YOLO COUNTY HEALTH AND HUMAN SERVICES AGENCY (HHSA)

Spirituality and Behavioral Health

All Behavioral Health Staff Training
Thursday, August 2, 2018, 8:30 – 10 a.m.
Community Room, Gonzales Building, 25 N. Cottonwood Street, Woodland

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1. **Welcome and Sign In**

2. **You Are Invited To . . .**
   - A. Increase Understanding of Spirituality, Faith and/or Religion of those we Serve
     1) Importance in Recovery and Resiliency
     2) Role in Acceptance or Traumatic Experiences
     3) Framework for Understanding Cause and Remedy for Problems and/or Mental Health Conditions
   - B. Explore Personal Spiritual Beliefs/Practices/Experiences and Impact on Serving Others
   - C. Build Your Cultural Competency (Knowledge/Skills/Practices) to Enhance Your Cultural Humility

3. **Resources and References (Attachments)**

4. **Increasing Our Knowledge and Awareness to Better Serve**
   <u>Panel – Special Guests/Faith Leaders/Faith Liaisons</u>
   - A. Sharing
   - B. Questions for Special Guests/Faith Leaders/Faith Liaisons

5. **Evaluation** – *please complete and submit at "Sign In" table*
   Certificate of Attendance – *if needed, please pick up at end of training near the Sign-In table.*

Notes

Panel - Spirituality and Behavioral Health

Facilitator: Tessa Smith, HHSA Outreach Specialist/Family Partner

A. Sharing
B. Questions for Special Guests/Faith Leaders/Faith Liaisons

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Special Guests/Faith Leaders/Faith Liaisons:

Bonnie Berman President of Congregation Bet Haverim
Alan E. Brownstein Past Co-President of Congregation Bet Haverim
Mike Duncan (Concow/Wailaki/Wintun/Western Band Shoshone) Substance Abuse Counselor, Northern Valley Indian Health
The Rev. Terri Hobart Rector – St. Luke's Episcopal Church Active Member – Woodland Ecumenical & Multi-Faith Ministries (WEMM)
Khalid Saeed National President American Muslim Voice Foundation Member – Woodland Mosque & Islamic Center Active Member – Woodland Ecumenical & Multi-Faith Ministries (WEMM)
Tatiana Shevchenko Director - Russian Information and Support Services

Sharing (ten minutes each)

Name/Title
Role in Yolo County as Faith Leader/Faith Liaison
Faith/Religion You Will Share About

1) Tenets/Beliefs of Faith/Religion
2) Significant Observances, Customs and/or Practices
3) Teachings/Practices related to Women and Diverse Communities (LGBTQ, Diverse Racial and Ethnic Groups, Etc.)
4) Things Behavioral Staff Members Should Know and Do to Effectively Welcome, Include and Serve Individuals and Families

Spirituality and Behavioral Health

Resources and References

	Item/Handout	Notes
1	Mental Health and Spirituality Initiative: Consensus Definitions	Definitions provided by California's Mental Health & Spirituality Initiative Website: http://www.mhspirit.org/ Monthly Conference Calls 4th Wednesday of the Month, 9 to 10 a.m. Call-in number is 515-739-1529 and the access number is 982384#
2	Cultural Competence Continuum	Provides reminders of ongoing process to develop cultural competence and cultural proficiency.
3	Cultural Humility	Reminds us to be open to what a person has determined as a personal culture – personal expression of heritage and culture.
4	Newsweek Article: *Most LGBTQ Adults are Religious, Poll Finds*	Highlights importance of Religion for LGBTQ Adults *Note: As needed, search for LGBTQ Affirming Churches*
5	Article: Religious Barriers to Mental Healthcare -The American Journal of Psychiatry Residents' Journal	Identifies barriers and opportunities to address.
6	The Big Religion Chart	Provides summary of major religions and belief systems of the world. Source: http://www.religionfacts.com/big-religion-chart
7	Cultural Formulation Interview – Excerpts from DSM-5 - Patient Version and Informant Version	A set of 16 questions that clinicians may use to obtain information during a mental health assessment about the impact of culture on key aspects of an individual's clinical presentation and care.
8	Exploring Culture in CLAS: Religion and Spirituality	Provides highlights of webinar. Provides examples from questionnaires and Spirituality Assessment Tools (HOPE and FICA).
9	HOPE Approach to Spiritual Assessment	Identifies questions for HOPE Spiritual Assessment

MENTAL HEALTH & SPIRITUALITY INITIATIVE

Consensus Definitions

http://www.mhspirit.org/

Faith
Faith refers to confidence or trust in a set of religious principles or beliefs, including beliefs about the divine and beliefs that may not be based on proof.

Faith-based organization
Includes places of worship and nonprofit organizations, which have a long tradition of helping people in need and are an integral part of the social service network.

Practice-based organization
Traditions that do not include elements of faith or doctrine, but share a commitment to cultivating certain practices, such as meditation.

