3 The Process of Cultural Consultation

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Introduction

In this chapter, we describe the process of cultural consultations in terms of the specific steps from intake and triage, through interviewing and clinical data collection, to case formulation, communication of recommendations, and follow-up. Our aim is to provide sufficient detail about the nuts and bolts of cultural consultation and the actual process to help others wishing to set up similar services.

The CCS team works within the framework of the cultural formulation introduced with DSM-IV, to identify ways that cultural background and current contexts interact to shape the manifestations of illness, its course, and potential interventions. The aim is to complement standard psychiatric evaluation by focusing on social and cultural dimensions that may be less familiar and that tend to get less attention in routine care. The CCS consultants use models drawn from cultural psychiatry and psychology, cognitive behavioral therapy, family systems theory, and ecosocial systemic approaches that emphasize the social embedding of illness experience as well as gender, racialized identity, and ethnicity (see Chapters 7 and 8). Cases are formulated in terms of the interplay of personal and social meanings and dynamics that include interactions with families, communities, health care, and systems. While the consultations use psychiatric diagnostic categories (as presented in DSM-5 and ICD-10), they also explore the personal and social meanings of symptoms and include a broader problem list of social predicaments as well as sources of resilience and potential strategies for healing and recovery. The cultural formulation brings together psychiatric and cultural expertise in an integrated assessment and recommendations for more effective patient care.

The flow of patients through the CCS is depicted in Fig. 3.1. The process begins with an initial contact with the service by a referring clinician. The CCS coordinator does an intake and initial triage. The resource people needed to assess the case are assembled, and meetings are held with the patient and members of their entourage. An initial report and cultural formulation is prepared, and preliminary recommendations are conveyed to the referring clinician. The case is presented at a weekly CCS meeting, where the cultural formulation and recommendations are

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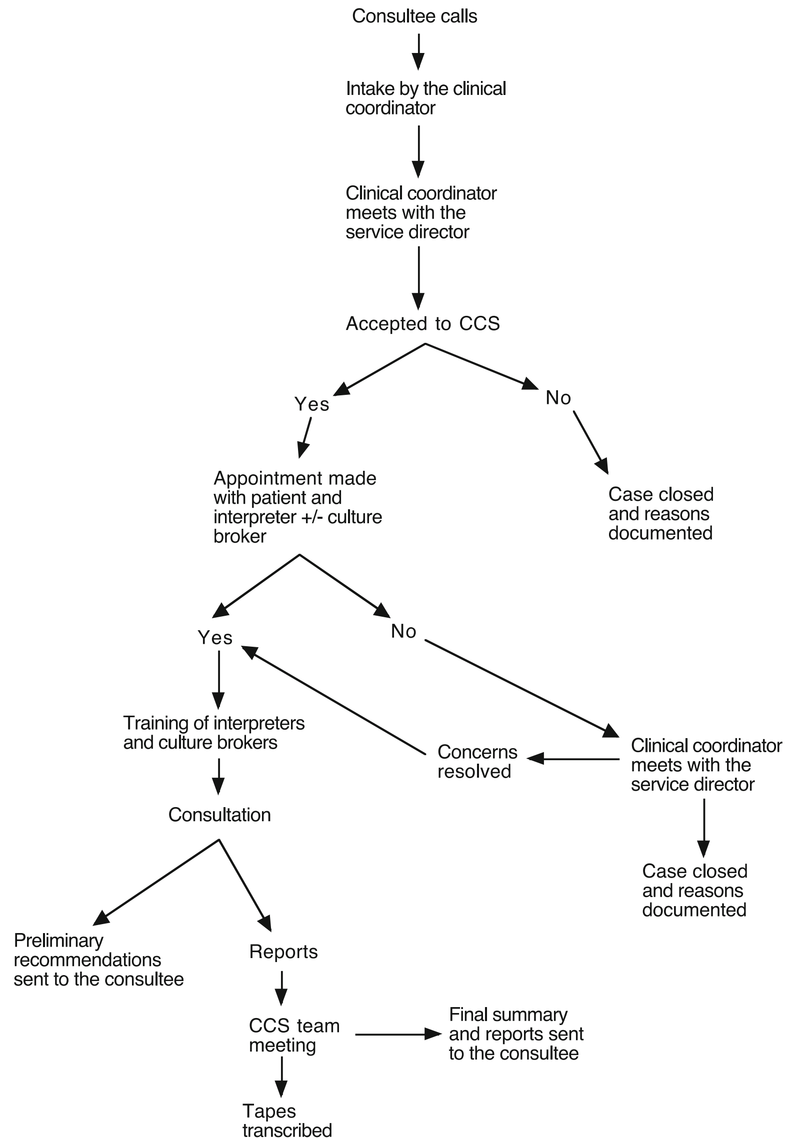

Fig. 3.1 Flow diagram of CCS procedure

discussed and refined. The full consultation report is prepared and sent to the referring clinician, and appropriate follow-up is arranged. In the sections that follow, we discuss each of these steps in detail.

Before the Consultation Request

As discussed in Chapter 2, when the CCS was established, the availability of the service was announced by sending a mailing to all psychiatrists and psychologists in the province and contacting regional comprehensive community clinics. Since that time, referrals to the CCS have come mainly from institutions located in highly diverse neighborhoods of the city that maintain ongoing links with the CCS. The good experiences of other practitioners in the institution are the most effective "advertising" for the service. Invited talks and presentations at health care and social service institutions and ongoing training activities also serve to make the service visible and stimulate referrals.

The CCS sees many patients referred by clinicians in the community who request clarification of diagnosis and refinement of treatment planning. The need for cultural consultation arises from perceived problems in clinical work with patients and their families. For example, a clinician may encounter a patient with linguistic, religious, or culture differences sufficient to pose a dilemma for routine care or undermine the clinician's usual confidence in making an accurate diagnosis or implementing appropriate treatment. Obtaining an outpatient consultation involves time and effort, and there is no financial incentive for referring clinicians. In general, therefore, cases must be puzzling, severe, or worrisome enough to overcome the time pressures and constraints of routine clinical practice, which encourages efficiency rather than engaging in lengthy consultations. Hence, when a clinician decides to enlist the help of the CCS, the clinical dilemma usually has advanced to a critical point or impasse, and the clinician is casting about for new directions. As a result, referrals to the CCS often occur at a time of crisis and are conveyed with some urgency. Yet the problems are often long-standing and complicated, requiring careful inquiry to understand and address.

Intake and Triage

Initial inquiries about the CCS, as well as intake and triage of all cases, are handled by the CCS clinical coordinator. At the time of the establishment of the CCS, the coordinator was a clinical psychologist who was able to provide information and perform basic triage at the time of first contact. In recent years, the initial contact has been with a nonclinical coordinator who has a clerical/administrative position, and the coordinator has worked closely with the clinical director (a cultural psychiatrist) who performs triage. The administrative coordinator uses a structured intake form to collect information necessary to open a case file and guide initial triage. Separate forms are used to collect information on referrals of individuals, couples and families, and groups (see Appendix A).

