Cultural Perspectives for Assessing Infants and Young Children

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Abstract and Keywords

This chapter presents an outline of eight general features of culture that provide a background for understanding the role of culture in assessment. The eight general features define culture as shared meaning; distinct from ethnicity, race, and minority status; as occurring in a setting or ecology; as dynamic and transactional; as experienced subjectively; as operating silently as well as with voices; as providing multiple views of reality and the world; as influencing the ways in which individuals express distress; and, for infants and toddlers in particular, as mediated through the parenting relationship. The authors distinguish the classification of disorder from the assessment of the individual and the role of current diagnostic systems, such as the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition, and the revised *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0–5)*.

Keywords: early development, culture, cultural formulation, diagnostic assessment

(p. 9) The importance of addressing cultural aspects of development and mental health has featured prominently in the strategic plans of the National Institute of Mental Health (2015), the National Institute of Child Health and Human Development (2012), and the Society for Research in Child Development (2019). Government and nonprofit agencies have held workshops and published papers outlining best practices for integrating culture into research, assessment, diagnosis, treatment, and service delivery (e.g., Calzada & Suarez-Balcazar, 2014; Institute of Medicine of the National Academies, 2013; Lewis-Fernández et al., 2014; Tribal Evaluation Workgroup, 2013). Additionally, the role of culture in developmental science and professional psychology has received renewed interest, with prominent journals publishing special sections on the importance of culture and diversity (e.g., Akhtar & Jaswal, 2013; Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009; Chen & Eisenberg, 2012) and many independent researchers publishing reviews (e.g., Garran & Werkmeister Rozas, 2013; Greenfield, 2018; Jensen, 2012).

The increasing diversity in the United States has put pressure on practitioners and social service agencies to improve their cultural competence to effectively serve an ethnically and linguistically diverse client base in terms of overcoming barriers to treatment, providing valid clinical assessment, and intervening more effectively. Becoming culturally competent is a complex process because the heterogeneity of the population demands adaptability and a commitment to embracing differences and developing a deep cultural knowledge rather than reinforcing stereotypes (Calzada & Suarez-Balcazar, 2014). A one-size-fits-all approach will not work because differences exist even within ethnic groups, which will make certain practices acceptable for some, but not for others. For example, the Hispanic population is expected to represent over 30% of the U.S. population by 2050 (as cited in Calzada & Suarez-Balcazar, 2014). Although 64% are (p. 10) from Mexico, the Hispanic label represents many Spanish-speaking countries of origin throughout the Americas. Generational differences; variations in assimilation (the process of becoming part of a larger group), acculturation (the process of cultural modification through adaptation and acquisition), and enculturation (the process of learning the practices and behaviors of one's birth culture); and intersections of these constructs with gender, immigrant status, race, and ethnicity add additional layers of complexity. All of this suggests that practitioners in the early 21st century working with young children and families must be knowledgeable about the essential roles of culture in shaping development as well as the expression, diagnosis, management, and treatment of social-emotional and other problems that can emerge in early development.

Given these facts, it is striking that cultural-based formulations have been difficult to include in clinical diagnostic assessments and that advances in this area, although substantial, have only recently addressed the earliest years of development. Accordingly, this chapter provides a framework for taking culture into account in the assessment of young children. After presenting our definitional perspectives with features of cultural influence on development, we will review progress and clinical thinking about culture and diagnosis since our statement over a decade ago, including a reiteration of our proposed adaptations to the *Diagnostic and Statistical Manual of Mental Disorders IV* Outline for Cultural Formulation (Christensen, Emde, & Fleming, 2004)—which the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (*DC:0–5*; Zero to Three, 2016) included in their 2016 update. Following this, we will present a hypothetical case example to illustrate an application of the adapted outline.

Cultural Definition and Influence: Eight General Features That Form a Background for Assessment

Culture can be defined as meaning that is shared by a group of people—with shared values, assumptions, beliefs, and practices that are transmitted across generations and brought to life through the daily behavior and interactions of people within a group. Culture supports early development in varied ways, most often operating silently in the back-

ground through the mediation of parenting. In addition to reviewing the particulars of cultural difference that contribute to development, we believe it is useful to identify some general features of cultural definitions and influence.

Culture as Shared Meaning

It is useful to distinguish the term culture—as shared values, rules, beliefs, and practices—from the terms ethnicity, race, and minority status. Ethnicity refers to an identity that is assumed, and to some extent chosen, by individuals within a group (Lewis, 2000). Ethnicity may be rooted in a common history, geography, language, religion, or other shared characteristics (American Psychiatric Association, 2013), while race refers to socially constructed categories of identity based on superficial physical traits like skin color that have varied over history and across societies. Race remains socially relevant because it supports racial ideologies, racism, discrimination, and social exclusion (American Psychiatric Association, 2013). Minority status is a descriptive population term often invoked for considerations of social policy. Culture, race, and ethnicity can enhance resilience by serving as sources of strength and group support, but they are also related to economic inequalities and discrimination that result in disparities in health and mental health status, as well as in the assessment and treatment of mental health problems.

Culture supports early development through the child's active participation in meaningful community activities, most often operating silently in the background through the mediation of caregiving and other early relationships in which the child is embedded (Chen & Eisenberg, 2012; Lamm, Keller, Yovsi, & Chaudhary, 2008; Rogoff, Paradise, Mejia Arauz, Correa-Chavez, & Angelillo, 2004). Supportive aspects of culture are often not readily appreciated by clinicians, who typically become aware of cultural influences among peoples only when they see differences (in practices, behavior, etc.) from their own cultural expectations. Understanding cultural influences on caregiving and other aspects of development is essential for clinical understanding because it provides an understanding of the issue from the client's perspective, promotes effective communication and well-being, and substantially improves diagnostic accuracy (Lewis-Fernandez et al., 2014).

Following others, we advocate that culture is an especially important aspect of the assessment and treatment process (Betancourt & Lopez, 1993; Coll & Magnuson, 1999, 2000; Emde, 2006; Lewis-Fernandez et al., 2014; Pumariega et al., 2013) and that an understanding of race and ethnicity and (p. 11) their intersections is an integral part of conducting a culturally informed assessment.

Culture Occurs in an Ecology

Cultural practices emerge and evolve in relation to environmental conditions, social settings, and historical context. As such, it is useful to bear in mind that culture not only occurs in an ecology, but also contains adaptations to it. The importance of setting or ecology for culture, as well as its influence on human development, has been conceptualized in some detail by Bronfenbrenner (1977, 1979) and Sameroff and Fiese (2000a, 2000b) and

given instantiation in the separate studies of rural African caregiving practices by Super and Harkness (1982, 1986) and LeVine and colleagues (1994). For example, infants' sleeping and feeding patterns are likely to be shorter but more frequent in a context where mothers engage in culturally supported daily routines that include the continuous carrying of their infants on their backs to soothe and quiet them. Similarly, the environmental demands of work for mothers in rural Africa, along with culturally derived expectations for childbearing and the availability of large family networks, are likely to be associated with routines in which infants and toddlers are cared for by siblings who are not much older than they are. Thus, customs of childcare, such as how infants are carried and the type and amount of supervision infants receive, are governed by assumptions about development espoused by cultures in particular environmental contexts (Harkness & Super, 1996). Furthermore, as Lewis (2000) and Rogoff (2003, 2011) pointed out, customs of childcare influenced by setting also include the ways in which parents or caregivers respond to infant cues, make determinations about the amount and type of stimulation (tactile, verbal, and social) an infant should receive, establish routines of infant care, and prioritize the teaching of skills that are valued in a particular culture (e.g., smiling, vocalizing, and play). It is important to note that although culture is embedded in an ecology, individuals who must leave these settings and migrate to new social settings do not lose their culture. They take the tools of their culture to the new setting, where they are adapted as needed.

