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STRENGTHENING THE DSM®
Incorporating Resilience and Cultural Competence
SECOND EDITION

Anne Petrovich, PhD, LCSW
Betty Garcia, PhD, LCSW

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We dedicate this book to the individuals and their families who, through their actions, demonstrate the power of hope in managing and living with a mental disorder.
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Foreword

The DSM-III multiaxial system was an important step forward in the official recognition of the importance of nondiagnostic factors for treatment formulation. This system included separate axes for psychosocial factors and global functioning, with the recognition that accurate and thorough assessment is necessary (although not sufficient) for effective treatment. The text of DSM-III also provided epidemiologic information in categories such as age at onset, course, prevalence, gender distribution, predisposing factors, and familial pattern.

As much of a step forward as DSM-III was in offering mental health practitioners a language with which to communicate, however, its focus remained on psychopathology—what was wrong with the organism. DSM-III and its followers, DSM-III-R and DSM-IV, did not discuss the other side of the coin—how to recognize and utilize diversity and an individual's resilience in the assessment and treatment of his or her mental disorder. With the first edition of this book, Drs. Garcia and Petrovich provided an important missing piece for our quiver of assessment tools. Now that DSM-5 has eliminated the multiaxial system, Drs. Petrovich and Garcia have reformulated their assessment and treatment strategies to focus on diversity and resilience, two components that may be more likely to be overlooked without the structure of separate axes. The text of DSM-5 still includes comments about culture-related diagnostic issues, and risk and prognostic factors, but the basic focus remains on psychopathology.

This new edition emphasizes the need for practitioners to take a broader view in our approach to assessment and treatment formulation and to understand and appreciate the diversity of our clients, and how their different cultures and life circumstances affect their needs today. This more panoramic view encourages us to keep in mind the whole person within a particular environment, from her or his own internal strengths to her or his family factors and other social supports, and even the political context of her or his world. Numerous case examples illustrate the benefits of taking into account our clients’ cultural backgrounds and how these affect their patterns of behavior and the resources they can draw upon to deal with or recover from their mental illness.

The first chapter of this book introduces the important role of culture and how it affects our experience of and expression of stress, as well as how it affects our help-seeking behavior. An appreciation of these factors is necessary to
understand the boundary between psychopathology and normality. This leads the reader to a multicultural perspective on mental health, acknowledging the complexity of factors that make up our social identities and contribute to personal resilience. The second chapter, illustrated with compelling case examples, reviews the development of the DSM® and adds a new model for assessing sources of resiliency and understanding the importance of diversity.

The chapters that follow focus on different major sections of the DSM-5 classification. Each chapter begins with a comprehensive description of the disorder(s) being covered, and how the diagnostic criteria have changed from DSM-IV to DSM-5. Current thinking about the etiology and course of the disorder of focus is then reviewed, followed by a section on evidence-informed practice that lays out leading therapeutic approaches to treating these disorders (for mood disorders, for example, this includes psychopharmacological and psychosocial interventions and the importance of matching the intervention to the patient).

A discussion of equity and diversity issues is followed by a description of strength-based contributions to the diagnosis and treatment of these disorders. Each chapter concludes with a case study of one of the major diagnostic categories covered in the chapter that is discussed with and without a diversity and resiliency formulation. Many of the chapters end with a list of suggested discussion questions and activities, and all chapters end with an extensive list of references. Throughout, many case illustrations are provided, and bulleted key points are highlighted in summary boxes to reinforce the main takeaways.

The authors don’t shy away from biological hypotheses about etiology and treatment, as many non-medical texts do. It is important for mental health professionals to have a full appreciation of the range of factors that affect mental health, including biological ones, so this content is particularly appreciated.

Drs. Petrovich and Garcia bring rich multidisciplinary backgrounds as clinical social workers and psychologists who practice as well as teach, and they have written a book as useful for practitioners as for teachers. With rich case examples and dozens of teaching aids, this comprehensive book will help all mental health practitioners to think beyond the strict framework included in the DSM, and evaluate and treat our clients with the whole person in mind.

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Preface

The DSM-5 signifies a major change in the diagnostic framework. The multiaxial system, introduced in the DSM-III and continued through the DSM-IV-TR, has been eliminated. The DSM-III was an important step forward because its multiaxial format promoted a view of individuals in the context of their lived experience and encouraged the exploration of important nondiagnostic factors relevant to effective treatment. A major challenge with the utilization of the DSM-5 is to introduce diagnostic protocols that focus on what has been lost with the elimination of the multiaxial system. In addition, the challenge for the clinician or educator is to find assessment formulations that address the whole person in her real-life contexts, which offer diverse sources of strength and resiliency to counterbalance sources of stress.

We were inspired to write the first edition of this book due to an interest in addressing the long-standing discontent with the ability of the DSM® to offer a diagnostic formulation that takes into account the rich diversity of life contexts and provides a coherent taxonomy as a guide to treatment decisions. The introduction of the DSM-5 now raises even more challenges to provide a realistic assessment that is functional and has relevance for all populations regardless of history, culture, and life conditions. We strongly believe that effective diagnosis requires a transactional perspective that views individuals in their biopsychosocial, cultural, and spiritual totality, in the context of their history and in relation to strengths originating in personal, family, community, and cultural sources.

The first edition focused on the need for culturally attuned clinical practice that recognizes disparities in mental health service delivery and treatment and greater integration of the individual’s strengths and resources, both internal and external, into the clinical formulation. The introduction of the DSM-5 has sharpened the focus of this second edition in several ways. The exclusion of an individual’s psychological, interpersonal, community, cultural, and spiritual sources of strength and resiliency from the current diagnostic classification system and diagnostic process results in the omission of rich and complex sources of information essential for a competent diagnosis (Alegria et al., 2008). This exclusion also undermines identification of vital social support and
empowerment. As a consequence, an accurate understanding of the individual in context is compromised, and much of what is needed for effective engagement, diagnosis, and formulation for treatment is lost. Our proposed diversity/resiliency formulation addresses contextual and individual factors related to diversity, equity, and resiliency, comprising internal and external resources that are essential to explore, recognize, and understand for effective clinical practice with the whole person. This, we believe, is an essential counterpoint to an exclusive focus on pathology and on related stress as found in the current structure of the DSM-5.

We continue to believe that social justice, the empowerment of oppressed groups, the participation of consumers in service delivery, and a family and community focus are undervalued in diagnostic formulations, research questions, treatment methodologies, policy formation, and program funding. We assert that these are increasingly important in the design of programs and interventions in the 21st century, in order to enhance the ability to utilize emerging research findings in genetics, neurobiology, psychopharmacology, and other biologically based treatments in an effective, culturally competent manner that helps our patients not only reduce their symptoms, but also go on to thrive and flourish.

Although it is a difficult goal to accomplish and often involves a delicate balancing act, we have decided not to limit our book to a discussion of the DSM-5 but to emphasize how engaging in truly significant assessment of the whole person leads to meaningful and relevant treatment. Thus, we have retained and attempted to strengthen the dual focus of the first edition: helping the reader use the DSM in a strength-based manner, and highlighting relevant resiliency- and diversity-based research conducive to effective intervention. In order to accomplish this, we have selected certain disorders, or groups of disorders, to discuss in greater depth, as it was impossible to do justice to the entire taxonomy of the DSM-5. We hope the reader will consider the wider application of our diversity/resiliency formulation in responding to any of the DSM-5 diagnoses!

We are appreciative of the clinical lessons derived from the region where we practice and teach, for it has one of the most diverse profiles in the nation. This context, our commitment to culturally competent practice, and the lively discussion introduced by our students regarding serving diverse populations in a creative, empowering manner, continues to challenge us to ongoing exploration and learning. We are also appreciative of the support given by our colleagues in taking time to review our work and provide incisive and thought-provoking feedback on our manuscript. We value the insight from colleagues in medicine, psychology, nursing, counseling, education, and social work. In addition, we want to emphasize strongly that we intend this book to have widespread applicability for clinicians and educators across the multidisciplinary spectrum of mental health practitioners, as well as for physicians in general practice (i.e., any setting in which the DSM is taught and/or utilized).
TERMINOLOGY

We note a few considerations in relation to the terminology used in this book. There are several distinctions about our use of terms that bear clarification, due to the assumption that although some terms are thought to mean the same thing to everyone, in reality there may be many interpretations of any one term or concept. Those that we feel merit explanation as to our usage include:

- The terms *client*, *patient*, and *consumer* are used interchangeably, consistent with multidisciplinary language.
- Masculine and feminine pronouns are used alternatively throughout the text with the intention of avoiding gender bias in our language.
- *Race*, *ethnicity*, and *culture* are used interchangeably to refer to what have been called “racial minorities” and/or to socially based class or group differences relevant to our diverse society. Our references to race are made in a context of recognition that race is a social construction rather than an indicator of real differences based on phenotype and other characteristics. *Culture*, however, may refer to occupational or other broad ranges of identities that are sources of meaning to individuals.
- *Diversity*, a broader term, refers to the multitude of complexities within and outside of our clients. This can include gender, social class, immigrant status, age, spirituality, as well as other relevant contexts.
- *Resiliency* refers to both inner, psychological sources of positive functioning as well as to external interpersonal, familial, cultural, and societal sources of support and strength.

