J. Psychosoc. Rehabil. Ment. Health (2017) 4(1):35–43
DOI 10.1007/s40737-017-0076-y

ORIGINAL ARTICLE

"I Got to Voice What's in My Heart": Participation in the Cultural Formulation Interview—Perspectives of Consumers with Psychotic Disorders

Anjana Muralidharan[1,2] · Rebecca M. Schaffner[1] · Samantha Hack[1,2] · Danielle R. Jahn[1,2,3] · Amanda D. Peeples[1] · Alicia Lucksted[2]

Received: 21 September 2016 / Accepted: 6 January 2017 / Published online: 21 January 2017
© Springer India Pvt. Ltd. (outsidethe USA) 2017

Abstract Consumers with serious mental illness (SMI) frequently disengage from treatment; tools to enhance rapport and therapeutic alliance with these consumers are needed. The Cultural Formulation Interview (CFI), published in the Diagnostic and Statistical Manual for Mental Disorders, Fifth Edition (DSM-5), assesses social and cultural context as it relates to mental health and has potential as a rapport-building tool. The present study aimed to examine the perspectives of consumers with psychotic spectrum disorders on participating in the CFI. Consumers (N = 14) with psychotic disorders were recruited from mental health programs at an urban Veterans Affairs Medical Center. They participated in the CFI followed by a debriefing interview, during which they were queried about their experiences with the CFI. Debriefing interviews were audio recorded and transcribed. Thematic analysis was used to collate the data and identify themes. Participants reported that the CFI was validating, therapeutic, and led to deeper realizations about themselves and their recovery. The CFI may be used to simultaneously enhance rapport and obtain meaningful health narrative data with consumers with psychotic disorders. The CFI may be a valuable tool to promote treatment engagement among individuals with SMI.

✉ Anjana Muralidharan
anjana.muralidharan2@va.gov

[1] Veterans Affairs Capitol Healthcare Network (VISN 5), Mental Illness Research, Education, and Clinical Center (MIRECC), 10 N Greene Street, Attn: VISN 5 MIRECC (Annex Bldg.), Baltimore, MD, USA

[2] Department of Psychiatry, University of Maryland School of Medicine, Baltimore, MD, USA

[3] Present Address: Primary Care Institute, Gainesville, FL, USA

Keywords Serious mental illness · Treatment engagement · Cultural formulation interview · Building rapport · Therapeutic alliance

Individuals with serious mental illness (SMI) benefit from consistent, long-term psychiatric and psychosocial treatment to maintain stability and promote recovery [1]. Unfortunately, systematic reviews indicate that individuals with SMI frequently disengage from mental health services [2–4]. Disengagement is often associated with increased risk for psychiatric hospitalization, homelessness, and incarceration [3, 5, 6]. Strategies to promote consistent engagement in treatment are needed.

Qualitative interviews with mental health consumers indicate that poor therapeutic alliance is an oft-cited reason for disengagement from treatment [7, 8], while perceived kindness, a sense of personal connectedness to providers, and trust in the therapeutic relationship are cited as reasons for continued engagement [9–12]. This is consistent with a significant body of literature that supports therapeutic alliance as a robust predictor of treatment engagement, medication adherence, and treatment outcomes across a wide variety of mental health diagnoses [13–17]. Evidence indicates that provider behaviors such as asking open-ended questions [18], demonstrating empathy [19, 20], using clinical terminology sparingly, and incorporating the consumer's language into the interaction [21, 22] contribute to good patient-provider rapport. In one study, "off-topic banter" in clinical encounters also contributed to good rapport, although it failed to provide practitioners with health narrative data, which can impede clinical care [23]. Concrete tools to promote provider behaviors that enhance rapport while furthering health narrative data collection are needed for providers to use with individuals with SMI.

The Cultural Formulation Interview (CFI; [24]) is a potential tool to facilitate rapport-building and therapeutic alliance. The CFI is an interview guide published in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; [25]) that provides questions and prompts to allow clinicians to assess consumers' social and cultural context as it impacts mental health and treatment. (See Table 1 for a list of core questions from the CFI.) The CFI offers a structure for clinicians to engage in person-centered assessment that elicits the consumer's illness narrative and enhances understanding of cultural context. Questions are open-ended and exploratory. The CFI emphasizes the importance of the consumer's perspective on his/her illness experiences. Interviewers are trained to conduct the interview in a person-centered manner, strictly using the consumer's language and focusing the interview on exploration of topics spontaneously reported by the consumer. This is in contrast to more traditional intake interviews, which typically focus on clinician-directed history-taking and diagnostic interviewing.

Burgeoning evidence supports the general clinical utility of the CFI. The CFI was tested in international field trials prior to its publication in DSM-5; consumer and clinician participants in these trials generally found the CFI to be feasible, acceptable, and useful [e.g., 26, 27]. Several studies illustrate the effectiveness of the CFI or its precursor, the Outline for Cultural Formulation (OCF), in resolving diagnostic uncertainty and increasing diagnostic agreement among clinicians [28–32]. The CFI has also been found to be useful in obtaining essential sociocultural information as a context for symptoms, contributing to a more in-depth understanding of consumers' illness experiences [33].

