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The Engagement Interview Protocol (EIP): improving the acceptance of mental health treatment among Chinese immigrants

Albert Yeung^{a,b,*}, Nhi-Ha T. Trinh^a, Trina E. Chang^a, and Maurizio Fava^a

^aDepression Clinical & Research Program, Massachusetts General Hospital, Boston, USA

^bSouth Cove Community Health Center, Boston, USA

Abstract

Many depressed Chinese immigrants are unfamiliar with Western psychiatric terminology and have high levels of stigma toward psychiatric illnesses, making it difficult to engage them into psychiatric treatment. We have designed the Engagement Interview Protocol (EIP), a semi-standardized protocol that incorporates cultural components to a standard psychiatric evaluation. The EIP elicits patients' narratives and uses anthropological questions to explore patients' illness beliefs, which are integrated with patients' information on medical and psychiatric history, psychosocial background and mental status examination so that treatment options can be negotiated in a culturally sensitive manner. In our field testing on depressed Chinese immigrants, the EIP model was found to be a practical tool that can be completed within the allotted one-hour time frame and was highly effective in facilitating the enrollment of patients in treatment for depression. The EIP is a concise, time-effective, user-friendly protocol that can be used both in research and real-world clinical settings with diverse patient populations.

Keywords

depression; engagement interview; Chinese Americans; mental disorders

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*Corresponding author. ayeung@partners.org.

Notes on contributors

Dr. Albert Yeung is the director of primary care studies at the Depression Clinical and Research Program (DCRP) at Massachusetts General Hospital (MGH) and assistant professor at Harvard Medical School (HMS). He obtained his medical degree from National Taiwan University, and his Doctor of Science Degree at Harvard School of Public Health.

Dr. Nhi-Ha Trinh is a research fellow and staff psychiatrist at the MGH DCRP and instructor in psychiatry at HMS. She earned her medical degree from University of California, San Francisco and her Masters in Public Health at University of California, Berkeley.

Dr. Trina Chang is a research fellow and staff psychiatrist at the MGH DCRP and instructor in psychiatry at HMS. She earned her medical degree and her Masters in Public Health from Columbia University.

Dr. Maurizio Fava obtained his medical degree from the University of Padova School of Medicine and completed residency training in endocrinology at the same university. He then moved to the United States and completed residency training in psychiatry at MGH, where he has been Director of the DCRP since 1990 and currently serves as the Executive Vice Chair for the Department of Psychiatry and Executive Director of the MGH Psychiatry Clinical Trials Network and Institute (CTNI), an academic CRO focused on coordinating and implementing multi-center clinical trials in psychiatric disorders. Dr. Fava is also Professor of Psychiatry at Harvard Medical School.

Introduction

Depression among Chinese Americans

There has been phenomenal growth in the population of Asian Americans in recent years. The number of Asian Americans in the USA increased from 7.3 million (3.4% of the US population) in 1990 to 10.1 million (4% of the population) in 2000, a 38% increase, with Chinese being the largest group (US Census Bureau, 2000). Despite the trend of growing ethnic diversity, disparities in the treatment of depression continue to be a significant public health challenge (US Department of Health and Human Services, 1999). In our earlier study of Chinese immigrants in Boston's Chinatown, the prevalence of major depressive disorder was 19.6% among underserved Chinese immigrants in an urban primary care setting and most of them (96.5%) were untreated (Yeung&Kung, 2004). There is an urgent need for culturally appropriate interventions to bridge these gaps.

Culturally sensitive treatment of depressed Chinese Americans

Our recent study on Culturally Sensitive Collaborative Treatment for Depressed Chinese Americans in Primary Care (MH67085-01A1) (Yeung et al., in press) was aimed at improving the recognition and treatment of depressed Chinese immigrants in primary care settings in collaboration with primary care clinicians. One of the challenges in this study was to convey the diagnosis of depression to Chinese immigrants, as many of them were unfamiliar with the concept of depression or might hold strong stigma against all mental illnesses (Yung & Kam, 2004). To overcome the challenge, we developed the Engagement Interview Protocol (EIP) to incorporate cultural components into the standard psychiatric interview (Morrison & Munoz, 2009) (see Appendix 1). The EIP is a semi-structured instrument that integrates patients' illness beliefs into psychiatric assessment and evaluation to improve the acceptance of psychiatric treatment among culturally diverse populations. By utilizing and integrating the information obtained from the EIP, clinicians may develop co-constructed illness narratives with patients and reframe the Western concept of depression into more culturally resonant forms.