Recovery
This focus on self-directed treatment is the third distinguishing feature of the recovery model. Treatment professionals act as coaches helping to design a rehabilitation plan which supports the patients' efforts to achieve a series of functional goals. Their relationship often focuses on motivating and focusing the patient's own efforts to help themselves. What is important, particularly during the initial stages of interaction is that professionals afford dignity and respect to those in their care.

Religion
A religion is an organization that is guided by a codified set of beliefs and practices held by a community, whose members adhere to a worldview of the holy and sacred that is supported by religious rituals.

Religious Professional
A religious professional is a person who is recognized by a faith tradition (or practice tradition) as a spiritual leader/teacher and is authorized by that community to conduct religious rituals. The preparation and rites of passage required to become a religious professional vary widely. The term does not apply to lay people who are followers of the tradition. Some examples include elders, pastors, imans, shamans, rabbis, gurus, ministers, priests, nuns, monks, or spiritual teachers.

Spirituality
Spirituality is a person's deepest sense of belonging and connection to a higher power or life philosophy which may not necessarily be related to an organized church or religious institution.

CULTURAL COMPETENCE CONTINUUM

Developing cultural competence is an evolving, dynamic process that takes time and occurs along a continuum. The National Center for Cultural Competence at Georgetown University's Center for Child and Human Development describes the six stages of this continuum in Infusing Cultural and Linguistic Competence in Health Promotion Training: Group Activity – Understanding the Cultural Competence Continuum – 2005 (PDF | 88 KB) :

- **Cultural destructiveness**. This stage is characterized by attitudes and practices (as well as policies and structures in organizations) that are destructive to a cultural group.
- **Culture incapacity**. This stage reflects the lack of capacity systems and organizations necessary to effectively respond to the needs and interests of diverse groups. This can include institutional or systemic bias, practices that may result in discrimination in hiring and promotion, or disproportionate allocation of resources that may benefit one group over another. This can also include subtle messages that certain groups aren't valued or welcomed.
- **Cultural blindness**. This stage describes a philosophy of "fairness" that views and treats all people as the same. This philosophy, however, can be problematic because people are different and have different needs. People deserve approaches that acknowledge and celebrate differences, while addressing these needs. Cultural blindness can in fact, negatively influence system policies by encouraging assimilation, ignoring cultural strengths, fostering institutional attitudes that blame consumers for their circumstances, and failing to hire a diverse workforce.
- **Cultural pre-competence**. This stage highlights the growing awareness of strengths (and areas for improvement) to respond effectively to culturally and linguistically diverse populations.
- **Cultural competence**. In this stage, acceptance and respect for culture becomes consistently demonstrated in policies, structures, practices, and attitudes. This can include an organization's commitment to human and civil rights, hiring practices that reflect a diverse workforce, and increased efforts to improve service delivery for racial, ethnic, or cultural groups.
- **Cultural proficiency**. In stage six, culture is held in high esteem and used as a foundation to guide all endeavors. Organizations that do this successfully continue to add to their knowledge base. They support and mentor other organizations seeking to improve their cultural competence and they advocate with and on behalf of populations who are traditionally underserved or not served at all. They also partner with other diverse constituency groups to help reduce and eventually eliminate racial and ethnic disparities.

Cultural Humility, Part I — What Is 'Cultural Humility'?

https://thesocialworkpractitioner.com/2013/08/19/cultural-humility-part-i-what-is-cultural-humility/

What is "cultural humility" (and what does it have to do with "cultural competence")?
To practice cultural humility is to maintain a willingness to suspend what you know, or what you think you know, about a person based on generalizations about their culture. Rather, what you learn about your clients' culture stems from being open to *what they themselves have determined is their personal expression of their heritage and culture*, what I call their *personal culture*.

In a compelling YouTube **video** by Director Vivian Chavez, Melanie Tervalon, a physician and consultant, and Jann Murray-Garcia, a nursing professor at UC Davis, thoughtfully discuss the philosophy and function of cultural humility. *https://youtu.be/SaSHLbS1V4w*

They describe cultural humility as having 'three dimensions.'

1) **Lifelong learning & critical self-reflection** — to practice cultural humility is to understand that culture is, first and foremost, an expression of self and that the process of learning about each individuals' culture is a lifelong endeavor, because no two individuals are the same; each individual is a complicated, multi-dimensional human being who can rightfully proclaim *"My identity is rooted in my history... and I get to say who I am."*

2) **Recognizing and challenging power imbalances for respectful partnerships** — while working to establish and maintain respect is essential in all healthy and productive relationships, the root of effective social work practice is in acknowledging and challenging the power imbalances inherent in our practitioner/client dynamics.

3) **Institutional accountability** — organizations need to model these principles as well (from micro, to mezzo and macro practice).

This model incorporates and expands upon what some adherents view as the limitations of "cultural competence."

Cultural competence is a helpful starting point in the development of a caring, compassionate, and effective practice, but in light of a deepening understanding of cultural humility its limitations are revealed.

Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education, Journal of Health Care for the Poor and Underserved (May 1998)
http://muse.jhu.edu/journals/hpu/summary/v009/9.2.tervalon.html

Most LGBTQ Adults are Religious, Poll Finds; Members of the Community Say They're Surprised

By Alexandra Hutzler On 6/17/18 at 6:10 AM

A new survey found that most LGBTQ adults in the United States are religious, and more than half are Christian, to the surprise of people of faith in the community.

Conducted by Buzzfeed and Whitman Insight Strategies, the survey, the most extensive of its kind, addressed more than 880 members of the LGBTQ community countrywide from May 21 to June 1. The study found that overall, LGBTQ people were mostly white, female and under 40 years old. More than half of those surveyed identified as bisexual, while the smallest group of people surveyed identified as transgender.

While 39 percent of those polled said they had no religious affiliation whatsoever, more than half of the respondents said they were regularly involved in faith organizations. A majority of people who were religious were Christian, with 23 percent identifying as Protestant and 18 percent identifying as Catholic.

Another 8 percent of those polled were Jewish, Muslim or Buddhist, and about 13 percent weren't sure when it came to religion.

But the journey to keeping their faith wasn't always easy, LGBTQ religious people and advocates told *Newsweek*.

Kate Mears, a transgender woman, told *Newsweek* she was raised in a conservative, religious household in a small suburban town near Grand Rapids, Michigan. She attended morning and evening church services regularly and grew up going to Christian schools. On New Year's Day in 2016, Mears told her family that she wanted to transition.

Her decision sparked a two-year debate with her church, which aggressively tried to convince her to de-transition or face excommunication. As a result, Mears fell out of contact with her family and was eventually dropped from the church's membership.

"I lost my family and church in the process," Mears said. But she soon found herself unable to let go of religion, which had become a central part of who she was, and eventually found another church, which accepted her with open arms.

"I hold on to my pain and try to use it to help people. I don't want anyone to feel like they have to abandon their religion," said Mears.

Marilyn Paarlberg, the executive director at the nonprofit organization Room for All, expressed surprise at the survey's findings.

"That is very surprising to me, because in my experience working with the LGBTQ community in the church, is that many of them have either left a long time ago or were exiled," she said. Paarlberg's organization is one of the biggest advocates for inclusivity of all genders and sexualities in the Reformed Church in America.

But Paarlberg noted that the church has made significant strides to be more open to people of all different backgrounds since the mid-2000s. "I think we looked at ourselves and said, 'We're better than this, the church is better than this,'" she said.

Tricia Sheffield noticed the changes happening in the church, which is why she became a reverend and now runs Middletown Reformed Church in New Jersey.

Sheffield was raised Southern Baptist but left the church when she was 30 years old—not because she was bisexual, but because she viewed the church as representing patriarchy, homophobia and racism.

After a decade away from religion, Sheffield returned the church at the age of 41, but only as an office administrator. "I had no intention to become spiritual again, but I began to see the kind of church I'd always hoped for," she said. Sheffield went on to study theology and queer theory, and became ordained in 2013.

Sheffield and her congregation recently marched in a parade to celebrate Pride Month; she said many of the marchers were stunned that a church group was walking with them to support LGBTQ rights.

"I know that many in the community have been shunned and may not feel welcome," Sheffield said. "But I think as churches have become more welcoming, people have found home again."

ARTICLE

Religious Barriers to Mental Healthcare

Emine Rabia Ayvaci, M.D.

Religion can be defined as the collection of beliefs, practices, and rituals related to the "sacred" (1). A religious group refers to a large number of people with shared spiritual values. According to DSM-5, religion is considered as part of the cultural context of the illness experience. However, shared values toward spirituality may indicate common characteristics among patient populations across different religious backgrounds. Providing culturally appropriate mental healthcare is further complicated by the fact that any one religious group may be comprised of a variety of ethnicities, socioeconomic classes, and subcultures with their own belief systems.

Religion plays an important role in American society. According to a national survey by Pew Research, more than 70% of Americans report being affiliated with a religious group, and 42% attend religious services weekly or almost weekly (2). People with persistent psychiatric disorders could rely on their religious beliefs to cope with their condition (3). In a study of 406 patients from 13 Los Angeles County mental health facilities, more than 80% of the participants reported using religious beliefs or activities to cope with daily difficulties and frustration (4). Another study using the National Comorbidity Survey data suggested that a quarter of religious people seek help from clergy as their first treatment contact for mental health problems (5). Several other studies have shown that religious involvement is associated with positive mental health outcomes (6–8).

Patients' tendencies to use religion when coping with mental health-related problems and the involvement of a nonclinical party can result in a complex model of mental healthcare delivery. The current literature regarding the interface of religion and psychiatric care primarily focuses on the outcome of the psychiatric treatments. This focus draws limited attention to religion's effect on service access and use. It is critical to understand the religious barriers to appropriate and efficient mental health delivery to different populations. The present review article focuses on potential barriers to access to mental health services among people with religious involvement. Access barriers may be grouped into three major categories: the patient level, the psychiatrist level, and the system level.