Evidence also supports the potential for the CFI as a rapport-building tool. Mental health clinicians who received cultural consultation based on the OCF reported

Table 1 Cultural Formulation Interview Questions

Section	Questions
Cultural definition of the problem	1. What brings you here today?
	2. Sometimes people have different ways of describing their problem to friends, family or others in their community. How would you describe your problem to them?
	3. What troubles you most about this problem?
Cultural perceptions of cause, context, and support	4. Why do you think this is happening to you? What do you think are the causes of your [PROBLEM]?
	5. What do others in your family, your friends, or others in your community think is causing your [PROBLEM]?
Stressors and supports	6. Are there any kinds of support that make your [PROBLEM] better, such as support from family, friends, or others?
	7. Are there any kinds of stresses that make your [PROBLEM] worse, such as difficulties with money, or family problems?
Role of cultural identity	8. For you, what are you most important aspects of your background or identity?
	9. Are there any aspects of your background or identity that make a difference to your [PROBLEM]?
	10. Are there any aspects of your background or identity that are causing other concerns or difficulties for you?
Cultural factors Affecting self-coping and past help-seeking	11. Sometimes people have various ways of dealing with problems like [PROBLEM]. What have you done on your own to cope with your [PROBLEM]?
	12. Often, people look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing have you sought for your [PROBLEM]?
	13. What types of help or treatment were most useful? Not useful?
Barriers	14. Has anything prevented you from getting the help you need?
Cultural factors affecting current help seeking	15. What kinds of help do you think would be most useful to you at this time for your [PROBLEM]?
	16. Are there other kinds of help that your family, friends, or other people have suggested would be helpful for you now?
Clinician-patient relationship	17. Sometimes patients and doctors misunderstand each other because they come from different backgrounds or have different expectations. Have you been concerned about this and is there anything that we can do to provide you with the care you need?

[PROBLEM] stands for the patient's definition of the problem in his/her own language. A definition of the problem is agreed upon in the first section of the CFI, "Cultural Definition of the Problem", and this definition is carried through the interview

improved communication, empathy, and alliance with consumers [34]. In a qualitative study of clinicians and consumers who engaged in the CFI, "enhancing rapport" was identified as a prominent theme; clinician participants believed that the CFI could significantly contribute to development of therapeutic alliance [35].

While the CFI shows general promise as a rapport-building tool, its applicability to individuals with SMI is less clear. Though the OCF framework was successfully used with consumers with psychotic-spectrum disorders in the context of a cultural consultation service [36], consumers with SMI in the DSM-5 field trials rated the CFI moderately lower than other mental health consumers in the domains of feasibility, acceptability, and utility [e.g., 26]. In addition, a qualitative study of clinician perspectives on potential barriers to CFI implementation found that clinicians raised concerns about conducting the CFI with consumers with psychotic disorders, stating that paranoid or tangential thought processes and cognitive impairment could interfere with the ability to engage in self-reflection regarding cultural identity and context [37]. The present study aimed to examine the perspectives of consumers with psychotic spectrum disorders on the process of participating in the CFI, to inform its potential use as a tool to enhance rapport and improve treatment engagement and outcomes in this vulnerable population.

Methods [A]

CFI Training and Fidelity [B]

Investigators attended a one-day, in-person training on the CFI with Roberto Lewis-Fernandez, M.D., lead developer of the interview, and Neil K. Aggarwal, M.D. Following the training model used in the DSM-5 field trials [38], the training included didactics and role-played administrations of the CFI. Ongoing consultation on the CFI was provided over the course of the study. Three co-investigators (A.M., S.H., and D.R.J.) conducted the CFIs for the study. CFI administrations were rated for fidelity by Dr. Lewis-Fernandez and/or one of the co-investigators (A.M.) using the CFI-Fidelity Instrument (CFI-FI; [39]). The CFI-FI was used to rate CFI administrations on the following: (1) clinician adherence (i.e., did the interviewer ask all CFI questions), (2) patient responsiveness (i.e., did the consumer provide a relevant response to each question), (3) clinician competence (i.e., did the interviewer engage in reflective listening, maintain a non-judgmental person-centered stance, ask relevant follow-up questions for clarification, and allow the consumer time to construct a cohesive illness narrative), (4) intervention distinctness (i.e., did the interviewer avoid lapsing into a more typical diagnostic interview or history taking), and (5) order (i.e., did the interviewer stick to the prescribed order of CFI questions). Thirteen out of fourteen administrations achieved excellent adherence and competence on all CFI-FI components, obtaining 95–100% of possible points on the measure. In one CFI administration, the interviewer unintentionally skipped six CFI questions; the data from this participant is still included here given that the emphasis of the present analyses is interview process, not content. A subset of rated CFI administrations (6 out of 14) was rated by both fidelity raters with near perfect inter-rater reliability (97.7% agreement).

