

Issues in the Assessment and Diagnosis of Culturally Diverse Individuals

*By Francis G. Lu, M.D., Russell F. Lim, M.D.,
and Juan E. Mezzich, M.D., Ph.D.*

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The Culture of Emotions

A Cultural Competence and Diversity Program

*Produced by Harriet Koskoff,
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**A 58-minute video training program
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Issues in the Assessment and Diagnosis of Culturally Diverse Individuals

Francis G. Lu, M.D., Russell F. Lim, M.D., and Juan E. Mezzich, M.D., Ph.D.

A consideration of culture is essential in the process of the interview, case formulation, diagnosis, and treatment of culturally diverse individuals. The evaluation of these individuals raises many issues that clinicians need to address to formulate an accurate diagnosis and treatment plan that will be acceptable to the patient. The assessment of minority patients has additional layers of complexity when compared with assessment of nonminority patients, especially when the patient has a different cultural or ethnic background from the clinician. Thus, clinicians need to develop culturally competent knowledge, attitudes, and skills. The clinician should have some knowledge of the patient's cultural identity, and the use of a cultural consultant may be appropriate to avoid biases and misdiagnosis (Budman et al. 1992), even if the clinician and patient are of the same culture and ethnicity (Comas-Diaz and Jacobsen 1991; T. L. Cross et al. 1989; Pinderhughes 1989). Also, clinicians need to be aware of their own cultural identity and their attitudes and beliefs toward ethnic minorities, because these will affect their relationships with patients. Finally, clinicians need additional skills because traditional methods of interviewing the patient may not be effective and psychological tests may not be adequate or appropriate. Clinicians may need to use an interpreter (Westermeyer 1990) or may need to conduct family interviews, and psychological tests may need modification (Marsella 1989).

Many organizations have begun to address these issues in the assessment and diagnosis of culturally diverse individuals. Both the American Psychological Association and the American Counseling Association have recognized the importance of considering the effect of culture on diagnosis and treatment. These organizations have published similar guidelines for clinical competence with culturally diverse individuals. The American Psychological Association (1993) guidelines acknowledge the necessity of assessing individuals in the context of their ethnicity and culture, respecting their indigenous beliefs and practices (including those involving religion and spirituality), assessing the patients' support systems, evaluating the patients in their primary language, and taking a history that accounts for immigration and acculturation stresses. The American Counseling Association guidelines stress the awareness of both patient and clinician beliefs, the attainment of background knowledge about the patient (including his or her worldview), and the development of culturally competent skills (Sue et al. 1992). In addition, the ICD-b (World Health Organization 1992) incorporated major methodological developments such as a phenomenological organization of nosology, use of more specific definitions for diagnostic categories, the employment of multi-axial framework, and the development of an international psychiatric lexicon (containing a description of culture-bound syndromes) as well as an international casebook. Finally, the American Psychiatric Association acknowledged the impact of culture and ethnicity on diagnosis and treatment, as stated in the introduction to DSM-IV (American Psychiatric Association 1994a):

Special efforts have been made in the preparation of DSM-IV to incorporate an awareness that the manual is used in culturally diverse populations in the United States and internationally. Clinicians are called on to evaluate individuals from numerous different ethnic groups and cultural backgrounds (including many who are recent immigrants). Diagnostic assessment can be especially challenging when a clinician from one ethnic or cultural group uses the DSM-IV Classification to evaluate an individual from a different ethnic or cultural group. A clinician who is unfamiliar with the nuances of an individual's cultural frame of reference may incorrectly judge as psychopathology those normal variations in behavior, belief, or experience that are particular to the individual's culture. (p. xxiv)

Whereas in DSM-III-R (American Psychiatric Association 1987) the importance of culture was only briefly acknowledged, DSM-IV has an appendix that contains an outline for cultural formulation and a glossary of culture-bound syndromes. In addition, “specific culture features” are considered where appropriate in the actual diagnostic categories. In summary, the consideration of cultural factors in the assessment, diagnosis, and treatment of culturally diverse individuals has gained recognition in a variety of disciplines in the last decade.

In this chapter, we present a brief history of psychiatric case formulation; define culture, ethnicity, and race; and focus on an explication and elaboration of the DSM-IV outline for cultural formulation. Aspects of cultural formulation include assessing a patient’s cultural identity and understanding how culture affects the explanation of the individual’s illness, support system, and the clinician-patient relationship as well as understanding how culture affects the assessment and diagnosis of culturally diverse individuals.

CASE FORMULATION: BACKGROUND HISTORY

The formulation of cases has been essential to the assessment, diagnosis, and treatment of patients since Freud’s time, and many models have been proposed to organize patient data and inform treatment. These models include the psychodynamic, the biological, the behavioral, and the biopsychosocial (Sperry et al. 1992). Earlier in this century, the psychodynamic model was the most prominent; it begins with the assumption that the patient’s problems can be understood as a result of conflicts that result in anxiety (Perry et al. 1987). The biological model, which posits an organic basis for psychopathology, was more commonly associated with other medical specialties and has become more prominent since 1950 with the advent of psychotropic medications (Ayd and Blackwell 1984), the discoveries of sensitive receptor assays resulting in more specific drugs (Snyder 1985), and the development of improved structural and functional brain-imaging techniques (Andreason 1989). The behavioral model operates on the premise that an individual’s behavior is determined by learning patterns such as disordered thoughts from an event, which then results in behaviors that are self-reinforcing (Cohen and Farrell 1988). The biopsychosocial model, which is based on systems theory, states that patients’ biological state, psychological makeup, and environment all affect their illness presentation and treatment (Engel 1980).

We believe that focusing on the cultural formulation enhances the usefulness of the biopsychosocial model, especially for culturally diverse individuals. The cultural formulation highlights the effect of culture on the expression of symptoms, definition of illness, and treatment. In the past, many authors have discussed the importance of considering the effect of culture on diagnosis and treatment. Fabrega (1987) and Kleinman (1988) agreed that culture affects the clinician’s impressions of normality and categories of illness. Rogler and Cortes (1993) stated that culture affects the patient’s access to mental health care. Sue and Sue (1990) stated that the impetus for the increasing interest in cultural issues lies in the recognition that our society is becoming multi-racial, multicultural, and multilingual, whereas the training of mental health professionals has not reflected this trend, preferring to remain monocultural.

CULTURAL FORMULATION

Hinton and Kleinman (1993) discussed a practical approach to making culturally appropriate formulations. The first step is to show empathy during the interview and then to elicit the patient’s perspective on the illness. Next, the patient’s experience can be assessed in the context of the patient’s family, workplace, health care systems, and community. Finally, the patient’s illness can be diagnosed both through DSM-IV categories and through the patient’s cultural idioms of distress. Hinton and Kleinman’s overall schema is similar to the one developed by the National Institute of Mental Health (NIMH) Culture and Diagnosis Group (Mezzich et al. 1993). The DSM-IV outline for cultural formulation includes the following:

Cultural identity of the individual. Note the individual’s ethnic or cultural reference groups. For immigrants and ethnic minorities, note separately the degree of involvement with both the culture of origin and the host culture (where applicable). Also note language abilities, use, and preferences (including multilingualism).

Cultural explanations of the individual's illness. The following may be identified: the predominant idioms of distress through which symptoms or the need for social support are communicated (e.g. "nerves," possessing spirits, somatic complaints, inexplicable misfortune), the meaning and perceived severity of the individual's symptoms in relation to norms of the cultural reference group, any local illness category used by the individual's family and community to identify the condition. the perceived causes or explanatory models that the individual and the reference group use to explain the illness, and current preferences for and past experience with professional and popular sources of care.

