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Does the Cultural Formulation Interview (CFI) for the Fifth Revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) affect medical communication? A qualitative exploratory study from the New York site

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Abstract

Objectives—Cross-cultural mental health researchers often analyze patient explanatory models of illness to optimize service provision. The Cultural Formulation Interview (CFI) is a cross-cultural assessment tool released in May 2013 with DSM-5 to revise shortcomings from the DSM-IV Outline for Cultural Formulation (OCF). The CFI field trial took place in 6 countries, 14 sites, and with 321 patients to explore its feasibility, acceptability, and clinical utility with patients and clinicians. We sought to analyze if and how CFI feasibility, acceptability, and clinical utility were related to patient-clinician communication.

Design—We report data from the New York site which enrolled 7 clinicians and 32 patients in 32 patient-clinician dyads. We undertook a data analysis independent of the parent field trial by conducting content analyses of debriefing interviews with all participants (n=64) based on codebooks derived from frameworks for medical communication and implementation outcomes. Three coders created codebooks, coded independently, established inter-rater coding reliability, and analyzed if the CFI affects medical communication with respect to feasibility, acceptability, and clinical utility.

Results—Despite racial, ethnic, cultural, and professional differences within our group of patients and clinicians, we found that *promoting satisfaction through the interview*, *eliciting data*, *eliciting the patient's perspective*, and *perceiving data at multiple levels* were common codes that explained how the CFI affected medical communication. We also found that all but 2 codes fell under the implementation outcome of *clinical utility*, 2 fell under *acceptability*, and none fell under *feasibility*.

Conclusion—Our study offers new directions for research on how a cultural interview affects patient-clinician communication. Future research can analyze how the CFI and other cultural interviews impact medical communication in clinical settings with subsequent effects on outcomes such as medication adherence, appointment retention, and health condition.

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Keywords

cultural psychiatry; cultural formulation; psychiatric anthropology; ethnicity and health; Hispanic; Latino

Introduction

Mental health researchers have grappled with service provision for diverse patients whose understandings of illness and treatment differ from biomedical practitioners. For three decades, the “new cross-cultural psychiatry” has advocated use of cultural interviews that treat patients as health informants (Kleinman 1977). Cultural interviews differ from standard interviews in that clinicians ask patients about the cause, onset, mechanism of action, level of severity, and treatment preferences of illness, known as the patient’s explanatory model (Kleinman 1980). This approach attempts to rectify the clinician’s focus on disease pathology rather than the patient’s psychosocial experience of illness (Eisenberg 1977). Clinicians who understand patient explanatory models may be able to negotiate treatment regimens that improve patient satisfaction and treatment adherence (Kleinman, Eisenberg, and Good 1978).

However, recent social science theories have challenged tenets of cultural interviews. For example, information technology and globalization have connected people formerly separated by geography, suggesting that culture is a continuous process of meaning making and transmission (Gupta and Ferguson 1992). Individuals also create identities around sexual orientation, profession, migration, or language that may be more salient than racial and ethnic origins (Aggarwal 2012b). Therefore, culture and mental health researchers need clinical tools that ascertain important aspects of patient identities and their influences on explanatory models. Medical communication researchers have also shown that it is not just patient identities, but also patient-clinician cultural differences that relate to communication behaviors linked to decreased patient satisfaction, such as physicians asking minority patients less open-ended questions, not providing information, and expressing criticism (Cooper-Patrick *et al.* 1999; Sleath *et al.* 1999; Johnson *et al.* 2004; Schouten *et al.* 2007). Therefore, culture in health settings can be seen as values and meanings communicated interpersonally between patients and clinicians with different identities searching for common ground (Bibeau 1997).

In recognition that culture and mental health researchers need better tools to conduct cultural interviews, psychiatrists, psychologists, and anthropologists created the Outline for Cultural Formulation (OCF) for the fourth revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (Mezzich *et al.* 1999). The OCF draws from social science theories and divides the clinical encounter into four domains: (1) cultural identity of the individual, (2) cultural explanations of illness, (3) cultural levels of psychosocial support and functioning, and (4) cultural elements of the patient-physician relationship, with a fifth domain summarizing information that influences diagnosis and treatment (American Psychiatric Association 2000, Mezzich 2008, Aggarwal 2012a). Through the OCF, clinicians can ask patients about views of illness and treatment to individualize care (Lewis-

Fernández 1996) rather than stereotype patients based on perceived racial or ethnic affiliation (Kleinman and Benson 2006). The OCF has allowed patients to narrate illness experiences and helped to educate mental health trainees in cultural competence (Lewis-Fernández and Díaz 2002). The OCF has also elicited international interest with case reports examining the role of patient identities, explanatory models, and concerns about the health system on service utilization (Caballero Martínez 2008).

Even though the OCF provides a format to conduct cultural interviews, problems have been identified with its implementation. First, busy clinicians have struggled to formulate questions from its vague outline (Lewis-Fernández 2009). Second, researchers have questioned the reliability of reproducing data without a standardized design (Alarcón 2009) given the different OCF-inspired questionnaires (Group for the Advancement of Psychiatry 2001; Bäärnhielm and Rosso 2009; Groen 2009a; Kirmayer *et al.* 2008; Mezzich *et al.* 2009). Third, the lack of clinician instructions has raised questions about whether it is a separate assessment from the standard interview (Caballero Martínez 2009) and in what service settings it should be conducted (Aggarwal 2012b). Therefore, Cultural Issues Subgroup for the fifth revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) has revised the OCF into the Cultural Formulation Interview (CFI). The CFI was created based on literature reviews conducted in 2010 and 2011 by this international consortium of culture and mental health experts to identify the OCF's shortcomings, with revisions discussed in biweekly conference calls from March until November 2011 (Aggarwal 2013). The group created a standard, manualized CFI with 14 stem questions and probes, question explanations, and instructions for clinicians to implement the CFI in its entirety at the beginning of any diagnostic evaluation. The CFI has been used in a DSM-5 field trial to test feasibility (can it be done?), acceptability (do people like it?) and clinical utility (is it helpful?) among patients and clinicians. Table 1 includes the CFI from the field trial with questions for clinicians (American Psychiatric Association 2012).

Table 1 links CFI questions with corresponding DSM-IV OCF domain. After a question on the patient's preferred term for illness, the clinician substitutes the patient's term for every question that includes the word "problem." This strategy draws on linguistic approaches in medical anthropology to improve satisfaction with informants (Nichter 1981), a finding confirmed in clinical studies when clinicians match patient vocabularies rather than use technical terms (Williams and Ogden 2004).

This paper presents data from the field trial CFI whose results informed the final, 16-item version in DSM-5. We sought to analyze debriefing interviews with all patients and clinicians in New York City through Lazare, Putnam, and Lipkin's (1995) framework on the 3 communication functions of the medical interview: (1) determine and monitor the problem, (2) develop, maintain, and conclude the therapeutic relationship, and (3) carry out patient education and implementation of treatment plans. This framework has been extensively used to understand the dynamics of patient-clinician communication (Simpson *et al.* 1991; Heritage and Maynard 2006; Roter and Hall 2006). Rather than retain the strict focus on clinical decision making, we undertook a separate analysis based on case reports that the OCF has helped clinicians overcome communication barriers to improve patient satisfaction (Caballero Martínez 2009; Groen 2009b). This study is timely since the CFI will

be widely disseminated through DSM-5, the latest revision of the psychiatric classification system used most throughout the world (Littlewood 1992).

