THE USE OF THE CULTURAL FORMULATION INTERVIEW AT HELEN JOSEPH HOSPITAL PSYCHIATRIC UNIT

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Plagiarism Declaration

I, _Mpho Tsikoane____________, declare that this research report is my own work. It is being submitted in partial fulfilment of the requirements for the degree of Master of Medicine in the branch of Psychiatry. It has not been submitted before for any degree or examination at this or any other University

MB TSIKOANE

November 2019

Dedication

This work is dedicated to my parents, siblings and fiancé for your unwavering support and love.

Acknowledgements

I would like to acknowledge the Helen Joseph Hospital Department of Psychiatry for the opportunity to conduct my research, as well as Professor Janse Van Rensburg for his teaching, support and guidance.

Presentations

1. WITS Department of Psychiatry Annual Research Day, 20 June 2018

Abstract

Introduction: The Cultural Formulation Interview (CFI) is an updated version of the Outline of Cultural Formulation that has been included in the DSM-5. The CFI has been identified as a cross-cultural assessment too and allows for a more structured collection of data enabling the clinician to make a more comprehensive assessment.

Purpose and study objectives: The aim of this study therefore was to describe the self-reported experience of culture in the expression of psychiatric illness and the role of cultural factors in the presentation of psychiatric problems, by administering the CFI in a group of patients in a local psychiatric unit.

Methodology: The study is a qualitative research that uses qualitative methods to describe the answers to the 16 questions that comprise the CFI as given by psychiatric patients. Interviews were conducted until data saturation had been achieved, which resulted in 22 interviews being conducted.

Results: A brief descriptive analysis of the demographic variables of participants was done, followed by a content analysis of their documented responses to the different CFI questions. The most common themes identified in the process were: “culture”, “religion”, “stigma”, “insight” and “integration of treatment modalities”. The field notes of the investigator were also summarised, concluding that conducting the interview was difficult at times especially, due to barriers resulting from language and educational difficulties. CFI content themes were also compared with current literature.

Conclusion: In this limited, local investigation, not all of the CFI questions in its current format offered any additional information that was not already a component of the current Colleges of Medicine of South Africa’s College of Psychiatrists’ long case presentation format. It does not seem to be necessary to conduct the CFI as a separate component of assessment, but some aspects of the CFI questions can be incorporated in the current long case format to offer some elaborated insight into local patients’ cultural explanation of illness. Some questions were repetitive and could therefore be clustered together as a single question. It has also been of note that patients felt misunderstood by their health-care providers if cultural considerations were not included and that they would prefer an approach which integrates western and local (African) cultural treatment modalities.

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Abbreviations

DSM-5: Diagnostic Statistical Manual of Mental Disorders 5th Edition

OCF: Outline of Cultural Formulation

CFI: Cultural Formulation Interview

DSM-IVTR: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision

SASOP: South African Society of Psychiatrists

CMSA: Colleges of Medicine of South Africa

CPLCF: College of Psychiatrists' Long Case Format

WHO: World Health Organisation

HREC: Human Research Ethics Committee

OPD: Outpatient Department

NCD: Neurocognitive Disorder

CHAPTER 1. INTRODUCTION

1.1 The role of culture in psychiatry

Psychiatry is a discipline that is multi-faceted and allows for the patient to be treated holistically and thus requires a biopsychosocial approach from the clinician and treating team.[1] In order to do so, aspects of the patient's identity, practices and norms to which the patient is affiliated, need to be understood by the clinician.

Of vital importance in diverse demographic groupings is culture. Culture influences patient care, especially in those patients who identify culture as having a role in their presentation, and it is important that treating clinicians have tools they can use to formulate psychiatric diagnosis.[2] Culture affects the encounter between the clinician and patient as well as the relationship that develops from this. It is therefore vital to consider cultural formulation as an integral component of every routine clinical psychiatric assessment.[2] According to the Cultural Issues Subgroup, quoted in the American Psychiatric Association's Diagnostic Statistical Manual of Mental Disorders 5th Edition (DSM-5), culture is a dynamic system of knowledge, concepts and practices that are learned and carried over generations, which comprises language, religion, spirituality, family structure, life cycle stages, rituals, customs, moral and legal systems within that specific community.[3]

From the literature, it has also become apparent that psychiatric patients yearn for more than a diagnosis, they have a need to for an appreciation of their symptoms from a psychiatric and social perspective.[2] Culture has an impact on views and experiences during a persons' life, which then has an influence on the patient's behaviour and the presentation of problems and symptoms.[4] People of different cultures may exhibit similar behaviours, but express them differently according to culturally-specific norms

and contexts.[4] Bhugra and Bhui hold that Western-specific misdiagnoses of psychopathology may occur due to limited cultural awareness.[4] This is evident when considering the body of knowledge describing the way in which psychological distress manifests.[3] Trujilo noted that although there has been emphasis on the biopsychosocial model of psychopathology in recent years, this approach should in fact be extended to become more comprehensive and therefore a bio-psycho-socio-cultural approach is proposed.[5]

As according to its definition, culture shapes every aspect of patients' lives and their care in psychiatry. It influences when, where, how and to whom they will narrate their experiences of illness and distress.[3] Culture also shapes the manifestation of symptoms and the models used by clinicians to interpret presenting symptoms in terms of psychiatric diagnoses. Lewis-Fernandez et al., therefore concurred that culture affects the clinical encounter for every patient and that a cultural formulation is an essential component of any comprehensive psychiatric assessment.[6]

According to Wohl, therapists who work with patients from various cultures must aim to attain as much knowledge as possible about a patient's culture in order to gain adequate insight into the patient's cultural influences and clinical presentation.[7] According to Tseng, the time is right for clinicians to focus more on culturally-appropriate care.[8] Kirmayer and colleagues demonstrated common cultural misunderstandings in practice, such as incomplete assessments, missing or incorrect diagnoses, poor rapport, non-adherence, and inappropriate treatment.[9] Lewis-Fernandez et al., also noted that psychiatric disorders across cultures show strong differences and similarities.[6] Some cultural groups may describe

psychopathology in more psychological and somatic terms, or they may connect symptoms together that other cultures would not necessarily acknowledge as related.

Bhattacharya et al., stated that culture can influence mental illness by defining the normal from the abnormal, by implicating etiological factors, influencing the clinical presentation and by determining help-seeking behaviour by the patient.[10] Cultural mechanisms can provide social support and socially acceptable outlets, which combine to give a meaningful and consistent world view.[10] They also highlighted the importance of how the doctor-patient relationship is affected by the training, experience, social class and ethnicity of the doctor, and by the experiences, educational and social background and ethnicity of the patient, as well as by shared and non-shared aspects of economic and political inclinations.[10] In many ways gender, socioeconomic or educational status, lifestyle, job or professional role may even overshadow the ethnic identity of the patient as communication barriers.[10] If cultural barriers are therefore over-emphasised, the service provider may be guilty of stereotyping the patient, whereas if ethnic considerations are under-emphasised, the doctor may be guilty of insensitivity to influences that may affect the dynamics of the interview.[10]

Lewis-Fernandez et al., further state that assessment interviews should be used as a starting point for understanding a patient’s distress and for developing collaboration between clinician and patient. It is, however, not uncommon for a diagnosis to be seen as the final stage in the consultation process. Language difficulties, compounded by the uncertainty of the idioms of distress, coupled with time restrictions and a quick application of the biomedical models to which the clinician is accustomed, may lead to inappropriate conclusions.[6] Some patients may therefore require a longer assessment before a comprehensive management plan can be formulated that represents the

optimal intervention for that individual. If the patient does not share the clinician's culture, any symptoms and signs must be assessed in a cultural context and revised in response to further information.[4] Culturally responsive services effectively address health care differences and increase the clinician's knowledge of cultural diversity. Introducing culturally conscious care increases the utility of services and reduces non-adherence.[11] Failing to account for cultural factors in mental illness can lead to mis-diagnosis and poor treatment adherence or treatment failure.[12] A cultural assessment should be a priority for assessment, diagnosis and management but yet the inclusion of culture in the education of health care practitioners faces ongoing institutional and operational barriers.[13]

1.2 Development of the cultural formulation interview

To recognise the importance of a cultural understanding of the patient, a semi-structured interview – the Cultural Formulation Interview (CFI), has been included as part of the DSM-5 recommendations.[10] The CFI allows for a more structured collection of data enabling the clinician to make a more comprehensive assessment.[3] The CFI has been identified as a cross-cultural assessment tool and was introduced as part of the proposed process of clinical assessment by the DSM-5, to revise shortcomings of the DSM-4 Outline of Cultural Formulation (OCF).[10]

Aggarwal et al., noted that although the OCF provided a framework for clinicians to organise a cultural formulation relevant to diagnostic assessment and treatment planning, it's use has been inconsistent, which prompted the need for guidance on implementation and application.[14] Cultural interviews differ from standard interviews in that clinicians ask patients questions about their understanding of the cause, onset, mechanisms of action, level of severity and about treatment preferences of illnesses,

known as the patient's explanatory model.[15] Kleinman et al., observed that clinicians who understand patients' explanatory models may be able to collaborate with the patient and negotiate treatment regimens that will improve patient satisfaction and treatment adherence.[15]

Even though the OCF provided a format to conduct cultural interviews, clinicians have questioned the reliability of reproducing data without a standardised design and the lack of clinician instructions has raised questions about the settings in which it should be conducted.[16] The CFI was consequently created based on literature reviews conducted in 2010 and 2011 by an international consortium of culture and mental health experts.[3] The group created a standard, manualized CFI with instructions for clinicians to implement it in its entirety at the beginning of any diagnostic evaluation. This version of the CFI has been used in a DSM-5 field trial to test feasibility, acceptability and clinical utility among patients and clinicians.[3] The DSM-5 Cultural Issues Subgroup identified five main situations when assessment of cultural factors may be relevant for patient care:[6]

- difficulties in diagnostic assessment based on the clinician's unfamiliarity with the patient's culture;
- uncertainty about how diagnostic criteria fit with the patient's symptoms;
- difficulties in judging illness severity or impairment;
- disagreements between the patient and clinician about the course of care;
- limited treatment adherence and engagement from the patient.