Cultural factors related to psychosocial environment and levels of functioning. Note culturally relevant interpretations of social stressors, available social supports, and levels of functioning and disability. This would include stresses in the local social environment and the role of religion and kin networks in providing emotional, instrumental, and informational support.

Cultural elements of the relationship between the individual and the clinician. Indicate differences in culture and social status between the individual and the clinician and problems that these differences may cause in diagnosis and treatment (e.g., difficulty in communicating in the individual's first language, in eliciting symptoms or understanding their cultural significance, in negotiating an appropriate relationship or level of intimacy, in determining whether a behavior is normative or pathological).

Overall cultural assessment for diagnosis and care. The formulation concludes with a discussion of how cultural considerations specifically influence comprehensive diagnosis and care. (American Psychiatric Association 1994a, pp. 843—844)

Before reviewing each of these topics, we need to define some key terms.

DEFINITIONS

Culture

As described by the NIMH Culture and Diagnosis Group (Mezzich et al. 1993) for incorporation into DSM-IV, culture and ethnicity are related concepts. According to that group:

Culture refers to meanings, values, and behavioral norms that are learned and transmitted in the dominant society and within its social groups. Culture powerfully influences cognitions, feeling, and "self" concept, as well as the diagnostic process and treatment decisions. Ethnicity, a related concept, refers to social groupings which distinguish themselves from other groups based on ideas of shared descent and aspirations, as well as to behavioral norms and forms of personal identity associated with such groups. (p. 7)

Culture has many meanings and can be thought of as the beliefs, customs, technologic achievements, language, and history of a group of similar people (Johnson 1988). Alternatively, it can be thought of as the values, meaning, and behaviors that are transmitted by the dominant group. Its precise definition is poorly agreed on; Kroeber and Kluckhohn (1963) listed more than 150 definitions. Linton (1945) defined *culture* as being a shared, learned behavior transmitted from one generation to another, having both external and internal components. The external components include beliefs, laws, traditions, customs, morals, and habits; the internal components consist of norms, rules, standards, ideals, and values.

Cultures also differ in their conception of personal identity. In general, Eastern cultures favor a group identity, whereas Western cultures favor individual autonomy. Another significant difference is the concept of the body. Western societies tend to see the mind and body as separate, whereas Eastern societies tend to see the mind and body as a whole. Cultural expectations and norms determine if a constellation of symptoms is judged as pathological or not. Various disorders have differing prevalences in different ethnic groups, and each group has variations in the expression of the illness (Burnam et al. 1987; G. J. Canino et al. 1987; Karno et al. 1987). For example, many Australians, who typically value independence, may have a more difficult time with depression because it makes them more dependent on others, whereas many Japanese, who value community-based decisions, may have less difficulty with depression (Radford et al. 1991). Each culture has its own range of communication style (e.g., language, gestures, and rituals), eating behaviors, family roles (e.g., marital, gender, and leadership roles), beliefs and rituals (e.g., child rearing and sexual practices), and ways of regulating aggressive and sexual drives. In summary,

culture can be understood as a complex construct of socially transmitted ideas, feelings, and attitudes that shape behavior, organize perceptions, and label experiences.

Ethnicity

Ethnicity refers to an individual's sense of belonging to a group of people sharing a common origin and history, along with similar cultural and social beliefs (Group for the Advancement of Psychiatry 1987). It is thus closely linked to the individual's self-image. *Ethnicity* also refers to shared descent and aspirations, as well as behavioral norms and personal identity. Finally, *ethnicity* may imply national and geographical origin, as well as religious beliefs. Incorrect assumptions about ethnicity, based on language or appearance alone, can lead to misunderstanding and misdiagnosis of culturally diverse minority individuals (Del Castillo 1970; Hughes 1993).

Race

In contrast to ethnicity and culture, *race* is not mentioned in DSM-IV; it refers to the biologically determined similarities of a group, which affect the interactions with others when perceived differences lead to the use of value hierarchies embodied in bias or prejudice. According to Pinderhughes (1989), *race* has "a different level of cultural meaning than ethnicity" (p. 71). For example, a West Indian black is ethnically and culturally different from an African American, yet both may be treated with the same prejudiced attitudes by whites. Pinderhughes stated that race has social meaning, assigns status, limits opportunities, and influences interactions between patients and clinicians. For example, the psychological effect of a person's facial complexion can be traced to the racism that has as its roots the history of conflicts between certain social groups in the United States. Racial prejudices influence the expectations that people have of one another and can lead clinicians to stereotype individuals.

CULTURAL IDENTITY

There are many components to a patient's cultural identity that go beyond the concepts of ethnicity and race, because a person may have several cultural reference groups. For example, two Hispanic persons may come from Mexico but may have different cultural identities depending on what socioeconomic status and geographical region from which they originated. Multiple factors affect an individual's cultural identity (Table 18—1).

It is vital to know these multiple aspects about patients' cultural identity to avoid misconceptions based on ignorance or stereotypes related to ethnicity and race or any one aspect of cultural identity. Clinicians need to explore the patient's developmental history to understand what makes him or her either different from or similar to a person born and raised in the predominant host culture in the United States. These characteristics may include country of origin, family structure, customs, values, and beliefs, as well as attitudes about medicine and psychiatry. If patients are recent immigrants, clinicians need to explore the immigration experience, including any trauma, separation, losses, alienation, class displacements, or disappointments. If the patients are not recent immigrants but belong to later generations, focus can be placed on the level of their acculturation, which refers to the degree to which they have adopted the beliefs, values, and practices of the host culture (Westermeyer 1993).

Previous work on the concept of cultural identity includes the concept of worldview, whether Eurocentric or multicultural, which avoids the use of labels that can oversimplify and stereotype (Ivey et al. 1993). Patients' histories can be thought of in terms of their personal, family, and cultural histories. These histories are held by the patients as constructs, which can be detected by their use of key words or words that they use over and over as they interact with the clinician. Kelly (1955) stated that constructs are not the concrete reality, but the individual's personal explanation and meaning. Family constructs can be elicited with a genogram and a developmental history. Finally, cultural constructs can be assessed by asking about gender, religious, or ethnic and racial issues among other aspects (Table 18—1).

Table 18-1. Aspects of Cultural Identity Development

Ethnicity	Gender
Race	Age
Country of Origin	Sexual orientation
Language	Religious and spiritual beliefs
Acculturation	Socioeconomic class and education

Another method of conceptualizing cultural identity is through an interpersonal grid, which involves assessing the patient's worldview by using system variables. The clinician attempts to discuss particular topic areas—such as demographic (age, gender, and location), status (social, educational, and economic), and affiliations (ethnic, religious, and family)—and the behaviors, expectations, and values associated with these factors (Pedersen and Ivey 1993). Thus, clinicians are better able to interpret and predict their patients' behaviors if they are aware of the differences between their own and their patients' explanations of behaviors. This model helps the clinician to understand that the same behavior can have different meanings to others and that behavior needs to be interpreted in the context of these topic areas.

Finally, another schema for understanding cultural identity is the multicultural cube, which adds the dimension of level of "cultural identity development" (p. 100) (Ivey et al. 1993). Cultural identity development refers to how the culturally diverse individual sees himself or herself in respect to the host culture. The least developed level is acceptance or conformity, which describes a compliant position. Following that level is one of dissonance, where the individual is in conflict with his or her own cultural identity and that of society. The next level is resistance, in which the individual rejects all that is the host culture. Following that level is one of introspection, which implies that both cultures can coexist, but that the host culture is irrelevant. Finally, there is the level of integrative awareness, in which individuals can accept the best and worst aspects of both cultures (Atkinson et al. 1989). Similar well-researched schema of racial and ethnic identity development has focused on African Americans (W. Cross 1991), African Americans and whites (Helms 1990), Asian Americans (Sue and Sue 1990), and Hispanics (Bernal and Knight 1993).

Assessment of Ethnicity

The ethnicity of a patient can be assessed by taking a careful history of the patient's development and family. Clinicians can ask patients to describe their grandparents' and parents' country of origin, religion, primary language, traditional roles, and traditional skills. Patients should be asked about their socialization experiences (such as their proficiency with their culture's native language), their role in their family constellation, special rituals during certain ages (rites of passage), religious practices, holiday observances, or preparation of ethnic food that they have observed with their families. Finally, patients should be asked to what extent they are following the ceremonies, rituals, customs, and hobbies of their ancestors and the level of contact they have with their relatives or ethnic organizations.

Language

Language identifies and codifies an individual's experience, which is not readily translated from one language to another without distortion. Because culturally diverse patients sometimes speak more than one language, it is important to determine what language they consider their primary language. Usually this is the language first learned however, it may not be the language of their ethnic culture, but of their host culture. It is the one in which they feel the most comfortable expressing themselves. If a secondary language is used, a more limited, and possibly inaccurate, history can result in misdiagnosis (Del Castillo 1970; Marcos et al. 1973). Advanced forms of communication—such as humor; assertiveness; and the expression of displeasure, frustration, and love—are hampered by the patient's lack of fluency in the new language (Westermeyer 1989). In

addition, communication includes nonverbal communication, such as distance between speakers, eye contact, physical touch, and local forms of gesticulation. Different ethnicities also communicate in different styles. For example, Sue and Sue (1990) stated that there are high content groups, such as African Americans, Asians, Hispanics, and Native Americans, who use different nonverbal communication than other ethnicities, such as whites.

Migration History

For recently immigrated patients, an important part of their cultural identity relates to their migration history, which should be recorded in the psychosocial history section of the written evaluation. As described by Lee (1990) (Table 18—2), the purpose of a migration history is to determine the patient's background history and to measure their baseline functional level as well as the generational status of the patient. There are actually two parts to the migration history: the pre-migration history and the immigration history.

Table 18—2. Migration history

Premigration history
Country of origin, family, education, socioeconomic status, community and family support, political issues, war, trauma.
Experience of migration
Migrant versus refugee: Why did they leave? Who was left behind? Who paid for their trip?
Means of escape, trauma.
Degree of loss
Loss of family members, relatives, friends.
Material losses: business, careers, properties.
Loss of cultural milieu, community, religious, spiritual support.
Traumatic experience
Physical: Torture, rape, starvation, imprisonment.
Psychological: Rage, depression, guilt, grief, posttraumatic stress disorder.
Work and financial history
Original line of work, current occupation, socioeconomic status.
Support systems
Community support, religion, family.
Medical history
Beliefs in herbal medicine, somatic complaints.
Family's concept of illness
What do family members think the problem is? Its cause? What do they do for help? What result is expected?
Level of acculturation
First or second generation.
Impact on development
Level of adjustment, assess developmental tasks.

Source. Adapted from Lee, 1990.

A pre-migration history includes country of origin, position in the family, education, employment status, level of support, political issues, experiences of war, and traumatic events. It may be helpful to know the recent history of the region, common religious beliefs, and from which social class the patient originated. The clinician's goal is to understand the patient's former baseline life experience in their native country prior to migration.

The immigration history includes the reasons for leaving, who was left behind, who paid for the trip, and hardships endured and trauma suffered, including experiences of torture, beatings, starvation, rape, and imprisonment in a refugee or detention camp. Patients can be described as "migrants" or "refugees"; migrants leave their country voluntarily and often easily, whereas refugees are either forced out or flee the country surreptitiously, encountering many traumas and losses. Clinicians need to explore the extent of loss and traumatic experiences. These can include the loss of family members, relatives, and friends; material losses of property, financial resources, businesses, and careers; and loss of their cultural milieu, community support, and religious and spiritual support.

Degree of Acculturation

Immigrants routinely experience some degree of culture shock, and clinicians can assess the patient's level of adjustment by inquiring about his or her competence in the English language and in negotiating the tasks of learning to live in this country. This can be seen in activities such as the successful attainment of housing, employment, and childcare and a mastery of public transportation. Demographic information can help assess the rate of acculturation. Important variables include the number of years spent in the United States, the age at the time of immigration, exposure to Western culture in the country of origin, and contacts with native-born Americans. Younger immigrants acculturate more quickly and learn English faster than older immigrants. Standard parts of the psychosocial history should be utilized to assess the rate of acculturation; these include occupational and social histories. The occupational history should survey the difference between the patient's work status in the United States and in the patient's home country.

A patient with a history of downward mobility in his or her occupational status could develop lowered self-esteem and insecurity, which might precipitate a mental disorder. The social history can also help determine how much support the patient can rely on from family or an extended network, such as family organizations or churches. Living in an ethnic community can also buffer the acculturation process. The patient's proficiency in English and contact with others outside of the cultural enclave are useful measures of acculturation. Of note is that DSM-IV has a new category for "acculturation problem" in the section titled "Other Conditions That May Be a Focus of Clinical Attention," indicating that distressing acculturation experiences can occur without necessarily labeling them as symptoms of a mental disorder.

Another way of assessing the degree of acculturation of patients is by a framework that is numerative (i.e., first generation, second generation, third generation) or descriptive (i.e., traditional, transitional, bicultural, Americanized) (Lee 1990). Traditional families are born and raised in their country of origin. In general, these immigrants speak only their native language, live in ethnic enclaves (like Chinatown or "Little Italy" in New York City), and could have a rural background. They tend to approach problems in a more concrete manner and are more likely to have adjustment disorders and major depression and to describe their problems in somatic terms. Transitional families have parents that speak very little English, whereas their children are better acculturated. They commonly have parent-child conflicts, role confusion, and marital difficulties. These families suffer from the erosion of the authority of the parents by their dependence on their children for linguistic and cultural translation. The most effective therapies for these patients are cognitive and behavioral. Bicultural families have parents who are professionals or business owners and are primarily English speaking. The parental authority is egalitarian as opposed to patriarchal. These families traditionally live in the suburbs. They are often more stable than the above two family structures. Finally, Americanized families are usually several generations removed from immigration. Often the original native culture is lost, because parents and children speak only English. Interethnic marriage is more common, and families are individualistic, competitive, and egalitarian. They are usually stable and present no significant differences from Westernized patients.

A final way of looking at acculturation was described by Padilla (1980), who suggested both that acculturation can be thought of in more than one dimension and that the clinician should assess separately degrees of identification with the host culture and with the original culture. In connection with this, bicultural individuals seem to have better social adjustment and performance than those who either identify only with the new culture and lose affiliation with their family origins or identify only with the original culture and seclude themselves into cultural ghettos.

Gender

Gender identity issues also interact synergistically with ethnic identity to shape one's cultural identity and have many implications for assessment and treatment. Notman et al. (1991) and Myers (1991) concisely reviewed the impact of both female and male gender identity or development across the life cycle. They pointed out the complex interaction of gender identity and age on one's cultural identity. Fullilove (1993) outlined how minority women's status affects health status, sexual practices, and treatment settings. Comas-Diaz and Greene (1994) stressed the het-

erogeneity among women of color by integrating culturally relevant and gender-sensitive issues into guidelines for clinical practice with African American, Latina / Hispanic, Asian American, American Indian women, and West and East Indian women.

