningful patterns of need that are predictable and natural within larger cultural models. People may attribute their symptoms to social causes or to underlying physical pathology. People generally match the treatment they seek to their beliefs about the cause of the distress (Chrisman & Kleinman, 1993; Guarnaccia, Rivera, Franco, & Neighbors, 1996; Hinton, Um, et al., 2001; Jenkins, Kleinman, & Good, 1991; Kirmayer, 1993; Kirmayer, Dao, & Smith, 1998; Kirmayer & Young, 1999; Kleinman, 1988, 1996, 2003; Pang, 1998).

Cultural models also guide evaluations of the social significance of symptoms or illnesses. For instance, beliefs that an illness is caused by the failure to carry out an important social role will be negatively evaluated in a culture that emphasizes group responsibility and harmony. When people believe that the social evaluation of their distress will be negative, they will have emotional responses of shame, humiliation, anxiety, or fear. Cross-cultural assessment must therefore use culturally specific symptom patterns as a starting point to ask questions about perceived cause and perceived social stigma. These meanings greatly affect what people eventually do about their suffering, as well as their evaluations of the effectiveness of these efforts. The interview questions of the CEI focus on the social implications of the patients’ sensations and experiences, both in their own emotional system, and as they relate to help seeking. These questions also correspond to the broad categories of “Cultural explanations of the individual’s illness” in the cultural formulation.

Propriety, reciprocity, and help seeking

Culture influences the structure of a society, including identity and social roles, as well as power relationships between individuals, families, groups, and political institutions. In addition, the social structure of a given society regulates and enforces compliance with the rules and norms for members of the social group. These rules become incorporated into cultural models of gender, role definitions and role performance, and norms of propriety. Rules for appropriate conduct include gender- and role-related gestures, speech patterns, manners of dress, and emotional displays. Finally, cultural models of reciprocity enhance or inhibit support giving and help seeking, including how to ask for help, who to ask, and how the helpfulness should be repaid (Bachnik, 1994; Hendry, 1992; Saint Arnault, 2002, 2009). Rules, norms, and ideals about being self-reliant, avoiding direct communication of personal needs, and emotional expression are included here, as well as behaviours that foster conflict, indicate deviance, or that warrant ostracism are part of the cultural models of propriety and social exchange. Causal interpretations and evaluations of social significance interact with social networks and social support to influence help seeking. The CEI, therefore, asks about

social roles and personal identity, and how these influence social interaction; the social significance of their sensations or symptoms; and about the processes of social support and social exchange. These interview questions correspond to the portions of “the cultural identity of the individual” and the “cultural factors related to psychosocial environment and levels of functioning” within the cultural formulation.

Research design and methods

This instrument was developed for an NIMH research study aimed at examining the interactions between distress experiences, cultural interpretations, social structures, and help seeking for first-generation Japanese women living in the USA. This larger project used a mixed-method, longitudinal, multiphase design (Creswell, Feters, & Ivankova, 2004; Saint Arnault & Feters, 2011; Tashakkori & Newman, 2010). The larger study involved a survey of a random sample of 212 first-generation Japanese women drawn from community and clinic populations. The survey included questions about demographics, distress experiences, values and attitudes related to distress and help seeking, and help-seeking experiences in the last year (Saint Arnault, 2009; Saint Arnault & Feters, 2011). A highly distressed subsample was asked to participate in the interview phase of the study. We screened for distress level using the CESD-Korean version, Revised (CESD-K-R) a version of the Center for Epidemiologic Studies-Depression Scale (CESD) (Radloff, 1977) revised for use with Asian samples (Noh, Kasper, & Chen, 1998). We also measured participants' symptomatology with the Composite Symptoms Checklist (CSC), a 130-item multidimensional symptom measure adapted from standardized somatic, affective, and interpersonal checklists (Kitayama, Markus, & Kurokawa, 2000; Kitayama, Markus, & Matsumoto, 1995; Lubin & Zuckerman, 1999; Markus, 1991; Pennebaker, 1982; Yasuda, Lubin, Kim, & van Whitlock, 2003). Women who scored 16 or higher on the CESD-K-R and/or who had 12 or more symptoms on the CSC were considered to be highly distressed and invited to participate in the second phase of the study (see Saint Arnault & Feters, 2011). The data provided here are from interviews from a subsample of 24 women who were assessed as being “highly distressed” by these criteria, and who agreed to be further contacted by our research team. All material and procedures were approved by the Human Subjects Institutional Review Board of Michigan State University, and all research materials and interviews were conducted in Japanese.