The goal of the initial intake is to document the nature of the request and to assess whether it qualifies as an appropriate referral to the service. A standard procedure is followed to collect information and triage all cases:

1. The referring clinician, individual, or organization requesting the consultation is identified along with their contact information, institutional affiliation, and profession.
2. The identity (name, date of birth, migration status, country of origin, languages, ethnicity) and contact information for the patient and, if appropriate, their immediate family are recorded.
3. The primary case manager or practitioner following the patient in treatment is determined as a way of knowing to whom the recommendations should be directed and to ensure that the CCS can maintain its consultative role.
4. Other key people involved in the case are noted, e.g., social worker, lawyer, youth protection worker, and school contacts.
5. The reasons for the consultation request are recorded in an open-ended way, with additional questions to clarify and complete information regarding the circumstances of the patient and referral.
6. The referring clinician is then asked to specify the *cultural* reasons for which they were seeking consultation. If they are unclear, they may be read a list of options from which they can choose. They are encouraged to choose as many categories as apply to their request.
7. Referring clinicians are asked what their expectations are with respect to how the service might assist them. Again, referring clinicians are read a list of options from which they can choose. If they indicate they are requesting that the service takes over treatment of the patient, it is immediately clarified that our role is consultative.
8. In cases where the request for a consultation is not appropriate, the reasons why the request falls outside the role of the CCS is clarified, and the referring clinician is redirected to other resources. In some cases, the request can be addressed by providing information.

For example, common requests involve locating an interpreter or community resources to provide some social support or help navigating bureaucratic systems. Such interventions are recorded on the Limited Intervention Form (Appendix A). The CCS maintains a database of information on these resources and can direct the caller to the appropriate service.

9. If the consultation request falls within the scope of the CCS, the clinical coordinator clarifies whether the patient is aware that this request is being made and whether the referring clinician feels that the patient understands what the cultural consultation will involve. The clinical coordinator tells the referring clinician to advise the patient of the consultation and provides a brief description of the consultation process, as well as an indication of the length of time needed to arrange the consultation. A typical notification includes the following:

    > Thank you for having referred your patient to the Cultural Consultation Service. Before Mr./Ms. [name of patient] arrives, we need you to tell him/her a little about our service. Please explain that he/she will be meeting with an evaluation team that may include a psychiatrist, an interpreter, and someone knowledgeable about your patient's culture to help us understand him/her better. There may be a student in attendance. The Cultural Consultation Service is a research clinic and periodically evaluates its effectiveness. In a few months, a research assistant will contact you to ask a few questions.

    This procedure is essential to allow the coordinator to contact the patient to schedule an appointment as trouble free as possible.

10. Once the intake information has been gathered, the CCS coordinator contacts the patient by telephone to set up an appointment for the assessment. At this time, the coordinator outlines the steps in the consultation, indicates who will be present, and reassures the patient about confidentiality. The coordinator also greets patients when they arrive for their appointment and introduces patients and their families to the consulting team. At the end of the evaluation session, the research assistant is introduced to the patient to obtain informed consent and collect preliminary information for the ongoing evaluation of the CCS. The coordinator sets up follow-up appointments as needed. If at any stage, either the referring clinician or the patient no longer wishes to proceed with the consultation, the reasons for the refusal are recorded.

Based on the referral request, the clinical director determines the type of cultural consultation needed. Cultural consultations generally take one of three forms:

1. A direct assessment of a patient by a cultural consultant, interpreter, and/or culture broker preferably with the participation of the referring clinician. A complete assessment usually involves 1–3 meetings with the patient, a brief written report transmitting initial preliminary recommendations, followed by a clinical presentation to the team for discussion, and a longer cultural formulation report with a summary of final assessment and recommendations.
2. The second major form of consultation occurs strictly between the referring clinician and the cultural consultant, without the patient being seen directly. Typically, the referring clinician presents the case and the specific questions or concerns to be addressed during a clinical meeting in which the CCS team members and the invited consultant discuss the case to clarify social context, identify cultural issues, and develop recommendations for culturally appropriate clinical management and treatment interventions.
3. Some consultations involve recurrent problems affecting a series of cases, systemic or institutional issues, or the relationship of an organization to a cultural community. In this type of consultation, the focus may be on broader systemic issues rather than an individual case. The formulation, in these cases, aims to identify institutional strategies that can be used to improve cultural competence and safety.

Assembling the Consultation Team

Depending on the type of cultural consultation and details of the case obtained at the time of triage, the coordinator and director determine the specific resources needed for the case. These may include clinical consultants, interpreters, culture brokers, and other professionals or resource people from the community. Guidelines for working with interpreters and culture brokers are present in Table 3.1 and discussed in more detail in Chapters 6 and 7.

Table 3.1 Guidelines for working with interpreters and culture brokers

Before the interview
• Explain the goals of the interview to the interpreter or culture broker
• Clarify the roles of interpreter, culture broker, and clinician (to free the culture broker from language translation, an interpreter participates as well)
• Explain that the culture broker may ask questions during the evaluation depending on need but may also simply observe and provide background information and interpretation afterward during the debriefing or case conference outline the conduct of the interview (sequence of topics, tasks, etc.)
• Discuss the social position of the interpreter or culture broker in their country of origin and in local community in so far as it may influence the relationship with the patient
• Explain the need for literal translation in the mental status examination (e.g., to assess thought disorder, emotional range and appropriateness, suicidal intent)
• Ask for feedback when something is hard to translate
• Discuss etiquette and cultural expectations relevant to the interview process
During the interview
• Arrange seating (usually in a triangle)
• Introduce yourself and the interpreter or culture broker to the patient
• Discuss confidentiality and ask for patient consent to have the interpreter, culture broker, or others present
• Look at and speak to the patient; use direct speech ("you" instead of "she/he")
• Use clear statements in everyday language
• Slow down your pace; speak in short units
• Clarify ambiguous responses (verbal or nonverbal)
• Ask the patient for feedback to insure that crucial information has been accurately communicated
• Give the culture broker ample opportunity to seek clarification for issues that have not been addressed
• Give the patient ample opportunity to ask questions or express concerns that have not been addressed
• Some culture brokers may take over the interview in an inappropriate manner. In such cases, the lead clinician should call for a break in the interview to clarify the roles of the clinician and culture broker
After the interview
• Debrief the interpreter or culture broker to address any emotional reactions and concerns
• Discuss the process of the interview, any significant communication that was not translated, including paralanguage
• Assess the patient's degree of openness or disclosure
• Consider translation difficulties, misunderstandings
• Respond to questions the culture broker may have about the cultural formulation
• Review and itemize salient cultural themes with the culture broker for future reference
• Ask the culture broker if another meeting with the patient and family would be helpful
• Determine if future meetings would be best with the culture broker alone to foster open, uninterrupted communication with the patient and family
• Encourage the culture broker and address any doubts or discomfort about the intercultural work that must be done
• Explain to the culture broker that an honest evaluation of the patient's problems is crucial even if it portrays the culture of origin in a negative light
• Plan future interviews
• Work with the same interpreter/culture broker for the same case whenever possible

Adapted in part from Kirmayer, Rousseau et al. (2008)

When possible, the CCS team identifies a bilingual, bicultural mental health professional from a background similar to the patient to participate in the consultation process. Having a mental health expert who can communicate directly with the patient and provide the cultural context for illness, symptoms, and behaviors streamlines the process of clinical communication and cultural formulation. However, this only works when the clinician has a good understanding of the theory and conceptual models of cultural psychiatry and psychology so that they can link the clinical data with relevant aspects of the social and cultural context. Tacit knowledge of culture is not sufficient to work as a cultural mediator because cultural issues may be taken for granted, distorted, or ignored due to unexamined biases of the clinician. Hence, not every bilingual, bicultural clinician is equipped to contribute to cultural consultations. Moreover, given the high level of diversity among patients referred and the fact that many patients are from newer, smaller communities, patients often cannot be ethnically matched to a clinician. As a result, the CCS depends on a lead consultant who has broad knowledge of cultural psychiatry and who can work closely with an interpreter and culture broker throughout the consultation process.