HOW THE BOOK IS ORGANIZED

In Chapter 1, we address the importance of professional values that respect difference; we appreciate the role of culture in shaping attitudes (i.e., beliefs, feelings, and behavior) of individuals, families, and communities; and view culture as a source of resiliency and strength, considerations introduced by clinical practice on a global level and the systematic use of the *International Statistical Classification of Diseases and Related Health Problems* (ICD-10; World Health Organization, 1992). Chapter 2 addresses the development of the DSM as a context for our current focus on DSM-5, summarizes its strengths and weaknesses, and addresses the main controversies in current psychiatric diagnosis. As a corrective to mental health diagnosis based solely on pathology, we propose a model in Chapter 2 for assessing internal and external sources of resiliency and strength and conclude with contrasting case studies illustrating diagnosis with and without the use of the model. Each subsequent chapter is then organized by a discussion of the disorder(s), a case study that demonstrates a presenting problem related to the disorder, a summary of relevant research, and suggestions for multidisciplinary mental health clinicians and educators.
Chapters 3 through 9 deal with specific illnesses, including mood and anxiety disorders, severe mental illness, oppositional and conduct disorders, disorders co-occurring with substance abuse, and Alzheimer’s disease. Consistent with its position as its own separate chapter in the DSM-5, we have added a new chapter on “Trauma and Stressor-Related Disorders.” In selecting these particular disorders, we recognized the impossibility of reviewing the entire spectrum of disorders described in the DSM; instead, we chose to highlight diagnoses that challenge all the mental health disciplines, appear continuously in mental health clinics, and offer powerful ways to illustrate the utility of adding our proposed Axis VI to the DSM taxonomy. Chapter 10, “Future Directions,” identifies challenges that we propose lie ahead in the ongoing development of intelligent and compassionate mental health practice.

The organization of each chapter in this edition includes:

1. An introduction to a category of disorder
2. DSM diagnostic criteria (includes summary of changes from DSM-IV-TR, rationale and implications for treatment)
3. Current understanding of etiology and course of disorder and the role of biological, genetic, and psychosocial factors, incidence, review of developmental issues and co-occurring disorders, current thinking about risk and protective factors
4. Evidence based practice (EBP) that builds on neurobiological and psychosocial findings is identified; updated research findings on best practices are included.
5. An updated review of equity and diversity-disparities research findings is included. Disparities research addresses the differences between identified population needs and access of those populations to services. The concept of equity has emerged more recently in recognition that it is not sufficient for all populations to have access to standardized services and that services in fact, based on diversity and uniqueness, must be individualized and responsive to individuals’ lived experience in order to be effective. Factors related to disempowerment issues associated with socioeconomic class, ethnicity, gender, age, and disability in relation to disorders are explored
6. Examples of empowering, resiliency-based diagnosis and intervention
7. Presentation of a case study, including diagnostic formulation and treatment planning
8. A contrasting diagnostic assessment of the case study that compares a traditional DSM-5 diagnosis with and without the addition of the proposed diversity/resiliency formulation for addressing resources of strength and empowerment; all case studies have been constructed from true client experiences, or are composites of several client experiences, with identifying information and contextual clues altered for the purpose of protecting client confidentiality
9. Summary
10. Discussion questions and suggested activities for clinicians, supervisors, and educators
Ethnographic, narrative, and consumer-driven approaches to communication between clinicians and clients are integrated in our approach to the assessment and diagnostic process. Each chapter includes references to web-based resources that are relevant to research, assessment, and interviewing skills, such as assessment and interviewing protocols and research publications and documents. Inserts address core chapter concepts, discussion points, experiential exercises, and assignments. The updated assignments reflect strength-based multisystems practice and focus on assessment and interventions with individuals, families, and communities. Readers will be challenged to understand and incorporate the social construction of meaning in clients’ lives—based on cultural diversity, class, age, gender, life experiences, and other factors—and to view these complexities as sources of resiliency and strength as well as stress.

It is our hope that this text will embolden mental health professionals, educators, and students by clarifying the potential for DSM-5 to go beyond a focus on the presence of pathological symptoms and environmental stressors to address sources of resiliency, that is, to encounter the whole person. We present both traditional and innovative clinical diagnostic and assessment considerations from a strength-based theoretical perspective in the context of multicultural awareness and competence. We encourage an approach to diagnosis that has the potential to reduce the disempowering, stigmatizing effects of diagnosis by promoting strength and contributing to the possibility of clients’ flourishing. Our intention in this second edition is to promote critical thinking, based on an understanding of diagnostic systems, their essential components, and their relationship to the historical and cultural contexts of the individuals whom we serve. The DSM-5 introduces new possibilities for enhanced diagnosis, but it also contains a significant risk of reinforcing iatrogenic effects of the assessment and intervention processes. It is thus even more essential to recognize the limitations of the diagnostic systems we use to guide our professional practice. We believe it is our ethical and professional responsibility to promote dialogue that challenges these limitations and promotes the enhancement of effective understanding and intervention.

It is our intent that this text be applicable and have utility for all mental health professionals in social work, psychiatry, family medicine, psychology, rehabilitation counseling, marriage and family therapy, and nursing. We are deeply indebted to those consumers of mental health services who have shared their stories and inspired us with their resourcefulness and courage. They deserve the best we have to offer. We hope that the concepts put forth in this book will contribute not only to the enhancement of accurate and relevant clinical diagnosis but also to our commitment to the future in a more caring, compassionate society.

REFERENCES

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highlights diversity and resiliency. Our collaboration toward the second edition
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the wealth of authorship. Although we both have engaged in learning about
the DSM-5, Anne has presented workshops on the DSM-5; her insights into the
DSM are invaluable and add a layer of depth to the presentation of this content.
She is informed by years of practice wisdom, joyful teaching experience, and
active involvement in her community. Betty's perspective is enriched by teach-
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ONE

A Conceptual Framework for the Diversity/Resiliency Formulation

An accurate diagnosis comes from a collaborative effort with a patient. It is both a product of a good relationship and one of the best ways of promoting it. The focus, first and foremost, should be on the patient's need to be heard and understood. This must trump all else. Done well, psychiatric diagnosis leads to appropriate treatment and a good chance for cure or at least substantial improvement. Done poorly, psychiatric diagnosis leads to a nightmare of harmful treatments, unnecessary stigma, missed opportunities, and negative, self-fulfilling prophesies.

—A. Frances

Diagnosis is a critically important process that sets the stage for treatment and also establishes the groundwork for long-term consequences that bear on quality of life and social identity. Mental health professionals learn quickly that any individual you meet is more complex than his or her diagnostic label, and a central aim is to keep the whole person in perspective as one participates in assigning a categorical label to a person. The purpose of the Diagnostic and Statistical Manual of Mental Disorders (DSM®) is to provide a guide to clinical diagnosis through the identification of clearly articulated descriptive diagnostic criteria based on agreed-on symptoms of pathology for each disorder. As a taxonomy, the DSM provides the basis for unambiguous communication among professionals on symptoms associated with disorders. Knowledge of the DSM is required not only of all mental health clinicians but also of practitioners who provide a variety of other services to individuals, because mental health clients often receive a variety of services in settings such as schools, hospitals, and social agencies.

Discussion on a litany of limitations in the DSM has been ongoing in the literature and has called attention to potential changes that could lead to a strengthened diagnostic taxonomy (Kupfer, First, & Regier, 2002). Publication of the DSM-5 (American Psychiatric Association [APA], 2013), in principle, represents an advancement over the DSM-IV-TR's (2000) capacity for accurate and effective diagnostics. However, as discussed in this text, substantial discussion
continues regarding the assumptions underlying the structural changes and the effectiveness of the new diagnostic format and categories. We address the extensive changes in diagnostic categories and criteria/specifiers relevant to a discrete set of disorders. More important, we address the implications of deletion of the multiaxial format and introduction of a singular diagnosis that is complemented by narrative and outcome measures. One overriding concern is that the new format presumes that clinicians will, of their own accord, invoke use of DSM-5 codes that address “Other Conditions That May Be a Focus of Clinical Attention” (APA, 2013, p. 715). These “Conditions” reflect content previously addressed in axis IV that were required as part of a complete diagnostic. Most disconcerting is the loss of the multiaxial diagnostic format that mandated examination and documentation on mental illness and personality disorder, if relevant. Responses to the DSM-5 changes raise concern about potential harm in utilizing only one diagnostic label at the risk of losing the individual and his context.

Implications of the DSM-5 will be elaborated on in Chapter 2 as well as in relation to the seven diagnostic categories addressed in this text. The purpose of this book is to address changes in the DSM-5 and highlight diagnostic considerations that need to continue to be addressed in the process of increasing the accuracy, relevance, and effectiveness of the mental health diagnostic process. We hope to accomplish this via two main proposals. Our aim is to (a) balance the assessment of pathology with an appreciation of internal and external strengths and resources in order to understand more accurately the interaction of stressors and resources in the client's life, and (b) identify domains—to be explored in assessment—that illuminate the client's cultural, familial, and socioeconomic contexts and enhance diagnostic information.