Analysis of the demographic data for these women revealed that age, English language fluency, reason for coming to the USA, income, husband's position, employment status, and age of the youngest child were not significantly different between the interviewed sample and the survey sample. Only the depression level was significantly higher ($t=-4.309$, $df=204$, $p<.001$) for the interviewed sample ($N=21$; $M=13.9$) when compared with the survey sample ($N=185$, $M=6.2$).

The Clinical Ethnographic Interview

As noted earlier, the Outline for Cultural Formulation provided in the DSM-IV Appendix I provides a list of content to assess for a cultural formulation of distress, but does not specify ways to gather the information. Moreover, the topics in the DSM list are general domains of interest for any clinician dealing with any illness, and are therefore not specific to psychiatry. For example, all help seeking begins with symptoms of distress which people interpret, assessing the relevance of the symptoms in social context and seeking help accordingly (Saint Arnault, 2009). The interview presented here was developed to provide clinicians with a prescribed set of questions and methods to begin to ascertain the role of culture on patients' experiences, the meanings of their symptoms, and their pattern of help seeking.

The development of the CEI began in 1995 with a study of 25 Japanese women (Saint Arnault, 1998, 2002). These initial interviews focused on social networks, barriers and facilitators of help seeking, and the nature of social support. Next, the first author developed and pilot tested an open-ended method to assess the cultural meanings of distress. These questions were pilot tested with a different group of 10 Japanese women. At the start of the present study, these two interviews were combined and field-tested with an additional sample of six Japanese women. We assessed the flow of the interview, clarified the questions that were troublesome or difficult for the women to answer, and developed additional probes. We used cognitive interviews with these women to assess the acceptability and comprehensibility of the interviews (Willis, 2005).

During the process of developing the interview, it became clear that the methods of data gathering rooted in cultural norms and values were critical to the success of the interview. The interview style used in most mental health clinical encounters in the United States, which is based on cultural values of explicit verbal expression, abstract concepts, and logical explanation is not typical for many cultural groups, including the Japanese women in our study. In the Japanese case, the topic of the question had to be situated within a context, using culturally meaningful referents and concrete examples. In addition, direct questions were met with reserve or hesitancy. We therefore used our pilot interviews to create a series of exercises that allowed the women to describe their experiences in a situated and concrete way, and developed probes to elicit referents for further discussion. The following describes the interview with extracts from the transcripts to illustrate type of data obtained. Analysis of findings from the use of this interview are the subject of other publications (Saint Arnault & Roels, 2011; Shimabukuro & Saint Arnault, 2011).

Introduction, daily life, and social networks

The first questions in the interview ask the interviewee to describe a typical week. The probes ask the women to tell more about their roles in their family, as well as how they feel they were able to do those activities. We asked for information about how their roles were affected by social expectations of others, and if these expectations had changed recently. Next, we asked the interviewee to give us a “grand tour” of their social network. This question begins by asking the interviewee to draw a circle representing those closest to her, and to draw all of the people or groups with whom she interacts. During the discussion of these social connections, the interviewee and the clinician work together to clarify levels of intimacy and trust, relationship types, shared group affiliations, cultural identity, and patterns of reciprocal exchange.

The picture that the interviewee draws was placed within their visual field and was referred to often during the interview. Interviewees were encouraged to add additional people to the drawing at any time during the interview. The social network portion of the interview is essential for contextualizing the person’s distress or suffering, and relates to the help-seeking questions later in the CEI. Beginning the interview with the social network allows the clinician to work toward mobilization of social support, which is often critical when people are in crisis. This first set of questions takes about 20 minutes. Figure 1 is a composite drawing taken from several typical social networks encountered in our study. For research purposes, this section can be expanded to include other dimensions of social network formation and maintenance using techniques used in eco-mapping or social network mapping (Antonucci & Akiyama, 1987; Hartman, 1995; Hodge, 2000; Olsen, Dudley-Brown, & McMullen, 2004).

In the example in Figure 1, the social network reveals that our participant was engaged mostly with other Japanese people whom she refers to as “acquaintances.” Throughout all the interviews in our study, frequent casual encounters with people who are only

acquaintances turned out to be a primary stressor for the women in our sample. From the following quote, it can be seen that these acquaintanceships are a source of this woman's loneliness and distress:

[I mostly see] ...my husband ...and our children and other Japanese people ...who I met after I came here ...Japanese people at the same school. I'm not very close to them; I don't know if I can call them friends. Do you call them acquaintances? And people with [my husband's] company such as his supervisor's family, and his colleagues' families ...they are ...Japanese.