Age

Psychiatry has long acknowledged the impact of age on one's identity formation. As with gender, age interacts with the other aspects of cultural identity to influence development and psychiatric assessment and treatment. For example, I. Canino and Spurlock (1994) offered clinical guidelines for working with economically disadvantaged children and adolescents from culturally diverse backgrounds that recognize the significance of cultural variations in help-seeking behavior, discrimination, and socioeconomic pressures on children's adaptive responses and mental health. The American Psychiatric Association (1994b) Task Force on Ethnic Minority Elderly also presented specific outlines for clinical care of the elderly from the four major ethnic minority groups.

Sexual Orientation

Sexual orientation defines an essential aspect of one's cultural identity. Stein (1993) extensively reviewed the development and meaning of lesbian, gay, and bisexual identities. Furthermore, assessment and treatment implications are outlined for persons with these sexual orientation identities across ethnic, age, and class groups to acknowledge the synergistic impact of these aspects of cultural identity. This work will be greatly expanded on in a forthcoming work by Cabaj and Stein (in press).

Religion and Spirituality

Diverse cultures possess diverse religious and spiritual beliefs that are an important aspect of cultural identity and that affect health (Numbers and Amundsen 1986; Sullivan 1989) and mental health. Fitchett (1993) reviewed 28 methods of spiritual assessment in pastoral care, some of which can be applied to both hospital and outpatient contexts. Most significantly, for religious and spiritual identity development, is the work of Fowler (1981) on the stages of faith.

CULTURAL EXPLANATIONS FOR ILLNESSES

From a clinical point of view, understanding the patient's view of his or her illness helps determine our assessment and our treatment plan. Different cultures express their symptoms differently (Kleinman 1988), and concepts of illness also vary with culture. For example, for the Chinese in Hong Kong, Cheung (1987) found that patients had three explanatory models for mental disorders. They could explain their illness as based on psychological, somatic, or mixed factors. Their explanation of the illness influenced how they went about getting help. The patients who had purely psychological explanations were the least likely to seek help. Because of this, Cheung recommended that clinicians specifically inquire about psychological symptoms, because these patients were not likely to volunteer them.

Idioms of Distress

Idioms of distress were defined by Nichter (1981) as the ways in which individuals "express, experience, and cope with feelings of distress" (p. 399). These are further described as "culturally constituted in the sense that they initiate particular types of interaction and are associated with culturally pervasive values, norms, generative themes, and health concerns" (p. 379).

In the DSM-IV appendix on culture-bound syndromes, there is a glossary listing "some of the best-studied culture-bound syndromes and idioms of distress that may be encountered in clinical practice in North America" (pp. 844—845). An example listed is *ataque de nervios*, a syndrome of uncontrollable shouting, crying, trembling, and aggression typically triggered by a stressful

event involving family and followed by amnesia. Also included is *nervios*, a state of vulnerability to stress, marked by headaches, irritability, stomach problems, inability to concentrate, and dizziness. These two idioms are typically seen in Latino patients. Another example is *zar*, a syndrome of being possessed by spirits, evidenced by shouting, singing, crying, and a withdrawal from daily tasks.

A final example of a common idiom of distress is somatization, which can be seen in Hispanics, Asians, and people from Islamic cultures, among others, who can present with somatic complaints. In these cultures, most difficulties are conceptualized as somatic, and mental difficulties are either not conceptualized or are stigmatizing and therefore not even talked about (Angel and Guarnaccia 1989; Blue and Gonzalez 1992). It is important to remember that idioms of distress are not limited to one ethnic group, but can be seen in many ethnic groups. Finally, any of the idioms of distress can be pathological, depending on the level of disability. Without a knowledge of idioms (e.g., *ataque de nervios*), clinicians could make an erroneous diagnosis of panic disorder or somatization disorder (Guarnaccia et al. 1990).

Norms

Clinicians need to realize that cultural norms will influence how particular behaviors are judged. What may be abnormal and psychopathological in Western culture may be considered normal and culturally acceptable in a non-Western society, and vice versa. Egland et al. (1983) studied bipolar illness in the Amish people, a culture that is known for its restraint in the expression of emotions. The Amish definitions of *grandiose* described behavior within the host culture's norms of behavior, such as driving a car or planning a vacation during the "wrong season," yet exceeded their norms sufficiently to meet criteria for bipolar disorder, because they were Amish. Individuals from diverse cultures present difficulties in diagnosis and treatment because the norms and expectations that are used to evaluate them may be different for different cultures.

Idioms of distress or culture-bound syndromes in other cultures may be considered outside the boundaries of expected illness behavior of the predominant culture. It is imperative that clinicians judge possible symptoms and syndromes of psychopathology against a knowledge of the cultural norms of the patient's cultural identity. If one is not aware of one's lack of understanding, errors can be made either by overpathologizing what is considered normal in that culture or by ascribing to cultural normality what is actually considered psychopathological in that culture.

Newhill (1990) described a series of guidelines for interpretation of "psychotic" symptoms for clinicians in culturally diverse individuals. First, the clinician should determine if there is any factual basis for ideas of persecution. Next, the clinician must determine if the patient's behavior is present in other members of their community, and if the behavior is explicable in terms of past experiences or as a belief of the patient's community. The clinician should consider the possibility that the patient's description is a figure of speech. Often, the presentation is one between an explainable model and psychosis. A cultural consultant may be needed to help with this process of understanding (Wudman et al. 1992).

Culture-Bound Syndromes

Culture-bound syndromes represent conditions that tend to emerge or adopt a distinct presentation in specific cultures. They often incorporate local symptom constellations. They are important to identify, because the patient's definition of the illness has an impact on the effectiveness of the treatment, which must optimally operate within the patient's belief system. DSM-IV defines culture-bound syndromes as "recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category" (p. 844). An example of a culture-bound syndrome is *taijin kyofusho*, a Japanese syndrome that refers to an individual's intense fear that his or her body or its functions are offensive to other people. Of note is that this syndrome is listed as a diagnosis in the Japanese clinical modification of ICD-10. Neurasthenia or *shenjian shuairuo*, another culture-bound syndrome, is characterized by mental and physical exhaustion and may fit DSM-IV criteria for mood or anxiety disorder, as well as neurasthenia in ICD-10. Culture-bound syndromes are discussed further by Hughes and Wintrob (Chapter 22, this volume).

Explanatory Models

According to Helman (1990), explanatory models are how a patient explains his or her illness. It consists of the patient's notions of the illness etiology, timing, mode of onset, pathophysiology, natural history, severity, and appropriate treatments, and it is specific to a single episode of the illness. Clinicians can elicit the patient's explanatory model by asking what the patient thinks has happened, why, and why now. Next, the clinician asks what will happen if nothing is done, and what effect it will have on others. Finally, the patient is asked what should be done about it. An example of an explanatory model that some Westernized patients are comfortable with may be the psychodynamic, whereas some traditional Native Americans may be more comfortable with an explanation from their witch doctor that they have "broken a taboo" of their family. In addition, they may also believe that they can hear the voice of a dead person calling to them as the spirit travels to the afterworld. If a clinician was unaware of this belief, the patient could be diagnosed as psychotic. In summary, to avoid such misconceptions, clinicians should ask patients what they believe is causing their illness, why it is a problem now, what will happen if they get no treatment, and what type of treatment they desire (Kleinman 1988).