Study Procedures [B]

Because of the circumscribed nature of the research question (i.e., what are consumers' experiences with the CFI), it was estimated that 12–15 participants would be sufficient to achieve data saturation [40]; the final sample consisted of 14 participants. Consumers with SMI were recruited from mental health programs at an urban Veterans Affairs (VA) Medical Center in the mid-Atlantic United States through clinician referrals, approved recruitment flyers, and review of clinic rosters. A partial HIPAA waiver was obtained to allow for chart review to confirm eligibility. Individuals between the ages of 18 and 80 years old, with a chart diagnosis of schizophrenia, schizoaffective disorder, or affective psychosis, who were receiving VA mental health services and deemed clinically stable by their mental health clinicians were eligible for participation. Exclusion criteria included lack of capacity to consent. To ensure a range of symptom severity in our sample, we purposefully recruited a subset of individuals with prominent psychotic symptoms through targeted recruitment via clinicians. Eligible participants provided written informed consent, preceded by a brief assessment to verify study comprehension. All study procedures were approved by the appropriate Institutional Review Board.

Eligible participants completed a one-time, two-hour study appointment which included two interviews. First, the CFI was administered by a trained researcher. CFI administrations generally took between 20 and 35 min. Then, another researcher conducted an approximately 30-min debriefing interview, querying the participant about his/her experiences with the CFI. (See Table 2 for questions from the debriefing interview.) Both the CFIs and debriefing interviews were audio recorded with participant consent.

Analysis [B]

The data for the present study were transcripts of the debriefing interviews that were conducted after the CFI. Thematic analysis was used to collate the data and identify

Table 2 Debriefing interview questions

Section	Questions
Content	What was discussed during the interview?
Importance of content	It sounds like you talked about a number of different things. What was discussed during the interview that was important to you?
	[FOLLOW UP ON CONTENT MENTIONED IN INITIAL DESCRIPTION OF INTERVIEW]
Emotions	What was it like to discuss these topics?
	You mentioned that talking about [X] was [EMOTION WORD]. What was [EMOTION WORD] about it?
	What questions in the interview made you particularly [EMOTION WORD]?
	If other Veterans were to do this interview, what would that be like?
	What would other Veterans like/dislike about this interview?
Cognitions	What was going through your mind during the interview?
	OK, so you were thinking [X]. What about the interview led you to think that?
	You mentioned that during the interview, you realized [X]. How did you come to that realization?
Utility	What would it be like if your mental health providers used this interview?
	You mentioned that talking about [X] during the interview was helpful. What was helpful about it?
	What was helpful/unhelpful about participating in the interview?
	How was the interview helpful/unhelpful?
Interviewer behaviors	Tell me what the interviewer did during the interview.
	What did you like/dislike about what the interviewer did?
	What was it like to interact with this interviewer? What did the interviewer do to make you feel that way?
Distinctiveness	Was this interview different from interviews you have had with your other mental health providers? How?
	You mentioned that no one had ever asked you [X] before. What was it like to talk about [X] in the interview?
	You mentioned that the interview was similar to interviews you have had with other mental health providers. How was it similar?

These questions were provided as examples for the debriefing interviewer to draw from. Debriefing interviews were tailored to the content presented by each participant

themes; themes were derived entirely from the data [41]. Initial codes were generated by two researchers (R.M.S. and A.M.) based on a systematic review of the dataset. Each researcher created a list of codes that identified relevant features of the data; this list of codes was condensed and edited iteratively through discussion and application of draft codebooks to multiple transcripts. Once the final codebook was established, all transcripts were independently coded by two researchers (R.M.S. and A.M.), who then met to establish consensus. Final codes were collated using the qualitative software program NVivo. Codes fell into three categories: interview content, interview process, and potential use of the interview in mental health services. The interview process codes were the focus of the present analysis; these were sorted into themes by the first author (A.M.) who created a draft thematic map. This draft thematic map was presented to two other researchers (R.M.S. and S.H.); collaboratively, the three researchers discussed theme names, scope, and content to produce a final thematic map representing the structure and relationship of themes to the data and each other.

Results [A]

Participants and Sample Characteristics [B]

A total of 14 participants completed the study; this included three individuals with prominent psychotic symptoms as indicated by the referring clinician. Participants were between 41 and 58 years old, majority male ($n = 12$) and African-American ($n = 11$), not currently working ($n = 13$), receiving some type of disability benefits ($n = 13$), and living unsupervised in private residences ($n = 9$). The majority had completed some college ($n = 10$).

Themes [B]

Three themes relevant to the process of CFI participation were identified (see Fig. 1). These themes are described below with quotes that are representative of each. Quotes are labeled with pseudonyms; see Table 3 for the demographic characteristics of each participant quoted.