In this next example, the woman considers the superficiality of the encounters in her social network, and how difficult it is to relax and trust in such a social network:

[I want to talk with these other Japanese women] because all of us have the same issues, you know? They openly tell me things like "Let's help each other," you know? But ...it [seems] ...to me that ...these members are really PRETENDING [emphasis by respondent] ...we kind of get together and have fun as a group, but ...everybody is pretending that they had no problem[s] and are living peacefully ...

The grand tour of the social network contextualizes the person within their network, and begins to give clues about how people relate to each other, what resources are available, and how people view each other in community contexts.

The body map

After the discussion about the social network, the interview begins to focus the woman on her recent distress experiences. Rather than begin with a list of predefined questions, we use the body map as an open-ended technique to allow the interviewee to describe her experiences. The body map is a visual analogue to help the interviewee represent and describe how they feel now without the constraint of predefined illness categories (Brett-MacLean, 2009; Cregan, 2006; Evans, 2010; MacGregor, 2009). In the body map method, the interviewee is asked to relax and to create a mental image of how they have felt in the last 2 weeks. The directions to the participant are:

Sit quietly ...feel and picture yourself in the last couple of weeks. Think about how you have felt ...Now, please draw how you have felt on this body ...How you have felt mentally, physically, socially, spiritually ...

Examples of body maps are provided in Figures 2 and 3.

During the body-mapping segment of the interview, women depicted emotional, psychosocial, and physical distress, and explained them in detail. In the following example, the interviewee explains how she felt during the last 2 weeks:

On the face, it's like this when I'm tired and here is the conflict in my mind ...for the physical thing ...I'm taking medication and it's managed, so, uh...I'm not very worried myself. [When I am taking care of my children] ...somewhere in the process I think, "Ah, but it's not good to, uh, nag the children this way," and change my mood...it's a cycle ...It's like moving to the next phase every 5 minutes...[here is] lightheadedness... I couldn't breathe...I guess I had stiff shoulders ...Headache ...

Another woman described her body map this way:

[This is a] gloomy feeling and ...and I kind of felt anger toward everybody around me. ...if there had been nothing but this, probably I wouldn't have survived ...so I was withdrawn ...like hiding this, this, this [weakening] ...Like something mental. ...[it was] about the fact that I lost my mother but that everybody [else still] has

their mother [so] I hated people around me and was very jealous ...I really felt pain in my chest ...It was sadness.

Finally, this young woman explains her picture this way:

I am recovering, but I still carry the intensity of my anger [from] back then when I feel anger ...I [have] developed a habit of having such intense anger ... Well, especially how I look in my eyes. My physical condition?...I felt stronger dizziness. But I habitually had lightheadedness before ...I think my eyes were always half-open ...or I always had fishy eyes ...I couldn't control myself I think I was like ...a zombie. ...I was not a mother at that time ...I don't really think I was a human being. It's all about being regretful ...my regret just adds up. And that regret never went away.

The lifeline

The lifeline is a graphic depiction of one's life that can serve as retrospective and holistic representations of experiences, helping participants link past experiences with subsequent actions (Frank, 1984; Gramling & Carr, 2004; Shimomura, 2011; Taguchi, Yamazaki, Takayama, & Saito, 2008). In the CEI, we provided the women a line across a blank sheet of paper, and asked them to situate major events along this line. Next, we asked them to draw another line that indicates the "ups and downs" or "highs and lows" of her life along that same lifeline. Drawing and describing the lifeline requires the respondent to refer to the times in her life when things were troublesome and when she perceived herself unable to manage, cope, or function. In describing these times, she discusses how this time in her life felt to her, the symptoms she experienced, the events surrounding them, the meaning she attached to them, and her help seeking. Both the social network and the life-line drawings are also referred to throughout the interview as we investigate the meaning of these low times for her and the people in her life, as well as the types of help she sought – or did not seek but wanted – during her low times. Examples of lifelines are provided in Figures 4 and 5.

In the following quote, the woman explains her distress in her own words:

[During this time I felt] ...Hostile. And, well ...lonely ...An abandoned feeling was somewhat there ...I guess I had a little stomachache ...I think I had heart palpitations ...I became sick ...Cold hands and feet. Choking sensation ...Gloomy [and] ...Sad. I had anger as well and a lump in my throat ...it's hard to divide them...all of them are kind of together.

This woman explains how severely "down" she was this way:

I mean it's my stomach. Um, around the neck, really heavy and it was like there were no muscles around my neck. It was weak ...In addition, before those symptoms, my whole body hurt, the whole body It hurt all the time. When I ate, I would vomit everything I ate, so I couldn't eat much [mumbling, recall: she vomited blood first and everything in her stomach; and her head was heavy and hazy and unclear] ...I just hang in there by killing my emotions ...I am disgusted emotionally ...I think I am in a little depression...but I can hardly figure out what it is, whether my mood is depressed or my body is in pain. Surely [I call it], "anger with nowhere to go" and "disgust."