We propose that attending to the client's cultural contexts and sources of resiliency must be a formal part of the diagnostic process, in order to understand the client more comprehensively and to develop a treatment plan that incorporates the client's complex contextual world. In this chapter we review issues that continue to challenge the development of a more effective application of the DSM. Specifically, there is a need for a more thorough diagnostic process comprising diverse populations and for the incorporation of sources of strength and resiliency in the diagnostic process. This chapter addresses culture and mental health by focusing on updated theoretical and research literature that has explored the meaning of the diverse contexts of our clients and the complex interactions among constructs such as culture, social class, ethnicity, gender, and race. It summarizes the relationship between these contexts and the experience of seeking and receiving help for a diagnosed mental illness and concludes with a rationale for our proposed diagnostic template/format presented in Chapter 2. Chapter 2 presents the diagnostic protocol proposed in this text to enhance a culturally relevant diagnostic process that incorporates internal and external sources of client resiliency.

A major challenge in conducting effective diagnosis is to factor in the totality of the individual in relation to his or her context. Inclusion of the cultural contexts within which individuals live strengthens the clinical formulation, so that it captures the subtleties and substance of experiences and worldviews.
This will enhance the clinician's understanding of mental disorders through the lens of multifaceted cultural and socioeconomic contexts.

The changing demographics of American society, evidenced by the skyrocketing growth of ethnically diverse groups, contribute to the urgency for the DSM to provide a framework for accurate diagnosis with all individuals, regardless of such diverse factors as national origin, ethnic identity, religious/spiritual beliefs, socioeconomic position, and gender identity. A relevant mental health workforce is one that is prepared for the heterogeneity in the populations served. An estimated one out of three Americans is a member of a historically underrepresented group (HUG); and as the growth rate of diverse groups increases, immigrant communities are expanding to all corners of the United States. These facts present an immediate challenge to all mental health providers. The Hispanic population alone is projected to almost triple between 2008 and 2050, which means that Hispanics will represent almost one in three residents in the United States (Bernstein & Edwards, 2008). These changes present opportunities for mental health professional communities to evaluate their diagnostic strategies, treatment approaches, and interventions. This increased diversity demands an examination of the assumptions we make about the efficacy of our work when the complexity of clients' lives is taken into account. It also requires attending to the emergent voices of consumer advocates and an effort to make consumers active partners in the diagnostic and treatment process. It is increasingly essential that clinicians understand the need to practice in a culturally congruent manner.

KEY POINTS

1. As the client population becomes ever more diverse, the need for cultural competence in the diagnostic process is crucial.
2. Accurate diagnosis should include the assessment of internal and external sources of resiliency and strength, particularly as these relate to socioeconomic and cultural contexts.
3. Relevant assessment requires a mutual process of collaborative partnership with the consumers of mental and behavioral health services.

CULTURAL COMPETENCE: STATUS OR PROCESS? INTERPERSONAL OR MULTILEVEL LENS?

Surprisingly, the misconception remains alive and well in mental health and other services that cultural competence is a status to be achieved in the realm of interpersonal ability. Perhaps the confusion is contained in the term competence. This concept suggests to many clinicians that it is possible to achieve a final state of cultural competence by taking a class or securing a certificate, when in reality all learning activities are but points on a lifelong process of ongoing heightened awareness. The concept of culturally competent practice has evolved
to include an emphasis on one's actions and behaviors, not just what one feels or one's level of awareness. This focus highlights the identification of measurable behaviors and outcomes that can confirm or disconfirm effectiveness. This approach goes beyond the mere intention of implementing empathic interventions based on awareness and sensitivity. We can assume that all clinicians have the intention of conveying empathy. Culturally competent interventions are observable behaviors associated with successful outcomes in relational terms (i.e., engagement, consumer adherence, and commitment to treatment) and are the consequence of the development of personal and interpersonal awareness.

The current focus on cross-culturally effective practice has returned to the earlier notions of cultural sensitivity and humility as gold standards of practice. The intent of this recent shift to the concept of humility is to highlight a focus on awareness of the limits of one's understanding, and the reality that the development of cross-cultural clinical skills is a lifelong endeavor. It is a process, not a status that is influenced by the institutional/organizational context and evolves in relation to changing cultures and practice demands. A process approach to the interpersonal level of cultural competence presumes that we can never entirely achieve full effectiveness in a culture different from our own. However, this does not preclude practice with the intention of meeting the ethical demands associated with the responsibility of having a basic understanding of and motivation to learn about our client's cultural context(s). Such an understanding allows the clinician to size up a client's uniqueness, distinct from stereotypes the clinician may hold (S. Sue, 1998), in relation to her own life experiences and social identifications.

The interpersonal process approach to cultural competence can also obscure the importance of defining cultural competence on multiple levels that lend themselves to ongoing education, research, and organizational proficiency. Clinical relational efficacy, ongoing professional development, and culturally relevant programming are only as strong as organizational policy and leadership that identify with and promote culturally relevant practices applying to all populations—for example, in relation to ethnicity, gender, socioeconomic class, and religion (APA, 2004; APA, 2003; National Association of Social Workers [NASW], 2007; see also the website for the National Center for Cultural Competence at Georgetown University, www11.georgetown.edu/research/gucchd/nccc). Our text focuses on the concept of competence—that is, on what clinicians do, with sensitivity, in a welcoming way with their clients/consumers of all backgrounds.

Conceptual frameworks that provide guides for effective practice with diverse populations also need to integrate factors—such as social power differences related to socioeconomic status and social standing—between clinician and client. It is invaluable for clinicians to attend to the implications of differences in privilege and social power between themselves and their clients. Foremost, the client's needs lead our engagement efforts; however, it is helpful for clinicians to be attuned to differences between themselves and the client that, if relevant, can benefit from acknowledgment. A clinical perspective that recognizes that there is greater heterogeneity within any group than between...
groups provides a basis to inquire about factors such as level of acculturation, religion, national origin, and socioeconomic class.

The concept of intersectionality assists in grasping the complexity of heterogeneity within groups by highlighting the intersecting and interacting elements of gender, socioeconomic class, ethnicity, religion, and other factors that combine in dynamic and changing ways depending on the experiences of an individual. The intersections of various factors related to culture and potentially to marginalized status—such as low socioeconomic status, gender, and disability—introduce unique subjective perspectives. A married, third-generation Latino female with a master’s or law degree will have different life experiences with privilege and marginalization than will a second-generation, single Latino female with a high school degree, even though they have the same working-class background. Not to address these complexities is to limit and distort one’s understanding of the client’s experience and worldview. Differences within groups belie stereotypes and evoke probing that reveals the client’s uniqueness and is premised on skilled and genuine inquiry. Clinicians must ask:

- What do I need to do to establish credibility with the population(s) that I serve?
- What conditions must I understand in this client’s culture in order to proceed in the diagnostic task?
- What is important to appreciate in the diagnostic process in relation to this person’s age, gender, or position in his or her culture?
- What approach will work best with this person in this situation—for example, in order to secure permission to inquire into sensitive areas? (D. W. Sue & Sue, 2008)

Conceptualization of effective culturally competent practice has further advanced, in line with social justice assumptions, to reframe culturally relevant practice as transformative for all levels of practice (i.e., practitioner, client, organization, institution)—that is, a process that promotes equity. Transformational change is change that leads to alterations in perception and meaning made by modifying one’s assumptions and expectations (Jones, 2010), resulting in behavior that is more “inclusive, discriminating, open, reflective” and emotionally open to change (Mezirow, 2003, p. 59). A multilevel approach to transformation presumes that clients, clinicians, organizations, and institutions change as a result of open exchange and professional growth, where previously unrecognized options and choices come to the fore in the process of greater culturally relevant skills and policy development. The new focus on equity in culturally relevant practice highlights the role of social justice in promoting clinical exchange and mental health services that are individualized and pertinent to clients and their families. This perspective represents progress beyond the concept of disparities; it is aimed at providing access to relevant services, and elevates the discussion to quality of services, individualized services, and goodness of fit of the clinical approach to the client’s needs.
KEY POINTS

1. Cultural competence is a process, not a status that is achieved and assumed.
2. Cultural competence is never fully attained, because we can never fully experience the diverse worlds of our clients.
3. Cultural competence is adequately evaluated only by examining behaviors and their outcomes in the lives of clients, utilizing the concepts of transactionality and intersectionality to embrace the complexity of an individual's unique experiences.
4. Effective cultural competence is transformative at individual, interpersonal, and institutional levels, thus promoting social justice at all of these levels.