With the development of the CFI, the DSM-5 has expanded the considerations of culture and context that was introduced earlier by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IVTR).[3] The Cultural Issues

Subgroup supports the CFI as a tool for facilitating cultural aspects of assessment and treatment planning in clinical practice.[3] By providing a clear and concise approach to cultural assessment and treatment planning, the CFI will allow clinicians to address some basic questions in psychiatry.[6] Research by Aggarwal and colleagues concluded that the CFI improves medical communication between patients and clinicians, mostly improving rapport and eliciting patient narration and understanding of their presenting complaint. The CFI shows acceptability and clinical utility in health settings.[14]

1.3 Cultural competence

The emphasis on the importance of culture has also introduced "cultural competence" as a required attribute which mental health care practitioners have to develop.[19] Cultural competence refers to the ability of mental health professionals and services to provide person-centred care to patients by taking into account the multiple and individualised cultural identities of each person receiving services.[20] The CFI was implemented among clinicians in the United States who were serving ethnically diverse patients to assess their cultural assessment and competence, other studies were conducted in India and Italy which found that there was a need for a culturally specific tool to help patients explain and explore their explanatory model of disease.[17] These studies further identified the need for cultural competence to be developed by mental health professionals especially in ethnically diverse and developing communities.[17]

Jadhav et al., aimed to demonstrate the clinical efficacy of cultural formulations for 30 randomly selected individual patients in a secure psychiatric setting, and found that culture is a crucial metaphor and way to engage with patients when they are acutely unwell, and that cultural formulations operationalise patients' concepts of culture and

not physician’s assumption of culture.[20] Cultural interventions were effective, practical and rewarding to both clinicians and patients.[21]

Cultural competence training should be included in curricula of psychiatry registrars and medical officers; however, a major limitation is the availability of time. A pilot study conducted found that a one hour didactic session about the CFI improved self-reported cultural competence of psychiatry residents and that there was no association between previous cultural exposure and the degree of improvement.[22] A study on cultural competence training for nurses, showed that a one hour cultural competency course for nurses improved cultural awareness.[23] A study conducted whereby psychiatry trainees underwent a twelve week course based on the CFI found that the trainees appreciated the individual approach the CFI created and prevented the stereotyping of patients.[24] Certain themes identified from their participation, include: (1) trainees discussing their own acculturation within the cultures of medicine and psychiatry; (2) cross cultural miscommunication occurs despite using hospital cultural and linguistic brokers; and (3) the relevance of cultural competence to formulating and implementing care for actual patients.”[24] The least participation related to the trainees ability to reflect on their racial, ethnic, linguistic or socio-economic background related to individual patients.[24]

Russel et al. noted that it is important to address the framework by looking at race, migration, acculturation, language, socio-economic status, political orientation, geographic location, as well as other aspects of identity.[21] Clinicians must be aware of and understand their own personal cultural identity and how it may impact them in the professional setting, as well as any biases and limitations of knowledge and skills that might affect the clinical encounter.[19]

1.4 The cultural formulation interview in practice

Russel et al., also noted that it is important to compare the cultural identity of the patient to that of the clinician, and stated that when planning treatment the following should be considered:[21] socio-cultural approaches which involve utilising cultural strengths where possible, such as family and spiritual/religious beliefs and practices; work with other systems of care such as faith organizations and leaders; becoming familiar with culturally related therapies; and involving the patient in treatment planning.[21]

Bhattacharya et al. noted that the clinician must identify whether a specific cluster of symptoms, signs and behavioural changes that are demonstrated by the patient is also interpreted consistently by the patients and their relatives, and how their personalized diagnostic models fit in with the psychiatric models.[10]

Russel and Lim stated that taking the time to examine interactions between the cultural identities of the clinician and that of the patient is essential when conducting the clinical interview.[24] They noted that it is important for clinicians: to look at their own cultural background; to think about the cultural identity of the patient compared to their own and move toward an approach of understanding the patient's identity; to maintain an ongoing assessment of the cultural elements within the relationship; to consider whether you have any specific knowledge of the patient's culture or ethnic group; and to consider the patient's motivation for seeking treatment from them.[25] The type of treatment recommended for the patient should be congruent with the patient's cultural experience and expectations. They noted that a large number of patients are non-adherent, and this can often be due to a non-biological explanation of symptoms, mistrust of medical institutions, fear of side effects and resistance to addressing any

disagreement with the treatment plan.[25] Routine use of the CFI can help clinicians identify the individualised needs and preferences by providing a better understanding of the patient within the context of his culture.[11] The CFI facilitated being more cognizant of the participant's background and subjective experiences which in turn provided for trust to be built. Data elicited through the CFI can also help to establish culturally relevant goals and subsequent effects on the participants social circle.[11]

The CFI addresses the patient's cultural perceptions but does not address the dynamics in the interaction between the clinician and the patient as clinical encounters are shaped by the cultures of both.[26] The illness distinction may simplify the clinical interaction and does not reflect the influences of personal and social experiences of the both the clinician and patient as well as the cultural diversity of the clinicians.[13] The clinical encounter is filled with tension that stems from social differences between clinicians who are experts biological aspects of mental illness and patients who are experts of their own lived experiences.[27] Attending to clinicians' and patients' cultural backgrounds and influence on the clinical encounters assists the inclusion of culture in mental health treatment.[27]

Stege and Yarris noted that specific questions of the CFI did not elicit anticipated responses but still suggest that the CFI can improve clinical encounters and confidence.[17] This is in keeping with research that states, *"patients' trust in clinicians, easy communication, and genuine concern for the patient are associated with patient satisfaction, duration of patient-provider relationships, and treatment adherence."* [28]

A study conducted by Aggarwal et al., on the barriers to implementing the CFI as perceived by patients and clinicians noted some important factors: the most frequent

patient-related factors were; "*lack of differentiation from other treatments, lack of buy-in, ambiguity of design, over-standardization of the CFI, and severity of illness.*"[28] Clinician-related factors were; "*lack of conceptual relevance between intervention and problem, drift from the format, repetition, severity of patient illness and lack of clinician buy-in.*"[28?] Future implementation of the CFI must address potential barriers to clinician buy-in such as the time required to conduct the interview, approximately 30-60 minutes was required when utilized as a stand-alone interview. Aggarwal et al., also noted that the time required for the interview was a barrier when used as part of a standard evaluation, the CFI required 15 minutes to complete excluding the use of supplementary modules.[28?] This can be addressed by working with health system administrators improve acceptance and to incorporate the CFI into the training of resident education and as part of routine clinical practice.[17]

Stege and Yarris found that the CFI was well received by clinicians and patients alike, it was evaluated to build trust and improving the clinicians' understanding of cultural factors impacting on mental illness.[17] In a study conducted by Vasuedo et al., showed that most patients valued the CFI and indicated that it helped explain their concerns and relevant background, they also did not object to the additional time required.[29] They further found that several clinicians were uneasy about the clinical value of the CFI, conducting such an interview at a first meeting before rapport is established and the additional time it would require. Clinicians made no distinction in the value of the CFI for patients with serious and common mental disorders.[29]

Aggarwal et al., found that clinicians had concerns about the use of the CFI in psychotic patients reporting that the presence of formal thought disorder was a threat to the cognitive ability required to give a coherent narrative.[28] Future revisions of the

CFI should include the influence of the clinicians' cultural orientation and personal experiences, even though there is a section that addresses the patient-provider relationship it relates more to miscommunication or lack of communication between the provider and patient, it does not address how the provider culture influences the therapeutic encounter.[17]

1.5 Culture in a South African context

To emphasize the importance of culture in clinical practice, the South African Society of Psychiatrists (SASOP) has e.g. also stated in their position statement on Culture, Mental Health and Psychiatry, that *"culture, religion and spirituality should be considered in the current training of young psychiatrist in order to better equip them for dealing with patients. This should be performed within the professional and ethical scope of the profession, and all faith traditions and belief systems in the South African society should be respected and regarded on an equal platform. Within the public sector domain, no preference for one particular tradition should be given over another regardless of the practitioner's own belief system. Building relationships of mutual trust and understanding will require training aimed at psychiatric practitioners, their patients, medical students as well as cultural and religious practitioners whom patients and their families may choose to consult at any given time. All forms of abuse and neglect should be identified and prevented, including the protection of patients within traditional and other religious healing systems."*[30]

Along with indigenous trends in other areas of the world and with the suggestions of the World Health Organisation (WHO), there is a lot of local interest in the integration of biomedicine with traditional healing, this interest indicates an important need for collaboration in psychiatry.[31] Swartz stated that a mutual network of referral between

western doctors and healers is alluded to by a number of authors.[31] A difficult question about collaboration is that of who holds the ultimate power, who fills the role of the ultimate decision maker.[31] Traditional practitioners including herbalists, faith healers and diviners provide an alternative culturally based system of healing.[32] The role played by traditional practitioners in providing mental health services within the South African context is notable as a substantial proportion of people seen by these healers suffer from mental health problems.[32] The provision of services by traditional practitioners may have a positive impact on community mental health, the traditional practitioner provides psychosocial support in areas that require attention in a person's life.[32] Saraceno suggests that in low to middle income countries, non-professionals which includes traditional practitioners offer a potentially important human resource for the provision of mental health care.[33] Traditional practitioners offer a culturally appropriate care linked to indigenous explanatory models of illness held by many South Africans. These may include spiritual understandings of cause, conflict with ancestors, failing to perform rituals and bewitchment.[32]

The Colleges of Medicine of South Africa's (CMSA) College of Psychiatrists' long case format (CPLCF) has been adjusted to include a cultural formulation that seeks to incorporate cultural perspectives or content that may contribute to the patient's presentation.[34] Locally in South Africa, this marks the importance of the role of culture and the effect it may have on the explanatory model, assessment and management of the patient.

From these perspectives, it therefore seems to be essential to provide comprehensive and culturally competent care and it can be deducted that culture clearly has a vital role in the assessment and management of patients. It further demonstrates the lack of

information on the local experience with the incorporation of the CFI in local South African clinical practice.

1.6 Study aim and objectives

The aim of this study therefore was to describe the self-reported experience of culture in the expression of psychiatric illness and the role of cultural factors in the presentation of psychiatric problems, by administering the CFI in a group of patients in a local psychiatric unit.

The objectives of this study were to:

- conduct the 16-questions of the CFI in a local clinical setting;
- describe and analyse the response of participants to the 16 CFI questions; and
- describe the experience of the interviewer conducting the CFI.

CHAPTER 2. METHODS

As the 16 questions of the CFI all require qualitative responses from participants (Addendum 1), this study was a prospective qualitative investigation of conducting the CFI during structured interviews with a group of mental health care users in a local Psychiatric unit.

2.1 Qualitative inquiry

Denzin and Lincoln have defined qualitative research as an activity that locates the observer in the world, consisting of interpretation of surroundings and practices that make the world visible and transform it into a series of representations by including field notes, interviews, conversations, documents, photographs and recordings.[35]

According to Denzin and Lincoln this involves:

(1) placing the researcher in an experienced real-life position; the researcher in this study was a female African medical practitioner specialising in Psychiatry. She belongs to the Basotho cultural group and is trilingual with Sesotho being her first language.

(2) interpreting theoretical paradigms and perspectives;

(3) selecting strategies of inquiry (e.g. ethnography, phenomenology, grounded theory);

(4) applying methods of data collection such as interviewing, observing, or focus groups; and

(5) the practices of the interpretation and presentation of the findings.[35]

2.2 Theoretical framework

For the purpose of this study a constructivist position will be adopted, which considers the varied, multiple subjective meanings of individuals' or groups' experiences, as

constructed from the discussion and interaction with participants. In addition, a phenomenological approach will be adopted, considering the lived experiences of participants regarding the cultural aspects (as the phenomena) described.