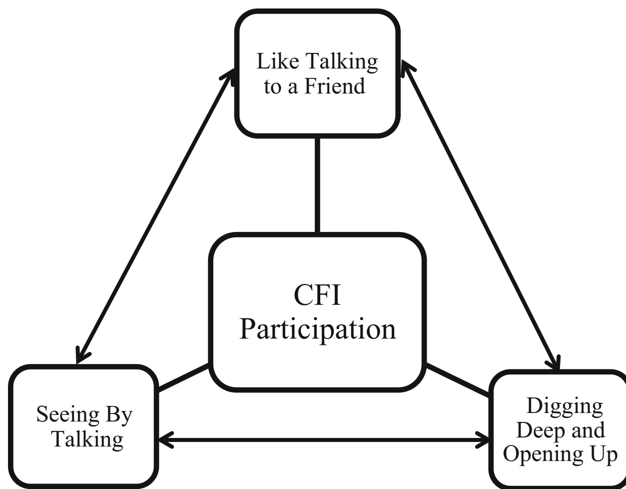

Fig. 1 Themes related to process of CFI participation identified in participant debriefing interviews

Like Talking to a Friend [C]

Participants were asked about their experiences interacting with the CFI interviewer. Participants generally described a positive interpersonal process. For example, Mr. A. and Mr. B. described the interaction as an easy, friendly conversation between equals.

> [The questions] were very direct and easy to answer and all that… They weren't thrown at me… It was more like, "what do you think?", there was no right or wrong answers which is very easy to deal with… So, it felt more like a conversation between two people… It's just two people talking here… **–Mr. A.**

> [Y]ou get that sometimes when you talk to doctors and physicians… they have the aura of they're better than, you know. They talk down to you… and it wasn't like that… It's like I'm like one of her own… It's like talking to somebody that's actually like a friend or somebody like that. Just inquisitive of… what makes you tick. **–Mr. B.**

Other participants expressed appreciation that the interviewers listened carefully and asked relevant follow-up questions; this made them feel validated, heard, and cared about.

> [I]t just kind of flowed… [F]rom one thing, she asked a question that was relevant, which showed me that she was really listening… [E]verything that I said, she backed it up and followed it up… with a pertinent question, which lets me know this lady is listening. And that made me feel good. She listened… without judgment… She just accepted what I said and then compounded on that. **–Ms. C.**

> Somebody actually cares, somebody actually listening to me. Somebody that actually understands what I'm talking about… She asked me the right questions and I felt comfortable answering. **–Mr. D.**

Some participants were experiencing more prominent psychotic symptoms, including hallucinations, delusional beliefs, and disorganized speech and thought processes. These individuals described talking to the CFI interviewer as different than talking to others they came across in their daily lives. For example, Ms. E., who experienced intermittent auditory and visual hallucinations, suicidal ideation, and self-harm behaviors, described her experiences with the CFI interviewer as follows:

> She listened… And she didn't… criticize me or tell me that I'm lying and all this, you know? And that felt good, you know? Because first I told my mom and she said, "Well, if you're going to kill yourself, you're not going to go to heaven and you'll never see me again because… I'm going to heaven." So every

Table 3 Participants Quoted

Pseudonym	Age	Gender	Race/ethnicity	Diagnosis
Mr. A.	58	Male	White	Schizoaffective disorder
Mr. B.	46	Male	Declined	Schizoaffective disorder
Ms. C.	53	Female	African-American	Schizoaffective disorder
Mr. D.	58	Male	African-American	Schizophrenia
Ms. E.	57	Female	African-American	Major depressive disorder with psychotic features
Mr. F.	55	Male	African-American	Schizophrenia
Mr. G.	45	Male	White	Bipolar disorder
Mr. H.	48	Male	African-American	Bipolar disorder
Mr. I.	57	Male	African-American	Bipolar disorder
Mr. J.	55	Male	African-American	Schizoaffective disorder
Mr. K.	42	Male	African-American	Bipolar disorder
Mr. L.	59	Male	African-American	Schizoaffective disorder

time I think about killing myself I think about her saying that, right? So that's when I went to tearing my skin apart because I had to feel alive. That's the only time I feel alive is when I feel pain… And my family… I just… get the feeling that they just don't like me… With [CFI INTERVIEWER] I felt relaxed, very relaxed… She didn't question what I was saying… she really wanted me to tell more of what was going on but she did it in a peaceful way, a very peaceful way… And I could tell that she was listening. **–Ms. E.**

Another participant, Mr. F., was in recovery from substance dependence, and struggling to find housing in a drug-free neighborhood. He exhibited circumstantial and tangential speech patterns and was at times difficult to understand. He shared the following about his experiences with the CFI:

I got to voice my opinion… what's on my mind, what's in my heart… It was beautiful… It was freeing, a weight lifted off my shoulder… I can't talk to other people because they just saw me and said… when you going some high? Or when you going to the store to get me this, get me a drink? **–Mr. F.**

Digging Deep and Opening Up [C]

In discussing their reactions to participating in the CFI, participants stated that the interview evoked deeply emotional responses and reflections. Participants asserted that the CFI challenged them to address difficult or emotionally-loaded questions they had not previously reflected on or had avoided considering. Overall, participants appreciated that the interview delved into complex questions that evoked insights and provided emotional release.