The standard psychiatric interview

A standard psychiatric diagnostic interview typically consists of the following sections: History of Present Illness, Past Medical History, Psychosocial History, Mental Status Examination and Psychiatric Diagnoses described in Five Axes. The EIP adds patients' narratives and eight anthropological questions (Kleinman, 1980) to explore patients' illness beliefs in the 'History of Present Illness' section and introduces two new sections, one on 'Culturally Sensitive Disclosure of Diagnosis' and another one on 'Customized Approach to Treatment Negotiation'.

Incorporating culture in psychiatric assessment

The key to providing culturally competent health care is the ability to understand the meanings of illness from the patient's perspective within the context of his/her cultural background, as well as to effectively communicate the basis of the medical treatment and its potential benefits using a framework and language that the patient can understand. To bridge

different worldviews between people from different cultures, anthropologists collect and analyze both the ‘insider’s’ or ‘native’s’ interpretation or ‘reasons’ for his or her customs/beliefs and the external researcher’s interpretations of the same customs/beliefs (Headland, Pike, & Harris, 1990). In contrast, in performing psychiatric assessments, clinicians are typically trained to collect data so that patients’ conditions can be classified as DSM-IV-TR disorders based on the presence or absence of certain symptoms (American Psychiatric Association, 2000). The patient’s perspective is usually overlooked or considered as ‘noise’ in the processing of clinical data.

The understanding of the patient’s’ perspective becomes much more important when a clinician sees patients from culturally diverse backgrounds or from a culture that is significantly different than his or hers. In such encounters, the clinician is like an anthropologist who tries to describe the lives and world of the patient of a foreign culture; here the clinician focuses on learning about the patient’s illness beliefs. To understand patients’ illness beliefs, Kleinman (1980) proposed listening closely to patients’ narratives and using eight anthropological questions to summarize the key elements of illness beliefs to bridge the clinicians’ and patients’ perspectives on the illness. These eight questions include: (1) What do you call your problem? What names does it have? (2) What do you think has caused your problem? (3) Why do you think it started when it did? (4) What does your sickness do to you? How does it work? (5) How severe is it? Will it have a short or long course? (6) What do you fear most about your sickness? (7) What are the chief problems the sickness has caused for you? and (8) What kind of treatment do you think you should receive? What are the most important results you hope to receive from the treatment?

In an effort to take into consideration the influence of culture on the psychiatric diagnosis, the DSM-IV compiled the Cultural Formulation model. The DSM-IV Cultural Formulation model uses a semi-structured evaluation format for the individualized assessment of cultural factors, including the patient’s identity, illness experience and context as well as of the clinician-patient relationship. In this model, every patient’s cultural background is described in a brief text that includes: (1) the patient’s cultural identity, (2) cultural explanations of the individual’s illness, (3) cultural factors related to psychosocial environment and functioning, (4) cultural elements of the relationship between the patient and the clinician and (5) an overall assessment of diagnosis and care (Lewis-Fernandez, 1996; Lewis-Fernandez & Naelys, 2002). This comprehensive assessment requires an extended interview that could take hours, making it an impractical tool for our study.

To address this issue, we developed the EIP based on the DSM-IV Cultural Formulation model, Kleinman’s anthropological questions and our own clinical experience serving immigrant populations from diverse cultural backgrounds. In order to fit the constraints of the standard one-hour psychiatric interview while also gathering sufficient information about the role of the patient’s culture, the EIP focuses on exploring the patient’s illness beliefs and explanatory model for his/her illness in order to facilitate the effective discussion of psychiatric diagnosis and engage patients in psychiatric treatment. The EIP is composed of six sections: (1) history of present illness, including the patient’s illness beliefs, (2) psychosocial history, (3) mental status examination, (4) DSM-IV diagnoses, (5) culturally sensitive disclosure of diagnosis and (6) customized treatment negotiation. Equipped with

this understanding, clinicians are better able to use mutually understood terminology and conceptual frameworks when they talk with patients about their experiences and treatment options.

In our field testing on depressed Chinese immigrants, the EIP model was found to be a practical tool that can be completed within the allotted one-hour time frame and was highly effective in facilitating the enrollment of patients in treatment for depression (Yeung, Yu, Fung, Vorono, & Fava, 2006). With its streamlined format, the EIP has the potential to be used as a training tool to provide culturally sensitive assessment to patients from diverse backgrounds and as a routine clinical assessment instrument for all populations to enhance cultural sensitivity.