2.3 Trustworthiness

The different trustworthiness strategies, according to Guba, that were adopted in this study are dependability and confimability.[36] Dependability refers to an audit or tracking of the research decisions. Confirmability, instead of objectivity, ensures the findings from the data are logical.[36]

2.4 Study sample

A purposive sample of patients was included in this investigation from the Helen Joseph Hospital Psychiatric Unit, attending the out-patient clinic or being admitted as inpatients. Selection criteria included:

(1) being able to provide informed consent (voluntary users according to the Mental Health Care Act); [38]

(2) understanding and communicating in English; and

(3) being older than 18 years of age.

Some representation in terms of cultural/religious affiliation was attempted, considering the following main categories: African Traditional Religion, Christian and Muslim as per national census.[39]

2.5 Data collection

Data sources included: (1) transcribed responses of participants to CFI interview questions (Addendum 1), which were conducted simultaneously with the routine the College of Psychiatrists' long case format (CPLCF), (Addendum 2); (2) participants' clinical records; and (3) field notes by the investigator on the logistics and experience of conducting the CFI interviews (Addendum 3). Participants who gave consent for audio recording had their responses to the specific questions of the CFI recorded and subsequently transcribed, the rest of the participants who did not agree to audio recording had their responses noted by the researcher as the interview progressed. Field notes were compiled during the conducting of the CFI on the circumstance and environment in which the interview took place, on the level of patient engagement, as well as on time and communication aspects such as language use and level of education (Addendum 3).

2.6 Data saturation and analysis

A brief description of the respective participants was done, followed by a content analysis of their documented responses to the different CFI questions. Interviews were conducted until data saturation was achieved - which was achieved after conducting 22 interviews. Data from the interview content was analysed by using thematic content analysis through the coding of the data. Responses to each question was analysed and categorised into themes and subthemes.[35] Provisional themes were identified from recurring words, ideas and concepts from the data. Possible relationships between these themes (concepts) were identified, through which final categories of themes and subthemes will be synthesised.[35] Key quotations from the interviews were included in

this synthesis to provide the necessary evidence of how the identified concepts were derived from the interview content.[35]

2.7 **Ethics**

Ethics clearance was obtained from the WITS Human Research Ethics Committee – Medical (HREC), reference number M160517, prior to initiating the study and approval to conduct the study will be obtained from the CEO of Helen Joseph Hospital (Addendum 4). An information sheet explaining the study was made available to and discussed with every prospective participant (Addendum 5). Written informed consent was obtained from each participant to participate in the CFI as well as to audio-record the participants' responses to the questions.

CHAPTER 3. RESULTS

All of the 22 participants gave informed consent to take part in the study. While only two participants provided informed consent to be audio recorded, the interviews were documented by the investigator. Data saturation was reached at this stage, as most participants started to respond in a similar or same manner to majority of the questions. The black participants who made specific reference to a cultural explanation for their medical problem varied across cultural affiliations. No specific culture was therefore identified as having predominance.

Themes and subthemes were identified from the content in the responses of each question and presented in tables with the specific question content added in bold text. Themes were motivated by citing relevant quotations from the interview content (in italic text), providing a chain of evidence. To establish this chain of evidence, the reference system used, indicates the source of the content as “P_Q_”, where P refers to the “Participant” and Q to the “CFI Question”. Repetition of themes were indicated by an asterix (*).

3.1 **Description of participants**

In terms of sex, 18 males and four females participated in the study, while 18 were Black, two Coloured and two Indian. From these noted their c*ultural affiliation to be* Zulu (8), Sesotho (3), Xhosa (5), Ndebele (1), Igbo (Nigerian) (1) and Tamil Indian (2). Fifteen participants indicated that their religious affiliation was Christian, two Hindu, one Muslin and four “other”. The initial purposive sampling strategy was not realised as initially intended as the resultant sample was heterogenous. Of the participants, seven were having a primary school education, eight had secondary education less than grade 12, while seven had a matric (Grade 12) qualification.

Eighteen of the participants were voluntary mental health care users, while four were admitted for 72-hour assessment. Ten of the participants were treated for a psychotic disorder, eight for a mood disorder, three for an associated medical condition, while in one patient no diagnosis was made yet at the time of the interview.

3.2 Field notes on conducting the interviews

The field notes on the interviewer's experience with conducting the CFI in a local clinical setting, were compiled in terms of the following aspects: environmental factors; time factors; fluency in English; and level of patient engagement (Table 1).

Table 1. Summary of field notes components

Influencing factor			**Number**
Environmental factors	Interview venue	Emergency Department	6
		Psychiatry ward	6
		Medical ward	2
		Outpatient department (OPD)	8
Time factors	Duration of total interview	<30 min	16
		30-60 min	6
		>60 min	0
Fluency in English		Good	8
		Fair	10
		Poor	4
Level of engagement		Very good	10
		Good	7
		Poor; concrete; Neurocognitive Disorder (NCD)	3
		Very poor (psychotic)	2
Reflection by investigator	How did CFI affect clinical decision making - Participants 1-22 - Questions 1-16		

(1) **Environmental factors.** This was mainly determined by the interview venue and at times it affected the flow of the interview. Some venues such as the psychiatric and medical wards were prone to interruptions and background noise that would at times distract both the researcher and the participants. The outpatient department venue offered more privacy with much less distractions and interruptions and allowed for the interviews conducted there to flow in a more cohesive manner.

(2) **Time factors.** The main determinant of the duration of time was related to the researcher having to re-phrase or elaborate on some questions when the participants were unclear about what was being asked. Another factor was that some participants were concrete and needed the questions to be structured in a very basic manner.

(3) **Fluency in English.** Language was a major factor in participants whose first language was not English, it presented difficulties with comprehension of questions and the content which was being asked of them. At times the researcher had to translate some questions to allow the participants to grasp and understand the questions in order to give feedback. Although time was spent on elaborating on questions because participants were not fluent in English which is a notable limitation, it does however highlight the need for the CFI to be appropriately translated and standardised to suit the South African demographic.

(4) **Level of engagement.** Majority of participants had good to very good level of engagement and managed to interact well, however five participants had poor to very poor engagement due to their mental state that was affected by either psychosis or a degree of cognitive impairment. It is notable that the inclusion

of these participants is questionable they were included as part of the sample to explore the feasibility and efficacy of the use of the CFI to yield any beneficial results in participants whose mental status is impaired.

(5) **Reflection by investigator.** The semi-structured interview questions of the CFI are being structured within three sections and different domains as identified in the literature review and DSM-5, namely:

- **Section A. Cultural definition of the problem (Questions 1 to 3).** It was the interviewer's experience that these questions were easily answered by participants as it essentially comprised the main complaint and reason for presentation, as well as the history of main complaint and related symptoms.
- **Section B. Cultural perceptions of cause- context and support (Questions 4 to 10)**
    - **Causes** - Questions 4 and 5 were easily answered by participants, however there was notable repetition of answers from section A. These questions were expansion of the main complaint as well as highlighting psychosocial support/impact.
    - **Stressors and support** - Questions 6 and 7 were also easily answered as participants generally understood the questions as pertaining to factors that improve their condition and those that exacerbate it respectively.
    - **Role of cultural identity** - Compared to the other questions, Questions 8 to 10 required much more clarification and elaboration to be provided by the researcher. Participants struggled to understand the terms used and what was being asked exactly. The terms "identity" and "background" needed definition and

expansion, it was difficult to conceptualise "identity" as it is multi-factorial. Question 8 and 9 were answered with difficulty and the responses were brief and lacked content. Question 10 was answered by only 16 participants and those who did not answer, stated that they could not answer the question, the fifteen of those who did respond merely responded with a "no".

- **Section C. Cultural factors affecting self-coping and past help seeking behaviour (Questions 11 to 16)**
  - Self-coping (Question 11)
  - Past help seeking (Question 12)
  - Barriers (Question 13)
  - Preferences (Questions 14 and 15)
  - Clinician patient relationship (Question 16)

Question 11-15 were answered easily and without any elaboration from the researcher. Question 16 revealed that all participants felt misunderstood by their health care provider. Many participants felt that they were not listened to noting that some of their concerns were invalidated or disregarded. As part of their management, some respondents believed that integration of their treatment was possible in order to receive a holistic treatment approach. Many participants verbalised a sense of powerlessness in influencing their own treatment, some wanted to have their cultural affiliations included in the treatment model. This seemed to be more of an issue where the doctor was concerned as there seems to be some anxiety regarding the response they may get from the doctors should they suggest that a cultural ritual would be the appropriate management.

Difficulties experienced in conducting these interviews included that participants were often unable to understand questions as phrased in the standardised interview. Much of the time, the investigator had to elaborate or re-phrase the question for the participant to understand.

3.3 Cultural formulation interview content

The data collected from the respondents' replies was analysed and themes and subthemes were highlighted. These were identified in a hierarchal manner which is listed below from the most to the least commonly replicated themes. Themes identified from the responses to the 16 CFI questions included:

Table 2. Identified themes from responses to 16 CFI questions

<u>Repeated themes *(most to least common)*</u>: ○ ***"Culture" [******]*** ○ ***"Religion" [*****]*** ○ ***"Family/friend support" [****]; "Medical help/Doctors" [****]*** ○ ***"Belief system" [**]; "Stigma" [**]*** ○ ***"(Mental) Illness" [*]*** • ***<u>Single themes:</u>*** ***"Communication"*** ***"Community"*** ***"(Need for) help"*** ***"Helplessness"*** ***"Ignorance"*** ***"Integrated care"*** ***"Insight"*** ***"Lack of support"*** ***"Psychosocial stressors"*** ***"Self-support"*** ***"Uncertainty"***

Table 3: Meaning of identified themes according to the online Lexicon dictionary

"Culture"	1. The arts and other manifestations of human intellectual achievement regarded collectively," e.g. *'20th century popular culture'*; 2. The ideas, customs, and social behaviour of a particular people or society; e.g. *'Afro-Caribbean culture'*

"Religion"	*Particular system of faith and worship*
"Support"	*Bear all or part of the weight*
"Helplessness"	*Inability to defend oneself or act effectively*
"Belief system"	*Set of principles or tenets which together form basis of religion, philosophy and moral code*
"Stigma"	*A mark of disgrace associated with a particular circumstance*
"Mental illness"	*A condition which causes serious disorder in a person's behaviour and thinking*
"Communication"	*Imparting or exchanging of information*
"Community"	*Group of people living in the same place or having a particular characteristic in common*
"Ignorance"	*Lack of knowledge or information*
"Uncertainty"	*State of not knowing*
"Self-support"	*Surviving without outside assistance*
"Psychosocial stressors"	*Relating to interrelation of social factors and individual thought and behaviour*

These main themes and related subthemes, which were also identified, are presented in the following paragraphs.

3.3.1 Question 1. What brings you here today? How would you describe your problem in your own way?

The themes and subthemes identified from the CFI participants' content in terms of Question 1, are listed in Table 2.