The questions were things that I normally wouldn't think about so it just, you picked your brain coming up with the answers… Normally you go through life and you don't really think. **–Mr. G.**

I kind of had to dig deep sometimes to think about something or come up with, dig deep and all that inside myself… It wasn't bad. I mean, it was kind of reassuring, I guess, you know, to find it in myself. Sometimes it's easier to answer to other people than to answer to yourself… It's easier to answer somebody else than it is to answer yourself because sometimes we have a tendency to avoid our own selves. We try to anyway. I do. **–Mr. A.**

Yeah, she made me think. She sure did. I mean she went deep in my head… It was a relief. **–Mr. D.**

Similarly, another participant, Mr. H., was pleased by the person-centered focus of the questions which required his unique input as opposed to fact recitation.

I've had interviews where they go, "Do you drink? How much do you drink? Do you smoke? How much do you smoke?" Interviews like that, but this was more, "How do you feel about this and how do you feel about that? What's going on with you and this and that?"… [The CFI] was more personal. I had to really think about me and… not just recite statistics about me… so that was different. –**Mr. H.**

The atypical interview questions and personally reflective nature of the CFI created an environment where some participants chose to be more vulnerable than they typically are with providers or social supports. Ms. E. was struck by the amount of personal information she had revealed.

[The CFI] asked questions that they don't ask at the other places, you know?… I'm just, I'm glad I came… Because like I said, it felt good telling her… what my life is about… I can't tell everybody, I can't tell, you know? I told her things I never told anybody else. **–Ms. E.**

While participants felt participating in the CFI was worthwhile, they did note that digging deep and being vulnerable were not necessarily painless or easy. Participants stated that the personal exploration and reflection required to answer the questions sometimes sparked sad or uncomfortable emotional responses that are important to acknowledge. One participant, Mr. I., stated:

I mean it still brought out a lot of sadness in me, so it hit a lot of areas in my life that I'm just not proud of, or I just haven't gained control of yet. And whenever I talk about them, it just makes me sad because I can't understand why I go through what I go through… And I feel so alone… I shouldn't feel the way that I feel. My life should not be the way that it is. [tearful] –**Mr. I.**

Another participant, Mr. J., observed that the self-reflection involved in the interview triggered feelings of discomfort and unease.

It was interesting. It was a little uncomfortable but as we went on I got comfortable with it… Some of the personal questions, me having to describe feelings and reasons for my feelings. Those are difficult to describe… It was difficult to put in words how I feel and the reason I feel that way… It's not that I didn't like any of [the questions]. I mean I didn't have a dislike for any of them. Some was more

> uncomfortable than others. I guess it was the fact that I had to talk about me. –**Mr. J.**

Seeing by Talking [C]

Participants indicated that the CFI provided space for them to share their stories, and that the simple act of speaking the words aloud made their struggles feel real and tangible. This process helped them to see that they were coping and functioning well despite their mental illness.

> Well… it made me lay hold to my mental illness specifically and to see that I'm getting better, that I'm growing… it made me look from the inside out. It made me feel like, listening made me feel like I could see myself from the inside out and see what I was feeling. Now I can hear what I'm feeling; now I see what I'm feeling. And now I know why I feel what I feel, and now I can think correctly about the way I feel. –**Ms. C.**

> Makes it real… I mean, mental illness isn't something you can actually touch or see sometimes. Explaining to someone else what you're going through makes it tangible in a way… Because it makes me feel like I just didn't make it up. It's something that really happened to me and I'm showing somebody look here it is right here. –**Mr. K.**

Participants also shared that by talking to someone about the topics covered in the CFI, they realized something positive about their mental health recovery.

> It was refreshing, you know, because it put me in a—it put me in another space, a good mood. It put me in a good mood because I actually started realizing that I'm doing pretty good right now. You know? Even though I've been going through some things physically and everything like that, and I—and financially, but I'm still—you know, I'm doing good. I haven't—I haven't let my illness be the focal point of my life. I'm learning more and more how to, you know, deal with it. When it comes on, how to put things in place to minimize the effects. –**Mr. H.**

> Well, it helps me to understand that just because I have a mental illness doesn't mean that I can't function as other people do. With therapy and medication I can live a normal life… That helps when you can talk with someone about a problem and see through—see your way through your problem by talking. That helps a whole lot. –**Mr. L.**

Discussion [A]

The present study examined the perspectives of individuals with psychotic disorders on the process of participating in the CFI. Participants reported that interacting with the CFI interviewer was validating and therapeutic. In addition, the CFI appeared to provide a safe space for participants to reveal important, even difficult, things about themselves and their life experiences. The interview process aided participants in the construction of a coherent illness narrative, which led to deeper realizations about themselves and their recovery. Overall, these data support the potential for the CFI as a rapport-building tool for individuals with psychotic disorders.