PROBLEM AREAS AND BEST PRACTICES FOR MENTAL HEALTH

Considerable conceptual and empirical work addresses the basis for advancing efforts to increase effectiveness in engagement with clients of all backgrounds. Much of this writing delineates significant clinical issues associated with contextual factors such as culture and socioeconomic class. There are several streams of literature in this regard; these bear on the DSM as a social construct, the consequences of bias in the diagnostic process, and proposals for improved competency in diagnosis and assessment. Marsella and Yamada's (2000) review of the literature on culture and psychopathology observes that although the role of culture in influencing the “onset, expression, course, and outcome of psychopathology” is understood, still there remains a need to recognize the assumptions based on Western culture that underlie the DSM conceptualization of health and illness (p. 801). Snowden's (2003) discussion on the nature of bias and the need to know more about when and how it operates addresses the stark consequences of the overdiagnosis of schizophrenia in African Americans (Baker & Bell, 1999), the dilemma of clinicians’ overpathologizing ethnic individuals by misinterpreting normative behavior as indicative of a mental disorder (Lopez, 1989), and, however inadvertent, the potential for bias to undermine the ever-important therapeutic alliance (Hovarth, 1994).

In their study of 129 mental health intakes, Alegria et al. (2008) data on missing information and bias in the clinical encounter found that clinicians rely more on client report than on DSM criteria. This is particularly interesting in that it seems to counter a lot of critics who feel that diagnosis is based too much on criteria, defined as the DSM identification of symptoms that may or may not fit the individual’s experience. In practice, clinicians may be compensating for the weaknesses of the DSM in the diagnostic process. Alegria et al. (2008) propose that the clinical information gathered in the diagnostic assessment and the values that underlie how that information is used in clinical decisions can compromise the accuracy of the diagnosis. Yamada and Brekke's (2008) review of the literature on the need for integrating sociocultural issues into the assessment process concluded with the proposal of an assessment protocol that explores changes in environment, stressors, support, life-control concerns, status
of literacy and communication, reference group/network, and expectations about treatment. Moreover, they suggest that the clinician's inquiry and demonstration of curiosity has the additional benefit of communicating interest in the uniqueness of the client and facilitates engagement, thus strengthening the therapeutic alliance.

In response to the need for culturally informed services and equity, all mental health professions have taken steps to address these issues in various ways. Some of these efforts include the development of cultural competence standards and the establishment of commissions for the purpose of developing guidelines for practice and research and/or policy statements (APA, 2004; APA, 2003; NASW, 2007).

KEY POINTS

1. Inadvertent bias in the DSM has resulted in the overpathologizing of certain groups by ignoring key strengths and aspects of culture.
2. Culture impacts the way psychopathology is understood and expressed.
3. All the mental health professions have taken steps to address cultural factors in diagnosis.
4. In practice, clinicians unintentionally may go beyond the symptom checklist structure of the DSM when they are engaged in diagnosis.
5. Expressing curiosity in the assessment process facilitates effective engagement with the client, which, in turn, enhances the accuracy of diagnosis.

CREATING A CULTURALLY RELEVANT, RESILIENCY-BASED DIAGNOSIS

The proposals put forth in this book are premised on a culturally competent mental health workforce comprising interdisciplinary professionals; this includes psychiatrists, primary care physicians, social workers, psychologists, psychiatric nurses, marriage and family therapists, licensed professional counselors, and pastoral counselors. The collaborative effort among professionals is challenging from many perspectives and strengthening it has become even more important due to the Patient Protection and Affordable Care Act. Health care and behavioral health providers will increasingly need to be skilled in working together in collaborative teams and in a variety of multidisciplinary contexts that include colocations, health care organizations, and other formal and informal networks. Skills in interprofessional collaboration will be increasingly required as a basis of effective communication across disciplines and organizations. Various disciplines approach mental health practice from a variety of missions, purposes, professional identities, theoretical perspectives, ethical standards, and role definitions, with varying degrees of relative power and status. When these professional differences are taken into consideration, the concept of cultural diversity and competence becomes even more complex, as each discipline has its own culture, influencing the clinician’s sense of self and role with respect to the client.
Moreover, mental health consumers are rightfully demanding a place at the table through the efforts of organizations such as the National Alliance for Mental Health and the advance of the Recovery Model. The future will bring an even greater need for professionals in all fields to work collaboratively, both with one another and particularly with mental health patients, families, and communities. For one, diversity in the mental health workforce will increase as consumers, in the role of peer support, take their place on interdisciplinary teams. It is hoped that more collaboration, it is to be hoped, will increasingly enhance communication between clinician and client in the diagnostic process.

A multicultural perspective in mental health recognizes the value of and appreciation for the complexity of factors that make up social identity and contribute to personal resilience. This perspective assumes that resilience is promoted by several factors related to culture, including the client’s values and beliefs, family ties, and social network resources. When this approach is incorporated into the structure of the DSM diagnostics, the diagnosis can become more grounded in a strengths perspective that examines and assesses clients’ abilities to cope with and rebound from the challenges of living with a mental disorder. This perspective also explores culturally relevant options that help promote greater knowledge about an individual’s mental disorder and acceptance of it. It is based on the view that culture and other client contexts are sources of resiliency and all too often are examined only from the perspective of finding pathology. We propose an empowering perspective that counterbalances an exclusive focus on pathology. This positions culture where it belongs, at the core of diagnosis, rather than as an afterthought or impediment relegated to a DSM appendix or romanticized as a consequence of a reductionist approach. All too often Culture 101 is thought of as learning about cultural practices (e.g., food, music, family traditions) at the cost of inquiring about the specifics of the individual client’s perceptions and meanings concerning her own life. The discussion on the status and application of cultural content in the diagnostic process draws from the empowerment perspective and Recovery Model principles.

Our emphasis on a multicultural perspective with respect to resiliency and strengths takes into consideration several aspects of the experience of ethnic (e.g., African American, Latino, Asian, Native American) diversity and the heterogeneity within each of these populations. Although we address HUGs in the United States, we recognize that the complex issues faced by these groups are confronted by many populations that deserve unique attention. On a national level, clearly there are many U.S. populations, such as South Pacific, Islamic, and Eastern European, that require increased attention in relation to behavioral health issues. Moreover, there is much to be gained as we expand our awareness of behavioral health issues to include the global, international context and its implications for consumers’ lived experience. Regrettably, dominant American culture has all too often marginalized these communities into the “other.” To a large degree, the post-9/11 epoch has promoted and increased our recognition

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1 In this work we refer to Americans of Latino and Asian descent as Latino and Asian.
of the richness and contributions of other cultures in general, their perspectives on behavioral health, and relevant approaches to effective interventions.

Particular attention is given to the roles of social power, discrimination, racism, and the effects of social marginalization (e.g., invisibility, devaluation) in the lives of individuals with mental disorders. The presence of low-income status and low levels of formal education associated with many, but not all, ethnically diverse individuals suggests that meaningful efforts to comprehend and work with such individuals must be carried out within the context of their socioeconomic and cultural worldviews. This attention to the intersection between ethnicity and socioeconomic class will focus clinicians’ attention on clients’ experiences with access, efficacy, and social privilege and penalty. Equally important, an awareness by the clinician of the contribution of culture to client sources of internal and external support and resilience is critical to accurate diagnosis and effective intervention.

KEY POINTS

1. Culturally competent, resiliency-enhanced diagnosis requires greater collaboration among mental health professionals and between professionals and consumers.
2. In the diagnostic process, clients must be understood in the contexts of socioeconomic and cultural factors.
3. These factors contribute sources of resiliency as well as stress.

PSYCHOPATHOLOGY, CULTURE, AND MENTAL HEALTH

Culture has a powerful role in the psychological life of individuals. It plays a vital role not only in forming social identity and thus the shaping of preferences, interests, and needs but also in defining distress. Clinicians are challenged to learn many nuances across different cultures. These nuances include attending to the following questions: What is a normative part of life experience? What is not normative? What are culturally relevant ways of coping? What are one’s sources for help-seeking? Contextual considerations, such as whether the cultures one identifies with value collectivistic or individualistic behaviors, have significant impacts on the options that consumers seek out once they recognize a need to address psychosocial distress. Although a traditional culture might lead an individual to seek out community-recognized elders, an Euro American\(^2\) working-class individual might first turn to religious sources, and a middle or upper class professional might seek out psychotherapy. Culture influences how a mental disorder is experienced; it determines how it is expressed and how symptoms are interpreted. It also identifies acceptable means of coping, determines how the disorder is viewed socially, and identifies relevant sources of help (Alarcon, Westermeyer, Foulks, & Ruiz, 1999; Kirmayer & Young, 1999; Nichter, 1981).

\(^2\) This text will use Euro American, ethnic White, and European American interchangeably to describe individuals whose social identity reflects a European background.
Eshun and Gurung's (2009) discussion of health seeking and coping highlights cultural variations in explanations of precipitants of mental disorders, which can be viewed as supernatural factors or personal deficits in social functioning.

Not to be underestimated is the decisive influence that one's cultural context has on where one first seeks help. Rogler and Cortes's (1993) discussion on help-seeking pathways describes how culture and worldview influence what can be construed as a trusted source with whom one can disclose sensitive experiences for the purpose of securing help. It is critical to understand these culturally shaped behaviors in regard to early intervention and collaborative efforts with other health care professionals, including indigenous healers. These help-seeking pathways vary based on ethnicity, socioeconomic status, and/or religion/spirituality.

As a contextual worldview related to ethnicity, religion, and other factors, culture influences individual behaviors such as cognition, perception, beliefs, values, interpersonal interactions, customs, and institutions developed by social groups (Cross, Bazron, Dennis, & Isaacs, 1989). As a social construct, culture is not static; it changes over time in response to an individual's experiences and the understandings that evolve from this; as such, culture is instrumental in the development of the labels individuals place on their experiences (Lu, Lim, & Mezzrich, 2008). Thoughtful exploration means listening for idioms of distress and explanatory models of mental illness that are derived from client's cultural identifications. One cannot make assumptions about ethnic identity based on an individual's phenotype (i.e., physical appearance, such as skin color, hair texture, facial features), an individual's values, or even the meaning of terminology. It is important for clinicians to develop effective engagement skills that facilitate explorations of the client's subjective experiences. Stories abound in clinical settings, for example, of using Spanish language from one national origin to speak with a Spanish-speaking client from a different national origin, only to discover that one has inadvertently offended the client. For example, a clinician of Mexican heritage once described, when a Dominican client shared a photo of her son and the clinician called him guapo (i.e., good-looking), the client was startled, because that term means “angry appearing” in the Dominican culture!

Concepts such as explanatory models and idioms of distress assist in listening to clients' narratives with the intent of learning from clients how they understand their condition and the manifestation (i.e., symptoms) of what they are coping with. The concept of explanatory models refers to the constructs used by individuals to explain how they understand their symptoms and their current situation, their timing, the types of symptoms that appeared at onset (e.g., lack of motivation, hallucinations), physical sensations associated with a mental health illness, and their beliefs about what is helpful for their condition (Helman, 1990). Lu et al. (2008) suggest that explanatory models can be explored by questioning clients about, for example, what they think has happened; what they believe are the reasons for their reactions (i.e., symptoms)—that is, why they developed; and why they think these reactions occurred now. These theorists also suggest inquiring about possible consequences if nothing is done, how others might be affected, and ultimately what clients think needs to be
done that can be helpful. Probes into clients’ understanding and perceptions of their symptoms can lead to narratives that illuminate how persons experience and express distress as well as how they manage their feelings about their difficulties (Nichter, 1981). Nichter (1981) suggests that these aspects, *idioms of distress*, are derived from cultural values, norms, perceptions of health issues, and cultural suppositions. The DSM’s "Glossary of Culture-Bound Syndromes" presents an extensive list of idioms of distress from various cultures, such as *ataque de nervios*, which is a culturally normative means of expressing distress and grief by agitated behavior and raised voice—for example, in response to an overwhelming personal loss.

A Spanish-speaking clinician once reported communicating in a prison setting with a monolingual Spanish-speaking client who had been stripped to paper clothes and placed in an observational cell by a well-intentioned monolingual English-speaking staff member. The client was thought to be in the midst of a psychotic episode following the death of her infant daughter and was talking to her daughter as if the daughter were alive. The clinician found the woman to be lucid and clearly aware that the infant had died; however, she expressed in Spanish that the grief felt unbearable.

Gurung and Roethel-Wendorf (2009) broaden the discussion of culture’s role in shaping perceptions and beliefs to suggest, from a *stress vulnerability perspective*, that stressors introduced by acculturation and/or cultural conflict wrought by tensions among traditional first-generation and second- or third-generation offspring descendants deserve special attention. This perspective opens up questions regarding the mental health implications of stress in life experiences associated with one’s social identity, ethnicity, social class, or other variables that can generate stress.

The concept of *microaggressions* (Pierce, Carew, Pierce-Gonzalez, & Willis, 1978) was developed in relation to personal violations that are experienced in relation to ethnicity and refers to everyday experiences of not feeling respected or valued. Awareness of microaggressions brings attention to the social consequences of having a severe mental illness that can evoke negative stereotypes and thus stigma. The perspective on microaggressions by D. W. Sue et al. (2007) offers insightful points on often neglected aspects of life experiences resulting from stigma, discrimination, and marginalization by highlighting how microaggression interactions are normative, embedded in daily experiences, and characterized by rudeness, negation, and exclusion. Common examples include being watched and/or followed in department store settings or students feeling that their professor has low expectations of their academic work. These experiences take their toll on the individual. The authors suggest that these realities in the lives of consumers have implications for clinical practice, specifically practice with individuals who are marginalized as a function of negative stereotypes and/or stigma. This places increased responsibility on clinicians to build an effective, attuned therapeutic working relationship.

The experience of microaggressions may arguably also permeate the context in which a variety of clinicians work, an area neglected in the research, which has focused almost exclusively on the client. For example, in the hierarchy of status, power, and financial remuneration among mental health professionals...
and peer support staff, those “low on the totem pole” may often feel marginalized or ignored in the work setting. This could be compounded if the low-status clinician is also a member of a marginalized cultural group in the community at large. Her special insights and useful contributions to the diagnostic, assessment, and treatment process may go unexpressed or be discounted, to the detriment of the client and effective treatment planning and intervention.

Accurate diagnosis requires several capabilities that build on clear and knowledgeable clinical skill. In diverse settings, the ability to recognize the stereotypes and expectations that one brings to the clinical encounter is essential. With respect to ethnic populations, bias in assessment has been found to be a pattern in clinical settings rather than an isolated event. Snowden (2003) proposes that bias represents clinical judgments made about people of color, based on perceptions related to race or ethnicity rather than on discerning probes that delve into understanding the presenting symptoms from the perspective of the individual.

**KEY POINTS**

1. Culture defines how one experiences stress, what is considered normal, and how one seeks help.
2. Accurate diagnosis is impossible without attending to cultural idioms of distress and client explanatory models.
3. Many mental health consumers experience microaggressions on a daily basis; this requires special attention and sensitive attunement on the part of the clinician. Some clinicians, too, may experience microaggressions in the workplace.
4. Accurate diagnosis requires attunement not only to the client’s experiences but also to the clinician’s own sources of bias.

**THE DSM AND CULTURE**

Historically the DSM work groups have made attempts to address the cultural components of diagnosis in various ways. The DSM-IV-TR (APA, 2000) included a section titled “Outline for Cultural Formulation and Glossary of Culture Bound Syndromes” at the end of the text, and the DSM-5 has expanded this passage to include cultural formulation interview (CFI) questions. Although these additions have provided a valuable resource, there is much left to do, as evident in our review of the literature in the preceding sections.

The addition of the “Outline for Cultural Formulation and Glossary of Culture Bound Syndromes” (APA, 2000) was a significant step toward enhancing the responsiveness of the DSM format in addressing diverse cultures and their role in understanding mental illness. The idea for the cultural formulation was developed by the National Institute of Mental Health (NIMH) Group on Culture and Diagnosis in 1991, with the intent to “enhance the cultural validity and suitability of the DSM-IV” (Mezzich, 2008). This committee’s work on the review of existing literature identified four key areas to integrate into practice.
with diverse clients: the consumer's cultural identity, cultural factors in the consumer's disorder, cultural context and functioning, and cultural elements in the clinician–consumer interaction and relationship. Many complexities of social identity have become more clear over time, such as the reality that individuals may have several cultural identifications, not just one, and that such identifications are not either/or but rather degrees of identification with perhaps both dominant and traditional culture (Phinney, 2003).

The phases of the work group's efforts (Lewis-Fernandez, 2008) are instructive for the challenges faced by mental health professionals practicing within frameworks and approaches that facilitate interaction with the whole person in the context of his or her lived experience. Initially the work group proposed adding a sixth axis with the intent of providing a structure for grasping the subjective experience of individuals and their reference groups (Good & Good, 1986). However, the idea was abandoned when it appeared that such a device potentially could lead to a reductionist, decontextualized approach that would further obscure the individual as a function of the protocol. Lewis-Fernandez (2008) makes several observations regarding the intent. Foremost, the intent was to provide a guide composed of principles that affect “the way clinicians view all five axes … [and] to render visible the socially constructed context” that influences a consumer presentation and course of illness (p. 95). He added it was aimed at emphasizing the complex range of cultural factors—such as attributions of causality and patterns of help-seeking—such as clinician contextual, institutional factors. A need to recognize that “culture affects every aspect of the clinical encounter” was recognized. As such, it was hoped that the cultural formulation would promote the use of a “mini-ethnographic narrative assessment” that captured the individual's context sufficiently. It was also intended to highlight how cultural factors influence the manifestation of the clinical features (Lewis-Fernandez, 2008, p. 96).

The DSM-5 moved parts of the DSM-IV-TR Appendix I “Outline for Cultural Formulation and Glossary of Culture-Bound Syndromes” to Section III “Emerging Measures and Models” and to the “Appendix.” Section III includes expanded narrative on understanding the cultural context and revision of the “Outline for Cultural Formulation” to include more subtleties related to conceptualizations of distress, psychosocial stressors, and cultural features of vulnerability and resilience. Section III also includes the newly developed CFI, CFI–Informant Version (i.e., for collateral data gathering), and narrative on the “Cultural Concepts of Distress” (i.e., syndromes, idioms, and explanations). However, the narrative on examples of concepts of distress was moved to the Appendix (p. 833). Several changes were made consistent with the DSM-5 authors’ aim to emphasize that “clinically important differences often involve explanations or experiences of distress rather than culturally distinctive configurations of symptoms” (i.e., syndromes). For one, several culture-bound syndromes and idioms identified in the DSM-IV-TR were eliminated. However, the Appendix narrative on select

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3 We refer to “lived experience” in order to utilize wellness and recovery concepts that highlight consumer's experiences with mental illness.
“Concepts of Distress” is more extensive and addresses differential diagnostic concerns in relation to diverse cultural contexts and DSM-5 conditions.