The Engagement Interview Protocol

History of present illness with illness narratives and illness beliefs

The 'History of Present Illness' section records key clinical information about the onset of illness, symptoms, the course of illness and responses to treatment. Both the patients' illness narratives and illness beliefs are explored in this section of the EIP.

Patients' illness narratives—To understand patients' indigenous illness beliefs, anthropologists have pointed out the importance of listening to the patients' illness narratives, which are stories told by the patients using their own language and conceptualizations. In addition, it is helpful to explore the culture and social influences on the formation, shaping and presentation of patients' symptoms. A useful approach is to create a 'mini clinical ethnography' by using open-ended questions and to allow sufficient time, attention and interest for patients to describe their understanding of their illness (Kleinman, 1988; Weiss, 1997). Using this approach, the clinician can learn the patients' perspective and enter into their experiential world by empathically listening to the patients' illness narratives.

Patients' explanatory models—Understanding the 'cultural explanation of the individual's illness' is essential for achieving an intuitive and empathic understanding of the cultural meanings of symptoms to patients, for shaping how illness will be disclosed to the patients and for negotiating treatment approaches. To elicit the patient's cultural explanation of his/ her illness, the EIP has adopted Kleinman's (1980) eight anthropological questions (above). This data enables clinicians to co-construct interpretations of the illness with their patients, including bridging DSM-IV diagnostic categories with indigenous concepts and discussing treatment options in a culturally sensitive way.

Psychosocial history

This part of the psychiatric interview provides information on the patient's personality, cultural affiliation, self-identity, inspirations, major life goals etc., which correspond to two core elements of the DSM-IV Cultural Formulation model: the 'cultural identity of the individual' and the 'cultural factors related to psychosocial environment and levels of functioning'.

Within the constraints of time, the EIP uses direct questioning to elicit information on patients' developmental, immigration and work history, current social environment and perceived stressors. These items include: (1) country of origin, childhood developmental experience and academic and social experiences, (2) level of education and the schools attended, (3) immigration history (when applicable), including the reason for immigrating to the host country and how it took place, the duration of stay, current immigration status, cultural reference group, language abilities, degree of involvement with both the culture of origin and the host culture and the extent to which the goals of immigration have been achieved, (4) marital status, relationship with spouse and current marital issues if present, (5) spiritual/religious beliefs and how big a role religion plays in the patient's life, (6) family members, their locations, their socioeconomic status and occupation and their relationship with the patient, as well as whether the patient has a strong family support network, (7) past and current job history and (8) the patient's interpretations of social support networks, stressors and levels of functioning and disability.

A simple question like 'how do you like living in this country?' may elicit important information on the patients' adjustment to the host country. In addition, these questions may bring to light potential barriers to diagnosis and care, such as economic restrictions or family pressures that might affect a patient's ability to access treatment.

Mental Status Examination

Refer to Kaplan and Sadock (2000) for a discussion of general components of a mental status examination and Hays (2008) for a discussion of complexities regarding mental status examinations for minority patients.

DSM-IV-TR diagnoses

Psychiatric diagnoses are presented using the DSM-IV-TR five-axis format (APA, 2000). Despite the fact that some patients' explanatory models may not fit DSM-IVTR five-axis diagnostic categories, using this system of diagnoses facilitates communication among mental health professionals and insurance payors in the US healthcare system.

Culturally sensitive disclosure of diagnosis

Disclosure of the depression diagnosis to immigrant populations from diverse cultural backgrounds with traditional illness beliefs poses a special challenge clinically, since they tend to be less familiar with the concept of depressive disorders, hold high stigma towards psychiatric illnesses and interpret symptoms with indigenous beliefs (Yeung & Kam, 2004). In a recent article (Yeung & Kam, 2008), we proposed a systematic approach to providing culturally sensitive disclosure of diagnosis, which includes the following components: (1) eliciting patient's illness beliefs, (2) accepting multiple explanatory models, (3) reframing Western psychiatric concepts, (4) clarifying the meanings of diagnostic labels, (5) using flexible terminology and (6) disclosing diagnoses and treatment approaches in stages. Below we give an example of using this framework with the immigrant Chinese/Chinese American population.

Eliciting the patient's illness beliefs—As described above, the EIP elicits patients' beliefs about what their illness represents, what caused it and why it started, how it affects their life and what expectations they hold about treatment.