To maintain fidelity to the CFI, interviewers were required to follow the CFI script, ask individually tailored follow-up questions for clarification, and provide accurate repeating back of participants' experiences. Data within the *like talking to a friend* and *digging deep and opening up* themes suggested these interviewer behaviors contributed to enhanced rapport. Participants perceived the interviewers' careful listening and reflection as a demonstration of empathy, caring, and concern. In addition, participants expressed appreciation that interviewers asked open-ended questions that "made them think," and assessed their experiences holistically. Participants also remarked on the conversational nature of the interview, which could reflect an eschewing of clinical jargon on the part of the interviewer. Finally, participants commented on how well the interview process "flowed". This "flow" is likely attributable to how the CFI is conducted: the interviewer must adhere strictly to the consumers' language and terminology, and only explore topics as the participant introduces them. Jarring, pointed questions which are often included in standard clinical interviews (see Mr. H.'s quote in the *digging deep and opening up* theme) are absent from the CFI. Thus the CFI provided a scaffold for interviewers to engage in rapport-enhancing behaviors, and this resulted in a positive interview process from the participants' perspective.

A subset of participants with more severe psychotic symptoms also reflected on their experiences with the CFI. In a previous study, clinicians trained in the CFI expressed skepticism about using the interview with individuals with psychotic disorders, fearing that psychotic symptoms would interfere with the interview process [37]. On the contrary, the participants in the present study who were most symptomatic were particularly grateful for the chance to participate in the CFI and share their perspectives (see quotes from Ms. E. and Mr. F. in the *like talking to a friend* theme). They contrasted their experience in the interview with the criticism, blame, disbelief, or disregard they typically experienced in their daily interpersonal interactions. The CFI seemed to provide a structure for the interviewers

to listen to individuals sharing their psychotic experiences without judging or "correcting" these experiences. In this way, the CFI demonstrates the potential to be a powerful tool to counteract mental illness stigma and validate the experiences of particularly symptomatic individuals with psychotic disorders.

In addition, as supported by data in the *seeing by talking* theme, participants expressed appreciation that during the CFI they were able to share a positive, person-centered health narrative with an emphasis on the "whole self." By providing space for participants to construct this narrative, the CFI helped them develop a deeper understanding of themselves and their mental health recovery; they also felt more deeply understood by the CFI interviewer. In fact, following the study, Mr. K. stated that he felt better understood in this research study than he ever had previously by any of his doctors, expressed disappointment that the CFI interviewer could not be his mental health clinician, and requested a transcript of the CFI so he could share the results with his treatment team. Thus, it appears that in addition to enhancing therapeutic rapport, the CFI also contributes to the development of a meaningful health narrative which could have both clinical and personal utility and inform a recovery-oriented, person-centered approach to care.

It should be noted that all of the participants in the present study were Veterans who were actively engaged in mental health treatment at a Veterans Affairs Medical Center. Future studies could examine the perspectives of consumers with psychotic disorders in other health care settings or in the initial stages of seeking mental health treatment.

Conclusion [B]

Consumers with psychotic disorders described participating in the CFI as a positive interpersonal process which allowed space for them to reflect on their life experiences and mental health recovery. The CFI appears to provide a structure for interviewers to engage in rapport-enhancing behaviors with consumers with psychotic disorders.

Practice Implications [B]

The CFI may be used to simultaneously enhance rapport and obtain meaningful health narrative data with consumers with psychotic disorders, and may be a valuable tool to promote treatment engagement among individuals with SMI. Future studies could examine how to best carry forward and continue to cultivate the therapeutic rapport and understanding fostered through CFI participation, as well as whether the health narrative data obtained through the CFI could be recorded and disseminated to other treatment team members, in a way that preserves what is personally meaningful for the consumer.

Acknowledgement This work was supported by the Veterans Affairs Capitol Healthcare Network (VISN 5), Mental Illness Research, Education, and Clinical Center (MIRECC) Pilot Study Program. This research was also supported by the VISN 5 MIRECC and the Department of Veterans Affairs Office of Academic Affiliations Advanced Fellowship Program in Mental Illness Research and Treatment. The authors would like to gratefully acknowledge the efforts of Roberto Lewis-Fernandez, M.D., and Neil K. Aggarwal, M.D. in providing training and consultation on the Cultural Formulation Interview in support of this project. The contents do not represent the views of the U.S. Department of Veterans Affairs or the United States Government.

Compliance with ethical standards

Conflict of interest The authors have no conflicts of interest to report regarding this work.