Placement of the CFI in Section III and relegation of the distress examples to the Appendix has several implications. For one, this continues the DSM-IV-TR pattern of marginalized status of diversity and culturally relevant diagnostic content. In so doing, it places responsibility on clinicians to seek out this content and incorporate it in their diagnostic endeavors. Absent is the structure and direction that challenges clinicians to systematically explore and incorporate strength-based and diversity-sensitive information to view the individual in his totality.

The intent of our work is to advance the development of diagnostic strategies that give primacy to recognition of the person's uniqueness rather than to the diagnostic label in order to facilitate accurate diagnosis. An underlying assumption is that the cultural strengths and resiliency that all individuals have, regardless of ethnicity or culture, deserve more attention in the service of greater accuracy. Much work remains to be done in the development of a comprehensive diagnostic protocol that fosters accurate diagnosis in multicultural settings and that encourages the formulation of an ethnographic narrative. As a social construct, the DSM is founded on culturally grounded values of the medical model and thus potentially has limited application across diverse cultural settings. In addition, practice is frequently driven by organizational factors that stress rapid responses to the highest numbers of patients and place a premium on the use of psychopharmacology as a response to the complex worlds of clients. Redesign of the DSM-5 diagnostic format to one diagnosis, rather than using multiaxial domains, suggests organizational and psychopharmacological expediencies will continue to override individualization of the patient. The unexamined use of a culturally based protocol across diverse cultures raises questions regarding unintended consequences that could lead to harm rather than healing.

An effective DSM should minimally address the following: (a) the role of culture and ethnic identity in the individual's biopsychosocial makeup, functioning, perceptions of mental illness and coping methods; and (b) cultural and individual factors that are a basis of strength, resiliency, and resources. An effective DSM can lead the way to systematic assessment of multicultural realities that have a role in producing mental health disorders. These realities would encompass enduring, stressful events, and microaggressions (D. W. Sue et al., 2007) related to low-income status, marginalization, and low social power faced by individuals of all backgrounds, including immigrants and people with disabilities. Similarly, the role of important nonmaterial sources of strength and resiliency, such as spirituality and social support, can become a routine part of diagnosis and assessment.

In principle, the DSM-5 contains the flexibility and complexity to address the unique mental health concerns of all populations, regardless of ethnicity, gender, age, socioeconomic status, or national origin in a manner that encompasses the individual's strengths and capabilities as well as pathologies. In so doing, the individual's culture, spirituality, social support, and other unique sources of strength and resiliency could possibly become as integral a part of the diagnostic process as are symptoms of pathology and disrupted functioning.
Ideally, diagnostic accuracy will be aided by application of the new DSM-5 format and promote more rigorous understandings of individuals’ complexity and ultimately more effective treatment and intervention outcomes. The ideal, however, is unlikely to be realized in the complex, time-pressured world of mental health treatment. With the former axes system, the clinician was expected to attend at least to stressors in the client’s world and encouraged to add a cultural formulation. With the elimination of the multiaxial format, attending to cultural factors and dynamics becomes a more obscure possibility, dependent on a highly motivated, culturally competent clinician.

KEY POINTS

1. The DSM-5 modifications give recognition to inadequacies in the current taxonomy with regard to client contexts, including culture.
2. The culture of medicine, with its emphasis on pathology and the time pressures on its practitioners, reinforces ignoring client culture and sources of resiliency, thus reducing the accuracy of diagnosis.
3. Corrective changes in the DSM-5 did not promote a more accurate understanding of the uniqueness of the individual beyond the pathological label.

CULTURALLY COMPETENT MENTAL HEALTH: FROM DISPARITIES TO EQUITY

Mental health disparities research addresses the discrepancy between a population’s identified need for mental health services and its access to services (Alarcon et al., 2002; Alegria et al., 2008; U.S. Department of Health and Human Services, 1999; Vega, Kolody, Aguilar-Gaxiola, & Catalano, 1999). Yamada and Brekke’s (2008) review of research on how sociocultural factors influence access to services identifies factors related to clinician, programming, and organizational factors that can affect bias in the diagnostic process. This research highlights the necessity of providing quality, access, and continuity of services, with particular attention to patterns of diagnostic outcomes that might vary among populations (i.e., between White populations and other ethnic groups; Snowden, 2003).

Most significant, this body of research represents a shift in thinking about the underutilization of services to a transactional perspective that examines the contribution of organizational and consumer behavior factors that result in barriers to services or a lack of access to services, continuity of services, and individualized treatment. In addressing environmental factors that impact health status and quality of care (Aguilar-Gaxiola & Breslau, 2007), attention is given to outreach, culturally competent policy, and service delivery patterns. Factors such as program development, organizational mission and leadership, staffing, and other elements can pose barriers to effective multicultural service delivery and require attention in regard to consumer help-seeking pathways (Rogler & Cortes, 1993). Inquiry into the factors that contribute to disparities in services have identified bias in the form of the overpathologizing of
ethnic individuals’ behavior and minimization of their identified concerns (Lopez, 1989; Snowden, 2003) ethnic underrepresentation in outpatient settings and overrepresentation in inpatient and emergency care settings (Chow, Jaffee, & Snowden, 2003; Garyali, 1999; Mukherjee, Shukla, Woodle, Rosen, & Olarte, 1983; Strakowski, Shelton, & Kolbrener, 1993) as well as greater physical and mental disability resulting from lack of health care (U.S. Department of Health and Human Services, 2001). African Americans and Latinos with affective disorders have been found to be misdiagnosed more frequently with schizophrenia (Corrigan, 2014; Metzl, 2009; Mukherjee et al., 1983; Neighbors, Trierweiler, Ford, & Muroff, 2003; Trierweiler et al., 2000), and African Americans have significantly less outpatient psychiatric contact (Kales, Blow, Bingham, Copeland, & Mellow, 2000) compared with other groups.

CASE STUDY 1

A Young Adult and a Mental Health Emergency

A young adult African American male was found wandering the streets of a large American city gesticulating wildly and uttering obscenities. He was 6 feet, 3 inches tall, with a dark complexion and unkempt appearance; his hair was worn in short dreadlocks. He was brought in by police officers to the emergency room of a large inner-city hospital where differential diagnostic considerations included an assumption of homelessness, drug abuse, and/or schizophrenia. He was kept overnight for observation and released within 24 hours with a prescription for Haldol and a follow-up appointment with a public mental health psychiatrist and a substance abuse counselor. He failed to keep his follow-up appointments. During the assessment, he informed the psychiatrist on call that he was a PhD student in physics—a statement that was assumed to illustrate the presence of psychotic delusions; this information, however, was factual. He was suffering from bipolar disorder, not schizophrenia or drug abuse. He fit the prevailing stereotype of a young, inner-city African American male, and thus his strengths were left unrecognized and, in fact, were falsely interpreted as evidence of psychosis. Ashamed and bewildered by his own symptoms, the young man gave the hospital staff a false name. He did not return for the follow-up appointment and ultimately committed suicide.

■ What led to this young man’s becoming a casualty of an overburdened mental health system?
■ What led to the cultural bias that made his individualized needs invisible?

Attention to the fit between services and the specific needs of diverse populations—based on ethnicity, gender, age and other factors—has promoted increased focus on what constitutes culturally competent organizations, policy, and clinical practice (Cross et al., 1989). The underlying assumption of social justice in mental health service provision has now shifted from the term disparities to the concept of equity. Assurance of access to quality and individualized services now drives change efforts for more effective services. It became clear that
access to traditional services for all populations was not meeting the complex and changing needs of diverse groups. Passage of the Patient Protection and Affordable Care Act in 2010, and implementation in 2013, generated significant data on disparities in the American population regarding the privilege of health care insurance. It is alarming that children, the chronically mentally ill, and the aged, who are vulnerable segments of the population, often bear the brunt of the unequal distribution of health care services.

The concept of health equity puts forth disparity reduction goals, supports participatory processes that in the past were in the domain of the professional as expert, and identifies needed changes in policy and service delivery. Moreover, efforts are directed at risk reduction, prevention, reducing barriers to access, and supporting the development of a diverse professional workforce (see the website of the Massachusetts Office of Health Equity: www.mass.gov/dph/healthequity).