Accepting multiple explanatory models—Clinicians are encouraged to take an accepting stance even if their patients' explanations of their illness differ from the ones that Western medicine and psychiatry would offer. The patients' explanations hold meaning for them and should be used as the basis for discussing treatment rationale and expected outcomes.

Reframing Western psychiatric concepts—If patients are familiar with and are comfortable with conventional psychiatric diagnoses, reframing may not be necessary. Very commonly, however, patients from other cultures may not share those conceptualizations of psychiatric illness. In our previous study of depressed Chinese immigrants, when the patients were asked for a reason for their illness, 55% responded, 'I don't know', the rest of the patients attributed their symptoms to medical causes, interpersonal issues or magical forces (Yeung & Kam, 2004). For example, with Chinese immigrants the monoamine hypothesis of depression could be framed as an imbalance of chemicals in the brain due to stress. This explanation would be readily understood because it overlaps with beliefs from traditional Chinese medicine. According to this framework, an antidepressant would act to relieve symptoms such as sadness, insomnia and fatigue by restoring balance to the system, by tonifying (补脑 *bu nao*) or by strengthening the energy of the brain. Similarly, relating the concepts of 'balance' and 'imbalance' to the patient's interpersonal life and physical condition would be another way to tailor Western psychiatric concepts to fit within a contextual, family-centered, physical/somatic framework to Chinese patients. None of these explanations runs contrary to modern psychiatric thinking; rather, these reframings make the explanations more accessible and familiar to the patients.

Clarifying the meanings of diagnostic labels—Many Chinese immigrants tend to associate all psychiatric terminologies with insanity. It is important to explain to them what depression means. One useful approach is to say, 'You have reported having symptoms like sadness, sleep disturbance, loss of interest, blaming yourself, loss of appetite and being irritable. In the West, these symptoms are called depression.'

Flexible use of terminology—Using our experience working with Chinese immigrants, the choice of Chinese translations of psychiatric disorders is very important to avoid stigmatized connotations. To avoid being too technical, Western clinicians often use the more colloquial term 'depression' rather than 'major depressive disorder' when working with English-speaking patients. With Chinese-speaking patients, there are several choices of translation. Strictly translated into Chinese, the term 'major depressive disorder' becomes *zhong xing you yu zheng* (重型忧鬱症), which literally means 'severe depressive disorder'. In practice, clinicians or their Chinese interpreters often use the terms *you yu zheng* (抑鬱症) or *yi yu zheng* (忧鬱症), which would be translated as 'depressive disorder'. We suggest using an even more general term such as *you yu* (忧鬱), or

‘depression’, which, like its English equivalent, can refer to both a normal variation of mood as well as a pathological state. This term would be more acceptable to many Chinese immigrants who are less acculturated. This approach is analogous to the use of the more colloquial term ‘depression’ rather than ‘major depressive disorder’ with English-speaking patients in the West.

Going further, it would be acceptable to avoid mental health jargon altogether and use simple descriptive language. One example might be to inform a patient that ‘all your personal problems have taken a toll on you and now you are feeling sad and tired and you are having a lot of the symptoms associated with them.’

While we propose using flexible terminology, at least in the initial visits with Chinese immigrants, it needs to be emphasized that we do not endorse using deceptive terms with patients, since this would be ethically unacceptable and could jeopardize trust between clinicians and patients. Rather, our approach encourages providing a truthful description of the illness in plain language for patients with diverse cultural backgrounds.

Disclosing diagnoses and treatment approaches in stages—The technical term for the psychiatric diagnosis can and should be offered to the patient, but only after basic ideas have been communicated with minimal stigma and surprise. At that point, the term can be presented in a way that is culturally resonant.

A customized approach to treatment negotiation

After exploring the patient’s illness beliefs about the illness and taking the necessary steps to disclose the patient’s diagnosis, the clinician enters into the treatment negotiation. Treatment negotiation empowers the patient and shows that the clinician respects the patient’s point of view; in a practical sense, it may facilitate engaging the patient into treatment. Clinicians may start by providing the rationale for treatments, usually aimed at alleviating patients’ suffering and reducing the functional impairment caused by the medical/psychiatric conditions that prompted the visit. Clinicians should then discuss available treatment options, provide the rationale and pros and cons of each treatment and inform the patient of possible side effects (Fawcett, 1995). If the patient is reluctant to initiate treatment, then reassurance and clarification of underlying fears or worries about treatment are frequently helpful. Since many patients come to the clinic with specific illness beliefs, needs and requests in mind, clinicians need to be open-minded and flexible to allow open communication between patient and clinician (Lazare, Eisenthal, & Wasserman, 1975). Negotiation between patients and practitioners over salient conflicts almost always contributes to more empathic and ethical treatment. The questions from the History of Present Illness section: ‘What kind of treatment do you think you should receive?’ and ‘What are the most important results you hope to receive from the treatment?’ provide the background information for treatment negotiation.