References

1. Kreyenbuhl J, Buchanan RW, Dickerson FB, Dixon LB. The schizophrenia patients outcome research team (PORT): updated treatment recommendations. Schizophr Bull. 2009;36(1):94–103.
2. Bowersox NW, Saunders SM, Berger B. Post-inpatient attrition from care "as usual" in veterans with multiple psychiatric admissions. Community Ment Health J. 2013;49:694–703. doi:10.1007/s10597-012-9544-8.
3. Kreyenbuhl J, Nossel HR, Dixon LB. Disengagement from mental health treatment among individuals with schizophrenia and strategies for facilitating connections to care: a review of the literature. Schizophr Bull. 2009;35(4):696–703.
4. O'Brien A, Fahmy R, Singh S. Disengagement from mental health services: a literature review. Soc Psychiatry Psychiatr Epidemiol. 2009;44:558–68.
5. Fischer EP, McCarthy JF, Ignacio RV, Blow FC, Barry KL, Hudon T, Valenstein M. Longitudinal patterns of health system retention among veterans with schizophrenia or bipolar disorder. Community Ment Health J. 2008;44(5):321–30.
6. Oliver P, Keen J, Rowse G, Ewins E, Griffiths L, Mathers N. The effect of time spent in treatment and dropout status on rates of convictions, cautions and imprisonment over 5 years in a primary care- led methadone maintenance service. Addiction. 2010;105(4):732–9.
7. Priebe S, Watts J, Chase M, Matanov A. Processes of disengagement and engagement in assertive outreach patients: qualitative study. Br J Psychiatry. 2005;187:438–43.
8. Smith TE, Easter A, Pollock M, Pope LG, Wisdom JP. Disengagement from care: perspectives of individuals with serious mental illness and of service providers. Psychiatric Serv. 2013;64(8):770–5.
9. Easter A, Pollock M, Pope LG, Wisdom J, Smith T. Perspectives of treatment providers and clients with serious mental illness regarding effective therapeutic relationships. J Behav Health Serv Res. 2016;43:341–53. doi:10.1007/s11414-015-9492-5.
10. Green CA, Polen MR, Janoff SL, Castleton D, Wisdom JP, Vuckovic N, Oken SL. Understanding how clinician-patient relationships and relational continuity of care affect recovery from serious mental illness: STARS study results. Psychiatr Rehabil J. 2008;32:9–22. doi:10.2975/32.1.2008.9.22.