Culture Is Transactional

Culture is dynamic and transactional. Evolving history, with its changing norms, roles, and values, contributes to the dynamic and transactional nature of culture. Moreover, shared meanings change in the midst of adaptations to technology, influences from other cultural groups, and influences from developing individuals (e.g., Rogoff, 2011). The latter represent important transactional processes in which culture both provides influence to people and is itself influenced and changed. As noted in the previous section, people do not always stay within the ecology from which their culture emerged: They take their culture with them and either seek out people with similar cultural backgrounds or adapt their cultural norms and practices so that they fit within their new ecologies. For example, Lamm and colleagues (2008) examined changes in parenting ethnotheories (ideas about parental care that are shared within cultural groups) by interviewing mothers and grandmothers in four cultural environments. They found clear evidence of not only the transmission of parental beliefs from one generation to the next but also variation in adaptation to changing environments. For example, although no changes were found in the transmission of parenting ethnotheories of rural Nso mothers and grandmothers, there were pronounced differences between mothers and grandmothers in the urban Nso community.

The importance of understanding culture as a dynamic and transactional process has been documented by researchers who have reported differences in health and well-being outcomes in relation to generational differences in cultural practices (e.g., Lamm et al., 2008); immigrant status, that is, first-generation versus second- or third-generation immi-

grants (e.g., Calzada et al., 2015; Guarini, Marks, Patton, Flannery, & Coll, 2015); variations in acculturation and enculturation (e.g., Knight et al., 2014; Updegraff & Umaña-Taylor, 2015); and intersections with gender and ethnic identity (e.g., Horton & Shweder, 2004). One well-known example is the *immigrant paradox* (for a review, see Marks, Ejesi, & Coll, 2014). Notable findings include Guarini and colleagues' (2015) report that first-generation Latina adolescents demonstrated less risk of becoming pregnant than second- or third-generation Latinas. Furthermore, they found that this advantage came about because first-generation Latinas reported a lower number of sex partners than second- and third-generation Latinas. One limitation of this research is that very few researchers have examined how generational differences and immigrant status in particular impact infancy and early childhood. However, this research is helpful for understanding how generational difference and immigrant status might influence family processes.

(p. 12) Culture Is Experienced Subjectively

Culture is experienced subjectively by individuals. More specifically, culture guides early development by means of subjective experiences that are shared (i.e., *intersubjectively* experienced), especially between caregivers and children (Rogoff, 2003; Stern, 1985). Culture influences not only the physical setting and context for parents and young children, but also attitudes, expectations, and perceptions of safety and appropriate behavior. Parents share meaning in an intuitive manner with their children as they engage them in everyday learning activities.

Contemporary thinking in the field of child development, following Vygotsky (1978), portrays the parent as providing a psychological scaffolding for the child's learning, pulling the child forward in development according to what is sensed as appropriate in a *zone of proximal development*. There is an active process of *guided participation* or *apprenticeship* between adult and child, as Rogoff (1990) put it. Rogoff and colleagues have conducted several studies that clearly illustrate how this process of guided participation in meaningful community settings actively shapes cognition, leading to cultural variability in memory and learning styles (Tsethlikai & Rogoff, 2013), observation skills (Mejía-Arauz, Rogoff, & Paradise, 2005), and attention and learning (Silva, Correa-Chavez, & Rogoff, 2010).

Culture Operates Silently and With Voices

Culture operates silently as well as with voices. Rather than being obvious, or talked about, much of cultural influence involves procedural knowledge and mental activity. Procedural knowledge refers to information underlying a skill or set of behaviors that does not need to be represented in conscious awareness for the skill or behavior to be exercised (Clyman, 1991; Cohen & Squire, 1980). Knowledge organized procedurally contrasts with knowledge that can be accessed in awareness via processes of recognition or recall (usually referred to as declarative knowledge). Most rules that guide behavior in everyday circumstances have been learned in the course of development through many participatory experiences and are organized procedurally. Common examples include the

rules of grammar of a learned first language and the many rules that guide basic moral conduct, such as turn-taking and reciprocity in social interactions (Emde, Biringen, Clyman, & Oppenheim, 1991). Thus, although some knowledge about one's culture can be accessed consciously and declaratively, for example, in interviews, much culturally guided knowledge exerts its influence through internalized rules that govern how we find meaning in routines and social interactions, silently, without reflection and without awareness (Shepherd, 2011; Vaisey, 2009). Anthropologists have long known that participant observation and immersion in a culture—often by someone outside the culture—are methods that must supplement interviews of key informants to access this form of knowledge. In a similar vein, anthropologists have known that cultural models contain rules that regulate behavior through values, attitudes, and beliefs that are largely assumed by members of a particular group, rather than being explicit or formalized (D'Andrade, 1992; Weisner, Matheson, & Bernheimer, 1996).

Recent research on the cultural value of *respeto* in Latino families provides one example of the importance of these *internalized rules* for positive developmental outcomes (e.g., Calzada, Fernandez, & Cortes, 2010; Lorenzo-Blanco, Unger, Ritt-Olson, Soto, & Baezconde-Garbanati, 2013; Morgan Consoli & Llamas, 2013). The cultural value of *respeto* promotes harmony within and outside the family by teaching children to defer to their elders and to others with a higher level of social status (Calzada et al., 2010). Processes of *respeto* guide a good deal of what outsiders see as the routines of courtesy, as well as generosity, in Latino social interactions. In fact, according to Calzada et al. (2010), "respeto appears to delineate the boundaries of appropriate and inappropriate child behavior and to be an important determinant of parenting practices" (p. 78), with Latino mothers emphasizing the importance of teaching their children obedience and respect rather than the European American values of independence and autonomy.

Again, we are reminded that much of Eastern, Latino, and indigenous cultural practices have emphasized mutuality in development and the overlapping connections between the person and the other, whereas much of Western or European practice and thought, in contrast, has tended to emphasize individuality in development and treatment of the person as separate from others. Calzada et al. (2010) suggested that mental health interventions are likely to fail if they do not consider culture because Westernized models are not able to capitalize on socialization processes such as *respeto* that promote health and well-being in ethnic minority families. Infancy researchers have emphasized the development of mutuality and connectedness as well (e.g., Emde, 1980; Emde et al., 1991; Hsu, Iyer, & Fogel, 2014; Lavelli & Fogel, 2013; Sroufe, 1995). For example, Lavelli and Fogel (2013) found that (p. 13) mutual attentiveness and mutual engagement were important predictors of mother–child relationship quality. Moreover, Lavelli and Fogel suggested that teaching at-risk mothers how to engage in maternal mirroring and mutual attentiveness may be an important clinical tool for promoting positive developmental pathways.