Help-Seeking Behavior

Culture also affects help-seeking behavior; the definition of the patient's problem, how it will be expressed (somatically, behaviorally, or affectively), who should be consulted, and the preferred treatment strategies depend on the patient's explanatory model of illness (Kleinman 1988; McGoldrick et al. 1982; Rogler and Cortes 1993). For example, because some patients tend to act healthier than they appear to avoid the stigma of illness, a collateral history is sometimes necessary to obtain an accurate history. However, families and other informants also may minimize symptoms because there may be a stigma involved in even seeking assistance with mental disorders. Finally, culture affects patients' expectations of treatment. Many first-generation ethnic minority patients, such as recently immigrated Asians, expect their clinicians to be authoritarian, not egalitarian, and are confused by a non-directive stance (Schlesinger 1981).

Indigenous healing practices may be utilized; examples include curanderos, shamans, medicine men, and fortune tellers (Gaines 1991). A typical sequence of coping and help seeking in a traditional Chinese family might include intrafamilial coping, followed by consultation with trusted elders and friends. The family would then seek outside help, going to herbalists and acupuncturists. They might then consult a religious person, or a physician, but would present with somatic complaints. Finally, as the patient deteriorates, the family reaches its limit and can no longer maintain the patient at home. There often is a rejection and scapegoating of the patient to decrease the shame and humiliation to the patient's family. The last resort is often hospitalization in a Western hospital (Lin and Lin 1981).

CULTURAL FACTORS RELATED TO THE PSYCHOSOCIAL ENVIRONMENT

Thus far we have discussed the patients' cultural identity and their corresponding models of illness. The clinician's understanding of these areas will guide them to explore patients' particular stresses and coping mechanisms, including their support systems. The next section will discuss each of these topics in turn.

Stressors

In addition to the premigration and migration stressors, recent immigrants face a specific set of postmigration stressors. The immigrant must confront the need to learn the host language and customs and to negotiate the tasks of procuring housing, transportation, employment, and child care. In addition, the new migrant must cope with losses, the sequelae of traumatic experiences,

and experiences with racism, sometimes without the benefit of their familiar support systems. For some ethnic groups, asking for help is an admission that one has failed, and developing a psychiatric illness would be an additional stigma. Asian ethnic groups face an additional stressor in that any failure of an individual in the family reflects on the reputation of the entire family, causing a “losing of face” leading to shame and embarrassment. Children of immigrants may face other stressors such as role confusion.

Specific problems are associated with specific ethnic groups. For example, Hispanics encounter particular difficulties with some stressors. Cullen and Travin (1990) discussed the resistances that would inhibit Spanish-speaking sex offenders from participating in group therapy. First, they found that patients expressed themselves better in Spanish than in English, thus not being understood is a stressor. Next, their expected sex role was in conflict with their crime. For men, they were expected to be independent, strong, and aggressive and to identify with virility. To be homosexual or a child molester is a display of “lack of shame,” and an open discussion of sexuality would show a lack of respect to the therapist, adding to the patient’s shame. Finally, Hispanics derive their self-worth from how successfully they can accomplish their cultural role obligations, such as providing for the security and well-being of their family, and not their social status. Thus, for multiple reasons, a Hispanic convicted of a sex offense would be reluctant to participate in therapy because of his or her cultural beliefs.

Developmental, Family, and Psychosocial History

An understanding of family dynamics and cultural values is crucial in assessing the patient’s psychosocial environment. McGoldrick et al. (1982) described an approach to the assessment of the family, concentrating on the culture’s definition of family and changes in the life cycle of the family. To prevent stereotyping, generalizations about traditional ethnic groups must be used only as a backdrop to the assessment of a particular family.

A culturally diverse individual’s expectations of their life course is affected by their stage of development and age at immigration. Expectations of the achievement of milestones and definitions of family roles change when people migrate to different cultures. Assessing the expectations for the patient’s stage of development in the family life cycle is important because this is often disrupted by migration or influenced by experiences with racism. For example, children who ordinarily would be expected to have few responsibilities often suffer from role reversal when they are pressed into service as linguistic and cultural translators for their parents. Further, poverty related to race and social status will limit their opportunities and expectations. For example, in a major textbook on the psychosocial development of minority group children, Powell (1983) observed that African American children are affected by racist beliefs that they are substandard-human beings, Hispanic children are often subjected to differing sets of expectations from their parents and their white teachers. Native American children are often separated from their families, going against their custom of making the child the center of tribal life. Adolescents who migrate have difficulties because of multiple transitions. Young adults in the stage of identity formation can be cut off from their heritage and feel alienated. New families could lose their support networks.

Elderly persons feel the losses of migration more keenly because they leave behind more memories and connections than the younger immigrants. They often migrate at a later stage of life, making them less able to acculturate, and they have a higher risk of culture shock (Sakauye 1992). They are more likely to develop culture-bound syndromes and create difficulties in diagnosis because they typically speak only their native language. Ethnic minority elderly persons may feel displaced in Western societies in which elderly persons may be abandoned or placed in nursing homes.

Some specific issues with other ethnic minority elderly groups include 1) the overdiagnosis of schizophrenia and dementia in African Americans; 2) the undertreatment of Asian elderly due to poor education, superstition, and their fear of Western medications; 3) the underutilization of services by Hispanic elderly, secondary to their concerns about social stigma; and 4) the tendency of Native American elderly to rely on traditional healers, whose beliefs are poorly understood by Western clinicians (American Psychiatric Association 1994b).

Lee (1990) described other problems in the family associated with immigration. These include

changes in family dynamics, sometimes seen in the developmental crises of relocated children. Thus, an analysis of the family structure is an important part of the assessment. The clinician should know which family member has the most power and makes most of the major decisions. Changes in the balance of power in the family often caused by immigration can make children more powerful by virtue of speaking the language of the new culture. This potential role reversal caused by differing English-language ability between generations creates difficulties between parents and children and can lead to a split in loyalties. Some fathers may not be able to work, and their wives may have to go to work. The father may have to share his role with his children and his wife, and he may experience shame. Other types of family problems include intergenerational conflicts pivoting on age, education, and language. Conflicts may also develop with in-laws, marital partners, siblings, or a hostile-dependent relationship with a sponsor.

The family's concept of illness is also important in treatment. Clinicians need to understand the family's explanatory models and treatment expectations. A thorough medical history may help the clinicians to understand if their patients consider herbal medicine useful, or if they tend to express their distress in somatic symptoms.

Religion and Spirituality

Religion and spirituality have tended to be either ignored or pathologized by mental health practitioners. Reviews by Lukoff et al. (1992a, 1992b, 1993), Matthews et al. (1993), and Larson (1993) underscored the complex interaction religious and spiritual beliefs can have on an individual's mental health status, assessment, and treatment. These interactions point to often positive correlations with mental health status; the importance of a wide differential diagnosis during assessment, including the new DSM-IV "non-illness" category of religious or spiritual problem; and the importance of the acknowledgment of and working with these beliefs as possible supports for the person rather than just manifestations of psychopathology. Browning et al. (1990) presented information on the historical interactions between psychiatry and the Protestant, Jewish, and Roman Catholic religious perspectives. Religious institutions can provide support for culturally diverse individuals. For example, Griffith and Young (1988) described the therapeutic aspects of Christian religious ritual in African Americans. In addition, the interaction between religion and family can provide a source of support or stress that must be assessed, utilized, and addressed (Burton 1992).