Table 4. CFI Question 1: Themes and Subthemes

CFI Question 1. What brings you here today? How would you describe your problem in your own way?	
Themes	**Subthemes**
Culture Psychosocial stressors Need for help	Ancestral calling Ancestral communication Financial strain Family conflict

	Occupational stress Medical attention Uncertainty about mental health

1) **Culture**

The most replicated theme was that of culture and it was most repeated amongst the black participants, this was further broken into subthemes that were focused around ancestral communication and ancestral calling. Ancestors were highlighted as a source of communication whereby they convey special messages in a unique way, at times these messages are instructions that need to be followed or else it is believed that something ominous will occur to the participant and their family. This was noted to be common amongst the black participants of varied cultures and religious affiliations.

- *". . . it's my culture . . ."* (P1 Q1)[1]
- *". . . ancestors calling me to 'thwasa' . . . "*[2] (P3 Q1)
- *". . . ancestors are trying to give me a special message . . . "* (P4 Q1)
- *". . . I will always be sick unless I do what the ancestors want. . . "* (P22 Q1)

2) **Psychosocial stressors**

The theme of stressors was repeated multiples times by recipients of varying races and cultural backgrounds. The stressors were mainly financial strain, family conflict and occupation stress or unemployment. Financial and occupational stressors were a significant burden of distress amongst many participants

[1] P – Participant; Q - Question
[2] Thwasa – show signs of a changing state, as by spirit-possession to become a diviner or traditional healer

especially because they themselves were perceived as a financial burden to their respective families if they were unemployed. This further perpetuated conflict within the family of varying degrees especially in cases where the participants had the "sick role" or "problem" label thrust upon them.

- *"I am feeling stressed, I have no money to support myself . . ."* (P22 Q1)
- *"My family thinks I am not okay, I am always fighting with them . . ."* (P8 Q1)
- *"My boss will fire me unless I come for help. . . "* (P18 Q1)
- *"I am not coping at work. . . "* (P15 Q1)

3) **Need for help**

The need to get help, whether medical or otherwise was a pertinent theme through all respondents. Most respondents identified a need to get medical attention and others were uncertain about their condition but realised that some help was necessary. Many participants noted that they had a problem but were unsure whether they had a problem with their mental health and what kind of help this problem required.

- *"I am not sure what is happening to me, but I need help"* (P7 Q1)
- *"The doctors need to fix me, give me medication to make the voices stop"* (P11 Q1)
- *"I just need medication then everything will be fine"* (P13 Q1)

3.3.2 Question 2. How would you describe your problem to your family, friends or others in your community?

Table 5. CFI Question 2: Themes and Subthemes

CFI <u>Question 2.</u> How would you describe your problem to your family, friends or others in your community?	
Themes	**Subthemes**
Culture* Religion Illness	Sangoma training Traditional rituals Bewitchment Ancestral control Evil forces Demonic possession Illness

1) **Culture**

Culture was a dominant theme amongst the black participants with subthemes of sangoma training, traditional rituals, bewitchment as well as ancestral control. Sangoma training and traditional rituals were articulated as a form of treatment for the symptoms that the participants were displaying. The bewitchment and ancestral control were articulated as a diagnosis or reason for symptoms that were displayed.

- "I need to go thwasa so that I can become a sangoma" (P13 Q2)
- "The ancestors want me to perform a ritual at home to make things right with them" (P5 Q2)
- "Someone is bewitching me, they are jealous of me and want me to become mad" (P2 Q2)
- "The ancestors are controlling me, they want something from me" (P3 Q2)

2) **Religion**

The participants used religion as a description of illness with evil forces and demonic possession as prominent subthemes. The participants believed that their symptoms were as a result of evil forces attacking them or putting their faith to the test.

- “The devil is testing me” (P4 Q2)
- “There’s a demonic power that wants to take over my life” (P6 Q2)

3) **Illness**

Illness was a theme with subthemes of mental illness as well as other medical illnesses. Although the illness could not be described in medical terms the participants felt a general sense of being unwell.

- “Something is not right in my head” (P19 Q2)
- “I am losing my mind” (P16 Q2)
- “There is a chemical imbalance in my brain” (8 Q2)

3.3.3 Question 3. What troubles you most about your problem?

Table 6. CFI Question 3: Themes and Subthemes

CFI Question 3. What troubles you most about your problem?	
Themes	**Subthemes**
Stigma Helplessness	Discrimination Dependence Inability to help self Difficulty accepting

1) **Stigma**

Stigma and helplessness were themes that featured amongst all participants, with subthemes of discrimination, dependence, inability to help self as well as difficulties in acceptance of their current problem. Stigma was explained as a reason to avoid help seeking and disclosure of illness to others. It was also noted that self stigmatisation was also a significant problem for many participants which perpetuated feelings of helplessness.

- "People think that I am crazy" (P1 Q3)
- "People think that I am a mad person and don't want to be around me" (P21 Q3)

2) **Helplessness**

Participants explained feelings of inability to help themselves and how this often led to not being able to seek appropriate help.

- "I have no control over what is happening to me" (P12 Q3)
- "I can't help myself" (P17 Q3)
- "I can't accept that I am mentally ill, maybe I can do without the pills" (P2 Q3)

3.3.4 **Question 4. What do you think is happening to you? What is causing the problem?**

Table 7. CFI Question 4: Themes and Subthemes

CFI Question 4. What do you think is happening to you? What is causing the problem?	
Themes	**Subthemes**
Culture** Religion* Mental illness	Bewitchment Ancestral calling Demonic possession Evil forces

1) **Culture** with subthemes of bewitchment, ancestral calling and persecution. Bewitchment and persecution were seen as explanations that involved external and often unknown figures who were responsible for these experiences. Ancestral calling was a direct communication to the participants' ancestors and this was noted to be of the utmost importance to adhere to.

- "I am being bewitched" (P2 Q4)
- "The ancestors want me to be a sangoma" (P13 Q4)

- “The ancestors are punishing me” (P5 Q4)

2) **Religion** with subthemes of evil/demonic forces as well as testing of faith. Evil and demonic forces tempting or testing one’s faith was a major feature. No explanation was given for the reason behind the participants’ faith being tested and what the end goal would yield.

- “There is evil that is trying to overtake me, I must pray for God to release it” (P6 Q4)
- “There are evil forces at hand, the devil is testing me” (P6 Q4)
- “God is trying to test my faith, to see how committed and faithful I can be” (P3 Q4)

3) **Mental illness** was a significant theme that was a reason for illness and the recognition of this would assist in help seeking.

- “My mind is sick” (P7 Q4)
- “I am going crazy, I don’t have control over my actions” (P12 Q4)
- “I have lost control, I think I am not okay in my head” (P11 Q4)

3.3.5 Question 5. What do your family, friends or others in your community think is causing the problem?

Table 8. CFI Question 5: Themes and Subthemes

***CFI Question 5.** What do your family, friends or others in your community think is causing the problem?*	
Themes	**Subthemes**
Ignorance Culture*** Religion**	Labelling

1) **Ignorance** with subthemes of labelling specifically when the symptoms or diagnosis is misunderstood.
   - "They don't know what's wrong with me" (P9 Q5)
   - "They think I am crazy, and I must be locked up" (P2 Q5)
   - "They think I am making these things up, that I want attention" (P8 Q5)
2) **Culture which also leads to thoughts of ancestral communication and control.**
   - "They also say I am being bewitched" (P1 Q5)
   - "I must go thwasa" (P17 Q5)

Religion related to the testing of faith and demonic possession as a measure of good faith.

- "My faith is not strong enough, so God is testing me" (P21 Q5)
- "The devil is after me" (P4 Q5)

3.3.6 Question 6. Are there any kinds of support that make your problem better?

Table 9. CFI Question 6: Themes and Subthemes

CFI Question 6. Are there any kinds of support that make your problem better?	
Themes	**Subthemes**
Family Belief system- includes religious and cultural beliefs Medical help	Contact with religious and traditional healers

1) **Family**

- “My family has been very understanding” (P13 Q6)
- “My family has supported me through this entire nightmare” (P7 Q6)

2) **Belief system** which includes religious and cultural beliefs as a form of support and a coping mechanism.

- “My faith keeps me going” P(6 Q6)
- “I pray all the time for healing” (P16 Q6)
- “I know what the ancestors want me to do, that keeps me going” (P5 Q6)

3) **Medical help**

- “The medication helps me a lot” (P9 Q6)
- “The psychologists, doctors and occupational therapists know what I am going through, they are helpful to me” (P8 Q6)

3.3.7 Question 7. Are there any kinds of stresses that make your problem worse?

Table 10. CFI Question 7: Themes and Subthemes

CFI Question 7. Are there any kinds of stresses that make your problem worse?	
Themes	**Subthemes**
Family Stigma** Doctors	Labelling Being un-heard

1) **Family**

- “They don’t understand me” (P8 Q7)
- “They think that I am crazy” (P1 Q7)

- "No one wants to help me" (P2 Q7)

2) **Stigma** with a subtheme of labelling due to poor understanding and insight.

- "People treat me badly because I have a mental illness" (P10 Q7)
- "People in the community call me names and say I belong in the loony bin" (P19 Q7)

3) **Doctors** with a subtheme of being unheard. The participants expressed feeling misunderstood or unheard especially when family wherein conflict already exists.

- "They don't listen to me" (P20 Q7)
- "The doctors always believe my family and not me" (P22 Q7)

3.3.8 Question 8. Are there any kinds of stresses that make your problem worse?

Table 11. CFI Question 8: Themes and Subthemes

CFI Question 8. What are the most important aspects for you of your background and identity?	
Themes	**Subthemes**
Belief system* Family	

1) **Belief system**

- "My faith in God keeps me going" (P6 Q8)
- "I grew up in a very religious family, it's important that I honour that even when I am unwell" (P3 Q8)

2) **Family?**

- "My parents believe in the things that are happening to me, that the ancestors are talking to me like they did with my grandmother" (P5 Q8)

3.3.9 Question 9. Are there any aspects of your background or identity that make a difference to your problem?

Table 12. CFI Question 9: Themes and Subthemes

CFI <u>Question 9.</u> Are there any aspects of your background or identity that make a difference to your problem?	
Themes	**Subthemes**
Family Community	

1) **Family**

- **"**My family makes a difference, they make my problems better" (P19 Q9)

2) **Community**

- "The village I come from, people there are jealous of my family, it started with my grandfather's grandfather. It is because my family has a special connection with the ancestors." (P4 Q9)

3.3.10 Question 10. Are there any aspects of your background or identity that are causing other concerns or difficulties for you?

Table 13. CFI Question 10: Themes and Subthemes

CFI <u>Question 10.</u> Are there any aspects of your background or identity that are causing other concerns or difficulties for you?	
Themes	**Subthemes**
(No themes) - NOT ANSWERED	

3.3.11 Question 11. What have you done on your own to cope with your problem?

Table 14. CFI Question 11: Themes and Subthemes

CFI <u>Question 11.</u> What have you done on your own to cope with your problem?	
Themes	**Subthemes**
Belief system**	Prayer
Family/friend support	Ancestral communication
Self	Not being alone

1) **Belief system** with a subtheme of prayer. Prayer was noted to be a form of special communication with God that not only is a form of support but also an investment in the future and that things will get better. The same can be deduced by the concept of ancestors who are seen as a direct relation to God/Christianity.