Part of treatment negotiation may involve exploring the patients’ understanding as well as preference for medication treatment, counseling and other treatment measures and to clarify misconceptions or worries (e.g. can counselors keep things confidential) that might exist. For example, many Chinese immigrants are not familiar with psychotherapy treatment, what

it entails or how it could be helpful to them. On the other hand, a fraction of Chinese immigrant patients who are emotionally overwhelmed actively seek ‘talk therapy’ for their need for catharsis, emotional support and guidance. Many of them have heard of and like the term counseling ‘, 心理辅导 (xin li fu dao), which refers to psychological guidance or coaching.

Other patients may have a preference against medication treatment. For example, many Chinese immigrants either consider psychotropics to be treatment for the insane or question the usefulness of medications for solving their psychosocial problems, the focus of their worries. We find that the concept of imbalance of neurotransmitters in the brain triggered by stress and/or depression is helpful for framing this discussion and is well received by many Chinese Americans, probably because it is similar to the concept of imbalances of yin and yang, a cornerstone of Chinese philosophy.

The negotiation may end up with a compromise, which could be closer either to the patients’ or the doctor’s position. If for technical or ethical reasons the physician is uncomfortable with the compromise, referral should be made to another practitioner. It is important to maintain honesty, to accept criticism and to be open to discuss one’s uncertainty and the limits of one’s understanding.

Case vignettes

In the following section, we use the case vignettes of four Chinese patients who fit the DSM-IV criteria for major depressive disorder as examples of how to adopt patients’ illness beliefs in disclosing patients’ illness and in treatment negotiation. Identifiers have been changed and histories merged to protect patient privacy.

Vignette 1. The depressed patient who focused on anxiety symptoms

The patient was a single Chinese male in his twenties who had recently emigrated to the USA. He worked as a waiter in a restaurant and was under a lot of pressure as he had borrowed a huge sum of money to be smuggled into the USA. While he was preoccupied with anxiety symptoms, he reported having depressed mood, insomnia, irritability, loss of interests and difficulty concentrating when he was asked specifically about depressive symptoms. He had received no treatment for these symptoms in the past two years.

Patient’s explanatory model of his illness experience

1. What do you call your problem? – ‘Worries.’
2. What do you think has caused your problem? – ‘Immigration and language problems.’
3. Why do you think it started when it did? – ‘Two years ago after I came to the USA.’
4. What does your sickness do to you? How does it work? – ‘I cannot concentrate on my work.’

5. How severe is it? Will it have a short or long course? – ‘Pretty severe’; ‘It has lasted for a long time.’
6. What do you fear most about your sickness? – ‘That I might become impulsive and even hurt myself.’
7. What are the chief problems the sickness has caused for you? – ‘Too much worries in my head.’
8. What kind of treatment do you think you should receive? – ‘Try to stay in touch with my family.’ What are the most important results you hope to receive from the treatment? – ‘To get better.’

Culturally sensitive disclosure of diagnosis—The patient did not label his problems as depression and he focused on his anxiety and worries. Yet when he was asked about the depression symptoms, he acknowledged having many of them. He considered his symptoms a result of being under a lot of stress, particularly due to financial problems. When we tried to communicate with him about his illness, we adopted his explanatory model and used his own words in suggesting that it was likely that his symptoms were due to ‘pressure’ (ya li) in his life as a recent immigrant. We asked him if he had heard of depression (yi yu zheng) and whether he might be suffering from depression. He replied that he was not familiar with the term and he was not sure if he had the illness. We informed him that while it may be too early to conclude, there may be a possibility that he actually had depression.

Customized approach to treatment negotiation—In negotiating treatment, he was informed that there are medications available to reduce his worries as well as his other related symptoms, including insomnia, irritability and loss of interest, and that he should expect to ‘get better’ in several weeks. Possible side-effects of this class of medications were discussed. The patient agreed to try the medications and see if they could help him. He was prescribed mirtazepine at the end of the interview.