IMPACT OF CULTURE ON THE CLINICIAN-PATIENT RELATIONSHIP

Influence of Clinician and Patient Ethnicity and Cultural Identity

Race, ethnicity, and culture also affect the clinician-patient relationship, which, in turn, affects diagnosis and treatment (Rogler 1993). Both to avoid biases based on stereotypes of ethnicity or any one aspect of cultural identity and to understand how it impacts their interactions with patients, clinicians need to understand and appreciate their own multiple aspects of cultural identity development, and then that of their patients. They also need to be aware of their attitudes toward their patient's particular ethnicity to assist in engaging and understanding the patient (Spiegel 1976). Hughes (1993) described methods for clinicians to attain self-knowledge; he suggested that clinicians first examine their assumptions about their patients based on their first impressions during the interview and then critically analyze those signs (appearance, mannerisms, or behavior) that they are using to define "pathology." By looking for stereotypes that may be influencing their judgment and behavior toward patients, clinicians have an opportunity to confront their own biases and prejudices.

Pinderhughes (1989) advised clinicians who work with ethnic minorities to form experiential groups in which clinicians can freely discuss their own feelings, perceptions, and experiences of race, ethnicity, and power. She stated that clinicians can explore their own ethnic background by considering its historical influence on their attitudes, feelings, and behaviors. This personal exploration is maximized in groups, where individuals can confront the meaning and values of their ethnicity, along with their feelings about "difference," experiences of racism, and feelings of

powerlessness. Discussion questions that may be asked in these groups can be found in Table 18—3.

Table 18—3. Discussion group questions for cultural identity awareness exercise

1. What is your ethnic background? What has it meant to belong to your ethnic group? How has it felt to belong to your ethnic group? What do you like about your ethnic identity? What do you dislike?
2. Where did you grow up, and what other ethnic groups resided there?
3. What are the values of your ethnic group?
4. How did your family see itself, as similar to or different from other ethnic groups?
5. What was your first experience with feeling different?
6. What are your earliest images of race or color? What information were you given about how to deal with racial issues?
7. What are your feelings about being white or a person of color?
To whites: How do you think people of color feel about their color identity?
To people of color: How do you think that whites feel about their color identity?
8. Discuss your experiences as a person having or lacking power in relation to the following: ethnic identity, racial identity, within the family, class identity, sexual identity, professional identity.

Source. Pinderhughes, E: *Understanding Race, Ethnicity and Power: Efficacy in Clinical Practice*. Copyright © 1989 by the Free Press, a Division of Simon & Shuster. Reprinted with permission of the publisher.

Unacknowledged differences between aspects of the cultural identities of patient and clinician can result in assessment and treatment that is not optimally respectful of the patient and can be inadvertently biased or prejudiced. For example, the American Psychiatric Association's (1993) position statement on bias-related incidents noted that "bias-related incidents, arising from racism, from sexism, from intolerance based on religion, ethnicity, and national/tribal origin, and anti-gay and antilesbian prejudice, are widespread in society and continue to be a source of social disruption, individual suffering, and trauma" (p. 686). Mental health clinicians need to guard against letting such possible biases affect their work. In fact, the American Psychiatric Association (1990) issued "guidelines regarding possible conflict between psychiatrists' religious commitments and psychiatric practice." They stated that "psychiatrists should maintain respect for their patient's beliefs" (p. 542) and "should not impose their own religious, anti-religious, or ideologic systems of belief on their patients" (p. 542).

Pedersen and Ivey (1993) suggested examining the assumptions inherent in the clinician about other cultures and challenging them. In addition, the way that the patient sees the clinician will affect the alliance, through the information shared or not shared, both by client and clinician (McDonald-Scott et al. 1992). Finally, it is important for clinicians to realize that cultural norms will influence how particular behaviors are judged according to consensual standards.

Transference and Countertransference

Comas-Diaz and Jacobsen (1991) explored how cultural, racial, and ethnic factors can arouse ethnocultural transference and countertransference when the clinician and the patient are of different ethnicities (interethnic) and when they share a common ethnicity (intraethnic) (Table 18—4). An example of interethnic transference can be seen in a Native American's distrust of an authority figure from the dominant culture. Other examples include the patient being overly compliant and friendly in an attempt to negate a perceived power differential or denial, when patients may naively think that racial or cultural differences have no effect in therapy.

Table 18—4. Ethnocultural transference and countertransference

Interethnic transference

Overcompliance and friendliness
Denial of ethnicity and culture
Mistrust, suspicion, and hostility
Ambivalence

Intraethnic transference

Omniscient-omnipotent therapist
The traitor
The autoracist

Ambivalence
Interethnic countertransference
Denial of ethnocultural differences
Clinical anthropologist syndrome
Guilt
Pity
Aggression
Ambivalence
Intraethnic countertransference
Overidentification
Us and them
Distancing
Cultural myopia
Overidentification
Anger
Survivor guilt
Hope and despair

Source. Adapted from Comas-Diaz and Jacobsen. 1991.

Ethnocultural countertransference can also be seen. An example of interethnic countertransference is the cultural anthropologist syndrome, where the therapist may react to cultural differences by becoming an amateur anthropologist on an intrusive fact-finding mission, quite distinct from the relevant clinical concerns. Clinicians may have experienced trauma at the hands of a person from the same race as their patient and may displace their feelings about the incident to the patient and behave either aggressively or defensively. The therapist may not ask sensitive questions due to feelings of guilt or pity caused by overidentifying with the patient. Finally, the clinician may deny the importance of ethnic and cultural differences as they impact on the therapy.

Even sharing the same ethnicity with a patient may be problematic and bring up intraethnic transference and countertransference issues. An example of intraethnic transference, as cited by Comas-Diaz and Jacobsen (1991), may be seen in some Irish Americans, who may believe that Irish clinicians are less competent than other professionals and would think less of a clinician of their same ethnicity. On the other hand, a patient of the same ethnicity as the therapist may see the therapist as a kind of hero or heroine and expect to be rescued by the therapist. The patient may be critical of the therapist as a “sellout” to their ethnicity and not deserving of trust. Examples of intraethnic counter-transference include a clinician’s idealization of his or her own ethnicity’s strengths and projection of these onto the patients, which could set them both up for disappointments. Collusion or misinterpretations may occur because of an assumption of sameness. That sameness may be too threatening, and the therapist may react with defensive distancing. The therapist may react to demands made by the patient with anger because it reminds them of issues in their own lives. Finally, therapists from a disadvantaged background may feel guilty about having left others of the same ethnicity behind when they became professionals (Comas-Diaz and Jacobsen 1991).

Clinical Methods

A variety of methods are available to the clinician that can be used to establish rapport during the interview. Westermeyer (1989) discussed the usefulness of demonstration of interest, facilitating the patient’s story, clarifying the patient’s explanatory models, and ensuring that the interviewer’s questions are understood by the patient by having the patient restate the question. Clinicians can create rapport by assessing the symptoms that the patient is most comfortable expressing. These are usually the somatic symptoms; treating these with respect and appropriate concern often facilitates rapport with the patient. Patients presenting with somatic complaints should be evaluated as if they were presenting for medical evaluation, with an exploration of precipitants and ameliorating and aggravating factors. Next, the clinician should carefully review the patient’s complaints (review of symptoms), looking for the somatic symptoms of depression and anxiety (e.g., sleep or appetite disturbances, weight change, decrease in energy level, tachycardia, shortness of breath, and tremors). Once the patient is engaged, other more sensitive topics can be broached, such as the psychological symptoms of irritability, fears, thoughts of a gloomy future, crying spells, and

nightmares, and then personal or family problems. These psychological symptoms need to be assessed directly and include problems with concentration and memory, feelings of mistrust, hallucinations, intrusive thoughts, and suicidal or homicidal ideas (Cheung 1987). When dealing with traditional Asian clients, a quiet respectful demeanor is helpful, along with an acceptance of traditional healers (Meyers 1992).