- "I pray and ask God for strength" (P15 Q11)
- "I ask my ancestors to help me" (P21 Q11)

2) **Family support** where the sense of being alone was highlighted. Many participants experienced loneliness and a sense of having to cope alone.

- "I talk to my family, their support helps me through all this" (P9 Q11)
- "My parents have accepted me with my mental illness, I have the strength to deal with my illness" (P18 Q11)
- "My friends understanding, some of them even come for my follow up with me" P(9 Q11)

3) **Self** – as a measure of coping

- "I rely on myself to get by, I only have myself" (P2 Q11)
- "I have thought about suicide in the past, but my will to live and accept my condition was stronger" (P15 Q11)

3.3.12 Question 12. What kinds of treatment, help or advice in the past have you sought for your problem?

Table 15. CFI Question 12: Themes and Subthemes

CFI *Question 12.* *What kinds of treatment, help or advice in the past have you sought for your problem?*	
Themes	**Subthemes**
Religion*** Culture**** Medical	Prayer Traditional rituals

1) **Religion** with prayer as a subtheme which was experienced as a direct communication with God and although one sided it would often lead to revelations that would appease the anxiety.

- "I have asked my pastor to pray for me with holy water" (P9 Q12)
- "I was fasting and praying for days at a time" (P13 Q12)

2) **Culture** with subthemes of traditional rituals that need to be performed in order to make the situation better.

- "My family had a ritual for me so that the ancestors could forgive me for all the wrong I did" (P20 Q12)
- "We slaughtered a goat as a sacrifice to the ancestors to make them happy" (P15 Q12)

3) **Medical**

- "I went to doctors, but they said they can't find anything wrong in my body, so they sent me to a head doctor" (P7 Q12)
- "I spoke to a psychologist before, but it didn't help me" (P10 Q12)

3.3.13 Question 13. Has anything prevented you from getting help as you need?

Table 16. CFI Question 13: Themes and Subthemes

CFI Question 13. Has anything prevented you from getting help as you need?	
Themes	**Subthemes**
Lack of support Insight	

1) **Lack of support**

- "My family was not there for me, I felt alone" (P8 Q13)
- "My parents did not think I needed western help, they believed the ancestors would heal me" (P5 Q13)

2) **Insight**

- "I didn't understand what was wrong with me so I didn't look for help" (P21 Q13)
- "I couldn't accept that I was mentally ill, that I was mad" (P3 Q13)
- "The voices said I didn't need treatment" (P1 Q13)

3.3.14 Question 14. What kinds of help do you think would be most useful to you at this time for your problem?

Table 17. CFI Question 14: Themes and Subthemes

CFI Question 14. What kinds of help do you think would be most useful to you at this time for your problem?	
Themes	**Subthemes**
Religion**** Culture***** Medical	Faith healing Cultural rituals

1) **Religion** where faith healing was a subtheme. Christian participants of different races believed that mental illness was somehow a route to their greater connection with their faith and God.

- "I need to go back to church, I need the pastors to pray for me" (P6 Q14)
- "I think I need to fix my relationship with God and repent for my sins" (P19 Q14)

2) **Culture** was an expression of a solution to the presenting problem. Many African, black and male participants believed that the ancestors needed a ritual that would offer a form of appeasement.

- "I must go back to Lesotho and have a ceremony for my ancestors" (P5 Q14)
- "I must go thwasa, that's the only way the ancestors will be happy" (P13 Q14)

3) **Medical**

- "I just need to take my medication then I will be fine" (P8 Q14)
- "The doctors must find out what's wrong with me head, I will do anything they tell me to do" (P7 Q14)

3.3.15 Question 15. Are there any kinds of help that your family, friends or others in your community have suggested would be helpful for you now?

Table 18. CFI Question 15: Themes and Subthemes

CFI <u>Question 15.</u> Are there any kinds of help that your family, friends or others in your community have suggested would be helpful for you now?	
Themes	**Subthemes**
Religion**** Culture****** Medical**	Prayer Rituals

1) **Religion** with the subtheme of prayer that seemed to represent to represent comfort and solace from the situation.

- "My mother says I must find God then I will be okay" (P15 Q15)
- "My sister takes me to church with her, she thinks God will heal me" (P7 Q15)

2) **Culture** with a subtheme of ancestral/cultural rituals that would offer an answer to the symptom presentation.

- "My mother says I have upset the ancestors and need to apologise to them my sacrificing a sheep" (P17 Q15)
- "My family thinks I need to go thwasa to become a sangoma, they think that's what the ancestors want from me" (P13 Q15)

3) **Medical** and understanding that medical attention would offer an insight that other means may not offer.

- "My friends say I need to be admitted so the doctors can check my brain" (P14 Q15)
- "My mom says medication is all I need to balance my brain chemicals" (PP10 Q15)

3.3.16 **Question 16. Have you been concerned that the doctor may misunderstand your problem? Is there anything that can be done to provide you with the care you need?**

Table 19. CFI Question 16: Themes and Subthemes

CFI Question 16. Have you been concerned that the doctor may misunderstand your problem? Is there anything that can be done to provide you with the care you need?	
Themes	**Subthemes**
Communication Integrated care	

1) **Communication** whereby participants reported that being spoken to directly and having their problem explained in a manner that they could understand was of importance to them.

- "The doctors just speak and say things I don't understand" (2 Q16)
- "The doctors listen to my family and friends, they don't believe anything I have to say" (P11 Q16)
- "I just do what the doctors tell me to do, I don't really understand what is happening" (P6 Q16)
- "They don't know that this is a culture problem, but I will just co-operate so that they can discharge me" (P11 Q16)

2) **Integrated care** which would allow for a holistic approach to their care from the participants' point of view.

- "The doctors don't understand that this is also a culture problem, medication will not fix it" (P13 Q16)
- "I just want the doctors to let me go home for a ritual for my ancestors then I will come back to complete the hospital treatment" (P5 Q16)
- "I need the doctors to allow my sangoma to visit me in the hospital and connect with my ancestors, maybe that will help me get better faster" (P17 Q16)

3.3.17 Summary of themes and subthemes

A summary of themes and subthemes is presented in Table 20.

Table 20. Summary of Themes and Subthemes

<table>
<tr><td colspan="2">CFI <u>Question 1.</u> What brings you here today? How would you describe your problem in your own way?</td></tr>
<tr><td>Themes</td><td>Subthemes</td></tr>
<tr><td>Culture</td><td>Ancestral calling
Ancestral communication</td></tr>
<tr><td>Psychosocial stressors</td><td>Financial strain
Family conflict
Occupational stress</td></tr>
<tr><td>Need for help</td><td>Medical attention
Uncertainty about mental health</td></tr>
<tr><td colspan="2">CFI <u>Question 2.</u> How would you describe your problem to your family, friends or others in your community?</td></tr>
<tr><td>Themes</td><td>Subthemes</td></tr>
<tr><td>Culture*</td><td>Sangoma training
Traditional rituals
Bewitchment
Ancestral control
Evil forces</td></tr>
<tr><td>Religion</td><td>Demonic possession</td></tr>
<tr><td>Illness</td><td>Illness</td></tr>
<tr><td colspan="2">CFI <u>Question 3.</u> What troubles you most about your problem?</td></tr>
<tr><td>Themes</td><td>Subthemes</td></tr>
<tr><td>Stigma</td><td>Discrimination
Dependence</td></tr>
<tr><td>Helplessness</td><td>Inability to help self
Difficulty accepting</td></tr>
<tr><td colspan="2">CFI <u>Question 4.</u> What do you think is happening to you? What is causing the problem?</td></tr>
<tr><td>Themes</td><td>Subthemes</td></tr>
<tr><td>Culture**</td><td>Bewitchment
Ancestral calling</td></tr>
<tr><td>Religion*</td><td>Demonic possession
Evil forces</td></tr>
<tr><td>(Mental) illness*</td><td></td></tr>
<tr><td colspan="2">CFI <u>Question 5.</u> What do your family, friends or others in your community think is causing the problem?</td></tr>
<tr><td>Themes</td><td>Subthemes</td></tr>
<tr><td>Ignorance</td><td>Labelling</td></tr>
<tr><td>Culture***</td><td></td></tr>
<tr><td>Religion**</td><td></td></tr>
<tr><td colspan="2">CFI <u>Question 6.</u> Are there any kinds of support that make your problem better?</td></tr>
<tr><td>Themes</td><td>Subthemes</td></tr>
<tr><td>Family</td><td></td></tr>
<tr><td>Belief system- includes religious and cultural beliefs</td><td>Contact with religious and traditional healers</td></tr>
<tr><td>Medical help</td><td></td></tr>
<tr><td colspan="2">CFI <u>Question 7.</u> Are there any kinds of stresses that make your problem worse?</td></tr>
<tr><td>Themes</td><td>Subthemes</td></tr>
<tr><td>Family*</td><td></td></tr>
</table>

<table>
<tr><td>Stigma**
Doctors*</td><td>Labelling
Being un-heard</td></tr>
</table>

<table>
<tr><td colspan="2">CFI <u>Question 8.</u> What are the most important aspects for you of your background and identity?</td></tr>
<tr><td>Themes</td><td>Subthemes</td></tr>
<tr><td>Belief system*
Family**</td><td></td></tr>
<tr><td colspan="2">CFI <u>Question 9.</u> Are there any aspects of your background or identity that make a difference to your problem?</td></tr>
<tr><td>Themes</td><td>Subthemes</td></tr>
<tr><td>Family***
Community</td><td></td></tr>
<tr><td colspan="2">CFI <u>Question 10.</u> Are there any aspects of your background or identity that are causing other concerns or difficulties for you?</td></tr>
<tr><td>Themes</td><td>Subthemes</td></tr>
<tr><td>(No themes)-NOT ANSWERED</td><td></td></tr>
<tr><td colspan="2">CFI <u>Question 11.</u> What have you done on your own to cope with your problem?</td></tr>
<tr><td>Themes</td><td>Subthemes</td></tr>
<tr><td>Belief system**

Family/friend support****
Self</td><td>Prayer
Ancestral communication
Not being alone</td></tr>
<tr><td colspan="2">CFI <u>Question 12.</u> What kinds of treatment, help or advice in the past have you sought for your problem?</td></tr>
<tr><td>Themes</td><td>Subthemes</td></tr>
<tr><td>Religion***
Culture****
Medical**</td><td>Prayer
Traditional rituals</td></tr>
<tr><td colspan="2">CFI <u>Question 13.</u> Has anything prevented you from getting help as you need?</td></tr>
<tr><td>Themes</td><td>Subthemes</td></tr>
<tr><td>Lack of support
Insight</td><td></td></tr>
<tr><td colspan="2">CFI <u>Question 14.</u> What kinds of help do you think would be most useful to you at this time for your problem?</td></tr>
<tr><td>Themes</td><td>Subthemes</td></tr>
<tr><td>Religion****
Culture*****
Medical***</td><td>Faith healing
Cultural rituals</td></tr>
<tr><td colspan="2">CFI <u>Question 15.</u> Are there any kinds of help that your family, friends or others in your community have suggested would be helpful for you now?</td></tr>
<tr><td>Themes</td><td>Subthemes</td></tr>
<tr><td>Religion****
Culture******
Medical****</td><td>Prayer
Rituals</td></tr>
<tr><td colspan="2">CFI <u>Question 16.</u> Have you been concerned that the doctor may misunderstand your problem? Is there anything that can be done to provide you with the care you need?</td></tr>
<tr><td>Themes</td><td>Subthemes</td></tr>
<tr><td>Communication
Integrated care</td><td></td></tr>
</table>

CHAPTER 4. DISCUSSION

4.1 Interviewer's experience

The interviewer's experience of conducting the CFI was positive, specifically with regard to building of rapport and establishing a therapeutic alliance with the participants. The interviewer felt that being informed of the participants' explanatory model offered valuable insight that can be useful in potential management and care. The interviewer, however, had difficulty conducting the interview in its current format, as it often came across as repetitive with participants struggling to understand some questions and therefore there was an obvious lack of depth to the interview answers in general.