As discussed in Chapter 5, language interpreting is essential for effective intercultural work and is an ethical imperative in health services. Information on language fluency is gathered for each patient at intake and reassessed during the consultation. As a matter of course, the CCS uses professional interpreters whenever it appears that the patient has less than perfect fluency in English or French. In fact, interpreters are offered even if patients prefer to conduct the interview in limited English or French unless they refuse outright. The availability of interpreters signals to the patient that they have options for communication. They may find it easier to express complex issues in their mother tongue, and in families with varying levels of language proficiency, the presence of the interpreter increases the likelihood that previously silent members of the family system will speak up. Throughout the health care system, interpreters are underutilized, and for many patients seen by the CCS, this is the first opportunity to speak to professionals in their first language. Some patients have been moved to tears when finally offered services in a language of their choice.

There are many reasons for using professional interpreters rather than family members or other volunteers. Family members or other ad hoc or informal interpreters may not know how to translate language affected by severe symptoms, such as psychosis, and this can impede the diagnostic assessment. Nonprofessional interpreters may be embarrassed by material brought forward in the interview and may elect not to translate items that they feel should remain private. Even professional interpreters may be deeply affected by reports of trauma, suicide, marital infidelity, or aggression. Finally, it is possible that family members may be the direct cause of the patient's symptoms and have a stake in hiding their involvement, as in cases of domestic violence. Despite these issues, volunteer interpreters of convenience are frequently used in hospital settings. A key contribution of the CCS is the systematic use of professional interpreters who, over time, are well known to the service and can collaborate closely in the assessment process.

Cultural consultation often requires information about culture and social context that goes beyond what the patient and their family can provide even with the help of an interpreter. To provide this more detailed contextual information, the CCS employs culture brokers for most cases (see Chapter 6). Culture brokers or mediators are people with inside knowledge of the patient's culture of origin as well as some understanding of the concerns of mental health professionals and the local health care system. Often, culture brokers are professionals with a similar background to the patient. Sometimes they are academics (e.g., anthropologists, other social scientists) with extensive knowledge of the culture of specific geographic regions, ethnic groups, or communities. It is essential that they know about the current local context of the relevant migrant community rather than rely on idealized portraits drawn from the ethnographic literature. Culture brokers are important contributors to the

consultation process, providing crucial background information and insights that help to situate the case in social and cultural context. Depending on their level of expertise, they may be asked to prepare the cultural formulation, which then becomes part of the overall assessment by the clinical consultant.

In some cases, the CCS contacts other community resource people including members of community organizations, religious or spiritual leaders, or others to provide additional background information or identify potential solutions for clinical problems. To protect confidentiality, this may involve a general inquiry or discussion without mentioning any details of a specific case. If clinical details need to be discussed, this contact is done with the express permission of the patient. Some patients may want to invite community or religious leaders to the consultation so that their interests and views may be better represented.

Meeting the Patients and Their Entourage

The CCS coordinator contacts the patient to set up a meeting time convenient to them and to the consulting team. Usually these meetings are held at the Institute for Community and Family Psychiatry, a separate building which houses the outpatient psychiatry department of the Jewish General Hospital, including the CCS. The CCS coordinator greets the patients and brings them to the office or meeting room of the consultant. After the first interview, the coordinator, or a research assistant, obtains consent for inclusion of the patient's information in the ongoing research program of the CCS.

The consultant comes to the meeting with a general notion of the consultation request (which may have been clarified by contact with the referring clinician), the sociodemographic background of the patient as conveyed through the triage process, the presenting problems, and a variable amount of history depending on the detail of the referral notes. This information has already been used to identify the appropriate interpreter and culture broker or other resource people to participate in the assessment interview. However, much of this information may be imprecise and requires clarification with the patient.

Whenever possible, the consultant meets with the referring clinician, interpreter, and culture broker before seeing the patient to clarify their roles and modes of collaboration in the interview process. This is particularly important when the interpreter or culture broker has not worked with the CCS in the past. In some cases, the interpreter, culture broker, or a member of the referring clinical team has accompanied the patient to the interview, and the clinician usually will see them at the start to determine if there are specific issues to clarify or, less commonly, proceed immediately to introduce the patient to the evaluating team to insure they are comfortable with everyone present. Table 3.1 provides an overview of how to work with interpreters and culture brokers.

The initial discussion with the patient explains the nature of the CCS and the consultation process and explores their own understanding of the reasons for referral. This leads naturally to a discussion of patients' major concerns. Establishing the patients' own concerns and desire for help (which may differ substantially from the issues identified in the referral) is a crucial step in building a working alliance and the level of trust needed to collect information and, eventually, to convey recommendations to the patient and the referring clinical team. At the same time, patients are reminded that the consultation is confidential and nothing will be sent to other professionals without their consent.

Families play a central role in help-seeking for patients from many backgrounds. Although health care in North America tends to be focused on patients as individuals, engaging the family is essential both for proper assessment and to insure that interventions are acceptable and effective. Entering, engaging, and joining with the family are clinical skills derived from family therapy that are essential for the assessment process in cultural consultation (see Chapter 7).

Members of the referring treatment team are encouraged to accompany the patient to the consultation. These clinicians have essential

information needed to understand the reasons for consultation and to develop solutions. They often have long-standing and complex relationships with the patient and, at times, have their own agendas that may conflict with or eclipse the patient's primary concerns. It is important to strike a balance between collaborating with the referring clinician—seeing the case from their point of view, since they are, in a sense, the client in the consultation and one of the principal aims of consultation is to increase their cultural competence—and recognizing that the referring clinician and team are part of an interactional system with its own dynamics (see, e.g., Chapters 13 and 15). Sometimes the problems identified in cultural consultation are located in interactions of the referring team or institution with the patient or even in the referring team's internal dynamics. These systemic issues must not be misattributed to the patient, but they must be explored in a way that is respectful and nonthreatening for the clinicians who may be implicated and whose involvement will be important for any subsequent intervention.

Culturally Oriented Interviewing

DSM-IV introduced an outline for cultural formulation listing key areas of information useful in clinical assessment (American Psychiatric Association, 2000). This outline is organized in terms of four broad areas: (1) cultural identity of the individual, (2) cultural concepts of illness and help-seeking, (3) cultural dimensions of functioning and psychosocial stressors and supports, and (4) the clinician–patient relationship. Information about these areas is integrated into a case formulation with implications for diagnosis, prognosis, and treatment. The CCS has employed a modified version of this outline with additional issues addressing developmental history, migration trajectory, the role of religion and spirituality, and social structural adversities. Table 3.2 presents the current version of this outline. The outline serves as a useful reminder of key areas to explore in clinical assessment and a standard way to present the findings. However, the sequence in which specific topics are addressed and the way they are phrased will vary depending on the characteristics and concerns of the patient and consultant as well as the unfolding process of the interview.

Cultural Identity of the Individual

This first section of the cultural formulation describes the individual's main ethnic, linguistic, religious, or cultural reference groups. This includes the patient's self-identification and affiliation as well as personal and family background (which they may no longer identify with or, indeed, may be at odds with) and also categories that others may use to label or characterize the patient. Identity may be rooted in place of birth of self or family, religion, caste, spirituality, sexual orientation, occupation, or other affiliations. For migrants and racialized or ethnic minorities, the level of identification and involvement with the culture of origin and with the host culture or majority culture are both important. Answers to questions about identity are relative to the context and the patient's perception of the interlocutor. Thus, someone may identify as "Caribbean" or "West Indian" to a Euro-Canadian interviewer, but give more detail in terms of country, region, or parish to others from the same background. Identity is relevant to clinical care because it may influence patients' relationships with others in local social worlds, links to communities, access to resources, as well as developmental pathways and current predicaments. Language abilities, preferences, and patterns of use are especially important for identifying potential barriers to care, social integration, and the clinical need for an interpreter.