Culture Provides a View of Reality and Experience

Culture provides multiple views of reality and the world. In addition to everyday reality, most cultures support a variety of spiritual experiences that often contain alternative views of reality. These spiritual experiences may be important for understanding variations in health behaviors in families with young children—for example, related to diet, exercise, provisions for safety, and protections from toxins and abusive substances—as well as for understanding variations in opportunities for social connectedness and support. For example, Native American parents who participate in the Native American Church, sweat lodges, ritual dancing, and related spiritual affirmation experiences may be less likely to engage in abusing alcohol and other substances and hence be more available for caring activities with their infants and toddlers (Calabrese, 2007, 2008). The beneficial nature of these practices can be misunderstood, feared, and discouraged by majority professionals who are not familiar with the ceremony associated with practices such as peyote ingestion (e.g., van Tol, 2009). Similarly, Latino parents who participate in organized religious activities or other alternate belief systems about protection from evil spirits, curses, or illness may find support and benefit from these practices (Epstein-Ngo, Maurizi, Bregman, & Ceballo, 2013; Koerner, Shirai, & Pedroza, 2013). For example, Epstein-Ngo and colleagues (2013) reported that Latino adolescents growing up with high rates of community violence turned to religion and social support as the two most common forms of coping. The forms of play and types of stories that parents tell young children within a given culture also allow for alternative views of reality and, to varying degrees, for important “intermediate zones of experience” (Winnicott, 1971) in which child and parent can try out different cultural views, values, and worlds of belief and make-believe.

Cultural influences on general views of the world are important in the clinical assessment of families with young children. The fact that such influences may change in relation to time and context may make such assessments challenging, but no less important. We illustrate this using a cultural dimension for guiding development, namely, the view of individuality versus social connectedness or, in other words, the view of self in relation to others. Although Western views of self have typically been described as *self-contained* (Sampson, 1988) and *self-reliant* (Spence, 1985), in contrast to Eastern views of self as more other-oriented (Doi, 1973; Shweder, 1991), appreciation in the West of the self as connected, social, and dialogical has grown (Gilligan, 1982; Hermans, Kempen, & van Loon, 1992; Sampson, 1988; Stern, 2008). Moreover, as one might expect, within North America there is now appreciation of significant variations on this cultural dimension. Many Latino families, for example, may feel that maintaining a network of family connections and respect is more important than personal achievement (Calzada et al., 2010; Falicov, 1998). In a related vein, families also differ on cultural beliefs and practices concerning infant sleeping arrangements. Wolf, Lozoff, Latz, and Paludetto (1996) found cultural differences in co-sleeping practices were connected to different values about autonomy, independence, and interrelatedness. Japanese, Italian, and African American families co-slept with their infants more regularly than a U.S. White sample, with the former groups emphasizing the importance of the child learning a sense of interdependence in family and other relationships in contrast to an emphasis on autonomy. More recent research

suggests that within the same culture, economic context exerts a strong influence on co-sleeping patterns; mothers who had recently become wage earners were more likely to end the practice of co-sleeping earlier than non-wage-earning mothers (Yovsi & Keller, 2007).

Culture Influences Expressions of Distress

Also of importance is the fact that culture influences the ways individuals express distress and difficulty. The current *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) takes this into account with its Glossary of Cultural Concepts of Distress. Many of the syndromes listed involve the dysregulation of emotions and seem to be supported by cultural forms of belief in the power of strong emotions, such as in the syndrome of *ataques de nervios* in Puerto Rican and related groups. Expressions of grief and depression in some cultures (e.g., Asian) may be in somatic terms, such as gastrointestinal disturbances, rather than in terms of crying or mood changes (Kleinman & Good, 1986; Kleinman & Kleinman, 1986). Among Latino psychiatric patients, (p. 14) reports of altered perceptions (such as seeing and hearing things when alone) are independent markers of higher morbidity and mental health utilization (Lewis-Fernández, et al., 2010). Lewis-Fernández and colleagues (2010) speculated that among Latinos with traumatic exposure, these symptoms may be signs of *distressing dissociative capacity* that are unique and useful markers of mental health need.

Culture Is Mediated Through the Parenting Relationship

An eighth general feature of cultural influence is at the center of clinical assessment of young children. This feature acknowledges that in early development, *culture is mediated through the parenting relationship*. All the above-mentioned influences occur via parenting. Moreover, the field of infant mental health makes explicit that understanding the caregiving relationship and evaluating its qualities and variations are essential for the prevention and treatment of disorder early in life (Fraiberg, 1980; Pumariega et al., 2013; Sameroff & Emde, 1989; Shonkoff & Phillips, 2000; Stern, 2008; Zero to Three, 2005, 2016).

Direct evidence of the mediational role of parenting on culture comes from research on socialization practices. In particular, parental engagement in ethnic/racial socialization or socialization practices that directly transmit information about culture, race, and ethnicity to ethnic minority children has been associated with a range of positive developmental outcomes (see Neblett, Rivas-Drake, & Umaña-Taylor, 2012, for a review), including improved school readiness (Caughy & Owen, 2015), ethnic identity development (Umaña-Taylor & Guimond, 2010), and psychosocial outcomes (Burt, Simons, & Gibbons, 2012). Cultural socialization practices involve teaching children about their racial/ethnic heritage, history, traditions, and activities and promoting cultural, racial, and ethnic pride. Socialization processes also directly impact how children assign meaning and values to basic emotional capacities, with some emotions culturally emphasized and elaborated to support the transmission of social norms and values (Röttger-Rössler, Scheidecker, Funk,

& Holodynski, 2015). For example, Röttger-Rössler and colleagues (2015) found that among the Bara in Madagascar fear is emphasized, whereas the Tao in Taiwan stress anxiety as a focal socializing emotion. Cultural differences in socialization practices have also been linked to differences in children's normative self-regulation (for a review, see LeCuyer & Zhang, 2014).

We have mentioned how cultural influences result in parent-mediated variations in infant feeding, sleeping, security, and soothing. We have also mentioned how cultural influences result in parent-mediated variations in closeness inclinations, caring practices, feeling states, and what is communicated. Next, we consider some of these matters in relation to clinical assessment.

Current Integration of Culture and Clinical Assessment

The Relationship Context

Perhaps more than in any other field of assessment, the assessment of infant and toddler mental health acknowledges the embeddedness of the individual within the context in which he or she functions, placing a central focus on evaluating the child within the context of the parent (caregiver)–child relationship. The relationship context as a focus for assessment has dual origins. One origin has come from clinical experience. It finds itself echoed in the oft-repeated clinical phrases of Winnicott (1960, p. 587), "there is no such thing as an infant" (i.e., there is only infant with parent), of Fraiberg, Adelson, and Shapiro (1975), "ghosts in the nursery" (i.e., there are haunting effects of conflicted internalized relationships across generations), and of Fraiberg (1980, p. 53), "it's a little bit like having God on your side" (i.e., in parent–infant psychotherapy when benefiting from seeing the rapid development of the infant). This clinical tradition of infant mental health was the foundation of parent–infant psychotherapy with psychodynamic/systems approaches (Lieberman & van Horn, 2009), interaction guidance/educational approaches (McDonough, 2004), and combined approaches (Marvin, Cooper, Hoffman, & Powell, 2002).

Another origin of the focus on early relationships has come from the developmental sciences and from considerations of mental disorder in infancy and early childhood. In 1989, a multidisciplinary group of scientists and clinicians proposed that all mental disorder in the earliest years should be evaluated and treated in the context of evaluating the caregiving relationships. The task group proposed a scheme of relationship disturbances and disorder (Sameroff & Emde, 1989), which then became influential in the formation of a separately designated axis for this purpose that was included in the diagnostic classification system for ages 0–3 (Zero to Three, 2005).

As we turn to a review of major diagnostic systems and their applications for culturally based assessment, it is useful to recognize that the diagnostic (p. 15) process consists of two aspects: (a) the assessment of individuals and (b) the classification of disorder. On the one hand, the assessment of individuals involves a variety of evaluations of symptoms, suffering, and functioning and is considered within the context of family relationships, culture, and stresses that are both biological and environmental. The classification of disorder, on the other hand, involves a way of ordering knowledge about symptom patterns and linking these patterns to what is known in general about etiology, prognosis, and treatment and provides a link to services. Classification of disorder therefore facilitates communication among professionals. As Rutter and Gould (1985) emphasized and the *DC: 0–5* (2016, p. 7) reiterated, "we classify disorders, not individuals". Assessment, then, takes into account the ways in which the broader and cultural context of the individual's life shapes the experience and course of a given disorder.

Diagnostic manuals for classification of disorders have increasingly recognized the importance of understanding culture in assessments of etiology, prevention, and treatment. The central role of the individual's experience of disorder symptoms, in addition to biological and related factors, is seen as defining the meaning of disorder as well as its treatment, with such experience profoundly influenced by culture and context. Thus, in 1994, the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (*DSM-IV*), introduced an Outline for Cultural Formulation as an appendix to guide clinical evaluation that was intended as background for an interview, and this was followed by its continued appearance in the 2000 revision in *DSM-IV-TR*. The outline draws attention to assessing a patient's cultural identity, cultural conceptualization of distress, cultural features of vulnerability and resilience, and cultural features of the patient–clinician relationship. In the process of preparing for the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*), the problems of limited uptake by clinicians, however, were noted. This led to the introduction of a Cultural Formulation Interview, included as an appendix in *DSM-5* (American Psychiatric Association, 2013), with 16 questions provided to supplement the outline in the above areas. The *DSM* diagnostic classification scheme, however, does not address early childhood, nor does it cover a wider spectrum of cultural supports for adaptive development. Diagnostic schemes for early childhood, implemented by Zero to Three, have innovated by including assessments of caregiving relationships, as well as specified early childhood developmental syndromes and contextual stressors to classification systems (see the review in Egger & Emde, 2012, and Guedeney et al., 2003, for a validation study). The cultural formulation for infants and toddlers proposed in this chapter has been included in the 2016 edition of the *DC:0–5*.

The Approach of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition

In contrast to the multiaxial system of *DSM-IV*, *DSM-5* moved to a nonaxial documentation of diagnoses formerly contained on Axes I, II, and III with separate notations for important psychosocial and contextual factors formerly characterized on Axis IV and consistent with the *International Classification of Mental and Behavioural Disorders, 9th Revi-*

sion, Clinical Modification V codes and the new Z codes contained in the *International Classification of Mental and Behavioural Disorders, 10th Revision, Clinical Modification* (American Psychiatric Association, 2013). Axis V of *DSM-IV* contained the Global Assessment of Functioning scale, representing the clinician's judgment of the individual's overall level of "functioning on a hypothetical continuum of mental health–illness." The Global Assessment of Functioning scale was dropped from *DSM-5* for several reasons, including its conceptual lack of clarity (i.e., including symptoms, suicide risk, and disabilities in its descriptors) and questionable psychometrics when applied in routine practice. In its place, the World Health Organization Disability Assessment Schedule was included for further study in Section III of *DSM-5* (see the chapter "Assessment Measures"). The World Health Organization Disability Assessment Schedule is based on the *International Classification of Functioning, Disability and Health* for use across all of medicine and health care. The World Health Organization Disability Assessment Schedule (version 2.0) and a modification developed for children and adolescents and their parents by the Impairment and Disability Study Group were included in the *DSM-5* field trial.

The International Classification of Mental and Behavioural Disorders (*International Classification of Mental and Behavioural Disorders, 10th Revision*, World Health Organization, 2008a, 2008b) is multiaxial and similar in many respects to *DSM-5*.[1] (p. 16) Both systems have evolved from initially being concerned only with classification to increasingly dealing with the assessment of individuals by providing guidelines for the clinical formulation interview process. The *DSM-5* pushed the relevance of culture in the assessment of individuals to the forefront by including the Cultural Formulation in Section III—*Emerging Measures and Models*. The *DSM-5* Cultural Formulation includes an expanded version of the Outline for Cultural Formulation, which originally appeared in Appendix 1 of *DSM-IV*, as well as the Cultural Formulation Interview, an interview guide for clinicians seeking to gather information that will inform the outline.

The Outline for Cultural Formulation describes five areas for the assessment of individuals within cultural context, including: (a) cultural identity of the individual; (b) cultural conceptualizations of distress; (c) psychosocial stressors and cultural features of vulnerability and resilience; (d) cultural features of the relationship between the individual and the clinician; and (e) overall cultural assessment. As a guide for gathering information that will inform the outline, the Cultural Formulation Interview then directs the clinician to gather information in the following four domains: (a) cultural definition of the problem; (b) cultural perceptions of cause, context, and support; (c) cultural factors affecting self-coping and past help-seeking; and (d) cultural factors affecting current help-seeking. Within each of these four domains, the Cultural Formulation Interview provides examples of questions that can be asked of individuals to gather information relevant to framing the individual's presenting concerns within a cultural context. To this end, the outline and the Cultural Formulation Interview were designed to help clinicians learn more about the individual's cultural reference group and language use, the predominant idioms of distress, the individual's explanatory models for illness, culturally relevant perceptions of social stressors, available supports, sources of care, and interpretations of disability. The outline and the Cultural Formulation Interview also highlight the importance of under-

standing how differences in culture and social status between clinician and client can introduce challenges for diagnosis and treatment and therefore implicitly recommend that clinicians reflect on this in terms of awareness of their own cultural origins and perceptions. To this point, cultural sensitivity discussions and workshops can be helpful, and we recommend that they take place to supplement reflective supervision in infant mental health settings—especially when there is cultural diversity among staff and clients.

The *DSM-5* contains additional information and tools for integrating cultural information into assessment and diagnosis, including culture-related diagnostic issues to consider for specific disorders (e.g., information on cultural variations in prevalence, symptomatology, and associated cultural concepts), other conditions that may be a focus of clinical attention V codes (e.g., acculturation difficulty or religious or spiritual problems), and a Glossary of Cultural Concepts of Distress, which includes well-studied cultural concepts of distress that illustrate the relevance of cultural information for clinical diagnosis and some of the interrelationships among cultural syndromes, idioms of distress, and causal explanations. Many of the syndromes in the glossary involve the dysregulation of emotions and seem to be supported by cultural forms of belief in the power of strong emotions, such as in the syndrome of *ataques de nervios* among individuals of Latino descent.

Diagnostic Classification: The Zero to Three Approaches

The first edition of the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (*DC:0–3*) was developed in response to the need for classification of disorders experienced in the early years that were not covered in other systems of classification, such as the *DSM*. The *DC:0–3* was translated into multiple languages, and clinical trials of *DC:0–3* conducted in Montreal, Tel Aviv, Paris, Lisbon, and Topeka were useful in classifying disorders (Guedeney & Maestro, 2003). The *DC:0–3R* (Zero to Three, 2005) represented the first revision of this system with an emphasis on clarification of criteria and updates based on research designed to improve its usefulness in clinical case formulation. Similar to the *DSM-IV*, it was a multiaxial system. The first three axes addressed classification of disorders, while the fourth and fifth axes addressed individual assessment (psychosocial stressors and functional emotional and developmental level). Axis I of *DC:0–3R* contained an array of clinical disorders, either unique to the early years or with unique features. Axis II described relationship disorders as existing *between* caregiver and child rather than *within* a given caregiver or child. The implications of this approach were large, given that developmental research to (p. 17) that point had demonstrated clearly that infants may have qualitatively different relationships with different caregivers. Axis II in *DC:0–3* proved useful in translating clinical formulation into provision of services (Guedeney et al., 2003; Keren, Feldman, & Tyano, 2003). By defining a relationship disorder axis, *DC:0–3* and *DC:0–3R* targeted the evaluation of the caregiver–child relationship as central. The *DC:0–3R* went beyond *DSM-5* in assessing relationship context, but it did not provide a formulation or guide for assessing infant or toddler mental health or the caregiving relationship within a cultural context. However, in the 2016 update and expansion (i.e., to include diagnostic criteria for children up to age

5), *DC:0–5* included the cultural formulation for infants and toddlers first proposed in 2004 by Christensen, Emde, and Fleming and reiterated in this chapter, as a resource.

Cultural Formulations With Children

As evidenced by the lack of early childhood or caregiving considerations in the *DSM* Cultural Formulation and by the lack of a cultural formulation in *DC:0–3* and *DC:0–3R*, the formal incorporation of culture in infant and toddler mental health assessment has lagged until recently. This is not surprising, considering the relative newness of the field of infant and toddler mental health and the fact that the appreciation of cultural factors in development in general has lagged behind other approaches (Chalmers, 2013; Ortiz & Del Vecchio, 2013; Shonkoff & Phillips, 2000; Super & Harkness, 1986; Yamamoto, 1997). The *DC:0–3R* stated that any intervention or treatment program should include an assessment of family functioning *and cultural and community patterns* in addition to developmental history, symptoms, and assessment of the child's current functioning. It is therefore encouraging that *DC:0–5* now offers the cultural formulation presented here as a resource to clinicians to account for culture and community in their assessment of individuals.

Two contributions offer background for considering cultural assessments of young children. Novins et al. (1997) suggested adaptations to the *DSM-IV* cultural case formulation for use with culturally diverse older children and adolescents. These additions were applied to four case examples of American Indian children ages 6 and older. In their adaptations, Novins et al. suggested accounting for the developmental aspects of cultural identity, the cultural identity of the parents and/or other caregivers, the impact of a biracial heritage, and cultural aspects of the relationship between the parents and/or other caregivers and the therapist. In a similar vein, Johnson-Powell (1997) proposed a *culturologic interview* for use in framing child and adolescent mental health concerns and treatment approaches within the broader context of country of origin, reason for migration, language use, kinship support, beliefs about causality, child-rearing practices, sex roles, a description of community, life and home space, reasons for seeking help, description of help-seeking behavior, educational attainment, occupation, experiences with rejection, degree of acculturation, and degree of cultural conflict. Although these two efforts provide useful approaches for older children and adolescents, both remain limited in their clinical utility with infants and toddlers, the former because of its lack of attention to issues relevant to infancy and early childhood and the latter by its lack of detail (such as that found in the *DSM-5* Cultural Formulation).

A Proposed Cultural Formulation for Infant and Toddler Assessment

Considering both the promise and the limitations of existing systems, in 2004 we (Christensen, Emde, & Fleming) proposed adaptations to the *DSM-5* Outline for Cultural Formulation, which extended features proposed by Novins et al. (1997) and Johnson-Powell (1997) and were applicable to infant and toddler mental health assessment. As with the

DSM-5 outline, our purpose was to provide a framework for culturally situating infant and toddler mental health. In this section, we reiterate these adaptations to the *DSM-5* Outline for Cultural Formulation that increase its utility in infant and toddler mental health assessment. Our revision heavily reflected the eighth general feature of cultural influence discussed previously—in particular, that culture is mediated through the parenting relationship. In general, we conceived of this adaptation as both an extension of previous work and the beginning of efforts to make culturally informed assessment routine for infant and toddler mental health assessment.

Proposed DSM-5 Outline for Cultural Formulation Adaptations for Infant and Toddler Mental Health Assessment

Here we present the *DSM-5* Outline for Cultural Formulation along with our adapted text for infant and toddler mental health assessment (Table 1.1).

Table 1.1. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), Outline for Cultural Formulation Text and Revised Text for Use With Infants and Toddlers

1. Cultural identity of the individual	
Current *DSM-5* text	**Adapted text**
"Describe the individual's racial, ethnic, or cultural reference groups that may influence his or her relationships with others, access to resources, and developmental and current challenges, conflicts or predicaments. For immigrants and racial or ethnic minorities, the degree and kinds of involvement with both the culture of origin and the host culture or majority culture should be noted separately. Language abilities, preferences, and patterns of use are relevant for identifying difficulties with access to care, social integration, and the need for an interpreter. Other clinically relevant aspects of identity may include religious affiliation, socioeconomic background, personal and family places of birth and growing up, migrant status, and sexual orientation." (pp. 749–750)	*Cultural identity of child and caregivers*. Note the ethnic or cultural reference group for the child's parents and, if relevant, other significant caregivers. Cultural reference groups in addition to race, ethnicity, national origin, and acculturation may also include gender, gender identity, sexual orientation, religion, and socioeconomic status. Note how the parents or caregivers intend to raise the child with respect to their own ethnic or cultural reference group and, in particular, whether there are potential issues of multiculturality for the child. For immigrants and ethnic minority families, note the degree of involvement with both the culture of origin and the host culture and whether they anticipate any generational issues with respect to the involvement of the child in the culture of origin and host culture. Note here parent and caregiver language abilities, use, and preference (including multilingualism) and what language(s) they intend to teach the child.
2. Cultural conceptualizations of distress	
Current *DSM-5* text	Adapted text