4.1.1 Communication

This study aimed to explore the CFI as a cultural tool based on deductive content analysis of the interview content as well as the researcher's experience of the process. According to Aggarwal et al., both clinicians and patients thought the most important functions of the CFI were to 1) determine and monitor the nature of the problem; and 2) develop, maintain and conclude the therapeutic relationship.[14] The latter was also found in this study as a prominent theme from all participants who believed that communication or the lack thereof was a factor in feeling misunderstood and unheard by the clinician. Participant 2, for example, stated: *"The doctors just speak and say things I don't understand then they leave and don't check if I understood. Sometimes I am too scared to ask questions."* Participant 11 was particularly upset as he felt that he was being left out of his own management and all decisions were made by the doctor and family members. *"The doctors listen to my family and friends, they don't believe anything I have to say. I am the patient and not them, why don't they speak to me and hear what I have so say, what if my family is*

lying." Stege and Yarris found that both clinicians and patients found that the CFI helped to build trust and develop empathy which was important for the clinical interaction. Therefore, it shows that communication is essential in establishing rapport and building a therapeutic alliance with the participants.[17] The participants in this study often verbalised that they felt excluded from their own management and that the clinician disregarded their input. Vasudeo et al., noted in terms of communicating about mental health problems, that it is preferred by patients to explain their own concerns and regarded not only as very important for them, but also for the clinicians they consult.[29]

4.1.2 **Time**

Although there was some concern initially that interviews would require additional time which would prolong the entire assessment process, conducting the CFI questions additionally, actually did not take the investigator significantly longer than the usual time allocated to just conduct the routine long case interview. The majority of these interviews were conducted within 30 minutes, while those that were longer, did not require more than 60 minutes to complete. These longer interviews were mainly due to the need of the participant for the investigator to elaborate or explain several questions. This is in keeping with the report by Lewis-Fernandez et al., noting the duration of the CFI interview decreased by 4 minutes with a subsequent interview administration and that by the last administration, it took only 22 minutes to conduct.[40] Kleinman et al., estimated that an interview that included an CFI with a clinician new to a patient, should be scheduled for an additional 15-20 minutes, followed subsequently by the standard assessment.[15] Furthermore, according to Lewis-Fernandez et al., patients did not object to additional time needed for the CFI, however, participating clinicians had concerns about the additional time required, as well as conducting such an interview on their first meeting with a patient.[40]

4.1.3 **Barriers**

Some barriers experienced by the researcher in conducting the interview related to participants level of engagement, fluency in English and general understanding of the questions asked. In most of the interview questions the researcher had to elaborate on questions, as often, the participants were unable to understand. This related to the interview being conducted in English but when some questions were translated into an African language, there was a better understanding and input from participants. This is in keeping with findings by Vasuedo et al., whereby patients expressed the importance of speaking in their first language and acknowledge that expression would have been difficult in English[29], this study was done in India where the CFI had been conducted in local languages. Interview-related factors were mostly due to questions being difficult to interpret in the current standardised form of the CFI and this involved most questions being re-phrased and elaborated on by the researcher. These were similar findings in a study that found clinicians who strictly adhered to the CFI questions without probing or follow-up questions did not yield as much information about patients' cultural experiences as those who modified the questions according to the patients' understanding.[17] A number of patients had difficulties with questions about the role of cultural identity where some found the questions difficult to understand and answer.[29] However different to this study findings, Aggarwal et al., noted that both patients and clinicians did not report miscommunication and misunderstanding around the phrasing of questions.[14] Clinicians found some questions difficult to administer such as the section on clinician-patient relationship.[42] This study did not yield the same difficulty but noted that this question was by far the most easily administered by the researcher and answered by participants. It yielded insights into the participants' thoughts about the possible challenges in the clinician-patient relationship that may stifle rapport and

long-term management. Furthermore, the researcher noted that some questions did not yield any information at all that may contribute to the clinician-patient alliance such as Question 10. Stege and Yarris found that Question 8 was the most frequently misunderstood or not at all by patients, it was also noted that clinicians found it difficult to explain the meaning of the question to patients. Due to these factors the responses to Question 8 were limited or even non-existent.[17] They further note that although the responses did not yield aspects of each patient's individual identity, the question did bring about reflections on aspects of social relationships and experiences that contribute to mental illness.[17]

4.1.4 **Clinical value**

Conducting the CFI yielded some insights into its clinical importance, it is notable that it does not necessarily change the management in terms of pharmacological treatment, but it allowed the researcher to build rapport, to understand the participants' explanatory model and for the potential to establish a long-term therapeutic alliance. This benefit is not only in terms of communication between clinician and participant, but it also applies to the clinician being open to the patients' desire to seek cultural and traditional counsel as part of their treatment model. It is however notable that some questions of the CFI did not yield valuable, or additional information and question 10 was not answered at all. Despite these limitations, some important information was actually elicited through responses to the CFI questions, while significantly improved rapport was established. The study by Stege and Yarris had similar findings, reporting that while specific question items of the CFI may not elicit anticipated responses.[17] It was found that it enhanced the value of clinical encounters and increased trust between clinicians and patients.[27] Similarly, studies conducted to assess the feasibility, acceptability and clinical utility of the CFI,[14,29,40] found that both patients and clinicians found it to be acceptable, feasible and

clinically useful - which supported its inclusion in the DSM-5. Proctor et al.[41] offers these definitions:

- Feasibility - "*the extent to which new treatment or an innovation can be successfully used or carried out within a given agency or setting."*
- Acceptability - "*the perception among implementation stakeholders that a given treatment, service, practice or innovation is agreeable, palatable or satisfactory."*
- Clinical utility - "*the perceived fit, relevance or compatibility of the innovation or evidence-based practice for a given practice setting, provider, or consumer; and/or perceived fit of the innovation to address a particular problem."*

It was also noted by Procter et al., that there is room for extensive collaboration between the clinician, patient and family but also with cultural and traditional healers should the patient express such a need.[41]

4.2 **Limitations**

The CFI is made up of repetitive, philosophical questions and therefore it did not yield depth of content in this study. Many participants did not understand the questions as stated in the interview and often the researcher had to elaborate or explain what was being asked. It is of concern that only eight of the participants were fluent in English and it is clear from the results that the main determinant of the time taken to conduct the interview was elaborating on the questions; it therefore brings up the possibility that the participants were not appropriately selected. That said, The CFI is only available in English, it was not easy for the participants to express themselves in English, so some participants use their home language in order to express themselves. Limited presentation of participants' experiences is notable and hence the phenomenological approach was adopted. The experiences would have been

explored with in-depth open interviews while the CFI has very specific structured questions, with no option to reflect on how they feel or have experienced the questions and provided and hence the limitation arises.

4.3 **CFI content themes and comparison with literature**

The main themes identified from the responses of the CFI included: “culture”, “family”, “religion”, “medical help”, “stigma”, “helplessness”, “psychosocial stressors”, “lack of support communication” and “integrated care”. “Culture” and “religion” were repeated six and five times respectively with “stigma” repeated twice. The repetition of these themes is likely due to the superficial nature of the content received from the participants, while it was not possible to expand on these themes beyond the subthemes that were indicated. For “culture”, subthemes included “ancestral calling/control”, “bewitchment” and “traditional rituals”. “Religion” subthemes were “demonic possession”, “testing of faith” and “prayer”. Even with further probing and requesting clarity from participants, there was still a lack of depth to the answers.
The role of “culture” was of notable importance in clinical presentation and the explanatory model related to it as narrated by the participants. This involved content related to ‘bewitchment’, ‘ancestral control’ as well as ‘bad spirits’ related to the need for cultural rituals to be performed. Similar findings were noted by Stege and Yarris[17] as well as Diaz et al.[11], participants in these studies made direct connections between their clinical presentation and an explanation within a cultural or religious context. A participant reported that his presenting problem was as a direct consequence of his actions and therefore God or the ancestors were punishing him by giving him a mental illness.[11]
“Stigma” was a prominent theme which was repeated multiple times in response to different questions. It was viewed as a hindrance to seek medical attention and a

cause of fear for being labelled by community members and family. Although some participants had accepted their mental illness, they still feared disclosing it to their families, friends and communities in case of possible rejection. Stigma negatively impacts on mental health and recovery. As long as some cultures associate shame and dishonour with mental illness there will be a significant impact on help-seeking behaviour as well as treatment adherence.[42] Studies have found that the stigma of mental illness was the most significant barrier to seeking medical attention and that the lack of awareness and knowledge fell second.[43,44,45] Diaz et al., found that stigma related to mental illness was an important theme that came through in their study, participants who initially expressed concern about the negative perceptions of those around them, but were able to change their perspective, felt a lot of relief.[11]

"Social support" by family and friends was another prominent theme identified and was repeated four times. It was noted to be important to share the burden of illness and recovery, while social support seemed to impact positively on treatment adherence. The involvement of family was further an important factor for the majority of participants, as some made notable comments with regard to the relief it created to share their burden of illness with loved ones. Participant 7, for example, said: *"My family has supported me through this entire nightmare, it has been an ordeal for me, but they have helped me survive because they are with me every step of the way."* Similar findings were noted in a study by Diaz et al., whereby the disruption of relationships was a prominent theme and an important motivation in seeking help.[11]

