Cultural Formulation

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Understanding the cultural context of illness experience is essential for effective diagnostic assessment and clinical management. *Culture* refers to systems of knowledge, concepts, rules, and practices that are learned and transmitted across generations. Culture includes language, religion and spirituality, family structures, life-cycle stages, ceremonial rituals, and customs, as well as moral and legal systems. Cultures are open, dynamic systems that undergo continuous change over time; in the contemporary world, most individuals and groups are exposed to multiple cultures, which they use to fashion their own identities and make sense of experience. These features of culture make it crucial not to overgeneralize cultural information or stereotype groups in terms of fixed cultural traits.

Race is a culturally constructed category of identity that divides humanity into groups based on a variety of superficial physical traits attributed to some hypothetical intrinsic, biological characteristics. Racial categories and constructs have varied widely over history and across societies. The construct of race has no consistent biological definition, but it is socially important because it supports racial ideologies, racism, discrimination, and social exclusion, which can have strong negative effects on mental health. There is evidence that racism can exacerbate many psychiatric disorders, contributing to poor outcome, and that racial biases can affect diagnostic assessment.

Ethnicity is a culturally constructed group identity used to define peoples and communities. It may be rooted in a common history, geography, language, religion, or other shared characteristics of a group, which distinguish that group from others. Ethnicity may be self-assigned or attributed by outsiders. Increasing mobility, intermarriage, and intermixing of cultures has defined new mixed, multiple, or hybrid ethnic identities.

Culture, race, and ethnicity are related to economic inequities, racism, and discrimination that result in health disparities. Cultural, ethnic, and racial identities can be sources of strength and group support that enhance resilience, but they may also lead to psychological, interpersonal, and intergenerational conflict or difficulties in adaptation that require diagnostic assessment.

OUTLINE FOR CULTURAL FORMULATION

The Outline for Cultural Formulation introduced in DSM-IV provided a framework for assessing information about cultural features of an individual's mental health problem and how it relates to a social and cultural context and history. DSM-5 not only includes an updated version of the Outline but also presents an approach to assessment, using the Cultural Formulation Interview (CFI), which has been field-tested for diagnostic usefulness among clinicians and for acceptability among patients.

The revised Outline for Cultural Formulation calls for systematic assessment of the following categories:

- **Cultural identity of the individual:** Describe the individual's racial, ethnic, or cultural reference groups that may influence his or her relationships with others, access to resources, and developmental and current challenges, conflicts, or predicaments. For immigrants and racial or ethnic minorities, 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 difficulties with access to care, social integration, and the need for an interpreter. Other clinically relevant aspects of identity may include religious affiliation, socioeconomic background, personal and family places of birth and growing up, migrant status, and sexual orientation.
- **Cultural conceptualizations of distress:** Describe the cultural constructs that influence how the individual experiences, understands, and communicates his or her symptoms or problems to others. These constructs may include cultural syndromes, idioms of distress, and explanatory models or perceived causes. The level of severity and meaning of the distressing experiences should be assessed in relation to the norms of the individual's cultural reference groups. Assessment of coping and help-seeking patterns should consider the use of professional as well as traditional, alternative, or complementary sources of care.
- **Psychosocial stressors and cultural features of vulnerability and resilience:** Identify key stressors and supports in the individual's social environment (which may include both local and distant events) and the role of religion, family, and other social networks (e.g., friends, neighbors, coworkers) in providing emotional, instrumental, and informational support. Social stressors and social supports vary with cultural interpretations of events, family structure, developmental tasks, and social context. Levels of functioning, disability, and resilience should be assessed in light of the individual's cultural reference groups.

Cultural Formulation Interview (CFI)	
Supplementary modules used to expand each CFI subtopic are noted in parentheses.	
GUIDE TO INTERVIEWER	INSTRUCTIONS TO THE INTERVIEWER ARE *ITALICIZED*.
The following questions aim to clarify key aspects of the presenting clinical problem from the point of view of the individual and other members of the individual's social network (i.e, family, friends, or others involved in current problem). This includes the problem's meaning, potential sources of help, and expectations for services.	*INTRODUCTION FOR THE INDIVIDUAL:* I would like to understand the problems that bring you here so that I can help you more effectively. I want to know about *your* experience and ideas. I will ask some questions about what is going on and how you are dealing with it. Please remember there are no right or wrong answers.
CULTURAL DEFINITION OF THE PROBLEM	
Cultural Definition of the Problem	
(Explanatory Model, Level of Functioning)	
Elicit the individual's view of core problems and key concerns. *Focus on the individual's own way of understanding the problem.*	1. What brings you here today? *IF INDIVIDUAL GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE:* People often understand their problems in their own way, which may be similar to or different from how doctors describe the problem. How would *you* describe your problem?
Use the term, expression, or brief description elicited in question 1 to identify the problem in subsequent questions (e.g, "your conflict with your son"). *Ask how individual frames the problem for members of the social network.*	2. Sometimes people have different ways of describing their problem to their family, friends, or others in their community. How would you describe your problem to them?
Focus on the aspects of the problem that matter most to the individual.	3. What troubles you most about your problem?
CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT	
Causes	
(Explanatory Model, Social Network, Older Adults)	
This question indicates the meaning of the condition for the individual, which may be relevant for clinical care. *Note that individuals may identify multiple causes, depending on the facet of the problem they are considering.*	4. Why do you think this is happening to you? What do you think are the causes of your [PROBLEM]? *PROMPT FURTHER IF REQUIRED:* Some people may explain their problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes.
Focus on the views of members of the individual's social network. These may be diverse and vary from the individual's.	5. What do others in your family, your friends, or others in your community think is causing your [PROBLEM]?
Stressors and Supports	
(Social Network, Caregivers, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Cultural Identity, Older Adults, Coping and Help Seeking)	
Elicit information on the individual's life context, focusing on resources, social supports, and resilience. May also probe other supports (e.g., from coworkers, from participation in religion or spirituality).	6. Are there any kinds of support that make your [PROBLEM] better, such as support from family, friends, or others?
Focus on stressful aspects of the individual's environment. Can also probe, e.g., relationship problems, difficulties at work or school, or discrimination.	7. Are there any kinds of stresses that make your [PROBLEM] worse, such as difficulties with money, or family problems?
Role of Cultural Identity	
(Cultural Identity, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Older Adults, Children and Adolescents)	Sometimes, aspects of people's background or identity can make their [PROBLEM] better or worse. By *background* or *identity,* I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, or your faith or religion.
Ask the individual to reflect on the most salient elements of his or her cultural identity. Use this information to tailor questions 9–10 as needed.	8. For you, what are the most important aspects of your background or identity?
Elicit aspects of identity that make the problem better or worse. *Probe as needed (e.g., clinical worsening as a result of discrimination due to migration status, race/ethnicity, or sexual orientation).*	9. Are there any aspects of your background or identity that make a difference to your [PROBLEM]?
Probe as needed (e.g., migration-related problems; conflict across generations or due to gender roles).	10. Are there any aspects of your background or identity that are causing other concerns or difficulties for you?

continued

Cultural Formulation Interview (CFI) (*continued*)	
Supplementary modules used to expand each CFI subtopic are noted in parentheses.	
GUIDE TO INTERVIEWER	INSTRUCTIONS TO THE INTERVIEWER ARE *ITALICIZED*.
CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING	
Self-Coping	
(Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors)	
Clarify self-coping for the problem.	11. Sometimes people have various ways of dealing with problems like [PROBLEM]. What have you done on your own to cope with your [PROBLEM]?
Past Help Seeking	
(Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship)	
Elicit various sources of help (e.g., medical care, mental health treatment, support groups, workbased counseling, folk healing, religious or spiritual counseling, other forms of traditional or alternative healing). *Probe as needed (e.g., "What other sources of help have you used?").* *Clarify the individual's experience and regard for previous help.*	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]? *PROBE IF DOES NOT DESCRIBE USEFULNESS OF HELP RECEIVED:* What types of help or treatment were most useful? Not useful?
Barriers	
(Coping and Help Seeking, Religion and Spirituality, Older Adults, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship)	
Clarify the role of social barriers to help seeking, access to care, and problems engaging in previous treatment. *Probe details as needed (e.g., "What got in the way?").*	13. Has anything prevented you from getting the help you need? *PROBE AS NEEDED:* For example, money, work or family commitments, stigma or discrimination, or lack of services that understand your language or background?
CULTURAL FACTORS AFFECTING CURRENT HELP SEEKING	
Preferences	
(Social Network, Caregivers, Religion and Spirituality, Older Adults, Coping and Help Seeking)	
Clarify individual's current perceived needs and expectations of help, broadly defined.	Now let's talk some more about the help you need.
Probe if individual lists only one source of help (e.g., "What other kinds of help would be useful to you at this time?").	14. What kinds of help do you think would be most useful to you at this time for your [PROBLEM]?
Focus on the views of the social network regarding help seeking.	15. Are there other kinds of help that your family, friends, or other people have suggested would be helpful for you now?
Clinician-Patient Relationship	
(Clinician-Patient Relationship, Older Adults)	
Elicit possible concerns about the clinic or the clinician-patient relationship, including perceived racism, language barriers, or cultural differences that may undermine goodwill, communication, or care delivery.	Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations.
Probe details as needed (e.g., "In what way?"). *Address possible barriers to care or concerns about the clinic and the clinician-patient relationship raised previously.*	16. Have you been concerned about this and is there anything that we can do to provide you with the care you need?

- **Cultural features of the relationship between the individual and the clinician:** Identify differences in culture, language, and social status between an individual and clinician that may cause difficulties in communication and may influence diagnosis and treatment. Experiences of racism and discrimination in the larger society may impede establishing trust and safety in the clinical diagnostic encounter. Effects may include problems eliciting symptoms, misunderstanding of the cultural and clinical significance of symptoms and behaviors, and difficulty establishing or maintaining the rapport needed for an effective clinical alliance.
- **Overall cultural assessment:** Summarize the implications of the components of the cultural formulation identified in earlier sections of the Outline for diagnosis and other clinically relevant issues or problems as well as appropriate management and treatment intervention.

CULTURAL FORMULATION INTERVIEW (CFI)

The Cultural Formulation Interview (CFI) is a set of 16 questions that clinicians may use to obtain information during a mental health assessment about the impact of

Cultural Formulation Interview (CFI)—Informant Version	
GUIDE TO INTERVIEWER	INSTRUCTIONS TO THE INTERVIEWER ARE *ITALICIZED*.
The following questions aim to clarify key aspects of the presenting clinical problem from the informant's point of view. This includes the problem's meaning, potential sources of help, and expectations for services.	*INTRODUCTION FOR THE INFORMANT:* I would like to understand the problems that bring your family member/friend here so that I can help you and him/her more effectively. I want to know about *your* experience and ideas. I will ask some questions about what is going on and how you and your family member/friend are dealing with it. There are no right or wrong answers.
	RELATIONSHIP WITH THE PATIENT
Clarify the informant's relationship with the individual and/or the individual's family.	1. How would you describe your relationship to [INDIVIDUAL OR TO FAMILY]? *PROBE IF NOT CLEAR:* How often do you see [INDIVIDUAL]?
	CULTURAL DEFINITION OF THE PROBLEM
Elicit the informant's view of core problems and key concerns. *Focus on the informant's way of understanding the individual's problem.* *Use the term, expression, or brief description elicited in question 1 to identify the problem in subsequent questions (e.g, "her conflict with her son").*	2. What brings your family member/friend here today? *IF INFORMANT GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE:* People often understand problems in their own way, which may be similar or different from how doctors describe the problem. How would *you* describe [INDIVIDUAL'S] problem?
Ask how informant frames the problem for members of the social network.	3. Sometimes people have different ways of describing the problem to family, friends, or others in their community. How would *you* describe [INDIVIDUAL'S] problem to them?
Focus on the aspects of the problem that matter most to the informant.	4. What troubles you most about [INDIVIDUAL'S] problem?
	CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT
	Causes
This question indicates the meaning of the condition for the informant, which may be relevant for clinical care. *Note that informants may identify multiple causes depending on the facet of the problem they are considering.*	5. Why do you think this is happening to [INDIVIDUAL]? What do you think are the causes of his/her [PROBLEM]? *PROMPT FURTHER IF REQUIRED:* Some people may explain the problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes.
Focus on the views of members of the individual's social network. These may be diverse and vary from the informant's.	6. What do others in [INDIVIDUAL'S] family, his/her friends, or others in the community think is causing [INDIVIDUAL'S] [PROBLEM]?
	Stressors and Supports
Elicit information on the individual's life context, focusing on resources, social supports, and resilience. May also probe other supports (e.g., from coworkers, from participation in religion or spirituality).	7. Are there any kinds of supports that make his/her [PROBLEM] better, such as from family, friends, or others?
Focus on stressful aspects of the individual's environment. Can also probe, e.g., relationship problems, difficulties at work or school, or discrimination.	8. Are there any kinds of stresses that make his/her [PROBLEM] worse, such as difficulties with money, or family problems?
	Role of Cultural Identity
	Sometimes, aspects of people's background or identity can make the [PROBLEM] better or worse. By *background* or *identity,* I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, and your faith or religion.
Ask the informant to reflect on the most salient elements of the individual's cultural identity. Use this information to tailor questions 10–11 as needed.	9. For you, what are the most important aspects of [INDIVIDUAL'S] background or identity?
Elicit aspects of identity that make the problem better or worse. *Probe as needed (e.g., clinical worsening as a result of discrimination due to migration status, race/ethnicity, or sexual orientation).*	10. Are there any aspects of [INDIVIDUAL'S] background or identity that make a difference to his/her [PROBLEM]?

continued

Cultural Formulation Interview (CFI)—Informant Version (*continued*)	
GUIDE TO INTERVIEWER	INSTRUCTIONS TO THE INTERVIEWER ARE *ITALICIZED*.
Probe as needed (e.g., migration-related problems; conflict across generations or due to gender roles).	11. Are there any aspects of [INDIVIDUAL'S] background or identity that are causing other concerns or difficulties for him/her?
CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING	
Self-Coping	
Clarify individual's self-coping for the problem.	12. Sometimes people have various ways of dealing with problems like [PROBLEM]. What has [INDIVIDUAL] done on his/her own to cope with his/her [PROBLEM]?
Past Help Seeking	
Elicit various sources of help (e.g., medical care, mental health treatment, support groups, workbased counseling, folk healing, religious or spiritual counseling, other alternative healing). *Probe as needed (e.g., "What other sources of help has he/she used?").*	13. Often, people also 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 has [INDIVIDUAL] sought for his/ her [PROBLEM]?
Clarify the individual's experience and regard for previous help.	*PROBE IF DOES NOT DESCRIBE USEFULNESS OF HELP RECEIVED:* What types of help or treatment were most useful? Not useful?
Barriers	
Clarify the role of social barriers to help-seeking, access to care, and problems engaging in previous treatment. *Probe details as needed (e.g., "What got in the way?").*	14. Has anything prevented [INDIVIDUAL] from getting the help he/she needs? *PROBE AS NEEDED:* For example, money, work or family commitments, stigma or discrimination, or lack of services that understand his/her language or background?
CULTURAL FACTORS AFFECTING CURRENT HELP SEEKING	
Preferences	
Clarify individual's current perceived needs and expectations of help, broadly defined, from the point of view of the informant.	Now let's talk about the help [INDIVIDUAL] needs.
Probe if informant lists only one source of help (e.g., "What other kinds of help would be useful to [INDIVIDUAL] at this time?").	15. What kinds of help would be most useful to him/her at this time for his/her [PROBLEM]?
Focus on the views of the social network regarding help seeking.	16. Are there other kinds of help that [INDIVIDUAL'S] family, friends, or other people have suggested would be helpful for him/ her now?
Clinician-Patient Relationship	
Elicit possible concerns about the clinic or the clinician-patient relationship, including perceived racism, language barriers, or cultural differences that may undermine goodwill, communication, or care delivery.	Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations.
Probe details as needed (e.g., "In what way?"). *Address possible barriers to care or concerns about the clinic and the clinician-patient relationship raised previously.*	17. Have you been concerned about this, and is there anything that we can do to provide [INDIVIDUAL] with the care he/she needs?

culture on key aspects of an individual's clinical presentation and care. In the CFI, *culture* refers to

- The values, orientations, knowledge, and practices that individuals derive from membership in diverse social groups (e.g., ethnic groups, faith communities, occupational groups, veterans groups).
- Aspects of an individual's background, developmental experiences, and current social contexts that may affect his or her perspective, such as geographical origin, migration, language, religion, sexual orientation, or race/ethnicity.
- The influence of family, friends, and other community members (the individual's *social network*) on the individual's illness experience.

The CFI is a brief semistructured interview for systematically assessing cultural factors in the clinical encounter that may be used with any individual. The CFI focuses on the individual's experience and the social contexts of the clinical problem. The CFI follows a person-centered approach to cultural assessment by eliciting information from the individual about his or her

own views and those of others in his or her social network. This approach is designed to avoid stereotyping, in that each individual's cultural knowledge affects how he or she interprets illness experience and guides how he or she seeks help. Because the CFI concerns the individual's personal views, there are no right or wrong answers to these questions. The interview follows and is available online at www.psychiatry.org/dsm5.

The CFI is formatted as two text columns. The left-hand column contains the instructions for administering the CFI and describes the goals for each interview domain. The questions in the right-hand column illustrate how to explore these domains, but they are not meant to be exhaustive. Follow-up questions may be needed to clarify individuals' answers. Questions may be rephrased as needed. The CFI is intended as a guide to cultural assessment and should be used flexibly to maintain a natural flow of the interview and rapport with the individual.

The CFI is best used in conjunction with demographic information obtained prior to the interview in order to tailor the CFI questions to address the individual's background and current situation. Specific demographic domains to be explored with the CFI will vary across individuals and settings. A comprehensive assessment may include place of birth, age, gender, racial/ethnic origin, marital status, family composition, education, language fluencies, sexual orientation, religious or spiritual affiliation, occupation, employment, income, and migration history.

The CFI can be used in the initial assessment of individuals in all clinical settings, regardless of the cultural background of the individual or of the clinician. Individuals and clinicians who appear to share the same cultural background may nevertheless differ in ways that are relevant to care. The CFI may be used in its entirety, or components may be incorporated into a clinical evaluation as needed. The CFI may be especially helpful when there is

- Difficulty in diagnostic assessment owing to significant differences in the cultural, religious, or socioeconomic backgrounds of clinician and the individual.
- Uncertainty about the fit between culturally distinctive symptoms and diagnostic criteria.
- Difficulty in judging illness severity or impairment.
- Disagreement between the individual and clinician on the course of care.
- Limited engagement in and adherence to treatment by the individual.

The CFI emphasizes four domains of assessment: Cultural Definition of the Problem (questions 1–3); Cultural Perceptions of Cause, Context, and Support (questions 4–10); Cultural Factors Affecting Self-Coping and Past Help Seeking (questions 11–13); and Cultural Factors Affecting Current Help Seeking (questions 14–16). Both the person-centered process of conducting the CFI and the information it elicits are intended to enhance the cultural validity of diagnostic assessment, facilitate treatment planning, and promote the individual's engagement and satisfaction. To achieve these goals, the information obtained from the CFI should be integrated with all other available clinical material into a comprehensive clinical and contextual evaluation. An Informant version of the CFI can be used to collect collateral information on the CFI domains from family members or caregivers.

Supplementary modules have been developed that expand on each domain of the CFI and guide clinicians who wish to explore these domains in greater depth. Supplementary modules have also been developed for specific populations, such as children and adolescents, elderly individuals, and immigrants and refugees. These supplementary modules are referenced in the CFI under the pertinent subheadings and are available online at www.psychiatry.org/dsm5.

CULTURAL FORMULATION INTERVIEW (CFI) – INFORMANT VERSION

The CFI–Informant Version collects collateral information from an informant who is knowledgeable about the clinical problems and life circumstances of the identified individual. This version can be used to supplement information obtained from the core CFI or can be used instead of the core CFI when the individual is unable to provide information—as might occur, for example, with children or adolescents, floridly psychotic individuals, or persons with cognitive impairment.

CULTURAL CONCEPTS OF DISTRESS

Cultural concepts of distress refers to ways that cultural groups experience, understand, and communicate suffering, behavioral problems, or troubling thoughts and emotions. Three main types of cultural concepts may be distinguished. *Cultural syndromes* are clusters of symptoms and attributions that tend to co-occur among individuals in specific cultural groups, communities, or contexts and that are recognized locally as coherent patterns of experience. *Cultural idioms of distress* are ways of expressing distress that may not involve specific symptoms or syndromes, but that provide collective, shared ways of experiencing and talking about personal or social concerns. For example, everyday talk about "nerves" or "depression" may refer to widely varying forms of suffering without mapping onto a discrete set of symptoms, syndrome, or disorder. *Cultural explanations* or *perceived causes* are labels, attributions, or features of an explanatory model that indicate culturally recognized meaning or etiology for symptoms, illness, or distress.

These three concepts—syndromes, idioms, and explanations—are more relevant to clinical practice than the older formulation *culture-bound syndrome*. Specifically, the term *culture-bound syndrome* ignores the fact that clinically important cultural differences often involve explanations or experience of distress rather than culturally distinctive configurations of symptoms. Furthermore, the term *culture-bound* overemphasizes the local particularity and limited distribution of cultural concepts of distress. The current formulation acknowledges that *all* forms of

distress are locally shaped, including the DSM disorders. From this perspective, many DSM diagnoses can be understood as operationalized prototypes that started out as cultural syndromes, and became widely accepted as a result of their clinical and research utility. Across groups there remain culturally patterned differences in symptoms, ways of talking about distress, and locally perceived causes, which are in turn associated with coping strategies and patterns of help seeking.

Cultural concepts arise from local folk or professional diagnostic systems for mental and emotional distress, and they may also reflect the influence of biomedical concepts. Cultural concepts have four key features in relation to the DSM-5 nosology:

- There is seldom a one-to-one correspondence of any cultural concept with a DSM diagnostic entity; the correspondence is more likely to be one-to-many in either direction. Symptoms or behaviors that might be sorted by DSM-5 into several disorders may be included in a single folk concept, and diverse presentations that might be classified by DSM-5 as variants of a single disorder may be sorted into several distinct concepts by an indigenous diagnostic system.
- Cultural concepts may apply to a wide range of severity, including presentations that do not meet DSM criteria for any mental disorder. For example, an individual with acute grief or a social predicament may use the same idiom of distress or display the same cultural syndrome as another individual with more severe psychopathology.
- In common usage, the same cultural term frequently denotes more than one type of cultural concept. A familiar example may be the concept of "depression," which may be used to describe a syndrome (e.g., major depressive disorder), an idiom of distress (e.g., as in the common expression "I feel depressed"), or a perceived cause (similar to "stress").
- Like culture and DSM itself, cultural concepts may change over time in response to both local and global influences.

Cultural concepts are important to psychiatric diagnosis for several reasons:

- **To avoid misdiagnosis:** Cultural variation in symptoms and in explanatory models associated with these cultural concepts may lead clinicians to misjudge the severity of a problem or assign the wrong diagnosis (e.g., unfamiliar spiritual explanations may be misunderstood as psychosis).
- **To obtain useful clinical information:** Cultural variations in symptoms and attributions may be associated with particular features of risk, resilience, and outcome.
- **To improve clinical rapport and engagement:** "Speaking the language of the patient," both linguistically and in terms of his or her dominant concepts and metaphors, can result in greater communication and satisfaction, facilitate treatment negotiation, and lead to higher retention and adherence.
- **To improve therapeutic efficacy:** Culture influences the psychological mechanisms of disorder, which need to be understood and addressed to improve clinical efficacy. For example, culturally specific catastrophic cognitions can contribute to symptom escalation into panic attacks.
- **To guide clinical research:** Locally perceived connections between cultural concepts may help identify patterns of comorbidity and underlying biological substrates.
- **To clarify the cultural epidemiology:** Cultural concepts of distress are not endorsed uniformly by everyone in a given culture. Distinguishing syndromes, idioms, and explanations provides an approach for studying the distribution of cultural features of illness across settings and regions, and over time. It also suggests questions about cultural determinants of risk, course, and outcome in clinical and community settings to enhance the evidence base of cultural research.

DSM-5 includes information on cultural concepts in order to improve the accuracy of diagnosis and the comprehensiveness of clinical assessment. Clinical assessment of individuals presenting with these cultural concepts should determine whether they meet DSM-5 criteria for a specified disorder or an *other specified or unspecified* diagnosis. Once the disorder is diagnosed, the cultural terms and explanations should be included in case formulations; they may help clarify symptoms and etiological attributions that could otherwise be confusing. Individuals whose symptoms do not meet DSM criteria for a specific mental disorder may still expect and require treatment; this should be assessed on a case-by-case basis. In addition to the CFI and its supplementary modules, DSM-5 contains the following information and tools that may be useful when integrating cultural information in clinical practice:

- **Data in DSM-5 criteria and text for specific disorders:** The text includes information on cultural variations in prevalence, symptomatology, associated cultural concepts, and other clinical aspects. It is important to emphasize that there is no one-to-one correspondence at the categorical level between DSM disorders and cultural concepts. Differential diagnosis for individuals must therefore incorporate information on cultural variation with information elicited by the CFI.
- **Other Conditions That May Be a Focus of Clinical Attention:** Some of the clinical concerns identified by the CFI may correspond to V codes or Z codes—for example, acculturation problems, parent-child relational problems, or religious or spiritual problems.
- **Glossary of Cultural Concepts of Distress:** Located in the Appendix, this glossary provides examples of well-studied cultural concepts of distress that illustrate the relevance of cultural information for clinical diagnosis and some of the interrelationships among cultural syndromes, idioms of distress, and causal explanations.

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