11. Padgett DK, Henwood B, Abrams C, Davis A. Engagement and retention in services among formerly homeless adults with co-occurring mental illness and substance abuse: voices from the margins. Psychiatr Rehabil J. 2008;31:226–33. doi:10.2975/31.3.2008.226.233.
12. Ware N, Tugenberg T, Dickey B. Practitioner relationships and quality of care for low-income persons with serious mental illness. Psychiatr Serv. 2004;55:555–9. doi:10.1176/appi.ps.55.5.555.
13. Frank AF, Gunderson JG. The role of the therapeutic alliance in the treatment of schizophrenia. Relationship to course and outcome. Arch Gen Psychiatry. 1990;47(3):228–36.
14. Lecomte T, Spidel A, Leclerc C, MacEwan GW, Greaves C, Bentall RP. Predictors and profiles of treatment non-adherence and engagement in services problems in early psychosis. Schizophr Res. 2008;102(1–3):295–302.
15. Martin DJ, Garske JP, Davis MK. Relation to the therapeutic alliance with outcome and other variables: a meta-analytic review. J Consult Clin Psychol. 2000;68(3):438–50.
16. Meier PS, Barrowclough C, Donmall MC. The role of the therapeutic alliance in the treatment of substance misuse: a critical review of the literature. Addiction. 2005;100:304–16. doi:10.1111/j.1360-0443.2004.00935.x.
17. Priebe S, Richardson M, Cooney M, Adedeji O, McCabe R. Does the therapeutic relationship predict outcomes of psychiatric treatment in patients with psychosis?A systematic review. Psychother Psychosom. 2011;80(2):70–7.
18. Roter D, Larson S. The Roter interaction analysis system (RIAS): utility and flexibility for analysis of medical interactions. Patient Educ Couns. 2002;46:243–51. doi:10.1016/S0738-3991(02)00012-5.
19. Booth N, Robinson P, Kohannejad J. Identification of high-quality consultation practice in primary care: the effects of computer use on doctor-patient rapport. Inform Prim Care. 2004;12:75–83.
20. Norfolk T, Birdi K, Patterson F. Developing therapeutic rapport: a training validation study. Qual Prim Care. 2009;17:99–106.
21. Dahm MR. Tales of time, terms, and patient information-seeking behavior-an exploratory qualitative study. Health Commun. 2012;27:682–9. doi:10.1080/10410236.2011.629411.
22. Williams N, Ogden J. The impact of matching the patient's vocabulary: a randomized control trial. Fam Pract. 2004;21:630–5. doi:10.1093/fampra/cmh610.
23. Angus D, Watson B, Smith A, Gallois C, Wiles J. Visualising conversation structure across time: insights into effective doctor–patient consultations. PLoS ONE. 2012;. doi:10.1371/journal.pone.0038014.
24. Lewis-Fernández R, Aggarwal NK, Hinton L, Hinton DE, Kirmayer LK. The DSM-5 handbook on the cultural formulation interview. Washington: American Psychiatric Publishing; 2016. p. 2016.
25. American Psychiatric Association. The diagnostic and statistical manual of mental disorders. 5th ed. Arlington: American Psychiatric Publishing Inc.; 2013.
26. Paralikar VP, Sarmukuddam SB, Patil KV, Nulkar AD, Weiss MG. Clinical value of the cultural formulation interview in Pune, India. Indian J Psychiatry. 2015;57(1):59–67. doi:10.4103/0019-5545.148524.
27. Lewis-Fernández R, Aggarwal NK, Lam PC, Galfalvy H, Weiss MG, Kirmayer LJ, Paralikar V, Deshpande SN, Díaz E, Nicasio AV, Boiler M, Alarcón RD, Rohlof H, Groen S, van Dijk RCJ, Jadhav SS, Sarmukaddam S, Ndetei D, Scalco MZ, Bassiri K, Aguilar-Gaxiola S, Ton H, Westermeyer J, Vega-Dienstmaier JM. Feasibility, acceptability, and clinical utility of the Cultural Formulation Interview: Mixed-methods results from the DSM-5 international field trial. Br J Psychiatry. http://discovery.ucl.ac.uk/id/eprint/1527445.
28. Adeponle AB, Groleau D, Kirmayer LJ. Clinician reasoning in the use of cultural formulation to resolve uncertainty in the diagnosis of psychosis. Cult Med Psychiatry. 2015;39(1):16–42. doi:10.1007/s11013-014-9408-5.
29. Baarnhielm S, Wistedt AA, Rosso MS. Revising psychiatric diagnostic categorisation of immigrant patients after using the cultural formulation in DSM-IV. Transcultural Psychiatry. 2015;52(3):287–310. doi:10.1177/1363461514560657.
30. Lewis-Fernandez R, Aggarwal NK. Culture and psychiatric diagnosis. Adv Psychosom Med. 2013;33:15–30. doi:10.1159/000348725.
31. Zandi T, Havenaar JM, Limburg-Okken AG, van Es H, Sidali S, Kadri N, van den Brink W, Kahn RS. The need for culture sensitive diagnostic procedures: a study among psychotic patients in Morocco. Soc Psychiatry Psychiatr Epidemiol. 2008;43(3):244–50. doi:10.1007/s00127-007-0290-0.
32. Zandi T, Havenaar JM, Laan W, Kahn RS, van den Brink W. Effects of a culturally sensitive assessment on symptom profiles in native Dutch and Moroccan patients with a first psychosis referral. Transcultural Psychiatry. 2016;53(1):49–59. doi:10.1177/1363461515577.
33. Rosso MS, Baarnhielm S. Use of the Cultural Formulation in Stockholm: a qualitative study of mental illness experience among migrants. Transcultural Psychiatry. 2012;49(2):283–301. doi:10.1177/1363461512442344.
34. Kirmayer LJ, Thombs BD, Jurcik T, Jarvis G, Guzder J. Use of an expanded version of the DSM-IV outline for cultural formulation on a cultural consultation service. Psychiatric Serv. 2008;59(6):683–6. doi:10.1176/appi.ps.59.6.683.
35. Aggarwal NK, Desilva R, Nicasio AV, Boiler M, Fernandez RL. Does the Cultural Formulation Interview 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. Ethn Health. 2015;20(1):1–28. doi:10.1080/13557858.2013.857762.
36. Adeponle AB, Thombs B, Groleau D, Jarvis E, Kirmayer LJ. Using the cultural formulation to resolve uncertainty in diagnoses of psychosis among ethnoculturally diverse patients. Psychiatric Serv. 2012;63(2):147–53. doi:10.1176/appi.ps.201100280.
37. Aggarwal NK, Nicasio AV, DeSilva R, Boiler M, Fernandez RL. Barriers to implementing the DSM-5 cultural formulation interview: a qualitative study. Cult Med Psychiatry. 2013;37(3):505–33. doi:10.1007/s11013-013-9325-z.
38. Aggarwal, N.K., Lam, P., Castillo, E., Weiss, M.G., Diaz, E., Alarcón, R.D., van Dijk, R., Rohlof, H., Ndetei, D.M., Scalco, M., Aguilar-Gaxiola, S., Bassiri, K., Deshpande, S., Groen, S., Jadhav, S., Kirmayer, L.J., Paralikar, V., Westermeyer, J., Santos, F., Vega-Dienstmaier, J., Anez, L., Boiler, M., Nicasio, A.V., Lewis-Fernández, R. (2015). How do clinicians prefer cultural competence training? Findings from the DSM-5 Cultural Formulation Interview Field Trial. Acad Psychiatry, 1–8.
39. Aggarwal NK, Glass A, Tirado A, Boiler M, Nicasio A, Alegría M, Lewis-Fernández R. The development of the DSM-5 cultural formulation interview-fidelity instrument (CFI-FI): a pilot study. J Health Care Poor Underserved. 2014;25(3):1397–417.
40. Guest G, Bunce A, Johnson L. How many interviews are enough? An experiment with data saturation and validity. Field Methods. 2006;18:59–82.
41. Braun V, Clarke V. Using Thematic Analysis in Psychology. Qual Res Psychol. 2006;3:77–101. doi:10.1191/1478088706qp063oa.