“Describe the cultural constructs that influence how the individual experiences, understands, and communicates his or her symptoms or problems to others. These constructs may include cultural syndromes, idioms of distress and explanatory models or perceived causes. The level of severity and meaning of the distressing experiences should be assessed in relation to the norms of the individual’s cultural reference groups. Assessment of coping and help-seeking patterns should consider the use of professional as well as traditional, alternative, or complementary sources of care.” (p. 750)	*Cultural explanations of the child’s presenting problem*. Note here who first noticed the problem (e.g., parent, other relative, day-care provider, physician) and, if referred by someone else, the extent to which the parents or caregivers also see a problem. Examine whether there is a conflict between the parent’s awareness and the extended family’s awareness of the problem within the context of cultural norms and traditions. Identify what the parents or caregivers observed to be the signals of distress displayed by the infant or toddler (i.e., how did the parents or caregivers know there was a problem?); the meaning and perceived severity of the infant’s distress in relation to the parents’ or caregivers’ expectations for the behavior and/or development of other infants or toddlers in their community/cultural group; whether there are any local illness categories to describe the child’s presenting problem; the parents’ or caregivers’ perceptions about the cause of, or explanatory models for, the child’s presenting problem; and parents’ or caregivers’ beliefs about treatment of the child’s presenting problem (including previous experiences with dominant and nondominant culture forms of treatment, current beliefs about and preferences for Western and non-Western forms of treatment, and beliefs about who should be involved in the treatment).
3. Psychosocial stressors and cultural features of vulnerability and resilience	

Current *DSM-5* text	Adapted text
"Identify key stressors and supports in the individual's social environment (which may include both local and distant events) and the role of religion, family, and other social networks (e.g., friends, neighbors, coworkers) in providing emotional, instrumental, and informational support. Social stressors and social supports vary with cultural interpretations of events, family structure, developmental tasks, and social context. Levels of functioning, disability, and resilience should be assessed in light of the individual's cultural reference groups." (p. 750)	*Cultural factors related to the child's psychosocial and caregiving environment*. **A.** Infant's life space and environment. Note description of child's physical life space, including community factors (e.g., ethnic/racial composition, urbanicity, crime, and cohesion) and home factors (e.g., people living in the home, their relationship to one another and the child, and presence of extended family and/or others), infant's sleeping arrangements, and parents' or caregivers' culturally relevant interpretations of social supports and stressors (e.g., role of religion, community, and kin networks).

	B. Infant's caregiving network. Note here the significant caregivers in the child's life, including the role and extent of involvement of primary (e.g., mother, father) and secondary caregivers (e.g., grandparents, siblings, community childcare providers, others). Note significant continuities and disruptions in the child's caregiving network (e.g., child's mobility between caregivers and the extent to which this mobility is fluid, predictable, and consistent versus the extent to which this mobility is unpredictable, inconsistent, and/or disrupted) and the extent to which these continuities or disruptions are normative within local culture. **C.** Parents' or caregivers' beliefs about parenting and child development. Note here any beliefs about parenting and child development not noted elsewhere, including range of views or discrepancies among parents or caregivers, such as ceremonial practices (e.g., naming), beliefs about gender roles, disciplinary practices, goals and aspirations for child, belief systems about children and child development, sources parents or caregivers turn to for advice about parenting, and beliefs about parenting or caregiving role.
4. Cultural features of the relationship between the individual and the clinician	

Current *DSM-5* text	Adapted text
"Identify differences in culture, language, and social status between an individual and clinician that may cause difficulties in communication and may influence diagnosis and treatment. Experiences of racism and discrimination in the larger society may impede establishing trust and safety in the clinical diagnostic encounter. Effects may include problems eliciting symptoms, misunderstanding of cultural and clinical significance of symptoms and behaviors, and difficulty establishing or maintaining the rapport needed for an effective clinical alliance." (p. 750)	*Cultural elements of the relationship between the parents or caregivers and the clinician*. Indicate differences in culture and social status between the child's parents or caregivers and the clinician and any problems these differences may cause in diagnosis and treatment. This may include differences in understanding the child's distress, communication difficulties caused by language, communication styles, or understanding about the involvement of others (e.g., extended kin) in the diagnosis and treatment process. Note how parents may perceive the role of the clinician and the parents' level of comfort with help-seeking. Also note how the parents' or caregivers' past experience with clinicians or treatment or service systems impacts the current clinical relationship. These considerations are reflected in the Irving Harris Foundation Professional Development Network's Diversity–Informed Infant Mental Health Tenets (Ghosh Ippen, Norona, & Thomas, 2012).
5. Overall cultural assessment	
Current *DSM-5* text	Adapted text

“Summarize the implications of the components of the cultural formulation identified in earlier sections of the outline for diagnosis and other clinically relevant issues or problems as well as appropriate management and treatment intervention.” (p. 750) “The formulation concludes with a discussion of how cultural considerations specifically influence comprehensive diagnosis and care.” (p. 844)	*Overall cultural assessment for child’s diagnosis and care*. Summarize the implications of the components of the cultural formulation identified in earlier sections of the outline for comprehensive diagnosis and care of the child and support of the parent–child or caregiver–child relationship.

(p. 18) (p. 19) (p. 20) (p. 21)

Narrative Review and Case Application of the Adapted DSM-5 Outline for Cultural Formulation

Here, we walk the reader through the adapted outline and apply each section of the outline to the hypothetical case of Riley, a 24-month-old American Indian girl referred for a psychological evaluation by her pediatrician.

Reason for Referral

Riley was a 24-month-old American Indian girl whose mother took her to the pediatrician because she seemed less energetic than usual and was increasingly fussy about what she ate. During the office visit, the pediatrician noted Riley’s lethargy, low social engagement, and apparent language delay. Because the pediatrician could not medically account for the changes in Riley’s energy and eating habits and because of the additional developmental concerns noted during the office visit, the pediatrician recommended that Riley’s mother seek a psychological evaluation for Riley.

Cultural Identity of the Individual

The outline first directs the clinician to describe the individual’s cultural identity, noting the individual’s ethnic or cultural reference group and the extent to which the individual is involved with both the culture of origin and the dominant culture. The individual’s language ability, use, and preference are also noted. For infants and toddlers, the *parents*’ cultural reference group and degree of involvement with host and dominant culture should be noted. More important, the parents’ *intentions* for raising the child with respect to the culture of origin and the dominant culture should be discussed. Following Novins et al. (1997), we suggest including, where relevant, a discussion of issues of multiculturality that may arise for an infant or toddler whose parents come from, and identify with, different cultural backgrounds. Finally, we suggest a discussion of generational issues, such as those that might arise as the infant or toddler grows older and may serve as a

cultural mediator or negotiator for the parents (e.g., in terms of language, especially for immigrant groups).

Case Example Application

The clinician may want to start the evaluation by asking about Riley's mother's background and Riley's developmental history. By doing so, the clinician would learn that Riley's mother was American Indian and grew up in a rural reservation community, but moved away to pursue educational and work opportunities in the city. Even though she had moved away, Riley's mother returned to the reservation community frequently to visit family and friends, with whom she maintained strong ties, and to attend cultural and community gatherings. She intended to raise her children, including Riley, with knowledge of their American Indian culture, including having them dance at powwows, spend time with extended family, and have naming ceremonies for them. Riley's mother spoke English as her first language, but also spoke some of her tribal language, including occasionally with Riley. She hoped Riley would learn more of the tribal language by spending time with family elders who were fluent speakers.

