The DSM-5 Cultural Formulation Interview: Bridging Barriers Toward a Clinically Integrated Cultural Assessment in Psychiatry

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ABSTRACT

The Diagnostic and Statistical Manual of Mental Disorders, fifth edition, (DSM-5) Cultural Formulation Interview (CFI) is a systematic, semi-structured interview developed to guide clinicians on conducting a cultural assessment in routine mental health settings. An international field trial with 318 patients, 75 clinicians, and 86 family members in 6 countries found the core version of the CFI to be feasible, acceptable, and clinically useful, and a growing evidence base has led to its inclusion in worldwide mental health services. We review the definition of culture that underlies the CFI, its development and components, and how to apply it in care. We also focus on barriers to its implementation and how these are being addressed by investigators and clinicians. The cultural formulation approach stemming from DSM-IV, of which the DSM-5 CFI is the latest iteration, constitutes the cultural competence paradigm with the largest evidence base in mental health service delivery. [Psychiatr Ann. 2018;48(3):154-159.]

The Cultural Formulation Interview (CFI) was included in the Diagnostic and Statistical Manual of Mental Disorders, fifth edition, (DSM-5) to guide clinicians on how to conduct a cultural assessment in routine...
mental health settings.\(^2\) The CFI operationalizes the Outline for Cultural Formulation (OCF), a conceptual framework introduced in \textit{DSM-IV} describing the content of a cultural evaluation.\(^5\) As a semi-structured instrument, the CFI includes instructions and open-ended questions for clinicians, a pragmatic definition of culture, and clear guidelines for its implementation.\(^1\)\(^6\) Use of the CFI is recommended during the initial evaluation of any patient, in all mental health settings, by any provider.

The basis for this recommendation derives from a substantial and growing literature that describes how culture shapes every aspect of psychiatric care, influencing patients’ experience of illness and distress, the patterning of symptoms, and the models clinicians use to interpret symptoms through psychiatric diagnoses.\(^3\) Culture also shapes patients’ perceptions of care, including what types of treatment are acceptable and for how long. Even when patients and clinicians share similar ethnic or linguistic backgrounds, culture affects care through other influences on identity, such as those due to gender, age, class, race, occupation, sexual orientation, and religion/spirituality.

**A DEFINITION OF CULTURE**

A multifactorial definition of culture that includes all these elements is a cornerstone of the development and implementation of the CFI.\(^7\) For the CFI, culture is not merely a set of group characteristics that are relevant for mental health care only when patients are considered “other” — different in critical ways from the clinician or from a dominant social group—such as due to their minority background, whether racial/ethnic, sexual, religious, linguistic, or otherwise.\(^5\) Instead, culture patterns the very process of meaning-making that every person engages in, as noted in the \textit{DSM-5} definition of culture:

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.\(^1\)

Such meanings can be inherited and acquired, derived through symbolic systems such as language and creed, inherent to patterns of social organization such as families and legal systems, and ever-changing as our priorities and identities shift according to our development along the lifespan. A fundamental tenet of this definition is that culture exists in the ties that bind people to social groups. Instead of reducing cultural identity to a single demographic trait such as language, race, or ethnicity without considering their affect on patients,\(^8\)\(^9\) the CFI encourages clinicians to inquire about the various sources of meaning that affect how all stakeholders in health care make sense of illnesses and decisions about care. Because cultural contexts and expectations frame the clinical encounter for every patient, not just those from underserved minority groups, cultural formulation is essential for any comprehensive mental health assessment.

**COMPONENTS OF THE CFI**

The expression “CFI” is used loosely to refer to three components for conducting cultural assessments. A basic assessment is obtained using the Core CFI, composed of 16 questions that cover four domains (Table 1): (1) cultural definition of the problem; (2) cultural perceptions of cause, context, and support (including cultural identity); (3) cultural factors that affect self-coping and past help seeking; and (4) cultural factors that affect current help seeking. These domains emerged from extensive cross-national experience with previous interviews that implemented the \textit{DSM-IV} OCF.\(^3\)

Two additional CFI components allow the interviewer to tailor the assessment to the needs of the patient and the service setting. An Informant Version of the CFI yields collateral information from companions and caregivers, and 12 Supplementary Modules help the provider explore specific subtopics. These include eight modules with additional questions on the domains of the Core CFI (eg, cultural identity) and four modules for specific subpopulations (eg, school-age children and adolescents, immigrants, and refugees). The American Psychiatric Association has made these interviews available for free on its website in recognition of the growing interest in cultural formulations.\(^10\)

Use of the CFI is designed as a tele-scoping process. For many patients, the information provided by the Core CFI may be sufficient; if used to frame a mental health evaluation, the Core CFI can establish a foundation for person-centered care by eliciting the patient’s context and perspective on which to build the rest of the evaluation and treatment negotiation process through a strong working alliance. If additional cultural information is needed, the other two CFI components can be used.\(^7\) \textit{DSM-5} notes situations when a comprehensive cultural assessment may be useful, including when there is difficulty making a diagnosis due to cultural misunderstandings or to the lack of fit between the patient’s presentation and diagnostic criteria; uncertainty in calibrating illness severity or impairment; disagreements over the course of care; and limited patient engagement and adherence.\(^7\) Consequently, the CFI may be
helpful at any point in care, not only during the initial assessment.

DEVELOPMENT OF THE CFI

The CFI underwent a rigorous process of development. This process was led by the DSM-5 Cross-Cultural Issues Subgroup and involved literature reviews, consultation with developers of OCF-based interviews, iterative CFI drafts, and expert consensus meetings. It culminated in an international field trial conducted in 11 sites and 6 countries between November 2011 and October 2012 with 318 patients older than age 15 years, 75 clinicians, and 86 family members of patients. Exclusion criteria were minimized to broadly test the implementation of the CFI in a wide range of patients and illnesses; patients were excluded if they were acutely suicidal, intoxicated or in substance withdrawal, or had a condition that interfered with their capacity to consent, such as dementia, intellectual disability, or florid psychosis.

Quantitative and qualitative assessment of patients, providers, and family members found the CFI to be feasible, acceptable, and clinically useful. Nevertheless, qualitative analyses of the New York site data and then of the full trial revealed limitations with this field trial version. Internal barriers to implementing the CFI were reported by patients and clinicians, pertaining to the content or format of the instrument itself, such as lack of differentiation of the CFI from routine clinical assessments or concerns about question clarity and ordering. Clinicians added external barriers, citing systemic concerns such as the time required for the interview. Most of the internal limitations were addressed in the revised version of the CFI published in DSM-5. Based on the field trial results, the revision clarified confusing wording, improved the flow of questions, and distinguished the intent of the CFI from other aspects of clinical management. Some external barriers, such as time of administration, were partly addressed by field trial findings showing that integration of the CFI in a diagnostic intake became significantly more efficient with practice; after a few administrations, the CFI questions took a mean of 22 minutes out of a 50-minute interview.

IMPLEMENTING THE CFI

DSM-5 CFI Guidelines recommend using the CFI for the cultural assessment of any patient. The CFI may be most useful when it begins the intake, because this allows the provider to initiate the therapeutic relationship by eliciting the patient’s views and expectations of illness and care, and modeling a participatory approach for the rest of the treatment. Supplementing the Core CFI with the Informant Version during the initial evaluation also helps involve the family or other caregivers in the process of care, insofar as clinicians have not violated medical confidentiality.

If used during an intake, the DSM-5 Guidelines recommend that demographic information first be obtained to tailor CFI questions to the person’s life circumstances and contextualize the patient’s responses. Separating the demographic data-gathering from the CFI focuses the flow of the interview on the person’s experience rather than a set of standardized descriptive categories. It’s important to remember that the CFI is not a checklist for which very brief answers may be sufficient, but rather a guide to a semi-structured interview that explores a person’s perspective. Questions may be rephrased or followed up with probes to elicit the goal of each CFI item, which is described in the left-hand column of the instrument.

Current usage is for the CFI to be administered completely in sequence, followed directly by the rest of a standard psychiatric interview. However, DSM-5 Guidelines allow for single questions or a subset to be inserted as needed in a clinical assessment. Alternatively, the CFI may be administered as a free-standing interview. Empirical data are needed to test the method of implementation with outcomes such as patient satisfaction or clinician fidelity to the CFI, which will likely depend on the overall clinical goal, staff availability, and the facility’s procedures.

Information obtained from the CFI should be integrated with other clinical material to achieve the aims of the clinical assessment, including culturally valid diagnosis, social history, treatment planning, and patient engagement and satisfaction. Using the information gathered from the CFI in treatment planning typically involves a process of negotiation between providers, patients, and sometimes relatives or other caregivers. Because the express purpose of the CFI is to impact...
care, translating the information into ongoing clinical activity is crucial. Providers should use the information gathered from the CFI to tailor clinical suggestions and to engage patients and caregivers in a conversation about the risks and benefits of the proposed treatment as well as its outcomes. A main goal of the CFI is to help clarify the views of the patient and his or her social network to enable this participatory process.

Several clinical agencies and programs are incorporating the CFI into their electronic health records in text fields for notes and as an overall formulation field. These formats facilitate incorporating the information elicited by the CFI directly into the mainstream of care, including sharing it with the rest of the clinical team.

BARRIERS

Despite the positive research described above and the growing use of the CFI in clinical care, some barriers to its implementation exist. Many are inherent to any new intervention or clinical instrument; others may be specific to the CFI. Finding ways to overcome these barriers is imperative for the uptake and sustainability of the CFI.

Need for Training

Novel approaches to care require additional provider training. For the CFI, training in what is meant by culture within the instrument is essential. A qualitative implementation study from Mexico revealed the potential limitations when the CFI was conducted without training beyond the written CFI Guidelines in DSM-5. The Guidelines alone were insufficient for instruction on questions about patients’ “background or identity” (questions 8-11; Table 1) for clinicians without previous social science experience. By contrast, the DSM-5 field trial registered positive findings after only a 2-hour training program for clinicians involving passive and active modalities.

Training is especially needed to clarify that implementing the CFI involves discovering the sources of meaning-making that matter to the patient and his or her community for the current episode of illness. These meaning processes are often seen by patients as taken-for-granted commonsense (“just the way things are”) or derive from unexamined influences related to their background and position in society not usually seen as cultural, such as education, class, or occupation, even though these strongly influence meaning-making.

Training, and potentially ongoing supervision, may also be necessary to prevent use of the CFI as a superficial checklist that does not fundamentally alter how patients and clinicians interact or how care is negotiated. Instead, the goal of the CFI is to advance a radical agenda—to change the way clinicians conduct a diagnostic interview so that the perspective of the patient becomes at least as important as the signs and symptoms of disease identified by the clinician; the mission of the CFI is, in effect, to expand what counts as data in a clinical encounter.

Attaining this goal requires fostering a dialogue in which a patient explores his or her ways of interpreting illness and care. This justifies the use of the CFI in its entirety, rather than as isolated questions in an otherwise unchanged evaluation; the CFI aims to create a flow of interaction and open-ended inquiry that promotes patient reflection and clinician responsiveness. Ensuring that the CFI is administered with fidelity is also a key aspect of training and supervision, a task facilitated by use of the CFI-Fidelity Instrument.

Finally, establishing the best training methodologies for the CFI is an active area of research. Key topics include evaluating the cost-benefit ratio of diverse training modalities, the resulting fidelity of CFI administration, and whether ongoing supervision is required to sustain fidelity over time. Currently, a 1-hour online English-language module is available worldwide for initial training on the CFI, which incorporates videos (passive) and action planner (active) training modalities (for information, email CECCinfo@nyculturalcompetence.org).

Limited Evidence Base on CFI

Efficacy

Although a growing research base shows that patients, clinicians, and family members perceive the CFI as useful for rapport and trust-building, eliciting information, enhancing clinicians’ understanding of illness, fostering patient’s self-realizations and validating their experience, and guiding treatment planning, no comparative efficacy research has yet examined the specific contribution of CFI-augmented care against usual mental health services. Research on cultural formulation approaches that operationalized the OCF prior to the CFI showed enhanced diagnostic validity compared to standard diagnostic procedures, suggesting this may also be the case for the CFI. Research in this area is ongoing.

Implementation May Require Planning

As with any new procedure, CFI uptake in clinical settings will depend on how flexibly it can be implemented. Data on this topic are scarce, although...
growing. To date, implementation strategies have been outlined to guide CFI uptake in various clinical settings.\textsuperscript{20,25,26} These emphasize the need for an implementation plan, ongoing communication among stakeholders, and tailoring implementation specifics to each setting. Programs or units that deliver clinical care in teams are in greater need of planning than solo practitioners, involving attention to buy-in, CFI scheduling within standard procedures, sharing CFI information, billing, integration with regulations, and quality assurance, among other topics.\textsuperscript{20,25}

Stakeholders may vary in their concerns, affecting implementation of: qualitative research and reactions from examined patients, clinicians, and administrators to the planned introduction into clinical services of evidence-based, culturally competent communication strategies at the heart of the CFI.\textsuperscript{27} The stakeholder groups differed with respect to strategies they found problematic, based on their distinct roles in the treatment process. Although patients uniformly favored discussing their treatment preferences, administrators uniformly disagreed, and clinicians had mixed opinions.\textsuperscript{27} Successful implementation of the CFI involves navigating these diverse concerns. Institutional support will prove crucial to successful implementation.\textsuperscript{20,25}

**CFI Utility May Vary by Patient Characteristics**

The CFI may be less acceptable and useful among patients with severe mental illness, particularly psychosis,\textsuperscript{15} although the evidence is mixed. A qualitative study with 14 Veterans Administration patients with psychotic disorders found the CFI to be useful in this population for rapport, validation, engagement, and the development of a positive, person-centered health narrative.\textsuperscript{15} No study examined severity of psychosis as a barrier to CFI implementation, marking one future direction for research. Providers should decide whether to use the CFI on a case-by-case basis rather than by diagnosis. Language fluency will also affect the quality of CFI information; research on its use with interpreters is now being conducted.

**CONCLUSION**

The DSM-5 revision process addressed the need for a standardized cultural assessment tool by developing the CFI, a systematic semi-structured interview that can be applied flexibly to diverse clinical situations and patient encounters. An international field trial found the core version of the CFI to be feasible, acceptable, and clinically useful, and a growing evidence base has led to its gradual inclusion in mental health services. Several barriers still exist to its widespread implementation, but they are being addressed by investigators and clinicians. The cultural formulation approach stemming from DSM-IV, of which the DSM-5 CFI is the latest iteration, constitutes the cultural competence paradigm with the largest evidence base in mental health service delivery.

**REFERENCES**