Cultural Conceptualizations of Distress

This section of the cultural formulation describes personal and cultural modes of expressing distress and symptoms, models of illness, and patterns and expectations for help-seeking.

Table 3.2 Outline for cultural formulation

I. Cultural identity of the individual
• Racial, ethnic, or cultural reference groups that may influence the patient's relationships with others, access to resources, and developmental and current challenges, conflicts, or predicaments
• For migrants, the degree and kinds of involvement with both the culture of origin and the host culture or majority culture should be noted separately
• Language abilities, preferences, and patterns of use are relevant for identifying issues access to care, social integration, and the need for an interpreter
• Other clinically relevant aspects of identity including religious affiliation, socioeconomic background, personal and family places of birth, and growing up, migrant status, and sexual orientation
II. Cultural conceptualizations of distress
• Cultural constructs that influence how the patient experiences, understands, and communicates their symptoms or problems to others
• Cultural syndromes, idioms of distress, and explanatory models or perceived causes
• Level of severity and meaning of the distressing experiences should be assessed in relation to the norms of the person's cultural reference groups
• Coping and help-seeking experiences including the use of professional as well as traditional, alternative, or complementary sources of care
III. Psychosocial stressors and cultural features of vulnerability and resilience
• Key stressors and supports in the individual's social environment (which may include both local and distant events)
• Experiences of racism and discrimination in the larger society
• Role of religion, family, and other social networks (e.g., friends, neighbors, co-workers) in providing emotional, instrumental, and informational support
• Cultural norms for family structure, developmental tasks, and community relationships
• Levels of functioning, disability, and resilience in relation to cultural norms and expectations for patient's gender, age, and social roles and status
IV. Cultural features of the relationship between the individual and the clinician
• Expectations for care and models and metaphors of helper or healer roles
• Differences in culture, language, and social status between a patient and clinician that may cause difficulties in communication and influence diagnosis and treatment
• Experiences of racism and discrimination in the larger society that may impede establishing trust and safety in the clinical diagnostic encounter
• Unrealistic expectations of the clinician by the patient and family
V. Overall cultural assessment
• Implications of the components of the cultural formulation identified in earlier sections of the outline for diagnostic assessment and treatment
• Other clinically relevant issues or problems as well as appropriate management and treatment intervention

Adapted from the CCS Handbook, Mezzich et al. (2009) and DSM-5 (2013)

Patients may use a variety of illness models to think about illness, including simple recollections of past experience, prototypes based on personal and popular examples, and explicit notions of causal mechanisms. Cultural models may be rooted in particular ontologies that include the role of spirits, ancestors, or other active agents in causing illness or promoting healing. These explanations or attributions influence help-seeking and expectations for care. Coping and help-seeking with persistent symptoms commonly involve the use of multiple resources including health care professionals as well as practitioners of traditional, alternative, or complementary medicine, religious and spiritual practices, and community organizations.

Psychosocial Stressors and Cultural Features of Vulnerability and Resilience

The third section of the cultural formulation identifies key stressors and supports in the

individual's social environment (which may include local and distant events) and the role of religion, family, and other social networks (e.g., friends, neighbors, co-workers) in providing emotional, instrumental, and informational support. Social stressors and social supports reflect specific expectations and demands associated with culturally prescribed developmental tasks, family structure, and life cycle rituals. Levels of functioning, disability, and resilience should be assessed in light of the person's cultural reference groups and age- and gender-related norms.

Cultural Influences on the Relationship Between the Individual and the Clinician

This section of the cultural formulation addresses the impact of culture and context on the clinician–patient interaction. Consultant and patient each brings their identities in the larger social world into the consulting room, and their perceptions of each other influence the working alliance. Differences between patient and clinician in social status, ethnicity, religion, and racialized identity may cause difficulties in communication and impede establishing the trust and open communication needed for accurate diagnosis and effective treatment. Patients' views of the clinician may be influenced by past experiences with institutions and other health care systems, as well as cultural models of the appropriate role of a helper or healer.

Overall Cultural Assessment

The overall assessment summarizes the implications of the information collected in earlier sections of the outline for psychiatric diagnosis as well as a broader problem list of clinically relevant issues. The formulation includes considerations of how best to approach the patient, social implications of the illness, resources of healing and recovery, as well as appropriate management and treatment strategies. Examples of a brief and full formulation are presented in Appendices B and C.

Although it was introduced over 20 years ago, the cultural formulation has not become a routine aspect of psychiatric assessment and care in most settings. In part, this may be because it was presented as an outline with little indication of how to use it. To promote the use of the cultural formulation, DSM-5 has introduced a brief cultural formulation interview (CFI) with 16 questions that provide a simple way to begin this type of inquiry (American Psychiatric Association, 2013). There is also a version of the CFI designed to elicit similar information from a key informant or accompanying person. A series of supplementary modules explore dimensions of the cultural formulation in more depth, giving examples of ways to inquire in more detail about explanatory models of illness, levels of functioning, social networks, psychosocial stressors, religion and spirituality, cultural identity, coping and help-seeking, and the patient–clinician relationship. Three modules address specific populations, with versions for children and adolescents, the elderly, and immigrants and refugees. A final module is addressed to caregivers and aims to elicit their own concerns as well as pertinent information about the context of caregiving and social support for the patient.

CCS consultants contributed to the development of the CFI in DSM-5, incorporating elements of the interview methods used in conducting cultural consultations. In general, the aim of culturally oriented interviewing is to explore each dimension of cultural identity, background, illness experience, help-seeking, coping, and adaptation. While many patients appreciate clinicians' interest in their background and history, it may not be immediately obvious to patients why these contextual details are relevant to their care. When patients have experienced stigma or discrimination or seen negative portrayals of their ethnic group or collective identity in the media, they may view questions about their background as invasive and threatening. The clinician should be prepared to explain why a particular aspect of the patient's background is potentially important for clinical care.

Generally, it is best to begin the assessment with questions about the patient's presenting

problems, concerns, and reasons for referral. Understanding this in detail will clarify the goals of the consultation, establish a common ground for further inquiry with the patient, and lead naturally to questions about the wider context. For example, exploring experiences of somatic symptoms or emotional distress leads naturally to questions about coping, the responses of others in the family or other social settings, past experiences with help-seeking and treatment, and concerns about the future. Furthermore, listening attentively to the patient's concerns, and displaying sincere interest and intention to help in a safe and confidential setting, establishes a trusting clinical alliance that can facilitate open discussion of sensitive topics.

The CCS inquiry aims to provide a clear picture of the patient's problems and potential solutions in social context. To that end, it is important that the clinician clarify unfamiliar or obscure details with the patient or others. This requires lines of questioning specific to each case, but the effort to clarify and understand must always be mindful of the patient's comfort and confidence in the clinician–patient relationship.

Areas of ambiguity usually remain, even after much inquiry, for reasons related to the clinician, the patient, and the context. The clinician may lack enough familiarity with the patient's background or lifeworld to know what questions to ask or may assume similarity or shared experience when there are actually differences. Intercultural work requires great patience and a high degree of tolerance for ambiguity and uncertainty. Clinicians may find this uncertainty threatening to their sense of competence and may push for clarity and closure before sufficient information has been collected. Finally, clinicians may find certain issues like racism or religious practices difficult to broach because of concern for patients' feelings or their own unexamined attitudes. All of these areas require training to attain a level of self-knowledge and skill needed to conduct the cultural assessment.