Riley's mother described a normal pregnancy and birth, free of complications. Riley's mother felt ambivalent about having another child, however, given that her other children were grown and in school and she had just returned to school herself to pursue a degree. Furthermore, Riley's father had left the family, leaving Riley's mother to parent on her own. As a single parent, Riley's mother relied heavily on a friend to take care of Riley so she could work and go to school. Because of the demands of work and school, Riley's mother allowed Riley to stay for long periods of time with her friend, including overnight. The friend had recently taken on new work, however, and was no longer able to care for Riley. As a result, Riley was again living at home full-time and attending a center-based day care during the day and had not had contact with her mother's friend.

Cultural Explanations of the Child's Presenting Problem

The second area outlined in the *DSM-5* Outline for Cultural Formulation addresses cultural explanations of the individual's illness. The unique ways in which the individual expresses his or her distress are noted here, along with a discussion of how the symptomatic expression compares to normative behavior in the cultural reference group. Any cultural explanations for the individual's experience of distress are discussed, as well as the individual's past experience with and current preferences for care. For infants and toddlers, we suggest beginning with a discussion of who first noticed the child's symptoms of distress (e.g., the parents or someone outside the family, such as a doctor or daycare provider) and the extent to which the parents or caregivers agree that the child's behavior is indicative of distress. This may be especially important in terms (p. 22) of help-seeking behavior, such that if the parents do not also see a problem, they will be less motivated to seek services for their child. Next should come a discussion of the parents' perceptions of the child's distress, how the child's behavior is viewed relative to other children's behavior in their cultural group, any cultural explanations for the child's distress, and the parents' experiences with and preferences for treatment. The extent to

which others are expected to be involved in treatment should also be noted, acknowledging that for certain cultural groups, children are frequently cared for by an extended network of kin.

Case Example Application

To learn more about Riley's mother's perceptions of the reasons for the pediatrician's referral, the clinician could ask Riley's mother why she thinks Riley was referred and whether she or anyone else was concerned about Riley's behavior. By doing so, the clinician would learn that Riley's mother understood that the pediatrician had referred Riley because of concern about her apparent lack of social engagement and possible language delay, although Riley's mother had only taken Riley to the pediatrician because she was less energetic than usual and was "fussy" about eating. Though Riley's mother was clearly aware of the changes in Riley's energy and eating, she did not notice the lack of engagement and language delay noted by the pediatrician. Riley's mother believed that what the pediatrician observed was instead evidence of Riley's easy-going nature. In her family and community, children were taught to learn through quiet observation of their surroundings and by listening to adults and elders. Riley's quiet nature, she believed, was evidence that she was a respectful child—a quality highly valued in their tribal community. When asked what she thought the effect of Riley's separation from her friend might be, Riley's mother stated that growing up, she had been around many different adults herself, and that whatever reaction Riley had would pass because she was "strong, and would grow out of it." She believed that facing some challenges was good for Riley's character, even at a young age. Furthermore, she respected Riley's ability to "be on her own" to respond as needed to what she faced in life.

Cultural Factors Related to the Child's Psychosocial and Caregiving Environment

The third area outlined by the *DSM-5* Outline for Cultural Formulation addresses cultural factors in the psychosocial environment that impact the expression, experience, and treatment of distress and disorder. Our suggested revision for this part of the outline is the most extensive and is heavily influenced by the view that culture is mediated through the parenting relationship for young children. In this section, we suggest addressing three domains: (a) the child's life space and environment; (b) the child's caregiving network; and (c) parent beliefs about parenting and child development. The child's life space and environment refer largely to his or her physical life space both in the home and in the larger community. This includes issues such as individuals in the home and their relationship to one another and community factors such as cultural composition, economic well-being, and social cohesion or lack thereof in the community. Parental interpretations of social stress and social support within this physical environment are also addressed. The child's caregiving network is especially critical for placing the child and his or her distress in context. This domain should inventory the significant caregivers in the child's life, acknowledging, as stated earlier, the importance of the entire network of both kin and non-kin caregivers involved in raising a child. The child's experience within this network of caregivers should also be described, such as the child's mobility within the network,

noting in particular both continuities and disruptions within this network of care. The final domain addresses parents' or caregivers' beliefs about parenting and child development not discussed elsewhere, such as ceremonial practices, beliefs about gender roles, and disciplinary practices. Also noted here are parents' goals and aspirations for their child, which can suggest a positive point for intervention because it provides the clinician with an understanding of potential strengths within the family.

Case Example Application

In Riley's case, the clinician might ask her mother to talk about Riley's home and caregiving environments, including potential sources of support for Riley within these spaces. Answers to the questions would provide the clinician with a more detailed understanding of how to address the presenting problem. In this case, the clinician would learn that Riley was living in a two-bedroom, subsidized apartment with her mother and siblings in a racially diverse urban community, but with few other American Indian families nearby. Riley's siblings shared one bedroom, while Riley shared a room and bed with her mother. Riley's mother valued sleeping (p. 23) time with Riley and said it made her feel closer to Riley. Sometimes Riley's mother's relatives would stay with the family. Most recently, a cousin came to live with the family; however, his disruptive behavior was causing problems in the home and jeopardizing the family's ability to remain. Riley's mother had been raised with a strong sense of duty toward her extended family, but at this time, that sense of duty conflicted with her sense of duty toward her own family. So while Riley's mother considered asking her cousin to leave, she felt conflicted and feared being judged by other family members. She worried that the stress she felt about this situation made her more impatient and irritable with her own children.

By asking about sources of support within Riley's environment, the clinician would learn more about the network of caregivers in her life and the cultural values assigned to this community of care. Riley's mother's friend had cared for her much of the time since she was born because Riley's mother trusted her and she felt her own time was already consumed with work, school, and other family commitments. Since Riley's mother's friend went back to work and Riley started attending the new childcare center, Riley had had no contact with her mother's friend. Riley's mother stated that during her own childhood, she was often cared for by people other than her biological mother and stayed variously with grandparents, aunts, and other extended family and friends. She also stated that when she was growing up, little distinction was made between cousins and siblings or between aunts and uncles and parents. Additionally, close family friends were often considered family and at times were ceremonially adopted into the family—rendering their relationship the same as if they were biologically related. Thus, the fact that Riley was variously cared for by her mother, her mother's friends, and sometimes other relatives was not unlike her mother's own experience growing up. In fact, Riley's mother saw it as a positive experience that Riley had close relationships within an extended caregiving circle—even as those relationships may come and go.

Finally, in applying the adapted Outline for Cultural Formulation to Riley's case, it would be important for the clinician to assess Riley's mother's beliefs about parenting and child development. When observed with Riley, Riley's mother seemed to engage in a hands-off style of parenting. To learn more about this, the clinician might ask how she was parented and whether she maintained a similar style of parenting herself, followed by questions about what she hoped for Riley and her life. By doing so, the clinician would develop a better understanding of how to help Riley's mother meet Riley's developmental needs and frame suggestions in a way that was supportive of Riley's mother's desires for her daughter. According to Riley's mother, her parenting style was similar to the way she had been raised and reflected a general respect for the fact that her children were autonomous and separate individuals, free to learn about the world through exploration and direct experience. She believed it was her duty to tell her children something once, but that it was up to them to follow the guidance after that, learning through natural consequences.