Mental Status Examination and Psychological Assessment

The cognitive and descriptive aspects of the mental status examination have been developed in Western European, British, and American settings. Although it is an effective way of organizing clinical observations, the standard mental status measures must be elicited, described, and integrated in ways sensitive to the patient's cultural identity. Patient responses are affected by the patient's culture of origin, educational level, and level of acculturation, among other factors. For example, the measure of orientation, commonly checked by asking patients the date, is affected by the use of differing calendars by various cultures and the degree of attention or inattention to time per se. Seasons vary around the world, depending on latitude, and some cultures do not use clocks (Westermeyer 1993). For some illiterate societies, a birth date is irrelevant information. The interpretation of tests of abstraction, such as proverb interpretation, are difficult to use because the meaning and wording of proverbs vary widely between different societies and language groups. Calculation ability among illiterate cultures is often limited to arithmetic with single digits. Also, the general usefulness of fund of information and geography questions can vary widely due to differences in educational backgrounds, even within the same cultural or ethnic group. It is often an incorrect assumption that all persons know much geography (Escobar et al. 1986). The naming of objects is affected by the patient's familiarity with the items chosen. Finally, short-term memory tests will be adversely affected if clinicians use unfamiliar items; thus it should be tested using familiar items. Similarly, three-step commands should be simple (Hughes 1993). Escobar et al. (1986) concluded that the Mini-Mental State Exam (MMSE) was influenced by age, ethnicity, educational level, and the language of the interview and recommended that it should be revised to remove social, educational, and cultural artifacts if it is to be used in a Hispanic population.

Marsella (1989) observed that many of the tests and self-assessment questionnaires used in research have been developed on Western subjects and are not appropriate for use among ethnic minority patients because they lack equivalence. Merely translating the items was insufficient and resulted in linguistic "in-equivalence," as meanings and connotations changed and idioms of expression differed between languages. Rating scales of symptoms can be utilized if translated, "back-translated" (verification of adequacy of translation by translating a statement from language A to language B and then, independently, from language B to language A), and validated (Mann and Mann 1991). Examples include the Hopkins Symptom Checklist-25, translated into Vietnamese, Laotian, and Cambodian (Mollica et al. 1987), and the Harvard Trauma Questionnaire, translated into the same three languages (Mollica et al. 1992). Finally, translated tests are often not standardized for the testing group and must be properly normed on a representative patient group. Other sources of error included poor or inaccurate assumptions and translation, biased analysis, and inappropriate instruments (Rogler 1989). Mere translation of existing rating scales must be viewed with caution unless these concerns are addressed.

Translation Versus Interpretation

Some culturally diverse individuals speak a language that is different from the clinician's primary language; thus, interpretation is needed, which is distinguished from translation in that it attempts to convey meanings that would be missed in translation, such as the connotation of particular words or the meaning of cultural idiomatic expressions. For example, when a patient is interviewed, the patient's intended message to the clinician could be lost if there is no direct translation in English. Likewise, if there are no equivalents for the clinician's question in the patient's language, the question may be answered in a misleading way. Terms for emotion may vary between cultures in radical ways. Some cultures do not have direct expressions for concepts such as "depression," "elation," and "love." If possible, the interview should be conducted in the language that the patient is the most comfortable, because symptoms will be expressed more completely in

the language in which the patient is most familiar. Likewise, if clinicians are not fluent in the patient's primary language, they will miss nuances that an interpreter might be able to explain, such as idiomatic expressions. The clinician's choice of the language for the interview can be unclear; some patients may speak more than one language. Often, the language chosen turns out to be a language common to both clinician and patient. Optimally, the patient's primary language should be utilized, however, because feelings can be left out because they are more difficult to express in a second language (Westermeyer 1989).

An optimal interpreter is trained in the basic aspects of psychiatric assessment and care. Interpreters facilitate translated communication because they are familiar with the purpose and objectives of an interview, such as the determination of symptoms and diagnoses, and have techniques of eliciting pertinent clinical information. In general, family members should not be used as interpreters unless absolutely necessary because they commonly may not translate everything that the patient says because of concerns of family privacy and shame or family dynamics (Westermeyer 1990).

Westermeyer (1990) described the relationships among the interpreter, patient, and clinician as points in a triangle. The clinician should face and speak directly to the patient; while the interpreter is speaking, the clinician can observe the patient's nonverbal communication. Other practical points for the interview include technique and content issues. One should allow adequate time, almost double of what would ordinarily be needed without an interpreter (Westermeyer 1989). Lee (1987) also referred to the triangular relationship of patient, interpreter, and provider as the "therapeutic triad"; communication can be channeled in six directions, from provider to interpreter, from provider to the patient, or from interpreter to patient, and vice versa. It is important for the clinician to speak slowly and clearly, to avoid jargon and idioms, and to stick to one topic at a time. Providers can assist interpreters by having a preinterview meeting in which the objectives of the interview, topics to be covered, how much time is available, and so on are discussed. Before the interview, it is important to clarify the type of interpretation desired, be it word for word, summary, or a cultural explanation, when the meaning of a patient's answer may be related to the patient's cultural identity. During the interview, clinicians must pay attention to the nonverbal communication between the provider and the patient, because this is the only form of direct communication that they have. These include nodding, smiling, eye contact, personal space, and foot tapping. Caution must be used in interpreting observations about nonverbal indicators because they can be confusing (Westermeyer 1989). It may be helpful to reserve interpretation until a better sense of their meaning can be obtained, perhaps with the help of a cultural consultant (Budman et al. 1992). Finally, a postinterview meeting can be helpful to clarify information and to share and discuss clinical impressions.

Cultural Consultants

To facilitate an accurate cultural formulation for patients whose cultural norms, idioms of distress, explanatory models, and family dynamics are unfamiliar to the clinician, the use of a cultural consultant may be most helpful. Certainly, if clinicians find that their assessment and treatment are not effective, having the services of a cultural consultant would be imperative. Such consultants would ideally be familiar with both the patient's cultural norms and basic psychiatric assessment skills. They are distinguished from an interpreter, as they are familiar with systems issues, and can often serve as a liaison between the staff and the patient. Budman et al. (1992) described the use of a clinical consultant in a case of an Arab adolescent who was hospitalized and was not improving. The consultant was able to provide insight into the patient's cultural values. For example, the adolescent was seen as overly dependent on his mother. In addition, he had symptoms of inappropriate responses to questions, excessive sensitivity to rejection, and social isolation. The consultant provided information that typical Arab families are enmeshed and that the patient's somatic symptoms were also a typical Arab method of expressing distress. Because the consultant was fluent in the patient's language and familiar with both Western and Arab paradigms of illness, the consultant was able to act as a liaison between the staff and the patient's family. With the aid of the consultant, the treatment team formulated an accurate diagnosis and devised an appropriate treatment plan.

CULTURAL ASSESSMENT: CULTURE AND ITS EFFECT ON DIAGNOSIS AND CARE

Cultural Competence

Another way clinicians can assess their ability to work with culturally diverse individuals is to assess their own “cultural competence.” Cultural competence is a set of culturally congruent beliefs, attitudes, and policies that make cross-cultural work possible (T. L. Cross et al. 1989). Cultural competence exists as points along a continuum, ranging from cultural destructiveness, cultural incapacity, cultural blindness, and precompetence, to cultural competence, and finally, cultural proficiency. Although originally written to describe systems of mental health care for children, this scale can be applied generically both to systems of care for adults and to individual clinicians. Furthermore, individual clinicians need to be aware of the system in which they operate because this will affect their ability to work with culturally diverse patients.