For their part, patients may find it difficult to clarify crucial elements of their cultural background and current context for similar reasons. They may not realize that the clinician does not share some of their experiences or that certain terms or concepts have different meanings across cultures. They may find certain lines of inquiry difficult to respond to because of strong emotions, fear of public exposure, and embarrassment or humiliation. Much cultural knowledge is tacit, so that patients may not be able to articulate the underlying conceptual models or values. Moreover, we are all embedded in social structures which may be hidden or taken for granted but that powerfully shape our experience. These structural dimensions are often crucial to understanding the social determinants of health. For example, hierarchies of power and inequities in health associated with racialized identities, caste, gender, and religious authority may all be viewed as simple facts about the world. Cultural ideologies may actually obscure rather than reveal these structural issues, since one function of culture is to normalize, legitimate, and maintain existing social arrangements. Adequate understanding of these structural dimensions of experience must then come from reflection by those who stand with one foot outside the system and can offer a self-critical perspective. For this reason, cultural consultation benefits from multiple perspectives and requires models of the determinants of health derived from research and critical analysis.

The third set of challenges in clarifying the nature of social and cultural issues in consultation stem from institutional constraints. Inquiry into social and cultural issues can be time consuming and resource intensive, requiring specific expertise and the use of interpreters, culture brokers, and others in multiple meetings with patients, their families, and service providers. Moreover, institutions may resist efforts to include attention to their own internal dynamics or position in the larger society as an essential component of the patient's predicament.

Preparing a Cultural Formulation

Cultural consultation aims to collect information needed to situate the patients' problems and concerns in social and cultural context. The cultural

formulation brings this information together in a narrative with a summary that identifies key issues and implications for diagnosis, prognosis, and intervention. In routine care, the cultural formulation may be integrated into the text of standard medical reports with elements in the history of present illness; past medical history; developmental, family, and social histories; and the mental status examination. The relevant cultural issues can then be brought forward in the case formulation. At the CCS, this format is sometimes used by bilingual, bicultural consultants who do not need a culture broker and who weave the cultural information throughout their psychiatric evaluation.

More often, the CCS presents the cultural formulation as a separate report that accompanies a standard psychiatric evaluation. The report follows the outline for the cultural formulation (Table 3.2) and ends with the summary of key issues. During the clinical case conference, the formulation is integrated with findings from the general psychiatric evaluation to reach specific diagnostic impressions and treatment recommendations for the referring clinician.

The formulation is not simply a list of salient features of the patient's cultural background and current context but focuses on specific issues relevant to diagnosis, prognosis, and treatment. Some cultural information is important because it is central to patients' self-understanding and therefore plays an essential role in person-centered care (Mezzich et al., 2010). Acknowledging the patient's own models of illness and core cultural values and allegiances is essential to insure a sense of recognition and responsiveness in the clinical encounter and provide a basis for collaboration and negotiation of clinical goals. Consultation work also requires close attention to the concerns of the referring clinician. There may be aspects of culture that are issues for the clinician but not the patient. For example, clinicians may find the patient's behavior hard to understand, and the consultation aims to explain these by putting them in context (see Chapter 15).

However, the clinically relevant facets of culture and context include issues that are important not because of their salience for the patient or the referring clinician but because they may play a role in specific processes that contribute to psychopathology, disability, healing, and recovery. Although a sensitive clinician can elicit the patient's concerns, cultural formulation requires attention to a broad range of contextual issues, some of which may be outside of the patient's awareness. Recognizing which elements are relevant depends on knowledge of the role of social and cultural factors in psychopathology. This requires familiarity with the research literature on cultural psychiatry, which can be found in scientific journals and textbooks. To produce a clinically useful formulation, cultural information must be organized and interpreted in terms of models of psychopathology and healing. These may be framed in terms of developmental processes, the dynamics of family systems, narrative and discursive processes of self-fashioning, and social contextual factors that influence identity and adaptation. The cultural consultant uses knowledge of the relevance of specific social and cultural determinants of health to guide the clinical inquiry and to construct a problem list and formulation that relates the particulars of the patient's cultural background and current social context to their health problems and potential solutions.

The Case Conference

Almost all cases referred to the CCS are discussed at a weekly multidisciplinary case conference. In addition to the consultant, the meeting usually includes the culture broker and students or trainees from psychiatry, psychology, nursing, social work, and social sciences. The referring clinician and their team are invited but are not often able to attend. This meeting allows the consultant to obtain the perspectives of participants from different personal and professional backgrounds to refine the cultural formulation. When the referring clinician or members of the patient's treatment team are present, the meeting also serves as an opportunity for clarifying details about the case, more general knowledge exchange and learning about the referring clinicians' per-

spectives, addressing their concerns, and engaging them in developing a treatment plan.

The clinical director, or other senior consultant, chairs the CCS case conferences. The format of the meeting usually involves an introduction of people present. The referring clinician or representative of the clinical team, if present, may then be asked to outline the reasons for consultation. They may also add clinical updates about the patient since the last CCS evaluative session. When the referring clinician is not present, the CCS consultant presents the case following the usual format of a medical or psychiatric case history. The consultant or the culture broker then presents the findings of the cultural formulation. The referring clinician, if present, may ask questions or make clarifications throughout this process. The implications for diagnosis and the specific referral questions (e.g., understanding specific symptoms, improving the clinical alliance, or addressing obstacles to treatment adherence) are then discussed. The chair of the meeting then summarizes the main findings and conclusions and outlines the final diagnosis and recommendations to be sent to the referring clinician.

When the referring clinician is present, the meeting process is more complicated and has elements of an intervention. The chair of the meeting must pay close attention to the dynamics of the meeting, insuring that the referring clinician is engaged, their concerns elicited, and their questions addressed which being overwhelmed with extraneous detail or emotionally challenging material. Because the systemic analysis of cases often implicates interactional issues between clinician and patient or within the health care system, the referring clinician may feel challenged or even criticized. It is essential that any critique be presented in a respectful way so that the clinician feels empowered and enabled to respond adequately to the situation. The aim of the CCS is not to take over the care of patients but to enable the referring clinical team to provide culturally appropriate care and to increase their capacity to deal with similar cases in the future.

Although the CCS clinical director, a psychiatrist, chairs the meetings, the use of the cultural formulation as a framework for presenting information and the focus of the CCS on social and cultural context gives a prominent place in the discussion to the perspectives of participants from other disciplines, like nursing and social work, that focus on experiential and social contextual issues (Dinh, Groleau, Kirmayer, Rodriguez, & Bibeau, 2012). The CCS case conference thus shifts the usual dominance of psychiatric perspectives toward a broader view that generates a clinical problem list that includes practical social issues and predicaments central to the patient's health and well-being. The cultural formulation provides a way to think about systemic issues in the health care system and encourages participants to identify gaps and issues that can be addressed through changes in policy and practice (see Chapter 16).

The CCS case conferences also serve an educational function for participants. We encourage students in health and social sciences to attend. Listening to the discussion helps them to understand clinical styles of reasoning and the challenges of applying social science perspectives to everyday clinical practice. Finally, the case conference meetings are audio-recorded (with the consent of all participants) and transcribed for ongoing research on cultural formulation (Adeponle, Thombs et al., 2012; Dinh et al., 2012).

Communicating with Referring Clinicians

Cultural consultation can be a lengthy process. To meet the needs of referring clinicians, CCS consultants prepare a brief preliminary report after the initial assessment of the patient (see Appendix B). This is usually less than one page in length and consists of key findings, preliminary diagnosis, and immediate recommendations. Giving this initial information to the referring clinician allows them to address urgent issues and sets the stage for the more detailed consultation that may follow weeks later (Appendix C).