Other participants expressed the lack of family support, which at times contributed to their mental illness, to be either due to conflict within the family, or being ostracised by family members because of mental illness. Participant 8 said: *"My family was not*

there for me, I felt alone. Their rejection of me depressed me even more and at times I would just cry because I had no one." Stege and Yarris also found that the CFI elicited important information on patients' thoughts about how their family's perceptions impact on their illness experience.[17] Vasuedo et al., note that the empathy shown by family and friends serves as a protective factor against mental health issues.[29] Marsella found that patients in third world and developing countries such as; India, Peru and Kenya; that lack support by family may lead to the person being neglected and ostracized, as there may be no government social support to act as a safety net.[46] Diaz et al., noted that the disruption of relationships as a major theme whereby if any conflict arose with important people then they would seek mental health care services.[11]

Psycho-social needs varied from financial, lack of support, poor access to care and unemployment and any traumatic experiences. This was a major contributor in participants seeking mental health services.[11] Diaz et al., noted that participants valued the attention given to their psychosocial needs and potential solutions and resources presented to them.[11]

"Medical help/doctors" is a theme that was repeated four times and although it lacked depth with regard to the exact expectations that the participants had of attending doctors, it did however indicate the importance of seeking medical attention for their symptoms. This was relevant even in some participants who indicated that their symptoms may have been related to culture, but they still need medical attention or the input of a doctor, before seeking traditional or cultural assistance. Participants in a study by Stege and Yarris reported that the CFI had assisted in building trust

between the clinician and participant and this would give them confidence to seek medical attention in the future.[17]

Interlinking themes included “communication” and “integrated care”. Communication was highlighted as a factor when many participants noted that they felt that the clinician misunderstood them and that they felt not heard. From the participants’ view, improving this domain, would lead to greater comfort in explaining their needs and contributions to their own continued care. This was further elaborated on where some participants felt that it was important for them to seek alternative therapies, which may come in the form of traditional and/or faith healers. It was further communicated that seeking these adjunct therapies, would not be a hindrance to continued psychiatric intervention and this was merely seen as an addition to their management profile. The Federation of Ethics Communities’ Councils of Australia suggested that clinicians adopt approaches that allow for differences across cultures that can integrate medical and Western ideas of health with traditional and community-based approaches.[47] Reguram et al., stated that approaches should be inclusive of traditional resources in communities who regard traditional healers and healing systems as well community involvement as integral components of their management.[48]

Lewis-Fernandez et al., found that the CFI of “Cultural Explanation of the Individual’s Illness” contributed less to final formulations than did other domains.[6] It was postulated that is was due to the fact that patients had multiple concurrent models of illness and that they were reluctant to offer views they believed were different to what the clinician expected.[43] A study by Aggarwal et al., found that there was a lack of differentiation from other treatments as the CFI seemed similar to aspects of the

standard interview.[28] This is of importance as clinicians may not implement the CFI if they believe it does not add any information.[28] Aggarwal et al., found that there was ambiguity of design with patients being unclear on what was being asked and how to answer with comprehension being a major issue.[28] The purpose of the CFI was noted by Aggarwal et al., to be unclear, as some clinicians were unsure about the relevance of the CFI and did not understand its use in addressing cultural misunderstandings.[28] Clinicians expressed uncertainty in how to utilize the information gained and make it part of the patient's assessment and management plan. Repetition of the CFI was a common experience in conducting this study, with the finding that some questions were repetitive and recurred in different forms. Therefore, repetition may be a notable barrier for clinicians if they consider the CFI to cover the same content repeatedly.[28] Some suggestions to counter this, may be to use parts of the CFI instead of the whole interview, to tailor the CFI based on patient profile and characteristics, and to use the CFI at the end of the interview, instead of the beginning.[28] Aggarwal et al., reported that lack of clinician motivation and buy-in was an important reason comprising the regular use of the CFI, especially if conducting the CFI is perceived to be as too much of an effort, or that the CFI may not assist with diagnosis, or that it may not yield results in relation to the time afforded to it.[28]

It is well known that traditional healers in South Africa are widely used and for many black people represent a significant parallel option to the formal health care system.[49] The ratio of traditional healers to medical doctors, for example, is 10:1 and an estimated 70% of South Africans utilise their services.[49] In most cases traditional healers do not separate mental illness into a different class of illness, as it is believed that the body, mind, soul and environment are all connected.[51] A study by Peltzer et

al., noted that mental illness was 14th on a list of conditions that were treated by traditional healers which only affected 9% of their clients.[52] Conditions like ancestral problems, affecting 23% of their clients, and spiritual illnesses affecting 21% of their clients, are characterised from a Western medicine perspective, as mental illness.[52] Kahn and Kelly noted the limitation that by studying indigenous conceptualizations of mental illness, cross cultural psychiatrists are often, from the very start, defining their research only from a Western medicine perspective.[53] Kleinman et al., also highlights this bias as follows: *"most transcultural psychiatric research is no more than the application of western psychiatric categories to non-western societies".*[15]

A study conducted by Molot et al., looked at conceptualizations of mental illness by traditional healers, as well as the understanding of biomedical practitioners of this parallel health care system.[54] They interviewed both traditional healers and medical practitioners in KwaZulu Natal and also presented vignettes of various mental illness scenarios presented to traditional healers, to get a more specific and symptom focused understanding of their perceptions of mental illness. They reported the following:

> *"Traditional healers' conceptualizations of mental illness: It was noted that traditional healers frequently identified psychosis as being a characteristic of mental illness while non-psychotic disorders such as anxiety and depression were not characterised as a mental illness. However, the traditional healers offered psychosocial solutions for depression and anxiety highlighting the importance of family and community in helping the client get through their distress."* [54]

About cultural versus psychiatric factors, they noted:

"*Some healers interpreted the psychosis vignette in a cultural context relating to bewitchment or thwasa. These traditional healers stated that they would not refer anyone with the symptoms of thwasa to a medical doctor as this was a strictly a cultural problem that needed a cultural solution which then result in the resolution of the apparent psychotic symptoms. Some medical practitioners stated that traditional healers are better equipped to deal with certain types of spiritual and cultural illnesses that western medicine cannot treat or even understand. However, they did note the difficulty in where to draw the line between what is cultural and what is medical in presentation. It is also imperative to note that the two do not exist strictly in isolation."*[54]

"In this study both the traditional healers and the medical practitioners acknowledged that there are certain problems that are beyond the scope of their respective abilities and may require consultation with another discipline. The coexistence of cultural and psychiatric illnesses re-enforces the notion that collaboration should be established between traditional healers and medical practitioners. Each entity provides unique services that can be stronger if used together for the greater good of the patient."[54]

The report by Hassim and Wagner reviewed the literature that focused on the dynamic influence of culture on psychopathology.[55] Three major themes were identified, namely, "cultural context", "evolving definitions of culture", and "culture and psychopathology":

- **Cultural context**. "*If the clinician's knowledge about the patient's culture suggests cultural competency then it is reasonable to believe that potential*

benefits result from this competence. These include offering culturally sensitive management and also helps establish rapport." [55]

- **Evolving definitions of culture**. *"Culture is socially interactional and consists of a collection of practices and joint interpretations. Culture is a unit of attitudes, beliefs, morals and behavioural perceptions shared by a community and carried down from one generation to the next. It does not relate to biological or individual performance but is an inherent part of the individual's knowledge and schema which develops in childhood and strengthened throughout the life span."* [55]
- **Culture and psychopathology**. *"The main considerations with regard to cultural phenomenon is whether it is culturally induced, culturally modified or culturally labelled. This emphasises that some phenomena require little psychiatry specific differentiation. Tseng states that the pathogenic effect relates to culture's tendency to affect the course of a disorder. Culture affects psychopathology through the patient's subjective experience of distress, patients show this distress in accordance with the standards and contexts as defined by their culture."* [55]

This review highlighted culture's influence on behaviour and that the dynamics of culture influence the way people behave when they are ill. Many clinicians depend on clinical impressions due to the failure of diagnostic classifications to include operational definitions with regard to culture, which often contribute to misdiagnoses. Presenting symptoms need to be interpreted within a cultural context, while ignoring the link between culture and pathology, often leads to inaccurate clinical impressions and diagnoses.

CHAPTER 5. RECOMMENDATIONS

In this particular local clinical setting, this limited qualitative study was able to identify the role of culture and the importance of its formulation to fully understand patients' presentation and to conceptualise collaborative care. Although the CFI revealed valuable insights, the investigator was able to identify that it may be more useful in local settings to consolidate some questions to avoid repetition. Of note, is that the first five questions of the CFI yielded the most information about participants' explanatory models, while Question 16 truly highlighted the gaps in the clinician-patient relationship. The CFI has been experienced, however, as also to be rather rigid in its current standardised form, which makes it difficult to administer it in participants whose first language is not English.

From these reported findings and experience with conducting the CFI in a local setting, it can be recommended that:

(1) Some aspects of the CFI should be included in the current CMSA's CPLCF, as it could easily form part of this basic assessment interview. More specifically, Question 1 to 5 as well as Question 16 can be included as these yielded the most useful information.

- For example, in the form of the "main complaint" and "history of the main complaint" which provides extensive detail with regard to the aetiological formulation of the patient, Question 1 to 3 can be placed here. This would prompt the interviewing clinician to, early on in the interview, ask questions specifically related to culture.
- Patients may, however, also be guarded about this, from this study's experience, it was clear that once the participant felt comfortable with the interviewing doctor and realised that she genuinely wanted to know how

they made sense of their illness, it was then much easier to establish and maintain the necessary rapport to inform the rest of the clinical assessment.

TABLE 21: PROPOSED CHANGES TO CPLCF TO INCLUDE CFI COMPONENTS

CPLCF	CFI COMPONENT
HISTORY OF MAIN COMPLAINT History of the presenting symptoms of the current illness episode, use the patient's own words where possible, mention positive and negative findings.	**CULTURAL DEFINITION OF THE PROBLEM** **1. What brings you here today? How would you describe your problem in your own way?** **2. How would you describe your problem to your family, friends or others in your community?** **3. What troubles you most about your problem?**
	CULTURAL PERCEPTIONS OF CAUSE, CONTEXT AND SUPPORT - **CAUSES** **4. What do you think is happening to you? What is causing the problem?** **5. What do your family, friends or others in your community think is causing the problem?**
PERSONAL HISTORY	- STRESSORS AND SUPPORT 6. Are there any kinds of support that make your problem better? E.g. support from your family, friends or others in your community 7. Are there any kinds of stresses that make your problem worse? E.g. money, family problems
	- ROLE OF CULTURAL IDENTITY 8. What are the most important aspects for you of your background and 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?
PAST PSYCHIATRIC HISTORY	- SELF COPING 11. What have you done on your own to cope with your problem?
	- PAST HELP SEEKING 12. What kinds of treatment, help or advice in the past have you sought for your problem? (Doctors, helpers ,healers) What types of treatment were most/least useful?

	- BARRIERS 13. Has anything prevented you from getting help as you need?
	PREFERENCES 14. What kinds of help do you think would be most useful to you at this time for your problem? 15. Are there any kinds of help that your family, friends or others in your community have suggested would be helpful for you now?
	CLINCIAN-PATIENT RELATIONSHIP **16. Have you been concerned that the doctor may misunderstand your problem? Is there anything that can be done to provide you with the care you need?**

(2) It was the experience of the researcher that some of the questions of the CFI came across as a repetition to the participants. To address this, it can be recommended that the administration of the CFI questions can be clustered as follows: Questions 1 and 4, Questions 2 and 5, as well as Questions 12 and 14.