This woman was trying to explain how much she needed help:

But my headache and lightheadedness never went away. [She described symptoms only when asked: scared, nervous, angry, frustrated, blue; cold hands and feet, stomach pain, abdominal distress, shoulder pain, constipation, lightheadedness;

disconnected, alienated, suspicious, resigned] ...Well, isolation was there ...dark, nobody hears me. It was as if I was locked in a dark place where nobody hears me no matter how hard I try. No matter how hard I try to get out, I couldn't come out. It was like nobody hears me even though I was screaming for help.

The probes used during the lifeline include the specific physical, emotional, and interpersonal symptoms they experienced during the "low" periods. Depending on the number and severity of the low points, women were asked to compare and contrast these times in terms of the symptoms. It is helpful to ask about the level of severity of the symptoms during these low points, although the graphic representation of the lifeline helps the interviewer quickly grasp the number and degree of low times. During the discussion of any given low point, we asked what the women thought might have triggered or caused the low point. We used probes into the meaning that these symptoms had for them, as well as for the people around them. Specifically, we asked how the low point affected their relationships with others.

The last section of the interview asks about what the women did to relieve their distress or get better during these low points. The help-seeking component of the interview focuses on and clarifies the specific efforts people made to relieve their symptoms. However, we have also found that questions about not seeking help can elicit useful information about causal interpretations and evaluation of social significance related to the symptoms, as well as social and structural barriers to help seeking. Other probes included questions about what worked well and what did not work, as well as specific types of help that were not mentioned during the lifeline, such as medications, herbs, exercise and diet changes, or other medical, psychological or alternative therapies that they tried.

Discussion

The development of the CEI was an attempt to create a user-friendly yet ethnographically sound instrument that could gather clinically pertinent information in a short time. However, it is not a brief interview, taking at least 60 minutes to complete. Therefore, it is probably most appropriate for intake sessions. This interview may be difficult to conduct in a busy clinical practice. The length of time it takes to gather cultural information remains a central problem for clinicians, and while the CEI assists with a format for collection, it does not solve this time challenge. In addition, our study was carried out by a trained researcher in the women's homes. It is possible that the clinical encounter in an office setting would not yield the detail we obtained. Our study matched both gender and language during the interviews, which may not be possible in every clinical encounter. Use of an interpreter would make the procedure lengthier and might produce less detail.

We aimed to gather relevant information in a way that did not rely solely on verbal self-expression, and created visual maps that could be used throughout the interview to help the clinician and the patient track their descriptions. We believe that this use of visual representations may be critical for people from cultural groups who express themselves in ways that are context-specific, tend not to use linear chronology, or do not have specific vocabulary for some abstract meanings or experiences. We found that the depictions helped ease the pressure on the participant to "make sense" of what they felt, or to communicate information to us in a format that suited our communication style. These pictures created space for reflection, and even a little playfulness. However, there remains the challenge of how to analyze these depictions, as well as how to compare them between patients. Our research team is currently testing whether these lifelines can be used to establish more quantifiable life-event calendars. Another potentially fruitful line of research might be to use body map drawings at repeated intervals over the course of therapy to assess symptom

change. However, additional questions need to be added to the interview about the specific efficacy of interventions.

The contents of the cultural formulation are complex and interrelated. The material from one section often relates to another, and description of one type of information informs or fleshes out another. Participants in our study continued to evaluate, rework, or clarify sections throughout the interview. Interviewer training is imperative to help track the threads and gather all the necessary information in the shortest amount of time.

The lifeline uses ups and downs to create a socioemotional map of the participant's life, and this map can help them structure and organize their illness narrative. However, the open-ended nature of the interview makes tracking the information difficult. Research on the impact of stress and distress on health in large groups will require innovations and methodological advances that can quantify, as well as qualify, key life events. Therefore, additional research is needed to extend this interview into mixed-method analysis approaches. For example, it might be possible to ask the participant to include major life events, dates, ages, children, and other benchmarks and rate these events along other dimensions, such as attitudes, values, or meanings using survey questions.

We believe that the CEI holds promise for standardizing the process and procedure of collecting clinically relevant data on culture and social context. The CEI is one of a collection of instruments that can be used to supplement other standardized psychiatric, psychological, and social assessments. We believe that this interview is flexible enough to allow for the development of more sophisticated probes in selected areas. For example, many of the questions posed by Mezzich et al. (2009) can be embedded into this protocol. In addition, if the causal attributions of the patient are of particular interest, elements from the McGill Illness Narrative Interview might also be used (Groleau et al., 2006).