As mentioned, referring clinicians are encouraged to participate in the CCS assessment interviews and the case conference. Taking part in the assessment interviews provides many benefits for

the referring clinician. They can ask their own questions and clarify any issues that are unclear. They become more familiar with the use of interpreters and culture brokers and establish their own links with these resources. Finally, their presence signals engagement in the case and may allow the consultation process to strengthen the working alliance. Of course, the presence of the referring clinician also complicates the interaction, and the consultant must manage the multiple and sometimes conflicting agendas of members of the referring clinical team, the patient, and their entourage. When the clinician takes part in the assessment, the CCS consultant usually meets with them immediately before the evaluation to clarify the reason for referral and afterward for debriefing.

Referring clinicians are also encouraged to take part in the CCS case conference, and this also affords them an opportunity to raise further questions and concerns. Often the primary care physician involved in the case cannot attend because of other time pressures, but one or more representatives of the team working with the patient are present. This allows the CCS consultant a chance to further assess systemic and institutional issues during the case discussion. Throughout, the aim is to understand the patient's problems in context and support the frontline workers in developing more culturally appropriate care rather than to critique the work of community clinicians.

Follow-Up

Most often the CCS consultation process involves only a single encounter with the patient and their entourage or, when more extensive assessment is needed, a series of two to three meetings over a short period of time. The service does not have the mandate or resources to provide ongoing services. Rarely, however, the CCS may be involved in repeated consultations or short-term treatment. This occurs when there is a good fit between the consultant and patient (e.g., ethnocultural match), and no other resources are available. On some occasions, this has led to long-term treatment of complex cases (see, e.g., Chapters 7 and 8).

The CCS remains available to support the referring clinician. This usually involves brief telephone contacts to provide specific information or suggestions. The clinician may also arrange to attend a CCS case conference to present new information and discuss the implications. When there are significant changes in the patient's condition or an unsatisfactory outcome from the initial consultation, a follow-up consultation may be arranged to clarify the issues. In some cases, complicated problems persist, and a patient is referred multiple times for follow-up consultations. As a result, the CCS may stay involved with some cases for several years.

A major goal of the CCS is to improve the cultural competence of frontline clinicians, mental health practitioners, and institutions. To that end, the CCS provides in-service training and uses consultations as opportunities for knowledge exchange. When certain types of problems recur in a particular organization or institution setting, the CCS may offer or be asked to provide in-service training to address relevant issues. These consultations aim to support organizational cultural competence and cultural safety (Brascoupé & Waters, 2009; Fung, Lo, Srivastava, & Andermann, 2012).

Evaluation of clinical services is also an essential component of the work of the CCS as we strive to establish the utility of cultural consultation in terms of its impact on patient care, clinician and organizational cultural competence, and health outcomes. Chapter 2 presents the findings from the initial evaluation of the CCS. This work is ongoing and integrated into the protocols and procedures of the service.

Dilemmas in Cultural Consultation

Obtaining a consultation through the CCS can be a slow process, sometimes taking weeks to organize. Referring clinicians, family members, language interpreters, and culture experts must be identified, contacted, recruited (by explaining what the CCS does and the specific role they are being asked to play in the consultation), and offered a mutually convenient time to meet together. The setting of the evaluation may need

to be negotiated according to the needs of the patient and the family. Along the way, treating clinicians may not see the utility of attending the consultation and may prefer that it takes place without them, or the patient may suddenly cancel the appointment at the last moment for reasons that are often unclear. Each disruption adds time to the already lengthy and sometimes frustrating procedure. Once the first evaluation takes place, further disruptions are common: patients or family members may arrive late, up to hours or even days after the scheduled time; patients may feel uncomfortable having interpreters or other members of the consultation team in attendance; or the patient's distress may be so overwhelming as to preclude meaningful assessment. After the evaluation begins, working through an interpreter may slow the clinical work down considerably, adding to the time of a regular evaluation (National Association of Community Health Centers, 2008). Often, after interviewing a patient the first time, it becomes clear that key family members or other informants are missing, thereby requiring a follow-up meeting and starting the whole process over again. All of these factors work against the model of routine psychiatric consultations that take place according to a predictable 50-minute hour.

While a basic cultural formulation should be part of routine clinical care, the cases seen by the CCS usually demand more in-depth work. The intensive nature of cultural consultation in terms of personnel, time, and resources and the high level of clinical skill needed to provide effective consultation are challenges to its implementation. Institutions may be reluctant to commit resources to clinical services perceived to be peripheral to the core tasks of mental health care. However, as illustrated in many of the clinical vignettes throughout this volume, the CCS works with very challenging cases where there are serious impasses. The time and effort required to understand the problem in context are well repaid when seemingly intractable problems are resolved and clinicians are empowered to respond more effectively to diversity.

Conclusion

We have outlined the process of cultural consultation in some detail to give a clear sense of what is involved. The approach we describe is pragmatic and can be adapted to a wide variety of settings based on demand and available resources. Other chapters in this book show how this process can give rise to new insights and reformulation of complex cases in ways that enhance clinicians' cultural competence, while improving the quality of care and clinical outcomes for patients.

Appendix A: CCS Intake Information

CCS

CULTURAL CONSULTATION SERVICE
NEW INTAKE FORM part 1 - Individuals

Type of case: # -

Date of referral(mm/dd/yy): ○ Urgent ○ Not urgent ○ ASAP

Referred by (Name & Institution) Institution Type
Referrer 1 Type
Referrer 2 Type
Tel.
Fax.

Principale Care Provider or Case Manager: Tel.:
Others involved in Patient Care: Tel.:

Patient's Family Name (Maiden Name) | First name

Address: Zip: | ○ Male ○ Female ○ Other
DOB(mm/dd/yy): Age:

Tel. (H): (W): | Marital Status:
Other Contact:

Immigrant Status: | Med. No. Exp.

Country of origin: | Patient's Medical Insurance Coverage
Year of arrival (yyyy): Month (mm): | ○ None ○ Private Plan ○ Fed. Refugee Plan ○ DK ○ Prov. Gov. Plan ○ Other...
Ethnicity:

Mother tongue: | Education Level: Nb of years:
Speaks English? French?

Other Languages Spoken | Empl. Status:
Occupation:
Religion:

Do you think the patient needs an interpreter? ○ NO ○ YES ○ DK If yes, preferred language:

Have you been using an interpreter for this patient? ○ NO ○ YES ○ DK If YES, language:

Why has an interpreter NOT been used? : ☐ Not Available ☐ Clinician acted as Interpreter ☐ Not Needed ☐ Other...

Comments:

Appendix B: Example of a Brief Consultation Report

CCS Preliminary Recommendations	Name of Patient: SMITH, George Date of Birth: Medicare No.: CCS Case #:

Date of Referral:	
Referred by:	Dr. X, Psychiatrist, Hospital Y (Department Z)
Reason for Referral:	Clarify contribution of cultural and religious beliefs to patient's symptoms and help-seeking behavior.

Impression:

Mr. Smith is a 31-year-old married, Haitian, Baptist man suffering from recently decreased sleep and an exacerbation of somatic and persecutory delusions, likely somatic illusions and/or hallucinations, and possible visual illusions.

There is a history of command auditory hallucinations although the patient denies auditory hallucinations today. He has been hospitalized twice previously, initially in 2012, with diagnoses including schizophreniform disorder, schizophrenia, schizoaffective disorder, and depression with psychotic features, with the most recent diagnosis being psychosis NOS. Previous chart notes indicate a limited functional capacity since the onset of illness, with abilities confined to caring for his home, and at least one illness exacerbation in the context of his children returning home from foster care.

Ms. Smith understands his problem as related to Vodou and believes the solutions available to him are prayer, Vodou-related treatments, and biomedicine. He describes his wife and their church in Montreal as identifying with a Baptist view of healing and says that they see his beliefs as evidence of mental illness, while family in Haiti seems to be more accepting of the idea that Vodou is contributing to his illness, although it is unclear to what extent they use that explanatory framework to understand all of the patient's symptoms.

Exacerbating factors may include a recent move, a change in his treatment team with less intensive follow-up, and possibly a change in medication. There may also be stress within the family, given the disagreements about the etiology of his symptoms and the appropriateness of various treatments.

It is important to note that Vodou in Haiti, while being tolerated to some degree by the Catholic Church, is eschewed as evil by most Protestant groups. This might be a source of family conflict and distress for the patient, exacerbating his symptoms.

The current working diagnosis is acute psychosis, due to exacerbation of paranoid schizophrenia.

Recommendations:

1. We will follow-up with the patient and his wife, to clarify her understanding of his illness, current functioning at home, premorbid functioning, their migration history, and whether he has any medical conditions that may need further medical attention.
2. Clarify current medication dosage (chart not available to us). We suggest increasing the dosage or switching to a different medication to control the patient's symptoms. He previously

responded to risperidone 3 mg, but this was discontinued due to hyperprolactinemia.

3. We recommend more intensive follow-up of the patient and his family by the referring team.
4. We will explore with the patient and her wife a possible renegotiation of illness explanatory frameworks and help-seeking behaviors, in order to ameliorate communication within the family and with the larger community and to facilitate coping.

Date of Consultation:

Consultant: (Signed) ___________________

Appendix C: Example of a Cultural Formulation

Cultural Consultation Service	
Cultural Formulation	
Name:	SMITH, George
Address:	
Telephone No.:	
Date of Birth:	
Medicare No.:	
Date Seen:	

A. **Cultural Identity**

1. **Cultural reference group(s)**
   Mr. Smith self-identifies as a Haitian, Baptist. His mother converted from Catholicism to Protestantism following an illness, after which her children converted as well. Mr. Smith's wife, however, is Protestant from birth. Mr. Smith says that while his mother sometimes left Protestantism, she herself "never did."
2. **Language(s)**
   Mr. Smith speaks Haitian Creole and French; he has a secondary 3 equivalent education in Creole.
3. **Cultural factors in development**
   Mr. Smith immigrated to Canada in 2004. No other information available on developmental milestones or education.
4. **Involvement with culture of origin**
   a. **Contact with family or friends in country of origin**
      Mr. Smith has regular phone contact with his family of origin in Haiti. Friends, relatives, and members of their congregation visit the family frequently to help with his difficulties.

      Diaspora Haitians often interact closely with family members back home. Many have relatives living in high-income countries, and the diaspora sends more than US$800 million annually to family and friends in Haiti. Mr. Smith says he sends money back home, but, in his case, he does not feel this is an obligation.
   b. **Involvement with community organizations**
      Nil—see below
   c. **Does patient attend a group with peers of his culture of origin (e.g., religious organization or leisure setting)?**
      Mr. Smith participates actively in a Baptist Church, both religious services and some social activities. He has considerable contact with other congregants. The pastor calls on his home regularly to see how he is doing.
   d. **Does patient have friends from his culture of origin?**
      Mr. Smith mostly socializes with Haitians and has many acquaintances in the community; he does not have close friends.
   e. **Does patient socialize with extended family members?**
      He has a large extended family with whom he speaks with regularly and has aunts in a nearby city that he sees occasionally.
   f. **What is patient's perception of his culture of origin?**
      Mr. Smith appears to identify positively with being Haitian.
5. **Involvement with host culture**
   Besides attending hospital appointments and group therapy sessions, Mr. Smith does not interact in a sustained fashion with the host culture. These interactions are relatively superficial. Prior to his illness, he worked at a car wash, in a warehouse, and a convenience store, all of which include other employees from diverse backgrounds. There is no evidence of a negative perception or experiences with the host culture.

   The patient's wife is more extensively involved in the host culture. She has worked as a cashier and as a hairdresser.

Although there is racism against people of African descent in Quebec, there is also a fairly close relationship and affinity between Quebec and Haiti, based to some extent on a common language (French). Quebec has a relatively large Haitian population with about approximately 100,000 Haitians in Montreal (Lecomte & Raphaël, 2011, p. 4). There is also a fairly close relationship between Canada and Haiti: a former governor general of Canada (Michaëlle Jean) was born in Haiti, and Haiti is second after Afghanistan in the amount of development assistance received from Canada.

B. **Cultural Explanations of the Illness**

1. **Predominant idioms of distress and illness categories and perceived causes and explanatory models (mechanism, treatment)**

   Mr. Smith's narrative is that "un mauvais esprit" has been waking him up at midnight, persecuting him, by walking around in his throat and stomach. He says she saw a cockroach—which is an embodiment of the evil spirit—coming out of his tongue as he was brushing it. Mr. Smith believes that a woman, with whom he used to be friends, wants him to die and made him mentally ill. Mr. Smith's problems seem to have been exacerbated by the fact that this friend lived with his family for a while. Mr. Smith says that he is fighting this but that the woman was jealous and acquired power over the patient by taking his clothes and letting his sweat touch her skin. In retrospect, the patient believes that during the period of time when this woman lived with him, she gave him potions to drink that made him ill and unable to gain weight from food. When the family went to Haiti together recently, Mr. Smith underwent *lavements* (cleansings) given by a Protestant group. These *lavements* helped him—he defecated bad things, an evil spirit, and the whole family believed he was healed. Mr. Smith believes he was victorious in his fight against the woman who had been harassing him, and therefore, he had no persecution for 2 years. In 2010, there was a recurrence of persecution. He thinks the same woman as before took his "bon ange," wanted to make him a *zombie*. She moved the neurons in his head, making her mentally ill and provoking his first hospitalization. He says the medication helped to move away the evil spirits and replace her neurons when she was "ill in the head" in the hospital; however, they do not help in any other way. Currently, the spirits come every 3 h during the day and all night. He needs to rub salt or lemon on his skin to get the spirits to leave. He also rubs mayonnaise to soothe her skin—as per recommendations from family members in Haiti. He is praying with the Bible and other people are praying for her and telling her to pray (a pastor from Haiti, her father-in-law, her husband), but this is not sufficient. Healers may be helpful as well. However, she does not want to go to Haiti to find such healers because it would imply a lesser trust in God's powers. She believes this persecution will not kill her because she herself never harmed the other woman, even when she was living in the same house.

   Mr. Smith uses various illness categories and explanatory frameworks: (1) Vodou in the religious sense and as referring to the common cultural beliefs in Haiti, (2) protestant belief in the power of God to heal, and (3) mental illness (mental health in Creole is "bien nan tèt" or being well in the head).

   According to the literature, the belief in illness being "sent" is not limited to those who believe in Vodou, but is rather an overarching Haitian understanding of illness attribution: "Vodou is based on a vision of life in which individuals are given identity, strength and safety in a dangerous world through the thick fabric linking them together with other human beings, as well as spirits and ancestors. For this reason, disturbances in health or luck are a sign that relationships have been disrupted and may need to be mended. Vodou rituals heal individuals and groups by strengthening and

mending relationships among the living, the dead, and the spirits" (Pierre et al., 2010).

Mental health problems are often attributed to supernatural forces. Mental illness, problems in daily functioning, and academic underachievement may all be seen as the consequences of a spell, a hex, or a curse transmitted by a jealous person. In such cases, people generally do not blame themselves for their illness or see themselves as defective. Indeed, the sense of self may even be enhanced as a curse is often aimed at a person deemed to be attractive, intelligent, and successful. Mental illness is also sometimes attributed to failure to please spirits (*lwa*s, *zanj*s, etc.), including those of deceased family members.

In Haiti, Vodou, while being tolerated to some degree by the Catholic Church, is eschewed as evil by most Protestant groups, although the language of Vodou may persist, even among Protestants, as seen above. Protestants that have emigrated may be more likely to look down upon traditional Vodou beliefs.

Mr. Smith believes that he needs to use a combination of treatment methods. This use of multiple sources is common in Haiti (as elsewhere) and in the Haitian community in Montreal. Some types of treatment methods are viewed more appropriate to certain circumstances. He has used Vodou spiritual healing, although he does not want his wife to know about this, because as a long-standing Protestant, she rejects this and would be angry with him if he knew. He uses folk "natural" healing methods like the *lavements* she received from the Church group and the ointments he uses on her skin. He also prays. In his belief system, God is the supreme healer. Finally, he also accepts biomedicine for mental illness, but his understanding of what mental illness is limited.

2. **Meaning and severity of symptoms in relation to cultural norms**
   a. **Of cultures of origin**
   Mr. Smith's beliefs about this other woman's powers and her persistent, preoccupied interpretation of his bodily symptoms are a delusional elaboration of Vodou beliefs, even according to Haitian beliefs, as confirmed by the culture broker.

   We were unable to speak with his family of origin to corroborate this information with them. They may be less aware of the severity of his symptoms given that they are in another country. However, his preoccupations are persistent, unlike the usual situation in illness caused by a spirit which presents as an acute crisis. Most people in his congregation understand his beliefs as related to mental illness. He is aware of this and states that the congregation members do not understand him and that friends tell him to "forget about the Vodou." The pastor "always prays" for him and has said that if she is "100 % with God," then the bad spirits will not be able to have power over him. According to Mr. Smith, his wife does not want to hear anything about evil spirits as she does not believe in them. She sometimes tells him it is "in your head." She believes medication and stress reduction, as well as prayer, will help him. Mr. Smith also says he has an aunt in Montreal who tells him to go to the hospital, take his medication, and pray.

   b. **Of host culture**
   Within the biomedical, North American host culture, Mr. Smith's beliefs are considered delusional. It is not clear to what extent his Haitian background was taken into account in previous treatment of his condition.
3. **Help-seeking experiences and plans**
   Mr. Smith's help-seeking reflects his own beliefs as well as his social networks. He goes to certain helpers because it is prescribed by doctors, people in authority like his pastor, his friends and extended family, and his wife. He avoids certain healers because it is proscribed (again, by her pastor, her husband), and finally he also finds ways to integrate her own beliefs about etiology and about what will be helpful.

a. **With the formal health care system**
Mr. Smith was hospitalized in psychiatry for the first time in Montreal. He is currently followed at a psychiatric outpatient department. He believes some of this health care system is helpful. However, he is using it mainly because he needs to keep the peace at home and also because it is something "to do… to keep me busy."

He believes the medications he takes are helpful only to improve sleep. He agrees that medication helped him when she was ill in hospital because his persecutor had made him mentally ill by affecting his brain ("a deplacé des neurones dans ma tête," lit. "moved the neurons in my head"). He does not believe that medication can help protect him from Vodou or help with the spirits. He has daytime sedation and a dry mouth and does not like the idea of increasing the dosage.

He comes to therapy groups because it is "something to do." At the groups, he is not introspective nor does he use them to better understand how mental illness affects him. This lack of self-reflection may partly reflect cultural values and style of coping that suggest it is not appropriate to dwell on one's ills but best to be active and to distract oneself.

b. **With traditional healers and alternative services**
Although the couple has different views about the appropriate use of traditional healers and other sources of help, they generally negotiate this without overt conflict.

Mrs. Smith states outright that, although prayer has a place in both their lives, the etiology of her husband's distress, and therefore the solution, is not solely religious, but is related to mental illness and is clearly exacerbated by stress. She therefore believes medications are the primary treatment he needs. She adds that most of the family and church community agree with her. Religion may help them to cope and prayer may help to distract Mr. Smith, and he receives support through the pastor's regular telephone calls.

Her attitude is reflective of the tension between Protestant beliefs and Vodou beliefs, which are more tolerated by the Catholic Church, but that also persist as an idiom of distress (rather than as religious belief) among most Haitians. Her perception that Mr. Smith's symptoms are signs of mental illness may be also related to the psychoeducation sessions in Montreal after her husband became ill.

While Mr. Smith has used Vodou spiritual healing in the past, he does not talk to his wife about it. He uses folk "natural" healing methods, as recommended by family in Haiti and applied by his children. He refuses to go search out a healer in Haiti, as suggested by some family members, in part, because this would be a potential source of conflict with his wife.

His need to pray when he experiences "persecution" is consistent with his Baptist background, as is his belief that God is the supreme healer. His desire to use Vodou techniques and herbal remedies is also culturally appropriate, but he makes excessive use of these remedies and attributes more extensive powers to substances like lemon and garlic than commonly seen.

C. **Cultural Factors Related to Psychosocial Environment and Levels of Functioning**

1. **Social stressors**
None identified in country of origin. Stressors related to immigration and difficulty adjusting to host country include:
   - Possible racism, although this has not been reported by the patient or his wife
   - Concerns about finding adequate employment and feelings of embarrassment about his lack of self-sufficiency
   - Financial stress
2. **Social supports**
For Mr. Smith, his wife and extended family in Haiti, as well as the pastor in his Church in Montreal, seem to be the most significant social supports.

3. **Levels of functioning and disability**
   Mr. Smith is not able to work. He functions best at home, where he does some household chores. He is not able to do much childcare and relies on his wife to look after the children and provide discipline. He does participate in religious services but does not play other social roles.

   It is not certain to what degree his functioning is limited as a result of acculturation difficulties, but it seems likely that a large component of his functional impairment is related to his mental illness. Further history is needed to be obtained to determine his functioning prior to the onset of the illness as well as regarding her functioning prior to the current exacerbation, in order to fully answer this question.

D. **Cultural Elements of the Clinician–Patient Relationship at Assessment**
   1. **What is the clinician's ethnocultural background?**
      The consultant in this case was a female psychiatrist who immigrated to Canada from Eastern Europe as a child. She has a personal appreciation of the challenges and hardships associated with immigration. The culture broker was a Haitian-Canadian graduate student in psychology. She has ambivalent feelings about Vodou as a healing practice, but she was able to reflect on her own attitudes and convey an attitude of interest and respect throughout the assessment. Mr. Smith clearly appreciated the opportunity to speak with the culture broker who he felt understood his background.

E. **Overall Cultural Assessment**
   Mr. Smith is suffering from a paranoid psychotic disorder. However, part of Mr. Smith's difficulties can be conceptualized as a religious conflict within his family. He negotiates the divergent beliefs, which are common of Haiti, in ways that preserve family harmony. To some extent, his wife may discount his ideas about Vodou because she views him as mentally ill, and this may reduce the potential for conflict. Mr. Smith makes effective use of local religious resources as well as some support from extended family. Other sources of support are limited. Psychoeducation does not appear to be engaging Mr. Smith's main concerns or preferred mode of coping. He is more interested in participatory, social activities, preferably in the Haitian community. Such activities would be more appropriate for Mr. Smith and may be more therapeutic.

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