The worst end of the continuum, cultural destructiveness, is exemplified by institutionalized or personal racism, where access to resources is denied on the basis of race and other aspects of cultural identity. The next stage is cultural incapacity, which can present itself in any helping relationship when an authority figure (teacher, counselor, or supervisor) has biased and lowered expectations of minority clients. The following stage is cultural blindness, which manifests itself in the “melting pot” attitude that “all people are the same” and that culture makes no difference in either their patient’s or clinician’s lives or experience. In this instance, ethnic clients are judged by the majority standards of performance and blamed if they are unable to accomplish the goals of the majority culture. The stage following cultural blindness is precompetence, where an agency realizes its weaknesses in serving minority groups and attempts to improve some aspect of its service. Cultural competence, however, is marked by the genuine and informed acceptance and respect of cultural differences. To achieve this, clinicians should have done a self-analysis of their cultural identity and biases, should become aware of the dynamics of difference inherent in working with minority patients, and must seek additional knowledge and resources to work with patients. The final stage of cultural proficiency is used to describe agencies and individuals who are adding to the knowledge base of culturally competent practice through research and other activities.

Values that are essential for cultural competence include mutual respect and the belief that cultural issues are important, that social systems are fundamental and valuable in treatment, that the family is an integral part of the patient and varies according to culture, that diversity is valuable, and that self-knowledge is necessary to deal with ethnic minority patients (T. L. Cross et al. 1989).

In conclusion, the openness of the clinician’s attitude is critical in avoiding biases in assessment and treatment. Clinicians must be willing to suspend judgment; accept new lifestyles; and approach ethnic minority patients with flexibility, warmth, understanding, and empathy (T. L. Cross et al. 1989).

CULTURE’S EFFECT ON DIAGNOSIS

A Western clinician using DSM-IV may naively assume that all individuals are equal; however, most clinicians believe that a relativist position is more appropriate (Hinton and Kleinman 1993). In fact, DSM-IV includes a section on specific culture features in the narrative description of diagnostic categories where appropriate. Because the nature of diagnosis is to distinguish abnormal from normal, clinicians need to consider cultural norms of behavior. Clinicians need to gather information, put the data in a historical perspective to help determine the stressors, and then make an assessment of the patient’s strengths and resources; all of these are affected by culture. Most culturally competent clinicians are familiar with the principle of cultural relativism, which holds that the language and customs of a people have to be examined in the context of that particular culture and judged primarily in terms of their utility to that culture (Johnson 1988). If principles of cultural relativism are not used, then the clinicians may fall prone to the “category fallacy,” which refers to using a classification scheme developed for one culture and applying it inappropriately to

another where there is no relevance and no equivalent meaning (Kleinman 1988). For example, using the Diagnostic Interview Schedule in other cultures might lead to an erroneous diagnosis of psychopathology of otherwise normal behavior (Guarnaccia et al. 1990).

Conduct, adjustment, anxiety, somatoform, dissociative, personality, and dysthymic disorders can show great variation across cultures (Kleinman 1988). On the other hand, certain schizophrenic and manic-depressive conditions show less variation across cultures, as do organic, metabolic, and substance abuse disorders (Johnson 1988). Further, clinicians need to be aware of differences in the prevalence of mental illness among various ethnic groups to make an accurate diagnosis based on the percentages of patients having a diagnosis (Burnam et al. 1987; G. J. Canino et al. 1987; Karno et al. 1987). For example, African Americans are more likely to have phobic disorder. However, epidemiological data must be interpreted carefully; although some studies have found a higher prevalence of schizophrenia in African Americans, once corrected for cultural differences, the prevalence appears to be the same as for the general population (Escobar 1993).

Kleinman (1988) took an anthropological view to diagnosis of psychiatric illnesses across cultures. He described it as understanding the interface between personal experience and the person's social world, which is mediated by the patient's language, symbols, and values. DSM-IV is a system that is embedded in a social structure, in which a Western clinician is culturally congruent and competent both through professional training and personal socialization. He suggested that the DSM approach excludes certain diagnoses that are common in other cultures but not in the Western world. An example of a case formulation using both Eastern and Western guidelines may be useful to illustrate the differences (adapted from Kleinman 1988).

Mrs. A., a 28-year-old Chinese woman experiencing significant social stressors, presented to a local clinic complaining of feelings of guilt, suicidal ideation, insomnia, anorexia, anergia, anhedonia, as well as chronic headaches, dizziness, tiredness, easy fatigue, weakness, and tinnitus. She would qualify for a diagnosis of major depression by DSM-IV criteria. However, by ICD-iD criteria, she could be given a diagnosis of neurasthenia, with secondary depression, consistent with the Eastern view that much of the feelings experienced by individuals can be explained by somatic causes. They would explain her basic problem as a "lack of energy" in the central nervous system, where a Western evaluator might emphasize the presence of unusual stress or conflicts. Hence, Mrs. A. has one illness, but two diseases if one uses both systems of classification.

Mrs. A.'s illness is expressed through her culturally determined idioms and social relationships. Thus, she will tell her physician of her physical complaints and leave out the emotional distress. Further, Mrs. A. knows about the syndrome of neurasthenia and will describe her symptoms in a cluster to her physician to match that syndrome, providing some certainty and order for her.

Practically, clinicians can make culturally appropriate diagnoses if they can obtain some basic information such as the patient's expectations regarding different healing systems (folk healers), their models of illness and causality, and their cultural standards of normality and abnormality. An individual's cultural identity influences his or her particular pattern of disease expression, the manner in which the illness is experienced, as well as the type of help he or she will seek. It is important to be able to determine how much of the patient's presentation is due to acculturation issues and how much is due to a cultural explanation like *attack de nervos*.

The NIMH Culture and Diagnosis Group (Mezzich et al. 1993) developed an outline for preparing a cultural formulation to be used with a multi-axial diagnostic system, which was incorporated into DSM-IV. Factors affecting Axis I and Axis II have already been discussed, in terms of consideration of norms and explanatory models. Pertinent to Axis III is the relationship between disease and culture, touching on illness distribution and course. Next, culture's impact on Axis IV was discussed on the influence of the family and the support system they afford. Finally, for Axis V, social and cultural expectations influence the patient's pattern of functioning, as well as the process of appraising functioning. Further information on the background of these contributions is available elsewhere (Mezzich et al., in press).

In summary, culture influences self-monitoring and the initial experience of distress and dysfunction, idioms of expression, the individual's model of illness and healing, and the presentations of psychiatric disorders.

CONCLUSION

The assessment and treatment of culturally diverse individuals is facilitated by an appreciation of their cultural identity (including their immigration history), explanatory models for their illness and symptom expression, and their support system. The clinician must understand the impact of culture on the clinician-patient relationship and how it affects diagnosis and treatment. It is important to understand the culture of origin and how this culture differs from Western culture. We can then better appreciate how the process of acculturation creates conflicts. Clinicians can then use their knowledge of the patient's culture to direct and augment therapeutic efforts.

In this chapter, we have explored some of the factors that make up a cultural formulation; it constitutes an appreciation of the cultural identities of both the clinician and the patient. It also addresses the impact of culture on the therapeutic alliance, as well as the diagnosis and treatment of psychiatric disorders. It is hoped that in accordance with the guidelines in this chapter, clinicians can more appropriately diagnose culturally diverse individuals by using interpreters, family members, cultural consultants, and culturally appropriate psychological tests and can also design culturally informed treatment plans involving psychopharmacology, psychotherapy, and sociotherapy.

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