In our follow-up interviews, women reported that participation in the interview was beneficial in promoting personal insight. Our experience with this interview process is that it promotes understanding, and fosters a shared exploration of the person's distress across the life course, while still accessing the ethnographically important information necessary to understand their experience in context. Finding ways to enter into the cultural models of our patients that facilitate understanding and mutuality can benefit patients and clinicians as well as researchers and students. Instead of complex lists of probes that may distance the patient from the clinician, and increase the perception of the culturally diverse patient as "other," interviews such as the CEI can provide intuitive, comprehensive, and engaging ways to gather elusive information.

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Shizuka Shimabukuro, PhD, MFT focuses on the cultural and social contributors to depressive symptoms among women and children, including mother–child relationships and development of mental health disorders among Japanese children.

Figure 1.
Sample social network.

Figure 2.
Body map.

Figure 3.
Body map.

Figure 4.
Lifeline.

Figure 5.
Lifeline.

Table 1

Relationship of the cultural formulation and the CEI

Theoretical concepts	Cultural formulation topic	Subheadings in DSM-IV outline*	CEI questions
Meaning Interpretation and social evaluation	Cultural identity of the individual	<ul style="list-style-type: none"> Individual's ethnic or cultural reference group(s) 	<ul style="list-style-type: none"> Describe your typical week
		<ul style="list-style-type: none"> Degree of involvement with both the culture of origin and the host culture (for immigrants and ethnic minorities) 	<ul style="list-style-type: none"> Describe your roles in your family and in your community
		<ul style="list-style-type: none"> Language abilities, use, and preference (including multilingualism) 	
Cultural models and symptom experience And meaning interpretation and social evaluation	Cultural explanations of the individual's illness	<ul style="list-style-type: none"> Predominant idioms of distress through which symptoms or the need for social support are communicated 	<ul style="list-style-type: none"> Body map and life line
		<ul style="list-style-type: none"> Meaning and perceived severity of the individual's symptoms in relation to norms of the cultural reference group(s) 	<ul style="list-style-type: none"> Using the distress experiences on the body map and lifeline, please describe what these symptoms mean about you as a person? What does it mean about you in your family, community?
		<ul style="list-style-type: none"> Local illness categories used by the individual's family and community to identify the condition 	<ul style="list-style-type: none"> What kinds of things do you think cause the ways that you feel? (ask about psychological, social, environmental, spiritual causes)
		<ul style="list-style-type: none"> Perceived causes and explanatory models that the individual and the reference group(s) use to explain the illness 	<ul style="list-style-type: none"> When you think about these feelings, what do you call them?
		<ul style="list-style-type: none"> Current preferences for and past experiences with professional and popular sources of care 	<ul style="list-style-type: none"> When someone has "X", do you think that is it normal? Typical? Severe?
Meaning interpretation and social evaluation	Cultural factors related to psychosocial environment and levels of functioning	<ul style="list-style-type: none"> Culturally relevant interpretations of social stressors, available social supports, and levels of functioning and disability 	<ul style="list-style-type: none"> What kinds of things did you do and did they work? Were there things you wanted to do but couldn't or didn't do?
		<ul style="list-style-type: none"> Stresses in the local social environment 	<ul style="list-style-type: none"> Depict your social network
		<ul style="list-style-type: none"> Role of religion and kin networks in providing emotional, instrumental, and informational support 	<ul style="list-style-type: none"> Who do you see regularly and what is your relationship with them?
Cultural elements of the relationship between the individual and the clinician	Cultural elements of the relationship between the individual and the clinician	<ul style="list-style-type: none"> Individual differences in culture and social status between the individual and the clinician 	<ul style="list-style-type: none"> In reference to your low points, to whom have you talked to help you feel better?
		<ul style="list-style-type: none"> Problems that these differences may cause in diagnosis and treatment (e.g., difficulties in eliciting symptoms and understanding their cultural significance, in determining whether a behavior is normal or pathological, etc.) 	<ul style="list-style-type: none"> Are there people you wanted to talk to but didn't? Why not?
			<ul style="list-style-type: none"> In reference to your low points, did you seek professional help to help you feel better? Describe how this went. How was it helpful?

Theoretical concepts	Cultural formulation topic	Subheadings in DSM-IV outline*	CEI questions
	Overall cultural assessment for diagnosis and care	Discussion of how cultural considerations specifically influence comprehensive diagnosis and care	

Note:

* Summarized from DSM-IV, pp. 843–844, American Psychiatric Association (1994) Appendix I: Outline for Cultural Formulation and Glossary of Culture-Bound Syndromes.