The greatest aspiration Riley's mother had for Riley was that she would one day go to college, have her own family, live a healthy life, and be respectful and strong. Riley's mother's belief that children were largely autonomous and separate individuals who needed to find their own way in life stemmed in part from what she said was her tribe's belief that children, before birth, had been taught many things about life by the spirits of those who had gone before and chose their families based on what they needed to accomplish on their path here on earth. Riley's mother said her family elders had taught her these beliefs about children and that when she needed advice about parenting, she turned to family and community elders.

Cultural Elements of the Relationship Between the Parent or Caregivers and the Clinician

The fourth area outlined by the *DSM-5* Cultural Formulation addresses cultural elements of the relationship between the individual and the clinician. Our revision here largely reflects a reframing from the individual perspective to the parental or caregiver perspective. This section directs the clinician to discuss cultural differences between the clinician and the child's parents that may impede the clinical relationship—because of difficulties in either communication (e.g., language) or understanding (e.g., different interpretations of the child's distress)—and the significance of these differences for diagnosis and treatment of the child.

Case Example Application

To address this area of concern, the clinician may want to let Riley's mother know that the clinician is aware that sometimes misunderstandings occur between doctors and patients because they come from different backgrounds, followed by asking (p. 24) whether she has had concerns about this and if there is anything the clinician should know to address these concerns. By asking this question, the clinician would learn more about barriers to seeking treatment and potential barriers for implementing a program of care. In particular, the clinician would learn that in Riley's mother's tribe, there are prohibitions against speaking of past problems. Questions about the child's developmental history, therefore, would need to be approached with care and perhaps asked about indirectly. In

addition, Riley's mother reported that she had some mistrust of psychologists because she had heard stories that if they did not agree with how a mother was raising her children, they would take the children away. She also remembered how, in her reservation community, word would get out to others that one was going to "mental health," feeding concerns about a potential breach of confidentiality.

Overall Cultural Assessment for Child's Diagnosis and Care

The fifth and final part of the *DSM-5* Cultural Formulation calls for an overall cultural assessment for diagnosis and care that is based on the preceding four sections. We made no revision to this section, except to frame the overall assessment in terms of diagnosis and care of the child.

Case Example Application

Riley's mother and the clinician espoused different views of attachment relationships and Riley's ability to endure the challenges she faced at the sudden loss of time with a caregiver (i.e., her mother's friend) with whom she had developed strong ties. This was an area in which the clinician needed to bring understanding and expertise about child development to bear in a way that respected Riley's mother's cultural beliefs, but also served the needs of the child, who seemed to be reacting to a disruption in her network of attachment relationships. The foremost issue in Riley's case was to support her mother in her cultural belief that an extended network of kin would benefit both her and her child. The challenge, however, was to help Riley's mother understand the importance of continuity in this network of care and the relevance of Riley's attachment to individuals in this network. The other challenge was to help Riley's mother find ways that she could maintain her respect for Riley "being on her own," but also intervene and provide stimulating and supportive engagement for Riley.

Case Example Takeaway Points

The hypothetical case presented here was intended to highlight several issues in conducting a mental health assessment of an infant or a toddler that is not only culturally sensitive, but also, more important, culturally relevant and meaningful to the point that it enhances the care that is delivered. Cultural assessment places the presenting concern within the larger cultural context, which provides for greater understanding of the disorder and suggests points for intervention. The presented case formulation also points out that clinicians must consider several important issues when conducting a cultural case formulation, often involving the balancing of two apparently opposite poles. Clinicians must balance cultural sensitivity on the one hand with useful concepts from Western psychological practice on the other. In Riley's case, the clinician needed to be sensitive to the fact that Riley's mother believed that Riley's mobility within her network of caregivers not only made her "stronger," but also provided her with the advantage of having an extended network of caregivers. To the clinician, however, it seemed clear that Riley was having an emotional reaction to her curtailed involvement with one of the attachment figures within this network of care, which made sense from the perspective of attachment

theory. The challenge, as stated in the overall assessment, was to help Riley's mother understand the importance of continuity in this network of care and the relevance of Riley's attachment to individuals in the caregiving network, while respecting the fact that she saw this as an experience that would strengthen Riley's character.

The case also highlights that, on the one hand, cultural assessment requires general procedural knowledge, while on the other hand, it requires specific cultural knowledge. General procedural knowledge involves the *how* of assessment—that is, how to approach a situation of cultural differences in a way that transcends the particulars of any one cultural group. This general procedural knowledge involves not only a basic acknowledgment and respect for the relevance of culture, but also the utilization of such tools as the *DSM-5* Outline for Cultural Formulation, which can be applied to the broad spectrum of cultural groups that might be encountered in practice. To address the relevance of culture to a particular case, however, clinicians must also possess specific knowledge about the cultural group from which children and their family come. However, this specific cultural knowledge must be (p. 25) held loosely, because parents may or may not espouse those beliefs. As such, not all parental beliefs are culturally supported and there will always be individual and generational differences in the understanding of broader cultural constructs (which speaks to culture's dynamic, transactional, and to some extent subjective nature).

Conclusion

In this chapter, we presented an outline of eight general features of culture that provide a background for understanding the role of culture in assessment. Those eight general features define culture as shared meaning, distinct from ethnicity, race, and minority status; as occurring in a setting or ecology; as dynamic and transactional; as experienced subjectively; as operating silently as well as with voices; as providing multiple views of reality and the world; as influencing the ways in which individuals express distress; and, for infants and toddlers in particular, as mediated through the parenting relationship. We distinguished the classification of disorder from the assessment of the individual and the role of current diagnostic systems, such as *DSM-5* and *DC:0–5*, in these pursuits.

As a cultural tool, the *DSM* has made significant contributions to the assessment of the individual with the inclusion of Cultural Formulation; the thrust of this chapter was to reiterate the adaptations made previously to the Outline for Cultural Formulation for use in assessment with infants and toddlers. By presenting a culturally formulated case example based on the adapted outline, we hoped to demonstrate the relevance of culture for infant mental health assessment and to highlight clinical issues raised in the pursuit of culturally relevant diagnosis and assessment. The need for cross-cultural awareness and understanding to inform the assessment of infant and early childhood mental health is perhaps even more imperative, given that the patient, the infant or very young child, may lack a voice in the process. Lewis (2000) stated that "cultural practices are not neutral; they come packaged with values about what is natural, mature, morally right, or aesthetically

pleasing" (p. 101). As clinicians and researchers, as those who must recognize they are in a position of power to affect and influence the lives of children, whether it be through policy at the broadest level or through intervention at the most specific level, it is imperative that we first acknowledge our own cultural assumptions and then acknowledge that there are other, perhaps equally valid, ways of understanding a particular situation and then bring this awareness to bear on the assessment process and the recommendations that follow.

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Notes:

([1]) We will focus on *DSM-5* rather than the *International Classification of Mental and Behavioural Disorders, 10th Revision*, in our subsequent discussion because of its inclusion of the cultural formulation and our proposed modification of it.

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