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ADDENDUM 1

CULTURAL FORMULATION INTERVIEW

CULTURAL DEFINITION OF THE PROBLEM

17. What brings you here today? How would you describe your problem in your own way?
18. How would you describe your problem to your family, friends or others in your community?
19. What troubles you most about your problem?

CULTURAL PERCEPTIONS OF CAUSE- CONTEXT AND SUPPORT

- **CAUSES**

20. What do you think is happening to you? What is causing the problem?
21. What do your family, friends or others in your community think is causing the problem?

- **STRESSORS AND SUPPORT**

22. Are there any kinds of support that make your problem better? E.g. support from your family, friends or others in your community
23. Are there any kinds of stresses that make your problem worse? E.g. money, family problems

- **ROLE OF CULTURAL IDENTITY**

24. What are the most important aspects for you of your background and identity?
25. Are there any aspects of your background or identity that make a difference to your problem?
26. 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 BEHAVIOR

- **SELF COPING**

27. What have you done on your own to cope with your problem?

- **PAST HELP SEEKING**

28. What kinds of treatment, help or advice in the past have you sought for your problem? (Doctors, helpers ,healers) What types of treatment were most/least useful?

- **BARRIERS**

29. Has anything prevented you from getting help as you need?

- **PREFERENCES**

30. What kinds of help do you think would be most useful to you at this time for your problem?
31. Are there any kinds of help that your family, friends or others in your community have suggested would be helpful for you now?

- **CLINCIAN-PATIENT RELATIONSHIP**

32. Have you been concerned that the doctor may misunderstand your problem? Is there anything that can be done to provide you with the care you need?

ADDENDUM 2

COLLEGE OF PSYCHIATRISTS′ LONG CASE FORMAT

Organization, Presentation and Communication Skills

When presenting a case the candidate must provide a logical narrative of the patient's story that flows from the main complaint. Please note that the headings below serve only as a guide and the order and content are flexible depending on the patient and the nature of the presenting problem. After hearing a case history, examiners should have a good understanding of the patient's presenting complaint, current situation and relevant background developmental, psychiatric, medical, family and social history. The patient's mental state needs to be described in detail including relevant bedside cognitive testing and a physical examination is essential. Candidates must present a well-integrated summary, case formulation, management plan and the patient's prognosis.

History

Mention any difficulties obtaining the history at the beginning of the presentation and comment on the reliability.

Demographics

- Name
- Age
- Language
- Marital Status
- Number of children
- Employment status, if unemployed: disability grant/pension/medical boarding
- Accommodation: location, formal versus informal housing, number of people residing in dwelling
- Religion
- Handedness
- Context of where patient was seen i.e. inpatient versus outpatient
- Route of referral
- MHCA status

History of Presenting Complaint

History of the presenting symptoms of the current illness episode, use the patient's own words where possible, mention positive and negative findings.

- Precipitant/s
- Temporal relationship between precipitant/s (e.g. substance misuse) and symptoms
- Duration of symptoms
- Evolution of symptoms
- Aggravating and relieving factors
- Associated medical and psychiatric symptoms including screen for DSM criteria symptoms of the current provisional diagnoses

- Response to medication and or therapy
- Systematic Enquiry: Screen for other relevant symptom clusters that may suggest the presence of another disorder e.g. mood, anxiety, psychotic, eating, substance use, cognitive and personality disorders

Past Psychiatric History

- First illness episode
- First contact with primary care physician, psychiatry, psychology, traditional or spiritual healer
- Previous psychiatric diagnoses
- Number and details of previous illness episodes: precipitants, duration, severity of symptoms, response to treatment, duration of remission
- First admission
- Number and details of admissions: MHCA status, duration, treatments
- Last admission
- Previous pharmacological, psychological and social managements and response to treatment. There should be sufficient detail to enable an assessment of the adequacy of the treatment e.g. dose, duration, adverse effects, adherence
- Previous ECT –no. of treatments and response/side-effects
- Psychosocial rehabilitation interventions
- Adherence
- Details of previous suicide attempts and deliberate self-harm

Past Medical and Surgical History

- Neurological conditions: head trauma, epilepsy, delirium, CNS infections
- Non-neurological conditions: diabetes, hypertension, thyroid disease, asthma, TB, HIV, syphilis, cardiac disease, renal failure, liver disease
- Gynaecological/obstetric history; contraception; pregnancy status/LMP
- Previous surgeries
- Known allergies
- Past and current treatments: side effects, adherence

Past Drug and Alcohol History

Current substance misuse problems must be explored in detail in the history of the presenting complaint including onset, precipitant/s, amount, effects, features of abuse and dependence, medical and psychiatric complications, attempts to stop, stage of change.

- Cigarettes: onset, duration, amount (pack years), attempts to stop
- Alcohol: onset, precipitant/s, duration, frequency, amount in units, features of problematic pattern of use, medical and psychiatric complications, attempts to stop, duration of remission
- Other drugs: Specify drugs used, onset, precipitant/s, duration, frequency, amount, features of problematic pattern of use, medical and psychiatric complications, attempts to stop, duration of remission
- Caffeine: amount, duration
- Over the counter medications: onset, precipitant/s, duration, frequency, amount, features of problematic pattern of use, medical and psychiatric complications, attempts to stop, duration of remission

Forensic History

- Cautions, charges, convictions for criminal behaviour
- Prison sentences: charge, duration, probation
- Current court cases pending

- Screen for antisocial behaviour

Family History

- Genogram including parents, siblings, spouse/partners and children
- Deaths: note age and cause
- Medical illness
- Mental illness: suspected symptoms, psychiatric diagnoses, suicide, substance misuse, treatments
- Nature of relationships: Refer to quality of attachment with primary caregivers.

Personal History

The depth and focus of the personal history should be guided by the working diagnosis.

Developmental

- Pregnancy: planned vs unplanned, mother's mental state, substance use, intrauterine infections, duration
- Mode of delivery, complications of labour, neonatal complications
- Milestones
- Illness/ physical trauma
- Abuse, neglect
- Parental separation, parental violence
- Enuresis, encopresis
- Traumatic events

Educational

- Age in grade 1
- Type of schooling
- Primary school
- Secondary school
- Tertiary education
- Problems: academic problems(e.g. learning difficulties, failures), bullying, separation anxiety, school refusal, truancy, conduct disorder symptoms, ADHD
- Protective factors: friendships, sports, hobbies, enjoyment of school

Occupational

- First job
- Number of and duration spent in subsequent jobs, reasons for leaving
- Most recent job
- Problems: discrimination, fired, mental and physical health hazards, medical boarding, disability grant

Psychosexual and relationships

- Current relationship status: duration, quality, domestic violence
- Previous relationships: number and average duration, patterns or problems, marriage/separation/divorce
- Sexual orientation
- Sexual problems
- Previous sexual trauma
- Number of sexual partners

- Previous STDs
- Contraception
- Number of pregnancies and complications including antepartum and post-partum psychiatric disorders
- Children

Current Social Circumstances

- Accommodation: water, electricity, overcrowding
- Employment
- Functioning: ADLs and IADL
- Support: family, friends, colleagues, religious organisations, hobbies
- Finances

Premorbid personality

- Self-description
- Hobbies and interests
- Religious affiliation/spiritual beliefs/cultural influences
- Coping skills, reaction to stress

ADDENDUM 3

FIELD NOTES ON CONDUCTING INTERVIEWS

LOGISTICAL VARIABLES	
ENVIRONMENTAL FACTORS	- Total number of patients booked at the clinic - Total number of patients seen by interviewer - Interview venue/space
TIME FACTORS	- Time booked for patient - Actual total duration of interview (minutes) - Time to conduct the Long Case Presentation Format (LCPF) - Time to conduct the Cultural Formulation Interview (CFI) - Additional time required
FLUENCY IN ENGLISH	- Level of education - Patient's fluency in English read; write; talk (poor, good) - Factor in extending time: Y/N
LEVEL OF PATIENT ENGAGEMENT	- Due to poor MSE very poor; poor, good, very good

ADDENDUM 4

INFORMATION SHEET AND CONSENT FORMS

1. PARTICIPANT INFORMATION SHEET

Title of Study: THE USE OF THE CULTURAL FORMULATION INTERVIEW AT HELEN JOSEPH HOSPITAL PSYCHIATRIC UNIT.

Introduction:

Good day, my name is Dr Tsikoane and I am a student in the Department of Psychiatry. Research is just the process to learn the answer to a question. In this study I would like to find out about the use of the Cultural Formulation Interview. Culture influences patient care, especially in those patients who identify culture as having a role in their presentation, and it is important that treating clinicians have tools they can use to formulate psychiatric diagnosis. Culture affects the encounter between the clinician and patient as well as the relationship that develops from this. It is therefore vital to consider cultural formulation as an integral component of every routine clinical assessment.

Invitation to participate:

I would like to invite you to participate in the following study which is considering the application of the Cultural Formulation Interview in addition to the normal interview that you would have when consulting with your psychiatric doctor. The researcher will ask you a list of 16 questions about culture and how it relates to your mental. It will be required of you to participate in the interview for an hour in addition to the normal psychiatric interview.

Participation:

Participation is voluntary and all participants must be 18 years and older. The participants must be able to communicate verbally in English. You are under no obligation to participate in the study and you are at no risk or penalty.

Confidentiality/ Anonymity:

Confidentiality will be maintained at all times and your personal details will not be divulged at any phase of the study. This will be done by not collecting identifiable data and by using codes for patient identification. The results will be collected and analysed by the researcher. The researcher will have access to the raw data as well as the research supervisor and statistician who will assist with data analysis.

Contact details:

HREC Administrator for participants - The purpose of this is for the participant should they require to direct queries, concerns or complaints regarding the ethical activities surrounding the study

HREC (Medical): Ms Z Ndlovu Administrative Officer 011 717 2700/1234/1252
zanele.ndlovu@wits.ac.za

Researcher: mpho.tsikoane@wits.ac.za

Thank you for taking the time to read this information sheet.

2. CONSENT FORMS

Study: THE USE OF THE CULTURAL FORMULATION INTERVIEW AT HELEN JOSEPH HOSPITAL PSYCHIATRIC UNIT.

1. Participating in the CFI interview

I ……………………………………………..…… (participant) hereby give my informed consent to participate in this study as explained to me by the researcher.

She has answered all my questions and I understand that the information will be kept confidential and anonymous for the purposes of the study only. I also understand that I will be able to withdraw from the study at any time, without being disadvantaged in any way.

Signature:
Date:

Witness:
Date:

2. Audiotaping of answers to CFI interview

I………………………….…………do hereby give informed consent for Dr Tsikoane,

the study investigator, to audiotape my answers to the different questions in the interview.

Signature:
Date:

Witness:
Date: