The Cultural Interview in the Netherlands

Foundation **Centrum '45**

Treatment of and research into the consequences of organised violence

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SIGMUND
Peter de Wit
U boft met mij als psychiater, meneer Kilim, ik heb veel ervaring met allochtonen.

En voor jullie is het normaal om geesten te zien. Dat hoeft niet meteen op een psychose te duiden.
Ahem.

Zo weet ik dat sommige medicijnen bij allochtonen een andere uitwerking hebben dan bij westerse patiënten.

Ik ben heel westers geworden, dokter.
U komt gewoon een uurtje zeuren?
Ja.

Structure of the Lecture

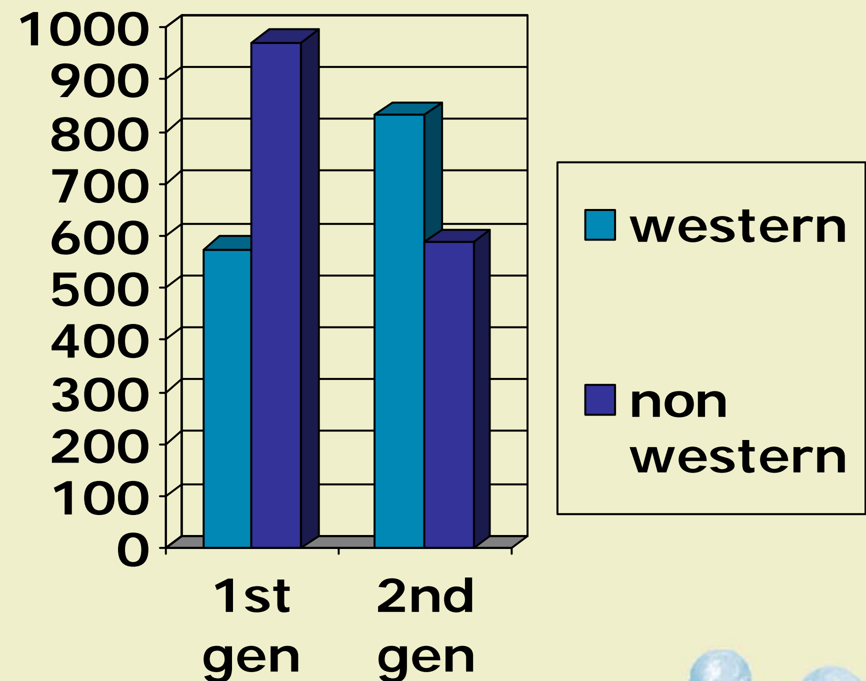
- Description of situation in the Netherlands and in our centre
- Description of the Cultural Formulation of Diagnosis
- Description of the Cultural Interview
- Publications
- Future developments and Conclusions

The Netherlands

- wealthy and prosperous country, mainly because of presence of international companies, trade firms and financial institutions
- peaceful since second World War, no great tensions between population groups
- last few years growing negative attitude towards immigrants

Population in 2002

- Total population around 16 million
- In three big cities with suburbs ('City of Holland') around 8 million
- Total migrant population: 3,95 million



Non Western Migrants (2002)

200
180
160
140
120
100
80
60
40
20
0

Surinam Turkey Moroc Neth.Ant

1st gen
2nd gen

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- Centre for traumatised refugees
- 27 clinical beds, 40 chairs in day clinic
- Two outpatient units: 5900 ambulant visits
- 400 new admissions in 2003
- More than 50 countries of origin

Assessment procedure

- Two or more diagnostic sessions
- Health questionnaires: Harvard Trauma Questionnaire, Hopkins Symptom Check List-25, PILL.
- Report with descriptive diagnostics
- Classification with DSM-IV-system

DSM-III (1980) and DSM-III-R (1987)

- Neo-Kraepelinian, phenomenological, descriptive
- Radical departure from contextual, meaning-centered diagnosis
- Syndromic aggregation, operationalized criteria
- Hierarchically organized discrete disease entities; multiaxial
- Minimization of etiological and pathophysiological classification
- DSM-III: no information on influence of culture
- In DSM-III-R: 2 paragraphs in Introduction

Towards DSM-IV (1994)

- APA Committee on Cross-Cultural Issues
- Meetings in 1991 and 1993 sponsored by APA/NIMH
- 45 cross-cultural experts together with 15 DSM nosologists
- Field trial with 4 main ethnic minority groups in US: African Am, Hispanic, Asian Am, Am Indian
- Papers published in:
  - Mezzich JE, Kleinman A, Fabrega H, Parron D (eds) Culture and Psychiatric Diagnosis: A DSM-IV Perspective, APA Press, 1996
  - Widiger T et al (eds) DSM-IV Sourcebook, Vol. 3, APA, 1997

Textual Recommendations by DSM-IV Cultural Committee

- Introduction: overview of culture in psychiatric disorder
- Multiaxial Assessment: culture and evaluation of 5 axes
- Cultural Formulation supported; Axis VI rejected (Guidelines to be included after Multiaxial section)
- Introductory paragraphs for each group of disorders and sections on "Specific Culture, Age, and Gender Features" for 73 individual diagnoses
- Glossary of Culture-Bound Syndromes and Idioms of Distress (28 categories, including Anorexia Nervosa, Chronic Fatigue Syndrome, and DID)
- Trance and Possession Disorder and MADD

Theoretical basis of CF --1

- Importance of socio-cultural context
  - Cultural particularism of illness experience
  - True of all clinical encounters, not just inter-cultural
- Culture as heterogenous, dynamic,
- Complexity of “cultural identity”
- Interaction between individual and collective meanings
- Local nosologies and idioms of distress
  - Severity, stigma, etiology, help-seeking
- Clinical ethnography,
- Explanatory Model
- Narrative approaches to suffering
  - Shared metaphors

Theoretical basis of CF --2

- Social interactional processes that contribute to illness
  - Illness "between", not just "inside" people
  - "Social", not "natural" course of illness
- Reflexions in social sciences/humanities (psychiatry has its own culture)
- Critique of zero-sum model of acculturation (integration, not assimilation)
- Equal value of reliability <u>and</u> validity
- Relativization of medical knowledge = accuracy of assessment, rapport
- Psychodynamic formulation

Results of DSM-IV Process

- Introduction and “Cultural Features” texts
- Introductions to groups of disorders
- Multiaxial Assessment text
- Cultural Formulation
- Trance & Possession Disorder and MADD

- Shortened and critique toned down
- Rejected
- Rejected
- Moved to last Appendix and linked to Glossary, from which “Idioms of distress” and 3 “Western” categories removed
- Moved to Appendix “Criteria sets & axes provided for further study”

Since DSM-IV 1994-2003

- Psychiatric residency education
  - Columbia, McGill, UCSF, Mt. Sinai-Cabrini, Tulane
- Entering Cultural Competence movement
  - State and federal standards for adequate care
  - Professional competence requirements, including for training
  - Surgeon General's Report on Mental Health: Culture, Race & Ethnicity
- Cultural Consultation Services (McGill, UC Davis)
- Research agenda for DSM-V
  - Kupfer D, First M, Regier D (eds), Washington DC: APA Press, 2002
- Yearly APA course on CF since 1997
- Publications
  - CF series in Culture, Medicine and Psychiatry
  - GAP, Cultural Assessment in Clinical Psychiatry, APPI, 2002
  - Articles, chapters

Content of cultural formulation

- Cultural identity of the individual
- Cultural explanation of the individual's illness
- Cultural factors related to psychosocial environment and levels of functioning
- Cultural elements of the relationship between the individual and the clinician

Cultural identity of the individual

- ethnic or cultural reference group
- involvement with culture of origin and host culture
- language abilities, use, and preference (including multilingualism)

Explanation of individual's illness

- idioms of distress
- meaning and severity of symptoms
- illness category
- causes or explanatory models
- preferences for and past experiences with professional and popular sources of care

Psychosocial factors and functioning

- stressors
- support
- levels of functioning
- disability
- including role of religion and kin networks in providing emotional, instrumental, and informational support

Relationship between individual and clinician

- differences in culture and social status
- resulting problems for diagnosis and treatment

Overall cultural assessment

- discussion of how cultural considerations specifically influence comprehensive diagnosis and care.

Need for cultural sensitive assessment (1)

- Information about cultural identity needed
- Different illness experiences and explanatory models (S. Ghane, 2003)
- Support system and functioning needs cultural view
- Cultural distance between physician and patient, even with non Western physician
- Choice for Cultural Formulation

Need for cultural sensitive assessment (2)

- Cultural Formulation in clinical cases (CM&P) were written after treatment
- Questions to have Cultural Formulation in assessment procedure were lacking
- Construction af a cultural interview for assessment according to CF

Cultural Interview (1)

- 40 open questions in a structured interview
- Following the topics of the CF
- At the end: questions about cultural distance filled in by assessing person
- Followed by recommendations for general assessment and treatment
- Written report

Examples of questions

- Which aspects form your own cultural background hinder you?
- What is the explanation your family gives for your complaints?
- Which kind of help did you get for your complaints till now (regular as well as alternative)?
- Could you tell something about you position in the family?
- In case you had emotional problems in your country of origin what did you do?
- Do you have the feeling that prayer helps you?
- How do you think about having treatment in another language than your mother language?

Cultural Interview (2)

- Pilot study with 30 patients
- Duration: 1-2 hours, dependent of patient and assessing person
- Feasible in all cases
- Provides much information
- Well tolerated and liked by most patients

Pitfalls in the interview

- To what extent is the interview structured?
- How to compare with culture of origin; and what is the calibration point?
- More information from culture of origin is needed
- Cluster 4 could not be asked for
- Who can interview? How much education?

Cultural Interview (3)

- Third edition of interview in Dutch (2004)
- Translations in English and German, and in Spanish in preparation
- Used in mental health care, in general health care and in research
- At the moment more scientific elaboration (clustering of questions, quantification)

Cultural Interview (4)

- First published in Dutch and English in 2002
- Available for free from the author
- Increased interest for CF in the Netherlands

Culture, classification and diagnosis (1)

Culture, classification and diagnosis (2)

- 3 theoretical chapters
- 17 case descriptions with CF
- Description of Cultural Interview
- Concluding chapter: comments on CF: culture is not static, culture as excuse for failing interventions, overemphasis on culture, gaps in CF (interpreters, culture of health care, subcultures)

Culture, classification and diagnosis (3)

- Conference on CF in 2003
- Book with proceedings from conference (in Dutch)

Future developments

- More research into and with cultural interview
- Questions of cultural interview in new assessment format
- More education among mental health workers in the Netherlands
- More activities from the Section on Transcultural Psychiatry of the Netherlands Psychiatric Association

Conclusions

- Cultural Formulation in mental health care is a good instrument for more cultural sensitive care
- Cultural Interview can give guidelines for better assessment, is feasible and well tolerated
- Overemphasis on culture however is a risk factor in care (for instance: also social status and deriving problems should be taken into account)

More information?

- www.rohlof.nl
- www.centrum45.nl

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Consult our website www.centrum45.nl for further information.