Implications of Diversity Demographics

The concept of multiculturalism gives recognition to the variety and significance of ethnic and class culture in the lives of individuals, families, and communities. Multicultural diversity has wide-ranging variation in definition and uses of the concept. In principle, it refers to the notion that “a variety of cultural identities can be lived out in the same society” (Van Soest, 1995, p. 56); moreover, it has become a lightning rod because it bears on the sensitive topic of “the meaning of America”—that is, who we have been, who we are, and what we as a nation wish to become (Hunter, 1991, p. 50). The complexity of individuals' lives, arising from their multifaceted social identity, suggests that a multicultural perspective is essential. In addition, accurate evaluation of mental health functioning in the context of culture and diversity must include socioeconomic factors that intersect with culture. Diversity considerations need to address various types of difference, for example, in relation to socioeconomic class, ethnicity, gender, disability, and LGBTQ considerations. The individual's social power or lack of it, and how this factor bears on coping with mental illness, is essential to understand.

The absence of a systematic way to examine contextual factors—such as socioeconomic status, immigration, poverty, discrimination, and stigma in the development and maintenance of mental disorders—risks vulnerability of the client/consumer to distortion, by mental health providers, of their lived experience and perceptions of that experience. Intersectionality addresses the importance of recognizing all facets of an individual's life experiences and how these various elements interact. Context helps us understand the contribution of a vast array of factors arising from situational, life course, family system, physical environment (e.g., poverty, neighborhoods, schools, justice system), and societal sources (e.g., racism, oppression, negative stereotyping). Understanding an individual's social identity, historical legacy, and social power alerts the clinician to the powerful influence on the individual of a reference group's view of a mental disorder. The identification of a disorder, the meaning it has in the individual's personal and social life, the diagnostic process, and the identification
of interventions are all affected by these factors. In particular, the individual’s capacity for hope and openness to change has a tremendous influence on how a disorder is managed.

CASE STUDY 2

A Suicidal Woman

A middle-aged mother of two daughters had struggled all her life with posttraumatic stress disorder and depression, compounded by intense shame and feelings of failure related to her perceived inability to be a good mother to her children because of her mental illness. Her childhood had been filled with severe physical, emotional, and sexual abuse and neglect. From late adolescence on, she had been repeatedly hospitalized in inpatient psychiatric units owing to her intense suicidality.

After approximately 20 years of inpatient and outpatient treatment by a variety of mental health professionals, she entered treatment with a psychiatrist who reduced her medication and encouraged her to give vent to her intense inner rage and grief, offering his office during their sessions as a safe refuge in which she could express her anguish and confusion. His therapeutic stance differed from that of previous therapists in that he refused to collude in agreeing with her self-identity as a chronic mental patient and challenged her to excavate her demons and replace her self-loathing with an acknowledgment of her intelligence, creativity, and ability to function successfully as a mother, grandmother, and citizen. The client sometimes referred to this process as “undergoing surgery without an anesthetic,” but she viewed it as lifesaving. She continues to take medication and to see her therapist regularly. She is currently active in her religious community and a leader in statewide and local community groups related to mental health. She has embraced the creative pursuits of gardening and community theater, is an active practitioner of meditation, expresses a delightful, long dormant sense of humor, and reads widely in theology and inspirational literature. In recent years, she has explored her Celtic identity and has become a much sought after speaker in graduate school classrooms, where she eloquently describes her journey into mental health and psychological flourishing. She states that when she became truly aware of “how we are all connected,” she began to heal.

- What processes and elements of this client’s experience with the psychiatrist were healing?
- If you were to implement this therapist’s strategies, what concepts would guide your practice interventions?
- What strengths do you see in the client that enabled her to empower herself and engage in transformative changes?
- How does our current system of mental health care work against this kind of effective treatment?
A small but significant literature on social justice and clinical practice points to concerns about how the diagnostic process is influenced by socioeconomic status (Rose, 2006) and power relations (Parker, 2003; Swenson, 1998). Rose (2006) emphasizes that life course events are cumulative and impact health; health status reflects an “embodiment of prior living circumstances” and has psychosocial dimensions. When low socioeconomic status is involved, these dimensions can promote “low self-efficacy, low self-esteem, and low intrinsic locus of control” (pp. 4–5). Parker incisively raises questions about clinicians' capacity for inclusiveness by asking if they primarily view the world from their own perspective, with attention only on those with more power than they, as opposed to mindfulness about their own privileges with respect to the realities of persons who are less privileged. For example, McIntosh proposes White privilege as referring to unearned assets that can be utilized on a daily basis, “but about which I was ‘meant’ to remain oblivious” (McIntosh, 2013, p. 187). On the other hand, target status perceptions are influenced by experiences with marginalization, devaluation, and invisibility. The concept of intersectionality highlights that most individual have some aspects of privilege and target status; some individuals have more of one than the other. Poland and Caplan (2004) suggest that there are several sources of bias in the diagnostic process arising from factors related to the clinician, professional values, and the context of the diagnostic process. Clinician-related qualities include attitudes about diverse groups, capacity for perspective taking (i.e., empathy), critical self-reflection, information processing biases, and inferences about medications. Factors related to professional values include terminology associated with particular professions, views of clients as passive recipients of care versus self-advocates, and economic requirements. Bias in contextual factors includes, in part, resource availability, requirements of funding sources, and organization of authority. These authors propose several changes that encompass the development of new, alternative diagnostic protocols, based on a strength-based critical-thinking approach, clinician awareness of the context of behavior, a multidimensional perspective, and a constructivist model framework (Corcoran & Walsh, 2006; Gray & Zide, 2005; McAulliffe, Eriksen, & Kress, 2005).

Diversity and Mental Health

Culturally competent practice is premised on culturally relevant organizational settings that provide the context for effective clinical practice. Although a thorough review of the relevant literature is beyond the scope of this book, we nonetheless assert the necessity of not falling into a monolithic, myopic vision that disembodies clinical practice from its context. We proceed to focus on the interpersonal, interactional skill that provides the foundation for effective practice. Both content and process clinical skills are vitally important in conducting an accurate diagnosis within the context of the individual's culture and life experiences. In the larger context of agreement regarding the importance of being informed about diverse cultural values, beliefs, and practices (i.e., content), much discussion continues about process issues, described as the clinician's
awareness of the significant role of clinician bias, countertransference, and oppression (Dean, 2001). Diversity in this text refers to the ubiquity of culture. All individuals live in the context of a culture based on ethnic, socioeconomic, religious identifications; however, there are many other identifications and communities, such as gender identity/orientation and physical/mental ability that are important to acknowledge. As complex beings, most of us identify with various communities as sources of meaning that represent an asset. It is essential to discover the various sociocultural connections individuals experience that provide a context for their experiences. Those cultural connections and affiliations constitute sources of strength that can have a healing role in treatment planning and interventions.

Diagnosis with diverse populations places greater importance on the knowledge of the cultural meaning of behavioral expression and on information about culturally relevant means for managing psychological states. This requires awareness and/or information gathering on the meaning of the symptoms within a culture and the contextual factors that influence the interpretation of the behavior. The roles of diversity and social power in the lives of clients necessitate mindful attention to sorting out to what degree the problem behavior is a function of a psychological disorder or represents survival in an oppressive situation (D. W. Sue & Sue, 2008). Regardless of one's theoretical approach, comprehensive data gathering is needed in this area and should be reflected in the formulation. It is also essential that the clinician have heightened self-awareness, attunement to others, and relational skills that enable connecting with diverse others for the purpose of creating a working alliance (American Psychological Association, 2003). It is also vital that attention is paid to the organizational and professional cultures that may be sources of hidden institutionalized bias within professional groups and between organizations and their clients.

PROMISING THEORETICAL AND APPLIED CLINICAL ORIENTATIONS

Strength-Based Practice

The core philosophy of strength-based and empowerment practice is increasingly embraced by social workers and other mental health practitioners (Glicken, 2004; Lee, 2001; Poulin, 2005; Saleebey, 2002). Collaborative relationships with clients are promoted and clients are viewed as possessing resources as well as problems. Research in health psychology, in particular, supports strength-based, resiliency-focused attitudes and practices. Enhanced self-efficacy is consistently a powerful predictor, sometimes the most powerful, of the ability to sustain commitment to a goal in the context of uncertain outcome and complex struggle in both organizational, community, and clinical contexts, and in a variety of life-enhancing endeavors, such as the ability to follow through on health-promoting behaviors, or to meet educational and other life-enhancing personal goals (Bandura, 1997). Some self-efficacy research has demonstrated that people sometimes improve their behavior more successfully when given feedback with their errors omitted entirely, focusing only on what they are
doing correctly (Bandura, 1997). The groundswell of emphasis on resiliency, expressed as positive personal strengths as well as interpersonal and community support in order to buffer stress and enhance coping with problems, is scientifically impressive and is striking a responsive chord with the public at large.

**Resiliency**

Practice that is premised on a value of wellness (Cowen, 1991) rather than pathology validates culture as a source of resiliency (Bonanno, 2004; Masten, 2001) and as a protective factor, it examines resources related to individual (attitude, social identity, coping), family (structure, communication, coping), and community (network, roles, support) sources. Assumptions about cultural patterns of behavior and preferences need to be suspended in favor of placing the individual in the foreground and disorder categorization in the background for the purpose of capacity building of individuals and their support systems. Physicians and the specific mental health disciplines of psychiatry, psychology, social work, and nursing ignore resiliency factors at a great cost to the client.