Vignette 2. The depressed patient who attributed her symptoms to psychosocial problems

The patient was a Chinese female in her 20s who had emigrated to the USA recently. She and her husband were divorced due to ‘incompatible personalities’ and she lived with her son. She had been laid off from her job three months earlier, which had caused significant financial hardship. The patient and her son shared an apartment with roommates and she complained about her cramped living conditions. When she felt like crying, she needed to bottle up her feelings as she did not want her roommates to see. She reported that she had been suffering from sadness, insomnia, loss of interest, irritability, guilt, loss of interest and difficulty concentrating. She had not received any treatment for these symptoms.

Patient’s explanatory model of her illness experience

1. What do you call your problem? – ‘Don’t know.’
2. What do you think has caused your problem? – ‘Financial pressure.’
3. Why do you think it started when it did? – ‘Since I was laid off several months ago.’

4. What does your sickness do to you? How does it work? – ‘Pressure from financial problems and crowded housing have caused my problems.’
5. How severe is it? Will it have a short or long course? – ‘Moderately severe’; ‘not sure.’
6. What do you fear most about your sickness? – ‘The influence of my emotions on the son.’
7. What are the chief problems the sickness has caused for you? – ‘Sadness, being irritable.’
8. What kind of treatment do you think you should receive? What are the most important results you hope to receive from the treatment? – ‘To improve in our living conditions.’

Culturally sensitive disclosure of diagnosis—The patient was aware of her own mood and depressive symptoms, although she attributed them to her financial and living condition rather than a mental condition. We agreed with her interpretation of the importance of her psychosocial stress or ‘pressure’ (in her own words) on the development of her symptoms. When we asked her if she considered herself having depression, she replied, ‘possible’.

Customized approach to treatment negotiation—She acknowledged that improving her housing conditions was important and we suggested that she look into applying to state-subsidized housing. In addition, we pointed out that the treatment of depression would help her to feel less stressed and irritable, as she feared the effect of her mood symptoms on her son. We informed her that with treatment of depression, her mood and other depression symptoms would improve and she would be more likely to function better when interviewing for new jobs. We offered her treatment options including medications and therapy and the patient agreed to be referred to a therapist.

Vignette 3. The depressed patient who focused on her somatic symptoms

The patient was a widowed Chinese female in her sixties who had emigrated to the USA several years ago. She lived alone in elderly housing and she provided childcare for her grandchildren several days a week. She felt that she had had difficulty adjusting to life in the USA and felt socially isolated and lonely. She complained about insomnia and headaches and was very worried about her sleep disturbance. She also endorsed having depressed mood, loss of interest, feelings of guilt, fatigue, difficulty with concentration, irritability and passive suicidal ideation on the depression screening questionnaire. She hoped to get medications for her insomnia.

Patient’s explanatory model of her illness experience

1. What do you call your problem? – ‘Insomnia and fatigue.’
2. What do you think has caused your problem? – ‘Adjustment problems in the US.’

3. Why do you think it started when it did? – ‘About six years ago when I came to the US.’
4. What does your sickness do to you? How does it work? – ‘When I cannot sleep, I feel tired and have headaches.’
5. How severe is it? Will it have a short or long course? – ‘Insomnia is pretty severe’; ‘it has been six years.’
6. What do you fear most about your sickness? – ‘Cannot sleep at night.’
7. What are the chief problems the sickness has caused for you? – ‘Insomnia.’
8. What kind of treatment do you think you should receive? – ‘Medications might help.’ What are the most important results you hope to receive from the treatment? – ‘To sleep well.’

Culturally sensitive disclosure of diagnosis—The patient focused strongly on her somatic symptoms, including insomnia, headaches and fatigue. She labeled her problem ‘insomnia’, which is very common among Chinese patients with depression. We explored if she had heard of depression and whether she considered herself to be suffering from depression. When asked, patient replied that she had sort of heard of depression, but did not think she suffered from depression. We explained that in the West, depression refers to a cluster of symptoms including sadness, insomnia, loss of interest, guilt feelings, fatigue, difficulty concentrating, irritability and suicidality, similar to many of the symptoms that she reported.

Customized approach to treatment negotiation—The fact that patient focused on her somatic symptoms, insomnia in particular, made the treatment negotiation easier. She had considered taking medications for sleep, but in the Chinese community ‘sleeping pills’ (an mian yao) have strong negative connotations, as these medications are considered to have potent addictive effects, many people in the Chinese community tend to avoid them if possible. We reassured her that we were not planning to use ‘sleeping pills.’ Rather, we planned to use medications like selective serotonin reuptake inhibitors, which were effective in treating insomnia and many of the symptoms she reported without any addictive potential. The patient was receptive to the recommendation and accepted an antidepressant, despite denying that she had a depressive disorder.

Vignette 4. The depressed patients who considered herself as having poor health with unidentified causes

The patient was a widowed Chinese female in her fifties who had emigrated to the USA several years ago. She was a housewife in China and worked as a home health aide in the USA. She reported having difficulty adjusting to life in the USA, feeling pressured and struggling with language barriers, financial problems and social isolation. She complained of insomnia, loss of interest, irritability, excessive worries, difficulty concentrating and multiple physical symptoms, including nasal congestion, facial swelling, joint pain and a ten-pound weight loss since emigrating to the USA. Her primary care physician did not find any specific illness after repeated examinations and laboratory tests.

Patient's explanatory model of her illness experience

1. What do you call your problem? – 'Don't know', 'it could be poor health.'
2. What do you think has caused your problem? 'Not sure.'
3. Why do you think it started when it did? – 'Three years ago after I emigrated to the US.'
4. What does your sickness do to you? How does it work? – 'I have poor health, not sure what has caused it.'
5. How severe is it? Will it have a short or long course? – 'Moderately severe', 'Not sure. It has been three years.'
6. What do you fear most about your sickness? – 'I might have an unidentified illness as I have been having a lot of problems.'
7. What are the chief problems the sickness has caused for you? – 'Not feeling well.'
8. What kind of treatment do you think you should receive? – 'Not sure.' What are the most important results you hope to receive from the treatment? – 'I want to feel better.'

Culturally sensitive disclosure of diagnosis—The patient was aware that she had multiple physical and emotional symptoms. She, like many Chinese immigrants with traditional illness beliefs, was unfamiliar with the concept of depression and attributed her symptoms to 'poor health'. During the interview, she was asked if she held strong opinions against being diagnosed with depression. She did not offer a direct answer, but remained skeptical that she had depression.

Customized approach to treatment negotiation—If the patient is not familiar with depression or feels stigmatized by being diagnosed with depression, treatment negotiation could focus on 'symptom reduction' through available effective treatments. The patient was encouraged to consider medication treatment as well as adopting self-management measures such as exercise, relaxation techniques, problem-solving skills and positive thinking for relief of symptoms. Although many patients are unfamiliar with depression or wary of the diagnosis, they may be willing to accept medications, including antidepressants, if reassured that these are safe medications that may reduce or even eliminate their symptoms.

Conclusion

Culture plays an important role in influencing the formation and presentation of psychiatric problems, and patients' illness beliefs. The EIP is a practical tool that incorporates cultural components into the usual psychiatric assessment format and is designed to fit a standard one-hour initial psychiatric evaluation. The EIP explores patients' cultural explanations of illness by eliciting patients' narrative descriptions and with structured questions. The EIP uses standardized items to elicit patients' psychosocial history and generates information on patients' cultural identity, psychosocial environment and levels of functioning. By providing a more complete understanding of the patients' cultural background, the EIP may improve

communication between practitioners and their patients and enhance culturally sensitive disclosure of psychiatric diagnosis and engagement of patient into psychiatric treatment.

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References

- APA (American Psychiatric Association). Diagnostic and statistical manual of mental disorder. 4th rev. ed. Washington, DC: Author; 2000.
- Fawcett J. Compliance: Definitions and key issues. *Journal of Clinical Psychiatry*. 1995; 56(Supplement 1):4–8. discussion, 9–10. [PubMed: 7836349]
- Hays, P. Addressing cultural complexities in practice: Assessment, diagnosis and therapy. 2nd ed.. Washington DC: American Psychological Association; 2008.
- Headland, TN.; Pike, KL.; Harris, M., editors. *Frontiers of Anthropology Series*. Newbury Park, CA: Sage; 1990. Emics and etics: The insider/outside debate.
- Kaplan, BJ.; Sadock, VA. *Comprehensive textbook of psychiatry*. 7th ed.. Philadelphia, PA: Lippincott Williams & Wilkins; 2000.
- Kleinman, A. Patients and healers in the context of culture: An exploration of the borderline between anthropology, medicine, and psychiatry. London: University of California Press; 1980.
- Kleinman, A. *The illness narrative: Suffering, healing, and the human condition*. New York: Basic Books; 1988.
- Lazare A, Eisenthal S, Wasserman L. The customer approach to patienthood: Attending to patient requests in a walk-in clinic. *Archives of General Psychiatry*. 1975; 32:553–558. [PubMed: 1124971]
- Lewis-Fernandez R. Cultural formulation of psychiatric diagnosis. *Culture, Medicine, and Psychiatry*. 1996; 20:133–144.
- Lewis-Fernandez R, Naelys D. The cultural formulation: A method for assessing cultural factors affecting the clinical encounter. *Psychiatric Quarterly*. 2002; 73(4):271–295. [PubMed: 12418357]
- Morrison, J.; Munoz, RA. *Boarding time: A psychiatric candidate's guide to Part II of the American Board of Psychiatry and Neurology examination*. 4th ed.. Washington, DC: American Psychiatric Press; 2009.
- US Census Bureau. *US Census*. New York: Department of Labor; 2000. 2000.
- US Department of Health and Human Services. *Mental health: A report of the Surgeon General—executive summary*. Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health; 1999.
- Weiss M. Explanatory Model Interview Catalogue (EMIC): Framework for comparative study of illness. *Transcultural Psychiatry*. 1997; 34:235–263.
- Yeung, A.; Kam, R. Illness beliefs of depressed Asian Americans in primary care. In: Georgiopoulos, AM.; Rosenbaum, JF., editors. *Perspectives in cross-cultural psychiatry*. Philadelphia, PA: Lippincott Williams & Wilkins; 2004. p. 21–36.
- Yeung A, Kam R. Culturally sensitive approach to discussing psychiatric diagnoses with less acculturated Chinese immigrants: Reconciling the gap using MDD diagnosis delivery in less-acculturated Chinese patients. *Transcultural Psychiatry*. 2008; 45(4):531–552. [PubMed: 19091724]
- Yeung A, Kung WW. How culture impacts on the treatment of mental illnesses among Asian Americans. *Psychiatric News*. 2004; 21(1):34–36.
- Yeung A, Shyu I, Fisher L, Wu S, Yang H, Fava ML, Yang H, Fava M. Culturally Sensitive Collaborative Treatment (CSCT) for depressed Chinese Americans in primary care. *American Journal of Public Health*. (in press).

Yeung A, Yu SC, Fung F, Vorono S, Fava M. Recognizing and engaging depressed Chinese Americans in treatment in a primary care setting. *International Journal of Geriatric Psychiatry*. 2006; 21:819–823. [PubMed: 16955440]

Appendix A: The Engagement Interview Protocol (EIP)

1. History of illness

A. Present illness

Patient's narratives on personal illness experience

Patient's cultural explanatory of his/her illness

1. What do you call your problem?
2. What do you think has caused your problem?
3. Why do you think it started when it did?
4. What does your sickness do to you? How does it work?
5. How severe is it? Will it have a short or long course?
6. What do you fear most about your sickness?
7. What are the chief problems the sickness has caused for you?
8. What kind of treatment do you think you should receive?
What are the most important results you hope to receive from the treatment?

B. Past psychiatric/medical history

C. Family history

2. Psychosocial history

- A. Country of origin and childhood development
- B. Education level
- C. Immigration history: the date, purpose, and process of immigration; adjustment in the host country
- D. Marital history
- E. Spiritual/religious beliefs
- F. Family support network: Whom do you live with? How's your relationship with your spouse, parents, siblings, children etc?
- G. Past and current job
- H. Social supports
- I. Stressors
- J. Levels of functioning

3. Mental status examination

Appearance:

Attitude:

Speech:

Motor:

Mood:

Affect:

Thought contents:

Cognition and intellectual resources:

Insight/Judgment:

4. Multi-axial diagnoses

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

5. Culturally sensitive disclosure of diagnosis

Elicit the patient's illness beliefs

Accept multiple explanatory models

Clarify the meanings of diagnostic labels

Sensitive and flexible use of terminology

Disclose in stages

6. A customized approach to treatment negotiation

Explore the patient's understanding and preferences for treatment

Discuss the pros and cons of treatment options

Negotiate and finalize treatment plan

Discuss potential side effects from treatment and possible remedies