It is important to clarify the definitions for culture, race, and ethnicity as proposed by the DSM-5 Cultural Issues Subgroup. Culture has been defined as dynamic systems of knowledge, concepts, rules, and practices that are learned and transmitted across generations, including language, religion and spirituality, family structures, life-cycle stages, rituals, customs, and moral and legal systems (American Psychiatric Association 2013). Race has been defined as a culturally constructed category of identity that divides humanity into groups based on superficial physical traits attributed to hypothetical intrinsic, biological characteristics (American Psychiatric Association 2013). Ethnicity has been defined as a culturally constructed group identity that defines communities rooted in history, geography, language, religion, or other shared characteristics (American Psychiatric Association 2013). Researchers have pointed to dilemmas in using racial and ethnic classifications: while their definitions change by country and over time, many granting organizations and health ministries mandate collection of racial and ethnic information to fund research demonstrating elimination of health disparities (Braun *et al.* 2007; Ellison *et al.* 2007). In mental health, for example, there is no standard way to collect racial and ethnic data (Aggarwal *et al.* 2012) and categories do not account for mixed populations (Mays *et al.* 2003). Nonetheless, the Institute of Medicine recommends collection of racial and ethnic data independent of social class, income, education, or occupation because racial and ethnic variables exert independent predictor effects on disparities (Smedley, Stith, and Nelson 2003).

We have collected racial and ethnic data based on US Census categories as descriptor variables to explain cultural processes in medical communication, not to reify disproven notions of biological difference. Culture frames multiple aspects of medical communication by influencing patient choices of providers, clinical role expectations, acceptable and unacceptable topics for discussion, treatment preferences, verbal assertiveness, and perceived bias of the healthcare system (Kleinman 1977; Kleinman 1980; Blackhall *et al.* 1995; van den Brink-Muinen *et al.* 2000; Kirmayer 2006; Schouten and Meeuwesen 2006; Suurmond and Seeleman 2006, Claramita *et al.* 2013). Patients who are born in the same society and can communicate in the same language as providers exhibit more verbal participation throughout medical interviews (Alegría *et al.* 2009). Conversely, minority patients who cannot communicate in the language of providers engender less empathy, receive less information, and participate less in treatment decisions (Ferguson and Candib 2002).

This study explores how the CFI as a cultural interview impacts medical communication between patients and providers of different races and ethnicities. Our research aims are to: (1) examine how the CFI affects medical communication from patient and clinician perspectives through qualitative data analysis based on Lazare, Putnam, and Lipkin's (1995) communication functions framework, (2) explore whether certain communication functions could be linked to patient and clinician racial and ethnic identity, and (3) assess how communication functions elicited through the CFI relate to feasibility, acceptability, and clinical utility.

Methods

Study setting and design

International experts in cultural psychiatry and medical anthropology designed the trial. The New York State Psychiatric Institute and Columbia University Department of Psychiatry formed a single research site and coordinated study logistics for all sites. The study started in November 2011 and ended in September 2012, although the New York site completed data collection in May 2012. Each site agreed to enroll at least 30 patients and partnered with clinics to meet this enrollment. The trial enrolled 321 patients across the United States (5 sites), Peru (1), Canada (3), the Netherlands (3), Kenya (1), and India (2). Data acquisition and analysis from all sites is underway.

Treating clinicians approached patients for enrollment. Research staff obtained informed consent and scheduled the interview. The interview with the research clinician new to the patient consisted of the CFI, designed to last 15–20 minutes, followed by a standard assessment. All sessions were audio-taped. Patients and clinicians completed questionnaires before and after (*below*). The study was approved by each site's Institutional Review/Ethics Board based on local requirements. In New York, outpatients were recruited from the New York Presbyterian Hospital, Washington Heights Community Service, and the New York State Psychiatric Institute.

Participants

Eligible patients were of any racial or ethnic background; between 18 and 80 years of age; fluent in the language(s) of local clinicians; and could have any psychiatric diagnosis. We enrolled White-American patients in recognition that they have cultural identities that influence diagnostic assessment, treatment planning, and service utilization (Aggarwal 2010). At New York, we enrolled patients who spoke Spanish and English, though other sites enrolled French, Mandarin, Dutch, Hindi, Hmong, Marathi, Portuguese, and Swahili speakers. We matched patients and clinicians by language to exclude interpreters who could influence patient-clinician information exchange. Patients were excluded if acutely suicidal; acutely homicidal; intoxicated or in substance withdrawal; or with any condition that could interfere with the interview such as dementia, mental retardation, or florid psychosis. Patients were purposively sampled, as treating clinicians referred stable outpatients who provided informed consent for participation. Patients were read a standard recruitment script. Patients were recruited in New York from November 2011 to May 2012 until at least 30 outpatients had been enrolled. Our site enrolled 32 patients.

Eligible clinicians had to have a terminal degree (MD, MSW, PhD, APRN) enabling them to see patients, consistent with professional requirements in their country. In New York, clinicians were on staff at the New York State Psychiatric Institute or New York Presbyterian Hospital. Each clinician conducted 3 to 6 interviews. We decided that clinicians who completed fewer interviews might not experience a learning curve, potentially affecting feasibility, acceptability, and clinical utility. Clinicians were restricted to 6 interviews to maximize participation. Each site hosted a 2-hour CFI training session with review of CFI guidelines, a video demonstration, and interactive role-playing.

Clinicians gave informed consent during training. Clinicians were excluded if they could not attend training or conduct 3 interviews. Clinicians did not interview their own patients, since their knowledge could confound study findings.

Assessments

Data gathering consisted of pre-interview, interview, and post-interview phases.

Pre-interview: patients and research clinicians completed a demographic survey with research staff. Referring clinicians also completed pre-CFI referral forms on patient diagnosis and recommended treatments. All patients completed a consent quiz. Patients over 64 years old completed a mini-cognitive exam to assess capacity to consent.

Interview: The study session included the CFI followed by a standard diagnostic assessment. A research clinician audio-recorded the interview with patient consent. The CFI and guidelines for administration were provided to each clinician.

Post-interview: The research clinician completed a post-CFI form on diagnosis and treatment with the same format as the form completed by the pre-CFI treating clinician. Patients and clinicians completed quantitative instruments developed for the study on CFI feasibility, acceptability, and clinical utility after every encounter. Patients and clinicians also participated in semi-structured debriefing interviews after every encounter. Table 2 lists questions from all semi-structured interviews on CFI feasibility, acceptability, and clinical utility that are this study's data sources.

Clinicians completed additional assessments: a semi-structured, debriefing interview on CFI training after their first CFI session; a quantitative debriefing instrument on feasibility, acceptability, and clinical utility after the first and third sessions to test effects of multiple CFI administrations; and an open-ended, semi-structured debriefing interview after the first and third sessions to test effects of multiple CFI administrations.