**Positive Psychology**

A growing body of literature asserts the philosophical position of positive psychology, which represents a paradigm shift in which the science of psychological health and well-being are studied as having equal and perhaps greater significance in relation to recovery from emotional problems than the focus on pathology (Linley & Joseph, 2004). Psychologists are paying systematic attention to the enhancement of personal and environmental strengths and positive coping skills, in the process of diagnosing and treating both mental disorders and related relationship problems (Bandura, 1997; Goleman, 2005; Gottman, Murray, Swanson, Tyrson, & Swanson, 2002; Gottman, Gottman, & Declaire, 2006; Peterson, 2006; Seligman, 2004; Seligman, Steen, Park, & Peterson, 2005). Linley and Joseph (2004) explore values and choices involved in self-regulation and the good life, healthy lifestyle practices, teaching strategies for the promotion of wisdom, the application of positive psychology in clinical practice, and the relationships among individual well-being, community, and social policy. Keyes and Haidt (2003) lament the narrowing of the field of psychology based on a disease model and call strongly for a new model of mental health that can encompass two dimensions, the mental health continuum and the mental illness continuum, as essential to accurate and useful diagnosis. Lopez et al. (2006) endorse this point of view and apply these concepts to their suggested alterations in the DSM, including their own concept of adding an additional axis to the diagnostic structure.

**Wellness/Recovery Approach Model**

Social work, in particular, is premised on the person–environment interaction and biopsychosocial approaches, and frames practice within resiliency and cultural diversity perspectives (Appleby, Colon, & Hamilton, 2007; Cohen,
Tran, & Rhee, 2007; Lum, 2011). These perspectives are increasingly recognized in all mental health professions. Corcoran and Walsh’s (2006) observation—that the lack of a systematic diagnostic mechanism for addressing resilience, strength, and positive extra-individual contexts in the individual’s life is lacking—summarizes a major theme in many writings. These authors go on to suggest that the “DSM makes no provisions for recording client strengths … [and] could allocate one or more axes to strengths” (p. 23). Noteworthy is that, in line with our first edition, the DSM-5 (APA, 2013) Cultural Formulation, the DSM-5 encourages identification of “psychosocial stressors and cultural features of vulnerability and resilience” (p. 750). Unfortunately, comments such as the aforementioned are buried in small print in Section III of the DSM-5 and are likely to be unnoticed. They underscore, however, the need to emphasize context and resiliency as the DSM-5 format risks losing sight of these factors in the diagnostic process.

The Recovery Model identified in the President’s New Freedom Commission on Mental Health Report (see the website for the President’s New Freedom Commission on Mental Health [2002], www.mentalhealthcommission.gov) assumes the capacity for resiliency in all individuals with mental health disorders. It shifts the medical model focus on symptom reduction and mental illness as disease to diagnosis and healing, meaning a focus on living with mental illness. This focus emphasizes the “recovery of functional abilities, [the ability to live] independently, to work productively, to have social relationships, and to participate in community life” (Spaulding, Sullivan, Poland, & Ritchie, 2010, p. 328).

Recognition of the significance of the consumer’s role in the recovery process promotes consumer agency in the diagnostic process, reframes the role of the professional as expert, and moves the consumer from the margin to the center. The idea of living with the illness as a central goal promotes the notion that the key aim of effective mental health services is for the consumer to “live with” mental illness and rebuild a life (Ralph & Corrigan, 2005) based on client self-determination. The role of the clinician in supporting exploration of consumers’ desires, abilities, and needs in the service of promoting a full life stands in sharp contrast to the traditional emphasis on symptom reduction. Noteworthy is the existence of a consumer/survivor movement, which has received increasing traction over the decades. Everett (1994) proposes the consumer/survivor movement as a fourth movement, following the asylum, mental hygiene, and deinstitutionalization movements. Further, she suggests that the consumer/survivor movement is split between advocacy and nonpsychiatric services-based recovery. At the heart of the movement is choice to determine one’s own way of living with one’s mental illness and integration into one’s community. Substantial attention is given to the presence of stigma, both personal and public (Corrigan, 2014; Frese & Davis, 1997).

**SUMMARY**

An approach that values diversity and culture and embraces a strengths perspective explores questions that all too often are not on the radar when diagnosis and treatment planning are based on standardized, traditional approaches or when
treatment is limited to medication. For instance, the use of bilingual, bicultural translators requires specific skills on the part of the clinician as well as the utilization of probes that tap into the client's perceptions of his or her experience.

In this book, attention is given to the instrumental role of formulation in conceptualizing the etiology of client’s problems via historical and cultural context and behavioral information (i.e., symptoms) and its importance in pulling together clinical understanding of sources that are internal and external. Our discussion particularly focuses on the development and application of a strength-based formulation that draws from several domains of an individual’s life and attends to resiliency in the person as well as in his or her network, family, and culture.

Much of the current theoretical discussion and empirical research concerning multicultural issues, however, is largely presented within a framework of pathology and/or ethnic/cultural explanations of mental disorders. The DSM-5 provides some contextualization via the V/Z codes; however, they are not systematically invoked via a DSM diagnostic format. The adaptive emphasis that we propose in this book examines cultural, intrapsychic, and contextual factors in terms of their contributions to an individual's strengths and resiliency. The proposed “Formulation Diagnostic Model” in Chapter 2 addresses the empowering aspects of the individual’s functioning and recognizes culture as an important variable in order to promote a more realistic diagnostic formulation that can provide a pragmatic link to treatment planning and intervention. We hope to strengthen the bridge between disparities and equity research and evidence-informed mental health practice with diverse populations in order to increase the relevance and accuracy of diagnosis and facilitate positive treatment outcomes for underserved populations. The DSM, we argue, needs to continue expansion that accounts for the client’s culture, multiple life contexts, and internal and external sources of strength, resiliency, and support.

DISCUSSION QUESTIONS AND ACTIVITIES

1. Describe the difference between pathology-based and strength-based approaches to understanding an individual.
2. Without censoring yourself, write down three adjectives that immediately come to mind when you think of the following: an old man, an old woman, an African American male, a Mexican farm worker, an anorexic female, an Asian American, a lesbian, a homosexual male, a homeless person, and a Euro American entrepreneur. Examine your adjectives for themes that might arise.
3. Describe the difference between culture as language and customs versus culture as personal identity. How do you think this would affect your ability to diagnose a client’s mental illness?
4. Think of your professional context (for example, school, clinic, private practice). What are the values of the professional culture? Do these values clash with the ethnically diverse cultures of clients? What enhancements or barriers to accurate diagnosis and treatment may exist?
5. Are there invisible cultures in your community? Think about this from an ethnic, social class, professional, gender, racial, and age perspective. If you can’t think of examples, ask this question of colleagues, friends, and a variety of community members until you hear some stimulating answers!

6. Find a colleague who is a member of a culture different from yours. Interview the colleague, using the structured interview format presented here. Then reverse roles and ask the colleague to interview you. Having completed this exercise, what were you able to learn about yourself and your partner? Write a paragraph about your experience.

   a. How is someone greeted in your culture? Is there someone who should be greeted first (e.g., father, recognized leader, male)? What body gestures are used (handshakes or bows, for example)? Is eye contact encouraged or avoided? How is respect shown?

   b. How should someone enter your home? If someone is invited for a visit, what is expected or appreciated (i.e., a gift, flowers, food)?

   c. Who in your family takes responsibility for things like the following, and what would he or she do about them?
      i. Preparing meals
      ii. Making sure children get to school and get their homework done
      iii. Helping with an important and serious problem or crisis
      iv. Taking care of a sick child or adult
      v. Taking care of elderly family members
      vi. Handling a marital problem or other family conflict
      vii. Managing a teenager in trouble with the law
      viii. Managing money

   d. Would your family seek help outside of the immediate family? From whom? What kinds of concerns would prompt you or your family members to seek outside help?

   e. If someone not of your culture were to try to help you with any of the problems in item “c”, what would be most helpful? How would it be different with someone of your own race/ethnicity/culture?

   f. What would definitely not be helpful, would be a big mistake, or would be harmful? How would this apply to someone of your own ethnicity/race/culture?

   g. What do you most treasure about your culture/ethnicity/racial identity? Are there ways in which you have chosen to reject or change aspects of your cultural heritage? If so, how and why?

   h. When have you felt most comfortable, most understood by someone of your own or another culture? What was special about this experience? When have you felt least understood, stereotyped, or treated without respect, and what stands out about this experience?

   i. What would be the most important thing you’d want your partner to know about your family and your culture/ethnicity/race?

7. Imagine that you had just been diagnosed with schizophrenia and/or Alzheimer’s disease. What would you want the mental health professional to know about you?
8. When you consider your worldview, what brings hope to your life? What factors contribute to your experience of hope?

9. Consider what “wellness” means to you. What comes to mind? What role do physical and/or psychosocial factors have? What role does your daily mood (e.g., energy, active) and/or life satisfaction have?

WEB RESOURCES

www11.georgetown.edu/research/gucchd/nccc
www.mass.gov/dph/healthequity

REFERENCES