Sites conducted translations based on need. Compared with original instruments, translated study instruments must demonstrate five forms of equivalence: (1) *content* – the content of each item is culturally relevant, (2) *semantic* – the meaning of each item is culturally the same, (3) *technical* – the method of administration (i.e. oral interviewing vs. paper and pen) is culturally comparable, (4) *criterion* – the method of interpretation is culturally the same, and (5) *conceptual* – the instrument is measuring the same construct in each culture (Flaherty *et al.* 1988). Although no consensus exists for translating study instruments (Maneesriwongul and Dixon 2004), the joint use of independent translations, back translations, and bilingual committees can ensure translation equivalence (Bravo *et al.* 1991; Weeks, Swerissen, and Belfrage 2007). For our Spanish translations, the third author independently translated the CFI and all forms into Spanish. These forms were then back translated in bilingual committees consisting of the first and third authors. Next, all forms were sent to collaborators in New Haven and Lima, Peru to check applicability with Spanish-speaking populations in all sites. Collaborators then reviewed translations with local staff before sending us final revisions. All of those involved in the translation process were

bilingual in Spanish and English. Translations for other languages were conducted in the exact same way with local primary investigators.

Data Analysis

Study sample characteristics were assessed by computing frequencies and percentages. The analytical team consisted of the first three authors: a research psychiatrist with a Master's degree in South Asian Studies, a clinical psychiatrist with a Master's degree in anthropology, and a Master's-level rehabilitation counselor. The rehabilitation counselor and research psychiatrist independently transcribed all interviews in English and Spanish verbatim for a quality check (Bernard 2006). We conducted a content analysis of all patient and clinician debriefing interviews through established methods. Content analysis is a systematic, objective method to describe and quantify phenomena through replicable, valid inferences from data to context (Krippendorff 2013). Deductive content analysis tests previous theories through the following steps: (1) selecting the textual unit of analysis → (2) developing a codebook of mutually exclusive categories based on extant theories → (3) coding the data → (4) reporting the data by category (Elo & Kyngäs 2008). We wanted to explore if the CFI improves medical communication.

Selecting the textual unit of analysis—In qualitative data analysis, multiple coders may draw different interpretations from a text. We selected each individual debriefing interview as the unit of analysis and each meaning unit to be the words or sentences that relate to each other through context and content (Graneheim and Lundman 2004). The first and third authors, bilingual in English and Spanish, reviewed all transcriptions together for data quality and finalized one transcription per interview. Afterward, all three team members read the transcript independently for content familiarity (Hsieh and Shannon 2005). We decided that the meaning unit should be longer than a word, but no longer than a paragraph to insure that all text would be coded discretely and appropriately.

Developing the codebooks—The strength of deductive content analysis is that extant theory can be supported, refuted, and extended. We searched the literature for theoretical frameworks from which codes and categories could be classified into codebooks (Hsieh and Shannon 2005). For our medical communication codebook, we used Lazare, Putnam, and Lipkin's (1995) framework on the 3 communication functions of the medical interview (*see above*). Within each function are tasks that can be analyzed as observable behaviors (Heritage and Maynard 2006). We sought to examine which tasks would appear in our dataset. For our feasibility, acceptability, and clinical utility codebook, we used Proctor *et al.*'s (2011) framework for implementation research. This framework distinguishes 8 implementation outcomes with definitions for feasibility, acceptability, and clinical utility to measure how interventions are introduced in clinical settings (Proctor *et al.* 2011). As an intervention introduced for clinical settings, we sought to describe implementation outcomes for the CFI. The first author created both codebooks with definitions for codes provided verbatim from the articles. Here, our data analytical strategy departed from the parent field trial which neither examined medical communication nor coded interviews for feasibility, acceptability, and clinical utility.

Coding the data—Each team member coded 10 randomly-selected transcriptions of patient and clinician debriefing interviews with the medical communication codebook (approximately 20% of the interview sample). Each team member coded each meaning unit with one unique code. To maintain analytical distance and reduce bias, no team member coded interviews in which he or she participated. Each team member independently coded transcriptions to generate preliminary codes. Team members created new codes when extant codes did not match their understanding of the content. We worked iteratively so that new codes could be compared with extant codes. We then met 5 times (once weekly during the coding step) to review transcripts, discuss codes, and reach consensus. New codes were added to the codebook following a process of iterative revisions that included all team members. We discussed concordance among codes and concepts, inviting challenges to initial interpretations. Descriptive memos were drafted to specify code definitions and parameters (appropriate and inappropriate use) through data examples. Independent coding continued for 3 rounds until new information produced no change to coding categories or revised codebooks. The first author uploaded all transcriptions into NVivo (QSR International, 2012) and then coded all transcripts. This process involved generating queries and reports in NVivo on major codes, exploring patterns, and drafting analytical memos on themes. To ensure rigor and validity, we used an audit trail of analytical memos and meeting notes, triangulation of narrative data, peer-debriefing sessions, and checking activities (Hsieh and Shannon 2005). After coding all text with the medical communication codebook, we classified all medical communication codes under feasibility, acceptability, and clinical utility in 2 meetings. Both codebooks are available.

Reporting the data by category—We used descriptive statistics to rank all codes since qualitative analysis rarely results in coded data that can be compared with statistical tests of difference (Krippendorff 2013).

Results

Sample Characteristics

Table 3 presents sample characteristics for Manhattan. We report data from all open-ended, semi-structured interviews (n=64) with patients (n=32) and clinicians (n=7). Patients were mostly over 50 years of age, female, and exceeded the 60% female means of clinic sites. Patients were also mostly Hispanic/Latino, approaching clinic means (75% in 2012) in the Washington Heights neighborhood. The most common diagnosis was a depressive disorder with most having a serious mental illness. A minority was employed part-time with the rest unemployed. Clinicians were mostly women and Hispanic/Latino. Psychiatrists conducted most CFI sessions, but social workers and psychologists also participated. The average length of clinician and patient debriefing interviews for all 64 sessions was 9.56 minutes (SD=4.48 minutes) and 10.70 minutes (SD=4.35 minutes), respectively.

First coding round: Does the CFI affect medical communication?

Table 4 presents themes on medical communication used to code debriefing interviews ranked by patient, clinician, and total sample. We wished to examine how our analyses of medical communication through the CFI fit within Lazare, Putnam, and Lipkin's (1995)

theoretical framework. Patients and clinicians considered the foremost functions of the CFI to be: (1) determine and monitor the nature of the problem, and (2) develop, maintain, and conclude the therapeutic relationship. Lazare, Putnam, and Lipkin (1995) included 2 tasks that we tried to code but for which we could not find instances: *negotiate preventive measures* and *communicating diagnostic significance* (not to be confused with *communicating care*). These 2 codes fell under the function of *carry out patient education and implementation of treatment plans*. We added a new category of *enhancing rapport through satisfaction with the interview* under the function *develop, maintain, and conclude the therapeutic relationship*. We report representative quotations and code analyses that appeared in >25% of our total sample.

Areas of agreement—Enhancing rapport through satisfaction with the interview – was the most coded communication task. Content for this theme appeared in 47 out of 64 interviews (73.4%) for 101 references. This code differed from *communicating care*. *Communicating care* emphasizes the clinician’s ability to express positive emotions such as respect, empathy, and support; the interview serves as the medium for the clinician to achieve these objectives. However, our new theme emphasizes positive emotions elicited by the CFI, not the interviewer. *Communicating care* is also unidirectional as the clinician communicates care to patients. Our new theme emphasizes how patients and clinicians feel increased rapport after the CFI, not just patients. We defined the new theme as: any discussion of how the CFI increased rapport between the patient and clinician independent of the clinician’s rapport-building skills.

One clinician’s experiences exemplified this communication task. A social worker with a doctorate and over two decades of clinical care described her CFI session positively:

‘I think that everyone who gets taught evaluation should be told that making rapport is the most important thing in the world, and you can’t make a diagnosis until you make rapport, and if you spend 10 to 15 minutes doing these questions, you’ll develop that rapport.’

Here, the clinician differentiated the interviewer from the interview. She noted that the CFI established rapport as an interviewing method. Rapport communicated through the CFI differed from the clinician’s inherent rapport-building skills.

Eliciting data – was the second most coded task. Content for this theme appeared in 46 out of 64 interviews (71.2%) for 82 references. We defined this theme as: any discussion of how the CFI produces information by letting the patient tell his or her own story, easing interview flow, using questions, and summarizing information.

Clinicians reported ease in eliciting data because questions were about patient experiences. For example, a 4th-year psychiatry resident stated: ‘I think the questions gave her a chance to tell her story about her cultural background, about what brought her to this country, and how her experiences as an immigrant helped her with depression.’

Patients also addressed how the CFI facilitates narration. A White-American patient in her early thirties in treatment for less than five years emphasized: ‘They [The CFI questions]

definitely touched on a lot of things that I would have taken many different sessions to discuss with my talk therapist or psychiatrist. So there's a lot more personal information in a shorter amount of time.'

Eliciting the patient's perspective – was the third most coded task. Content for this theme appeared in 44 out of 64 interviews (68.8%) for 97 references. We defined this theme as: any discussion of how the CFI elicits the patient's perspective on the illness around definitions, causes, mechanisms, fears, and goals.

Patients and clinicians agreed that the focus on eliciting the patient's perspective differed from standard interviews. Patients and clinicians ranked certain CFI questions as most helpful: the definition of the problem, expectations for treatment, and prior treatments most and least helpful. A third-year, minority psychiatry resident explained: 'I think it [the CFI] influenced the way I asked the questions with regard to past history. I ended up asking it more from the patient's perspective than I usually do instead of just going through a symptom checklist. 'It's getting a sense of what's most immediate for patients. What they see as their biggest problem.'

Perceiving data at multiple levels – was the fourth most coded task. Content for this theme appeared in 43 out of 64 interviews (67.2%) for 81 references. We defined this theme as: any discussion of how the CFI helps people use their five senses and personal responses to register verbal and nonverbal behaviors.

Clinicians reported that the CFI helped them understand patients, their problems, and types of therapies that could be integrated into treatment planning. A minority clinical psychologist with over five years of experience stated: 'I think the CFI helped to determine what services are most helpful for him [the patient], and the things that he really benefits from, and what he needs to continue to remain stable.'

Patients perceived data at multiple levels through appreciation of the socio-cultural contexts of illness. A White, English-speaking male patient with a post-graduate degree said: 'There were a couple times when I thought I realized, "Oh! That's an interesting connection between a life choice and certain mental health things." There were little realizations that gave my experiences with depression more structure, more perspective, as opposed to this one experience I had with a primary care person which was all symptomatic.' The CFI encouraged patients and clinicians to perceive data at multiple levels of awareness in different ways.

Communicating care – was the fifth most coded task. Content for this theme appeared in 35 out of 64 interviews (54.7%) for 61 references. We defined this theme as: any discussion of how the CFI helps clinicians communicate positive emotions such as rapport, support, and empathy.

Clinicians and patients found that the CFI relayed clinician warmth. The social worker exclaimed: 'The patient told me that he really liked the fact that I took a lot of time with him today and told me that he wanted me to be his doctor because I spent time with him. One of the things the CFI does is force you to sit with the patient and find out who they really are.'

In contrast to *enhancing rapport through satisfaction with the interview*, the theme *communicating care* illustrated how the CFI facilitated positive emotions from clinicians to patients.

Recognizing communication barriers – was the sixth most coded task. Content for this theme appeared in 20 out of 64 interviews (31.2%) for 25 references. We defined this theme as: any discussion of how the CFI helps patients and clinicians recognize problems by discussing differences, overcoming psychological barriers, providing emotional support, or negotiating communication differences.

Participants discussed how the CFI differed from standard assessments in which clinicians focus on making diagnoses. One White clinician noted that ‘the CFI doesn’t seem as rigid as the psychiatric interview.’ Another Latina clinician distinguished the CFI from the standard intake: ‘I think it [the CFI] just gave me more information than I would otherwise have obtained if I just focused mostly on the symptoms and the main issue or the problem for which the person is seeking services. This opens the channel to see the person in a broader context, to see aspects that are important for the person.’

Patients also observed differences between the CFI and standard assessment. A Spanish-speaking patient with a decade of treatment recalled his CFI session positively: ‘The difference with the CFI is the patience of the doctor. I didn’t notice pressure in him. I didn’t feel forced.’

Areas of difference—Table 4 also lists areas of difference among patients and clinicians. Patients and clinicians agreed that the CFI promoted behaviors within the first 2 functions of the medical communication framework, though tasks differed. The top 3 tasks from patient interviews were: *enhancing rapport through satisfaction with the interview*, *eliciting data*, and *communicating care*. For clinicians, the top 3 tasks were: *eliciting the patient’s perspective*, *eliciting data*, and *perceiving data at multiple levels*.

Table 5 reports race and ethnicity by participant in all CFI sessions as well as percent agreement of unique tasks coded from debriefing interviews. Only sessions 10, 12, 21, 22, and 28 demonstrated agreement of 50% or more, suggesting that patients and clinicians responded to different elements of medical communication. Clinicians in sessions 27 and 32 did not report content that could be coded through our framework.

In reviewing interview transcriptions, miscommunication occurred only around lack of clarity with the CFI, not with interpretations of the patient’s illness. For example, the patient in session 1 noted: “I think in the questionnaire [CFI] the only problem with the treatment question was that it was phrased for the past, but the meaning was for the present. And he corrected it.” No other patients noted problems with miscommunication. Clinicians also noted problems with phrasing. The clinician in session 12 mentioned: “This patient had trouble saying how she would label her problem if she were to use a word or expression to label it. I can’t, there’s not one word, there’s not one expression. For her it was hard, but eventually we came to something.” Clinicians reported problems with question phrasing in 15 of 32 debriefing sessions.

Table 5 also demonstrates trends in how tasks relate to ethnic and racial identity. The task *enhancing rapport* appeared in all interviews with African-Americans (sessions 16, 18, 26, 29, and 32). The combination of *eliciting data* and *enhancing rapport* appeared in 5 of 7 interviews with Afro-Caribbean patients (sessions 2, 13, 14, 17, and 23). The task *perceiving data* appeared in 5 of 8 interviews with White patients (sessions 1, 21, 22, 27, and 31). Our sample of 7 clinicians, all with different identities, also suggests differences by race and ethnicity. For example, 3 foreign born clinicians emphasized the affective components of the CFI. The task *communicating care* appeared in all but 1 of the White-European clinician's interviews (sessions 3, 6, 10, and 12). The tasks *communicating care* and *eliciting data* appeared in all 4 interviews with the Hispanic clinician (sessions 11, 13, 25, and 30). The tasks *enhancing rapport* appeared in all 5 of the Afro-Caribbean clinician's interviews (sessions 17, 20, 21, 23, and 24). In contrast, the sole White-American clinician emphasized how the CFI clarified patient-clinician differences. The tasks *determining areas of difference*, *eliciting the patient's perspective*, *perceiving data*, and *enhancing rapport* consistently appeared in all 3 interviews (sessions 4, 16, and 22) with her. Although the clinician sample was relatively small, the repeated presence of these findings by clinician suggests differences in communication tasks by race, ethnicity, and nativity.

To test findings on communication tasks differentially classified by race and ethnicity, we then compared patient-clinician dyads by racial and ethnic concordance. We excluded session 15 in which patient and clinician reported "mixed" race, but did not further specify race or ethnicity. This left 2 CFI sessions with White-Americans (sessions 4 and 22) and 3 sessions with Afro-Caribbeans (sessions 17, 19, and 23). In all 5 sessions, patients and clinicians reported that the CFI helped with *enhancing rapport*. However, *determining areas of difference* uniquely appeared in session 22 with the White-American patient and clinician. This task also appeared in the interview with the White-American clinician in session 4, but not with that patient, though that patient also reported only 1 theme compared to multiple themes reported by most other patients. The task *determining areas of difference* did not appear in sessions when patients and clinicians were both of Afro-Caribbean ethnicity. This suggests that White-Americans recognize patient-clinician differences of illness explanations as a potential communication barrier that the CFI may resolve.

Second coding round: How do CFI medical communication functions relate to feasibility, acceptability, and clinical utility?

Table 6 presents our classification for how communication functions through the CFI relate to feasibility, acceptability, and clinical utility, as defined by Proctor *et al.* (2011). They offer these definitions: *feasibility* – "the extent to which a new treatment, or an innovation, can be successfully used or carried out within a given agency or setting" (p. 69); *acceptability* – "the perception among implementation stakeholders that a given treatment, service, practice, or innovation is agreeable, palatable, or satisfactory" (p. 67); *clinical utility* – "the perceived fit, relevance, or compatibility of the innovation or evidence based practice for a given practice setting, provider, or consumer; and/or perceived fit of the innovation to address a particular issue or problem" (p. 69). We retained these definitions and added specifications for our codebook: *feasibility* refers to implementation logistics, *acceptability*

refers to emotional responses to the CFI, and *clinical utility* refers to the CFI's usefulness in a health setting.

All but 2 CFI communication functions fell under *clinical utility*. One Caribbean Hispanic female in her 60s valued the CFI for 'helping clinicians listen to people.' 'It's not that "you are a patient in a category, you don't have money, I'm going to treat you short and quick because in the end, you are not productive, you don't have anything." The CFI helps clinicians treat patients as human beings by giving them attention so they don't feel marginalized.' The social worker reported how the CFI helped understand patient priorities: "This guy has lifelong schizophrenia or a psychotic disorder and we can treat that by day treatment and medication. He defines his problems as, "he worries too much and he worries about his bills and his dreams" and if I don't address those, the other stuff won't work. That's really helpful for treatment planning."

Patients and clinicians believed that the CFI helped to communicate emotions in 2 ways that fell under *acceptability*: clinicians communicating care and the CFI enhancing rapport among patients and clinicians. No response was coded under *feasibility*.

Discussion

This study sought to explore if the CFI as a cultural interview affects medical communication based on a deductive content analysis of patient and clinician debriefing interviews from a DSM-5 field trial. This study also sought to relate communication functions through the CFI to implementation outcomes of feasibility, acceptability, and clinical utility. The study is timely since previous editions of the DSM have been used internationally.

Patients and clinicians thought that the foremost communication functions of the CFI were to (1) *determine and monitor the nature of the problem*, and (2) *develop, maintain, and conclude the therapeutic relationship*. We observed fewer themes for the third function, *patient education and implementation of treatment plans*. This may be explained by the pilot nature of our study in which patients and study clinicians met once. Patients were not educated about diagnoses from study clinicians and treatment plans were not implemented. It may also be explained by Lazare, Putnam, and Lipkin (1995)'s framework which is focused on providers rather than patients: '[T]his functional approach can be useful to clinicians, teachers, students, and investigators' (p. 4). The framework emphasizes 'patient education' whereas the CFI presumes that patients educate clinicians on their illnesses.

We found 4 main tasks within these functions: *eliciting data*, *eliciting the patient's perspective*, *perceiving data at multiple levels*, and *enhancing rapport through satisfaction with the interview*. We expected high responses to the first 2 tasks since the CFI is designed to obtain patient explanatory models. We did not expect the higher frequency of tasks for *perceiving data at multiple levels*. We also found differences in communication tasks based on racial and ethnic identity with *enhancing rapport* coded in most interviews with African-American patients, *eliciting data* and *enhancing rapport* coded in most interviews with Afro-Caribbean patients, and *perceiving data* coded in most interviews with White patients.

Systematic reviews note that minority patients may be less expressive with physicians than White patients (Schouten & Meeuwesen 2006). Our African-American and Afro-Caribbean patients may have responded positively to the open-ended nature of the CFI, though this finding needs confirmation in studies with larger samples. Patients and clinicians did not report miscommunication around patient interpretations of illness, but rather around the phrasing of certain questions. Clinicians have reported other barriers to using the CFI in clinical practice such as its standardized format (Aggarwal et al. 2013), but not around medical communication.

We also found differences in communication functions by clinician identity. Our 3 foreign-born clinicians of White-European, Hispanic, and Afro-Caribbean ancestry noted that the CFI facilitates *communicating care* and *enhancing rapport*. Our sole White-American clinician also reported *enhancing rapport*, but consistently reported additional functions of *determining areas of difference*, *eliciting the patient's perspective*, and *perceiving data*. We further examined ethnic and racial concordant patient-clinician dyads to test whether communication functions were linked to identity, finding that *enhancing rapport* appeared in all such dyads regardless of race or ethnicity whereas *determining areas of difference* was reported by 3 out of 4 White-American participants. Ethnically and racially concordant patient-clinician encounters demonstrate greater positive patient and physician affect (Cooper-Patrick et al. 1999; Saha et al. 1999). Clinicians often overestimate the similarity between patient and clinician explanatory models (Suurmond and Seeleman 2006), and our White-American clinician may have discovered patient explanations through the CFI that differed from her understanding. However, clinician ethnicity is confounded with age and gender (minority clinicians are more likely to be female and younger than White physicians), so future research should disentangle these correlated variables to assess their independent impact on communication (Roter 2003).

The CFI's structure may improve cross-cultural communication in ways consistent with medical communication research. The most prevalent theme *enhancing rapport through satisfaction with the interview* may have been accomplished through several mechanisms. The CFI uses open-ended questions that increase patient satisfaction (Roter and Larson, 2002). Clinicians incorporate patient terminology to build rapport (Williams and Ogden, 2004). Future research can dissect CFI sessions through methods such as the Roter Interaction Analysis System to examine if the CFI promotes clinician behaviors that improve medical communication. Studies can also compare the CFI against standard interviews for effects on medication adherence, appointment retention, and health outcomes.

Finally, we found that most communication functions of the CFI fell under *clinical utility* with only some under *acceptability*. This may result from Lazare, Putnam, and Lipkin (1995) regarding the medical interview as a tool for communication functions (*clinical utility*) through positive rapport (*acceptability*). The nature of our study may explain these findings. By facilitating logistics (*feasibility*), we may have reduced content from patients and clinicians around this theme. *Feasibility* and other implementation outcomes could be studied when the CFI is introduced for clinical use.

Our study has several limitations. First, our interviews present data from New York and may not be generalizable. Our content analysis on medical communication was undertaken for this dataset and is not an aim of the overall DSM-5 trial. Our sample predominantly enrolled women and Latinos, potentially influencing responses. Future studies could correlate gender and ethnicity with communication functions in more diverse samples. Our method of coding debriefing interviews can be extended to other ethnic and linguistic groups in the CFI field trials to demonstrate similarities and differences in how culture affects medical communication. Second, participants may have reported communication benefits from social desirability. All DSM-5 field trials have recruited convenience samples of volunteers. Nonetheless, we believe that patients and clinicians maintained their independence as reflected in our data around miscommunication based on question phrasing. Third, patient *acceptability* and feelings of enhanced rapport through the interview could be due to increased time spent with clinicians. Future studies could randomize patients to clinicians performing the CFI with clinicians asking other questions for the same amount of time to disambiguate time effects on patient satisfaction. Fourth, all participants knew that our study was not a clinical interview with a therapeutic purpose. This simulated nature may have affected coding proportions. Future research could determine whether coding frequencies for communication tasks change with clinical CFI use. Fifth, our study over-represented psychiatrists. Future studies could enroll samples balanced by profession for comparison with our findings. A more balanced sample would elucidate whether *feasibility* outcomes differ for psychologists and social workers who are reimbursed by time compared to psychiatrists who are increasingly reimbursed only for medication management in managed-care settings (Ware *et al.* 2000). Sixth, specific diagnoses may be less amenable to the CFI. Case reports suggest that acute mania and florid psychosis may not respond to cultural interviews (Aggarwal 2012a). Our pilot study excluded those with thought disorders and cognitive limitations. Implementation studies can map whether the CFI works better for certain diagnoses. Finally, deductive content analysis is typically used to compare data with extant theories. We may have been blinded to other possibilities of data analysis. Nonetheless, this is a limitation for all qualitative research.

Despite these potential limitations, our study points to new directions at the crossroads of cultural psychiatry and medical communication. In line with current social science research (Gravlee & Sweet 2008), we have reported data on race and ethnicity because these categories exist as markers of social difference and discrimination in the United States. Ironically, cultural competence initiatives in the United States have sometimes reinforced racial and ethnic stereotypes by presenting lists of traits for clinicians to remember rather than clarify the complex socio-cultural environments in which patients live (Gregg & Saha 2006; Jenks 2011). Therefore, we have used a process-oriented definition of culture proposed for DSM-5 that emphasizes dynamic patient-clinician interactions. Cultural studies of medical communication are especially important since patients and clinicians must negotiate relationships through shared languages, meanings, and objectives (Aggarwal 2011). The benefits of a cultural approach to communication are several. First, this relationship can teach us how culture is socially communicated. Culture frames how patients describe symptoms and illness explanations based on perceptions of clinician responsiveness and role expectations (Kleinman 1977, 1980; Good 1994; Kirmayer 2006; Kleinman and

Benson 2006; Lewis-Fernández and Díaz 2002). The patient-clinician relationship is also influenced by ethnic and racial relationships within society at large, requiring clinicians to avoid biases with patients (Lu, Lim, and Mezzich 1995). Studies of medical communication can move beyond race and ethnicity to examine how values and beliefs – the substance of culture (Kleinman and Benson 2006) – are shared and contested among patients and clinicians, with the medical encounter viewed as an ongoing negotiation. Second, since definitions of racial and ethnic categories vary across societies, a cultural approach to communication allows for international comparisons around the social differences of patients and clinicians (Schouten & Meeuwesen 2006). Our study indicates that the CFI may enhance cross-cultural medical communication. Whether it improves long-term treatment outcomes remains an area for research in cultural psychiatry, medical communication, and other fields concerned with culture's impact in health settings.

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Key Messages

- The Cultural Formulation Interview is a cultural interview included in DSM-5.
- The Cultural Formulation Interview improves medical communication among patients and clinicians mostly by increasing rapport and eliciting patient narration.
- The Cultural Formulation Interview shows acceptability and clinical utility in health settings.

Table 1**The Cultural Formulation Interview**

CFI Question	Relevant OCF Domain
1. What problems or concerns bring you to the clinic?	Cultural explanations of the individual's illness
2. What troubles you most about your problem?	Cultural explanations of the individual's illness
3. People often understand their problems in their own way, which may be similar or different from how doctors explain the problem. How would you describe your problem to someone else?	Cultural explanations of the individual's illness
3a. Sometimes people use particular words or phrases to talk about their problems. Is there a specific term or expression that describes your problem? 3b. What is it?	Cultural explanations of the individual's illness
4. Why do you think this is happening to you? What do you think are the particular causes of your problem?	Cultural explanations of the individual's illness
5. What, if anything, makes your problem worse, or makes it harder to cope with?	Cultural explanations of the individual's illness
5a. What have your family, friends, and other people in your life done that may have made your problem worse?	Cultural factors related to psychosocial environment and levels of functioning
6. What, if anything, makes your problem better, or helps you cope with it more easily?	Cultural explanations of the individual's illness
6a. What have your family, friends, and other people in your life done that may have made your problem better?	Cultural factors related to psychosocial environment and levels of functioning
7. Is there anything about your background, for example your culture, race, ethnicity, religion or geographical origin that is causing problems for you in your current life situation? In what way?	Cultural identity of the individual
8. On the other hand, is there anything about your background that helps you to cope with your current life situation? In what way?	Cultural identity of the individual
9. Sometimes people consider various ways of making themselves feel better. What have you done on your own to cope with your problem?	Cultural explanations of the individual's illness
10. Often, people also look for help from other individuals, groups, or institutions to help them feel better. In the past, what kind of treatment or help from other sources have you sought for your problem?	Cultural explanations of the individual's illness
10a. What type of help or treatment was most useful? Why?/How?	Cultural explanations of the individual's illness
10b. What type of help or treatment was not useful? Why?/How?	Cultural explanations of the individual's illness
11. Has anything prevented you from getting the help you need-- for example, cost or lack of insurance coverage, getting time off work or family responsibilities, concern about stigma or discrimination, or lack of services that understand your language or culture? What got in the way?	Cultural factors related to psychosocial environment and levels of functioning
12. Now let's talk about the help you would be getting here. Is there anything about my own background that might make it difficult for me to understand or help you with your problem? 12a. In what way?/Why not?	Cultural elements of the relationship between the individual and the clinician
13. How can I and others at our clinic be most helpful for you?	Cultural elements of the relationship between the individual and the clinician
14. What kind of help would you like from us now, as specialists in mental health?	Cultural elements of the relationship between the individual and the clinician

CFI - Cultural Formulation Interview

OCF - DSM-IV Outline for Cultural Formulation

Table 2**Semi-structured, Debriefing Interview Questions on Feasibility, Acceptability, and Clinical Utility**

Patient Topics

- 1 Overall, how did you feel answering these questions about your perspective?
- 2 How did the questions affect what you talked about with the clinician?
- 3 How did the CFI affect your relationship with the clinician?
- 4 How different were these questions from those of your other clinicians?
- 5 How did the CFI affect what you think or feel about mental health care?
- 6 What was most helpful about the questions of the CFI? Least helpful?
- 7 Are there any particular CFI questions that you think should be changed or removed, perhaps because they were unclear? Are there any additional questions that were not asked during the CFI, but should be included?
- 8 How do you think the CFI might affect your care?

Clinician Topics

- 1 Overall, how would you describe your experience using these questions of the Cultural Formulation Interview (CFI)?
 - 2 How did the inclusion of the CFI affect the content and the quality of the information you obtained?
 - 3 What impact did using the Cultural Information Interview have on your relationship with your patient?
 - 4 How did the CFI affect the differential diagnosis and the eventual working diagnosis?
 - 5 How did the CFI affect treatment planning?
 - 6 What was most helpful about the inclusion of the CFI in the clinical evaluation? Least helpful?
-

CFI - Cultural Formulation Interview

Table 3

Sample Characteristics of the New York site

	NYPH^b (n=10)	WHCS^c (n=22)	Total (n=32)	
<i>Patients</i>				
Mean age (SD ^d)	59.10 (10.56)	50.95 (14.40)	53.50 (13.69)	
Female	9	13	22	
Race/ethnicity				
Non-Hispanic White	1	3	4	
African-American	2	3	5	
Hispanic/Latino	7	16	22	
Other	0	0	0	
Employed (at least part-time)	2	3	5	
Primary diagnosis Post-CFI				
Depression	7	7	14	
Bipolar Disorder	2	5	7	
Schizophrenia	0	8	8	
Obsessive-Compulsive Disorder	1	0	1	
Psychosis Not Otherwise Specified	0	2	2	
	NYPH (n=2)	WHCS (n=2)	NYSPI^d (n=3)	Total (n=7)
<i>Clinicians</i>				
Mean age (SD)	53.00 (1.41)	35.50 (.71)	31.67 (2.31)	38.86 (9.92)
Female	2	1	2	5
Race/ethnicity				
Non-Hispanic White	1	1	0	2
Hispanic/Latino	1	1	1	3
Asian	0	0	1	1
Mixed	0	0	1	1
Profession				
Psychiatrist	0	1	2	3
Psychologist	0	1	0	1
Social worker	2	0	0	2
Rehabilitation counselor	0	0	1	1

^aSD - Standard Deviation

^bNYPH - New York-Presbyterian Hospital

^cWHCS - Washington Heights Community Service

^dNYSPI - New York State Psychiatric Institute

Table 4

The Communication Functions of the CFI Coded Through Qualitative Interviews

Codebook Category, Subcategory, and Definition	Lazare et al.	Study Analysis	Reported Functions				Total Prevalence		Overall Rank
			Patient Number	Patient Rank	Clinician Number	Clinician Rank	Total /64	%	
Determining and monitoring the nature of the problem									
<i>Diseases and disorders:</i> the CFI helps clinicians make a biomedical diagnosis	x	x	3	7	6	7	9	14.10%	10*
<i>Psychosocial issues:</i> the CFI illustrates how patients respond to their condition before entering medical care	x	x	1	9	9	6	10	15.60%	8*
<i>Eliciting data:</i> the CFI encourages communication skills by letting patients tell their own stories, facilitating narration, easing flow of the interview, using appropriate questions, or summarizing information	x	x	21	2	25	2	46	71.20%	2
<i>Perceiving data at multiple levels:</i> the CFI helps clinicians use their five senses and their own personal responses to register patient verbal and non-verbal behavior	x	x	18	4	25	2	43	67.20%	4
<i>Generating and testing hypotheses:</i> the CFI helps clinicians create or test hypotheses based on patient data	x	x	0	last	10	5	10	15.60%	8*
Developing, maintaining, and concluding the therapeutic relationship									
<i>Defining the relationship:</i> the CFI helps clinicians clarify their exact role in the patient's care	x	x	2	8	5	8	7	10.94%	11
<i>Communicating expertise:</i> the CFI helps clinicians demonstrate scientific competence and wisdom in their judgments and decisions	x	x	0	last	3	9	3	4.69%	13
<i>Communicating care:</i> the CFI helps clinicians communicate positive emotions such as rapport, interest, respect, support, and empathy	x	x	20	3	15	4	35	54.70%	5
<i>Recognizing communication barriers:</i> the CFI helps clinicians recognize and resolve communication problems with patients by openly discussing differences, overcoming patient psychological barriers, providing emotional support, or negotiating communication differences	x	x	5	5	15	4	20	31.20%	6
<i>Eliciting the patient's perspective:</i> the CFI elicits the patient's perspective on definitions, causes, mechanisms, fears, and goals related to the problem	x	x	18	4	26	1	44	68.80%	3
<i>Enhancing rapport through satisfaction with the interview:</i> the CFI increased rapport among patients and clinicians		x	28	1	19	3	47	73.40%	1
Patient education and implementation of treatment plans									
<i>Determining areas of difference:</i> the CFI helps clarify where patients and clinicians may disagree about ideas regarding the patient's sickness	x	x	4	6	10	5	14	25%	7
<i>Communicating diagnostic significance:</i> the CFI helps clinicians communicate the significance of the problem from a biomedical perspective, taking into account the patient's concerns, beliefs, and fears	x		0	last	0	last	0	0.00%	last

Codebook Category, Subcategory, and Definition	Lazare et al.	Study Analysis	Reported Functions				Total Prevalence		Overall Rank
			Patient Number	Patient Rank	Clinician Number	Clinician Rank	Total /64	%	
<i>Negotiating diagnostic procedures and treatment:</i> the CFI helps clinicians discuss diagnosis and treatment options	x	x	0	last	1	10	1	1.56%	14
<i>Negotiating preventive measures:</i> the CFI helps clinicians negotiate and recommend preventive measures	x		0	last	0	last	0	0.00%	last
<i>Enhancing coping:</i> the CFI helps clinicians work with patients to discuss coping strategies related to worsening social and psychological functioning from the illness or treatment	x	x	2	8	3	9	5	7.81%	12

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Table 5

Communication Tasks Reported by Patients and Clinicians Per Session

Session	Patient Ethnicity	Patient Tasks	Clinician Ethnicity	Clinician Tasks	% Agreement by Task Type
1	European-American	Communicating care, Perceiving data, Enhancing rapport	Mixed\$	Defining the relationship, Eliciting the patient's perspective, Generating and testing hypotheses, Perceiving data, Enhancing rapport	33.33%
2	Afro-Caribbean	Eliciting data, Eliciting the patient's perspective, Enhancing rapport	Mixed\$	Diseases and disorders, Determining areas of difference, Eliciting data, Eliciting the patient's perspective, Generating and testing hypotheses, Perceiving data, Enhancing rapport	42.86%
3	Mixed#	Communicating care, Communicating expertise, Enhancing rapport	White-European	Communicating care, Eliciting data, Eliciting the patient's perspective, Generating and testing hypotheses, Perceiving data, Recognizing communication barriers, Enhancing rapport	12.50%
4	White*	Enhancing rapport	White*	Communicating care, Determining areas of difference, Eliciting data, Eliciting the patient's perspective, Enhancing coping, Perceiving data, Psychosocial issues, Recognizing communication barriers, Enhancing rapport	11.11%
5	White-Hispanic	Determining areas of difference, Psychosocial issues, Recognizing communication barriers, Enhancing rapport	East Asian	Defining the relationship, Determining areas of difference, Eliciting the patient's perspective, Generating and testing hypotheses, Perceiving data, Recognizing communication barriers	25%
6	Mixed#	Communicating expertise, Eliciting data, Perceiving data, Enhancing rapport	White-European	Communicating care, Eliciting the patient's perspective, Perceiving data, Recognizing communication barriers, Enhancing rapport	14.29%
7	Mixed#	Communicating care, Eliciting data, Eliciting the patient's perspective, Perceiving data, Recognizing communication barriers, Enhancing rapport	Other	Diseases and disorders, Communicating care, Determining areas of difference, Eliciting data, Eliciting the patient's perspective, Generating and testing hypotheses, Psychosocial issues, Recognizing communication barriers	40%
8	Afro-Caribbean	Communicating care, Perceiving data, Recognizing communication barriers, Enhancing rapport	Mixed\$	Communicating care, Defining the relationship, Determining areas of difference, Eliciting data, Eliciting the patient's perspective, Generating and testing hypotheses, Negotiating diagnostic procedures and treatment, Perceiving data, Enhancing rapport	30%
9	Mixed#	Communicating care, Defining the relationship, Eliciting data, Eliciting the patient's perspective	White-European	Determining areas of difference, Eliciting data, Generating and testing hypotheses, Perceiving data, Enhancing rapport	12.50%
10	Mixed#	Eliciting data, Eliciting the patient's perspective, Enhancing rapport	White-European	Communicating care, Eliciting data, Enhancing rapport	50%
11	Mixed#	Determining areas of difference, Eliciting data, Eliciting the patient's perspective, Perceiving data	Hispanic~	Communicating care, Eliciting data, Eliciting the patient's perspective, Recognizing communication barriers	33.33%
12	Mixed#	Communicating care, Eliciting the patient's perspective, Enhancing rapport	White-European	Communicating care, Enhancing rapport	66.66%
13	Afro-Caribbean	Communicating care, Defining the relationship, Eliciting data, Eliciting the patient's perspective, Enhancing rapport	Hispanic~	Communicating care, Eliciting data	40%

Session	Patient Ethnicity	Patient Tasks	Clinician Ethnicity	Clinician Tasks	% Agreement by Task Type
14	Afro-Caribbean	Communicating care, Determining areas of difference, Eliciting data, Eliciting the patient's perspective, Perceiving data, Enhancing rapport	Other	Communicating care, Eliciting data, Eliciting the patient's perspective, Enhancing coping, Generating and testing hypotheses, Perceiving data, Recognizing communication barriers	44.44%
15	Mixed#	Perceiving data	Mixed\$	Diseases and disorders, Eliciting data, Eliciting the patient's perspective, Perceiving data, Psychosocial issues, Enhancing rapport	16.67%
16	African-American	Communicating care, Eliciting data, Eliciting the patient's perspective, Perceiving data, Enhancing rapport	White*	Determining areas of difference, Eliciting the patient's perspective, Generating and testing hypotheses, Perceiving data, Recognizing communication barriers, Enhancing rapport	37.50%
17	Afro-Caribbean	Communicating care, Eliciting data, Enhancing rapport	Afro-Caribbean	Diseases and disorders, Communicating care, Eliciting data, Eliciting the patient's perspective, Enhancing coping, Perceiving data, Psychosocial issues, Recognizing communication barriers, Enhancing rapport	22.22%
18	African-American	Diseases and disorders, Eliciting data, Eliciting the patient's perspective, Perceiving data, Enhancing rapport	Other	Communicating care, Eliciting data, Perceiving data, Psychosocial issues, Recognizing communication barriers	25%
19	Afro-Caribbean	Communicating expertise, Enhancing rapport	Afro-Caribbean	Communicating care, Eliciting data, Eliciting the patient's perspective, Perceiving data, Recognizing communication barriers, Enhancing rapport	14.29%
20	Mixed#	Communicating care, Enhancing rapport	Afro-Caribbean	Communicating care, Eliciting the patient's perspective, Generating and testing hypotheses, Perceiving data, Enhancing rapport	40%
21	White-Hispanic	Eliciting data, Eliciting the patient's perspective, Perceiving data, Enhancing rapport	Afro-Caribbean	Communicating care, Eliciting data, Eliciting the patient's perspective, Perceiving data, Psychosocial issues, Enhancing rapport	66.66%
22	White*	Communicating care, Determining areas of difference, Eliciting the patient's perspective, Enhancing coping, Perceiving data, Recognizing communication barriers, Enhancing rapport	White*	Determining areas of difference, Eliciting data, Eliciting the patient's perspective, Perceiving data, Enhancing rapport	50%
23	Afro-Caribbean	Eliciting data, Enhancing rapport	Afro-Caribbean	Eliciting data, Eliciting the patient's perspective, Perceiving data, Psychosocial issues, Enhancing rapport	40%
24	Mixed#	Communicating care, Eliciting data, Eliciting the patient's perspective, Perceiving data, Enhancing rapport	Afro-Caribbean	Enhancing rapport	20%
25	Mixed#	Eliciting data, Perceiving data	Hispanic~	Diseases and disorders, Communicating care, Eliciting data, Eliciting the patient's perspective	20%
26	African-American	Eliciting data, Eliciting the patient's perspective, Enhancing rapport	Mixed\$	Determining areas of difference, Eliciting the patient's perspective, Perceiving data, Enhancing rapport	40%
27	White-Hispanic	Diseases and disorders, Communicating care, Eliciting data, Eliciting the patient's perspective, Enhancing coping, Perceiving data, Recognizing communication barriers, Enhancing rapport	Other		0%

Session	Patient Ethnicity	Patient Tasks	Clinician Ethnicity	Clinician Tasks	% Agreement by Task Type
28	Mixed#	Communicating care, Eliciting data, Eliciting the patient's perspective, Perceiving data, Enhancing rapport	East Asian	Communicating care, Eliciting data, Perceiving data	60%
29	African-American	Eliciting data, Eliciting the patient's perspective, Perceiving data, Enhancing rapport	Other	Diseases and disorders, Eliciting data, Perceiving data, Recognizing communication barriers	33.33%
30	White-Jewish	Enhancing rapport	Hispanic~	Communicating care, Defining the relationship, Eliciting data, Eliciting the patient's perspective, Perceiving data, Recognizing communication barriers	0%
31	White-Irish	Eliciting data, Eliciting the patient's perspective, Perceiving data, Enhancing rapport	Other	Communicating care, Eliciting data, Eliciting the patient's perspective, Perceiving data, Psychosocial issues, Recognizing communication barriers	42.86%
32	African-American	Diseases and disorders, Perceiving data, Enhancing rapport	East Asian		0%

* Race provided, but not ethnicity

Mixed Hispanic and Afro-Caribbean ancestry

\$ Mixed, but race and ethnicity not specified

~ Ethnicity provided, but not race

% agreement is calculated by the ratio of shared reported tasks to total unique reported tasks

Table 6

Relating CFI Medical Communication to Feasibility, Acceptability, and Clinical Utility

Codebook Category and Subcategory	Implementation Outcomes		
	Feasibility	Acceptability	Clinical Utility
Determining and monitoring the nature of the problem			
Diseases and disorders			x
Psychosocial issues			x
Eliciting data			x
Perceiving data at multiple levels			x
Generating and testing hypotheses			x
Developing, maintaining, and concluding the therapeutic relationship			
Defining the relationship			x
Communicating expertise			x
Communicating care		x	
Recognizing communication barriers			x
Eliciting the patient's perspective			x
Enhancing rapport through satisfaction with the interview		x	
Patient education and implementation of treatment plans			
Determining areas of difference			x
Negotiating diagnostic procedures and treatment			x
Enhancing coping			x

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