ACCESS BARRIERS

Patient-Level

The help-seeking process starts with an individual's understanding and conceptualization of psychiatric disorders (Table 1). Interpretations of psychiatric symptoms are influenced by a patient's cultural experience, which includes religious beliefs and practices. Historically, psychiatric disorders were explained by supernatural phenomenon, such as demonic possession. Today, some religious people may believe that psychiatric disorders are caused by a "weakness in faith" and that the illness can be overcome or cured through "willpower" alone, rather than by seeking professional help from the mental health system (9). For example, in one survey, 85% of African Americans defined themselves as fairly religious or very religious, and researchers have found that there is a prevalence of a belief in this population that psychiatric disorder can be overcome by heroic striving (10). For this reason, some patients with religious affiliation may avoid contacting a psychiatrist. Even after contacting a physician, patients might avoid discussing their religious concerns with the provider because of their perception that psychiatrists are not sensitive to or knowledgeable about the religion (3, 10, 11).

Similar to patients, clergy also have various beliefs about psychiatric care and the perceived need for treatment

TABLE 1. Access Barriers to Care

Patient level
Conceptualization of disease
Beliefs in religious help for mental illness
Beliefs about perceived need for treatment
Use of nonpsychiatric forms of services
Fear of challenging religious beliefs
Fear of discrimination
Psychiatrist level
Difficulty recognizing nonpathological expression of religion
Reluctance in obtaining religious history
System level
Clergy's lack of familiarity with the system
Limited referral from clergy
Limited understanding of clergy
Lack of coordination between faith-based services and formal healthcare
Reluctance of collaboration by faith-based providers

(12, 13). In a survey conducted among 204 Protestant pastors, a significant portion of the participants attributed symptoms of depression to "lack of trust in God," and they were less likely to agree with the biological nature of depressive disorders (12). Another study conducted on Muslim clergy suggested that while imams can recognize the need for psychiatric care in a hypothetical clinical vignette, they could still be reluctant to make referrals to the mental health system due to concerns about discrimination based on their religion (13). Since clergy are a key entry point for a quarter of religious people, the clergy's perceptions of psychiatric disorders can lead to avoidance of referral to mental health providers.

Additional concerns among religious people may arise when they need inpatient level of care. In an observation study conducted at SUNY Downstate Hospital, Orthodox Jewish patients at the psychiatric inpatient unit experienced difficulties while following ward milieu due to conflicts with religious practice. For example, inability to pray at accustomed times exacerbated the anxiety of religious patients (14). For an outpatient treatment such as psychotherapy, nonreligious therapists can integrate religious components into their treatment; however, patients might have fears that the therapist will challenge their religious beliefs. This can be a barrier for patients who seek long-term treatments like psychotherapy (15).

Psychiatrist-Level

It is also important to note how psychiatrists relate religion and health. Clinicians' views of religion can shape how they interact with their patients (16) (Table 1). In a national survey, it was found that psychiatrists were less likely to be religious compared with nonpsychiatry physicians (15). Although psychiatric care promotes better understanding of patients' beliefs, patients still report difficulty finding a psychiatrist with an understanding of their religious beliefs. This can be especially prominent in religions with a relatively low percentage of psychiatrists within the population (2).

KEY POINTS/CLINICAL PEARLS

- More than 70% of Americans report being affiliated with a religious group.
- A quarter of religious people seek help from clergy as the first contact for mental health.
- Religious beliefs continue to be an important part of individuals' attitude toward seeking psychiatric care.
- Clinicians can use the HOPE questionnaire to assess patient's religiosity.

Psychiatrists frequently encounter patients with pathological expressions of religion, such as religious delusions (17). Psychiatrists may have difficulty separating normal and pathological expressions of religiosity, which becomes a barrier to understanding their patients. In an interview study, psychiatrists reported discussing religion with their patients in only 36% of cases, although they reported feeling comfortable talking about religion in 93% of the cases (3). None of the clinicians initiated the topic themselves. Patients in the same study reported avoidance of talking about their spirituality, especially when it overlapped with their positive psychotic symptoms. In the same study, psychiatrists discussed community resources of the religion with their patients but had difficulty discussing the subjective experience of their patients' religiosity.

System-Level

While religiosity and spirituality in American society have increased (2), there has been an increase in the use of nonpsychiatric forms of mental health services and a decrease in the use of psychiatric services (5). Because clergy are often the first entry point to mental health for religious people (5, 18), it is important to understand the role of religious institutions in service delivery. Despite the fact that use of clergy for mental healthcare is associated with good outcomes (19), we have limited understanding of the structure of faith-based service delivery. A cross-sectional survey found that counseling provided by clergy has low frequency, even for individuals with serious psychiatric or substance use disorders (5). In addition, coordination between faith-based services and formal healthcare has often been lacking (Table 1). A survey on clergy suggested that faith-based providers were found to be reluctant to collaborate with formal health services due to several reasons, including lack of demand from their community, financial limitations, and lack of specialized training (20). Even among clergy who have a willingness to refer an individual to a mental health provider, the lack of familiarity with the mental health system may remain a barrier (13).

IMPLICATIONS

The goal of this review was to raise awareness of access barriers to mental health treatment for religious people. Several barriers were identified and categorized according to patient, psychiatrist, and system levels. It is important for clinicians to be aware of these barriers and seek ways to educate themselves, their patients, and the community about the role of religion in mental health delivery. Different interventions can be used to overcome these barriers, especially at the psychiatrist level, such as assessing and understanding patients' beliefs and collaborating with clergy (17).

Assessing religious beliefs is now a standard part of psychiatric history. There are different protocols for how to assess patients' religiosity. One of them is the HOPE questionnaire [sources of **H**ope, **O**rganized religion, **P**ersonal spirituality and practices, **E**ffects on medical care and end-of-life issues], a protocol for asking patients questions about spirituality (21). The HOPE questionnaire could be a good guideline for residents. It is critical to understand

and discuss how patients shape their responses based on their religiosity. A psychiatrist should be aware of the obstacles and opportunities with regard to the religion-related issues during the interview. By understanding potential barriers at different levels, we can build individual and system-level approaches to improve mental health service delivery.

CONCLUSIONS

For a substantial part of the population, religious beliefs continue to be an important part of an individual's attitude toward seeking psychiatric care. As psychiatrists, we should be aware of both the opportunities and barriers for patients with religious involvement to receive appropriate care. In particular, understanding religiosity and its effect on service use suggests that we need to build new approaches to improve the service delivery to patients who have religious involvement and coordinate with the faith-based services. From a research standpoint, there is a strong need to understand faith-based factors that may improve access to mental healthcare.

Dr. Ayvaci is a third-year resident in the Department of Psychiatry, University of Texas Southwestern Medical Center, Dallas.

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Source: http://www.religionfacts.com/big-religion-chart

	Adherents	History	Gods	Meaning of Life	Afterlife	Practices	Texts
Aladura	1 million	Various prophet-healing churches founded since c.1918, West Nigeria.	Generally monotheistic; a mix of Anglican, Pentecostal and traditional African beliefs.	Strong emphasis on healing and salvation in this life.	Not emphasized; views vary.	Spiritual healing is central. Mix of Anglican and African rituals; a prophet plays a prominent role. Aladura Practices	none
Asatru	unknown	Revival of Norse and Germanic paganism, 1970s Scandinavia and USA. History of Asatru	Polytheistic, Norse gods and goddesses, Norse creation myths. Asatru Gods	Salvation or redemption not emphasized. Fatalistic outlook.	Valhalla (heaven) for death in battle; Hel (peaceful place) for most; Hifhel (hell) for the very evil.	Sacrifice of food or drink, toast to the gods, shamanism (less frequently), celebration of solstice holidays. Nine Noble Virtues is moral code. Asatru Practices	Eddas (Norse epics); the Havamal (proverbs attributed to Odin) Asatru Texts
Atheism	7.4 million self-identified atheists; 1.1 billion are religiously "unaffiliated"	Appears throughout history (including ancient Greek philosophy), but especially after the Enlightenment (19th cent).	There is no God or divine beings.	Not addressed. But many atheists believe that since there is no afterlife, this one life is of great importance. Only humans can help themselves and each other solve the world's problems.	none	none	Influential works include those by Marx, Freud, Feuerbach, Voltaire, and Mark Twain. Notable modern authors include Richard Dawkins and Carl Sagan.
Baha'i Faith	5-7 million	Founded by Bahá'u'lláh, 1863, Tehran, Iran. History of the Baha'i Faith	One God, who has revealed himself progressively through major world religions. Baha'i Beliefs about God	The soul is eternal and essentially good. Purpose of life is to develop spiritually and draw closer to God. meaning of life (Bahai)	Soul separates from the body and begins a journey towards or away from God. Heaven and hell are states of being. afterlife (Baha'i)	Daily prayer, avoidance of intoxicants, scripture reading, hard work, education, work for social justice and equality. Baha'i Practices	Writings of Bahá'u'lláh and other Bahá'í leaders. Baha'i Texts

Source: http://www.religionfacts.com/big-religion-chart

	Adherents	History	Gods	Meaning of Life	Afterlife	Practices	Texts
Bon	100,000	11th-century Tibet	Nontheistic Buddhism, but meditation on peaceful and wrathful deities.	Gain enlightenment.	Reincarnation until gain enlightenment	Meditation on mandalas and Tibetan deities, astrology, monastic life.	Bonpo canon
Buddhism	500 million	Based on teachings of Siddharta Gautama (the Buddha) in c. 520 BC, NE India. History of Buddhism	Buddhist gods include buddhas, bodhisattvas, arhats and deities; such as Tara, Kuan Yin, and Amida Buddha. Buddhist Gods & Deities	Escape the cycle of rebirth and attain nirvana (Theravada Buddhism). Become a boddhisatva then help others attain enlightenment (Mahayana Buddhism). The Meaning of Life in Buddhism	Rebirth or nirvana. Nirvana is seen simply as the cessation of suffering by some and as a heavenly paradise by others. Buddhism on the Afterlife	Meditation, mantras, devotion to deities (in some sects), mandalas (Tibetan) Buddhist Practices	Tripitaka (Pali Canon); Mahayana sutras like the Lotus Sutra; others. Buddhist Texts
Cao Dai	4-6 million	Founded in 1926, Vietnam by Ngo Van Chieu and others based on a séance.	God represented by Divine Eye. Founders of Buddhism, Taoism, Hinduism, Islam, and Christianity venerated, and saints including Victor Hugo.	Goal is peace and harmony in each person and in the world. Salvation by "cultivating self and finding God in self."	reincarnation until Nirvana/Heaven	Hierarchy similar to Roman Catholicism. Daily prayer. Meditation. Communication with spirit world (now outlawed in Vietnam).	Caodai canon
Chinese Religion	394 million	Indigenous folk religion of China. History of Chinese Religion	Dualistic yin and yang; mythological beings and folk deities. Chinese Traditional Religion Theism	A favorable life and peaceful afterlife, attained through rituals and honoring of ancestors.	judgment, then paradise or punishment and reincarnation afterlife (Chinese Religion)	Ancestor worship, prayer, longevity practices, divination, prophecy and astrology, feng shui. Chinese religious rituals and practices	none

Source: http://www.religionfacts.com/big-religion-chart

	Adherents	History	Gods	Meaning of Life	Afterlife	Practices	Texts
Christian Science	400,000	Founded by Mary Baker Eddy in 1879, Massachusetts. History of Christian Science	One God. No Trinity (in traditional sense). Matter and evil do not exist.	"Life, Truth, and Love understood and demonstrated as supreme over all; sin, sickness and death destroyed."	Heaven is "not a locality, but a divine state of Mind in which all the manifestations of Mind are harmonious and immortal."	Spiritual healing through prayer and knowledge, Sunday services, daily Bible and Science & Health reading. Christian Science Practices	Christian Bible, Science & Health with Key to the Scriptures
Christianity	2.2 billion Christianity Adherents	Life and teachings of Jesus of Nazareth (born c. 4 BCE), a Jew from Palestine under Roman rule Christian History	One God, who is a Trinity of Father, Son and Holy Spirit; angels; demons; saints God & Spiritual Beings in Christianity	All have sinned and are thereby separated from God. Salvation is through faith in Christ and, for some, sacraments and good works.	Resurrection of body and soul; eternal heaven or hell (most denominations); temporary purgatory (Catholicism) Christianity on the Afterlife	Prayer, Bible study, baptism, Eucharist (Communion), church on Sundays, numerous holidays. Christian Practices	Bible (Hebrew Bible + New Testament) Christian Texts
Confucianism	5-6 million	Based on the teachings of Confucius (551–479 BCE, China) History of Confucianism	not addressed	To fulfill one's role in society with propriety, honor, and loyalty.	not addressed	none Confucian Practices	Analects Confucian Texts
Deism	unknown	Especially popularized in the 18th-cent. Enlightenment under Kant, Voltaire, Paine, Jefferson, and others	One Creator God who is uninterested in the world. Reason is basis for all knowledge.	not addressed	not addressed	None prescribed, although some deists practiced prayer.	Thomas Paine's The Age of Reason and similar texts

Source: http://www.religionfacts.com/big-religion-chart

	Adherents	History	Gods	Meaning of Life	Afterlife	Practices	Texts
Druze	500,000	Founded by Al-Darazi in 11th century, Cairo, Egypt. Roots in the Isma'iliyya sect of Shia Islam.	Universal Intelligence (al-Aql al-Kulli) or Divine Essence (akin to Neoplatonism), of which al-Hakim is believed to be an incarnation.	Live a good life for a favorable reincarnation. Await the re-appearance of al-Hakim (a Fatimid caliph who disappeared in 1021), who will usher in a Golden Age for true believers.	Reincarnation. Heaven is a spiritual existence when one has escaped reincarnation. Hell is distance from God in lifetime after lifetime.	Modest lifestyles, fasting before Eid al-Adha. Beliefs and practices are hidden for protection from persecution. Special group of initiates called uqqal.	Al-Naqd al-Khafi (Copy of the Secret); Al-Juz'al-Awwal (Essence of the First)
Eckankar	50,000-500,000	Founded by Paul Twitchell in Las Vegas, 1965 History of Eckankar	The Divine Spirit, called "ECK."	"Each of us is Soul, a spark of God sent to this world to gain spiritual experience." Salvation is liberation and God-realization.	Reincarnation. The Soul is eternal by nature and on a spiritual journey. Liberation possible in a single lifetime.	Spiritual Exercises of ECK: mantras, meditation, and dreams. These enable Soul travel and spiritual growth. Eckankar practices	Shariyat-Ki-Sugmad and books by Harold Klemp. Eckankar sacred
Epicureanism	n/a	Based on the teachings of Epicurus, c. 300 BCE, Athens.	Polytheism, but the gods take no notice of humans.	Pursue the highest pleasures (friendship and tranquility) and avoid pain.	No afterlife. The soul dissolves when the body dies.	none	Letters and Principal Doctrines
Falun Gong	3 million (acc. to official sources); 100 million (acc. to Falun Gong sources)	Li Hongzhi in 1992 in China History of Falun Gong	Countless gods and spiritual beings. Demonic aliens.	Good health and spritual transcendence, achieved by practicing Falun Gong.	Not addressed	Five exercises to strengthen the Falun. Cultivation of truthfulness, benevolence and forbearance. Meat eating discouraged. Falun Gong Practices	Zhuan Falun and other writings by Master Li Falun Gong Texts
Gnosticism	ancient form extinct; small modern revival groups	Various teachers including Valentinus, 1st-2nd cents. AD	The supreme God is unknowable; the creator god is evil and matter is evil.	Humans can return to the spiritual world through secret	Return to the spiritual world.	Asceticism, celibacy	Gnostic scriptures including various Gospels and Acts

Source: http://www.religionfacts.com/big-religion-chart

	Adherents	History	Gods	Meaning of Life	Afterlife	Practices	Texts
				knowledge of the universe.			attributed to apostles.
Greek Religion	ancient form extinct; various modern revivals	Indigenous religion of the ancient Greeks, c. 500 BCE to 400 CE.	Olympic pantheon (Zeus, etc.) mixed with eastern deities like Isis and Cybele. Ancient Greek Gods	Human life is subject to the whim of the gods and to Fate; these can be partially controlled through sacrifice and divination.	Beliefs varied from no afterlife to shadowy existence in the underworld to a paradise-like afterlife (mainly in mystery religions).	Animal sacrifice, harvest offerings, festivals, games, processions, dance, plays, in honor of the gods. Secret initiations and rituals in mystery religions. Greek religious practices	Epic poems of Homer and Hesiod.
Hare Krishna	250,000-1 million	Bhaktivedanta Swami Prabhupada, 1966, USA (with roots in 15th-century Hindu movement)	Krishna is the Supreme God.	Salvation from this Age of Kali is by a return to Godhead, accomplished through Krishna-Consciousness.	Reincarnation until unite with the Godhead.	Chanting, dancing, evangelism, vegetarianism, temple worship, monastic-style living	The Bhagavad-Gita As It Is
Hinduism	1 billion	Indigenous religion of India as developed to present day. Earliest forms (Vedic religion) date to 1500 BCE or earlier; major developments 1st-9th centuries CE. Hindu History	One Supreme Reality (Brahman) manifested in many gods and goddesses Hindu Gods & Goddesses	Humans are in bondage to ignorance and illusion, but are able to escape. Purpose is to gain release from rebirth, or at least a better rebirth. meaning of life (Hinduism)	Reincarnation until gain enlightenment.	Yoga, meditation, worship (puja), devotion to a god or goddess, pilgrimage to holy cities, live according to one's dharma (purpose/ role). Hindu Rituals & Practices	Vedas, Upanishads, Bhagavad Gita, Ramayana, etc. Hindu Sacred
Islam	1.6 billion	Based on teachings of the Prophet Muhammad;	One God (Allah in Arabic); the same God revealed (imperfectly) in	Submit (islam) to the will of God to gain Paradise after death.	eternal Paradise or eternal Hell	Five Pillars: Faith, Prayer, Alms, Pilgrimage, Fasting. Mosque services on	Qur'an (sacred text); Hadith (tradition)

Source: http://www.religionfacts.com/big-religion-chart

	Adherents	History	Gods	Meaning of Life	Afterlife	Practices	Texts
		founded 622 CE in Mecca, Saudi Arabia. History of Islam	the Jewish and Christian Bibles		Islamic Beliefs About the Afterlife	Fridays. Ablutions before prayer. No alcohol or pork. Holidays related to the pilgrimage and fast of Ramadan. Muslim rituals and practices	Islamic sacred texts
Jainism ——	4 million	Founded by Mahavira, c. 550 BCE, eastern India History of Jainism	Polytheism and pantheism. The universe is eternal; many gods exist. Gods, humans and all living things are classified in a complex hierarchy. Jain theism	Gain liberation from cycle of rebirth, by avoiding all bad karma, especially by causing no harm to any sentient being. meaning of life (Jainism)	Reincarnation until liberation. afterlife (Jainism)	Monasticism under the Five Great Vows (Non-Violence, Truth, Celibacy, Non-Stealing, Non-Possessiveness); worship at temples and at home. Meditation and mantras. Jain practices	The teachings of Mahavira in various collections.
Jehovah's Witnesses ——	6.5 million	Founded by Charles Taze Russell, 1879, Pittsburgh History of the Jehovah's Witnesses	One God: Jehovah. No Trinity. Christ is the first creation of God; the Holy Spirit is a force.	Salvation is through faith in Christ and obeying Jehovah's laws. The End of the World is soon.	Heaven for 144,000 chosen Witnesses, eternity on new earth for other Witnesses. All others annihilated. No hell.	No blood transfusions, no celebration of holidays, no use of crosses or religious images. Baptism, Sunday service at Kingdom Hall, strong emphasis on evangelism. Jehovah's Witnesses Practices	New World Translation of the Scriptures Jehovah's Witnesses Sacred Texts

Source: http://www.religionfacts.com/big-religion-chart

	Adherents	History	Gods	Meaning of Life	Afterlife	Practices	Texts
Judaism	14 million Adherents of Judaism	The religion of Abraham (c. 1800 BCE) and the Hebrews, especially after the destruction of the Second Temple in 70 CE. History of Judaism	One God: Yahweh (YHVH) God in Judaism	Obey God's commandments, live ethically. Focus is more on this life than the next.	Not emphasized; views vary: no afterlife, shadowy existence, World to Come (similar to heaven), Gehenna (similar to hell), reincarnation The Afterlife in Judaism	Circumcision at birth, bar/bat mitzvah at adulthood, observing Sabbath, wearing tallit and tefilin, prayer services Jewish Rituals and Practices	Hebrew Bible (Tanakh); Talmud Jewish sacred
Mormonism	12.2 million	Revelations to Joseph Smith, 1830, New York. Mormon History	God the Father, the Son Jesus Christ, and the Holy Ghost are three separate individual beings	Return to God by faith in Christ, good works, ordinances, and evangelism.	All return to spirit world instruction before resurrection. Then Mormons to heaven with God and families; others rewarded apart from God; hell for those who still reject God. The Afterlife in Mormonism	Abstinence from alcohol, tobacco, coffee and tea; baptism for the dead; eternal marriage; temple garments under daily clothes; active evangelism. Mormon Practices	Christian Bible, Book of Mormon, Doctrine and Covenants, and Pearl of Great Price Mormon Texts
Nation of Islam	10,000-100,000	Founded by Wallace Fard Muhammad, 1930, Detroit, USA.	"One God whose proper name is Allah." Wallace Fard Muhammad became the divine messiah and incarnation of Allah in 1930.	"The Blackman is the original man." Live righteously and worship Allah.	Mental resurrection of the righteous. Black people will be mentally resurrected first.	Prayer five times a day. Work for the equality of the African race. Respect laws of the land, don't carry arms, don't make war. Healthy living and abstinence from alcohol, smoking and substance abuse. Modest dress.	Qur'an and "Scriptures of all the Prophets of God" are holy texts. Influential writings include Elijah Muhammad's Message to the Blackman in America (1965)

Source: http://www.religionfacts.com/big-religion-chart

	Adherents	History	Gods	Meaning of Life	Afterlife	Practices	Texts
New Age	5 million	Helena Petrovna Blavatsky and Annie Besant in the 19th C, Alice A. Bailey (1880-1949), flourished in 1970s and 80s	The Divine is an impersonal life force that pervades all things	Dawning of a New Age of heightened consciousness and international peace. Individuals can obtain a foretaste of the New Age through spiritual transformation ("Ascension"). More emphasis on the latter now. Evil comes from ignorance.	Reincarnation	Astrology; mysticism; use of crystals; yoga; tarot readings; holistic medicine; psychic abilities; angelic communications; channeling; amulets; fortune-telling	Works of a variety of New Age writers
New Thought	160,000	Phineas Parkhurst Quimby (1802-66) and others, late 19th century, USA.	Generally monism (all is One), but members might be theists, pantheists or panentheists. God is immanent; the universe is essentially spiritual.	Man is divine, essentially spirit, and has infinite possibility. Mind can control the body. Sin and sickness caused by incorrect thinking. Man can live in oneness with God in love, truth, peace, health, and prosperity.	"Life is eternal in the invisible kingdom of God."	Emphasis on spiritual and mental healing, but without rejection of modern medicine. Worship services; prayer for the sick; discussion of New Thought authors and ideas.	Writings of Quimby (such as the The Quimby Manuscripts) and other New Thought authors
Olmec Religion	extinct in original form	Indigenous religion of the Olmecs, Guatemala and Mexico, c. 1500-400 BCE	Mostly unknown due to lack of written records. Many gods represented in art, including the Olmec Dragon, Maize Deity, Bird Monster, and Were-Jaguar.	unknown, but art indicates importance of fertility (rain, corn, etc.)	unknown	sacrifices, large sculptures of human heads, cave rituals, pilgrimages, ball-courts, pyramids	none
Rastafarianism	1 million	Founded by Marcus Garvey in the slums of	God is Jah, who became incarnate in Jesus (who was	Humans are temples of Jah. Salvation is primarily in this world	Some Rastas will experience "everliving"	Many practices based on Jewish biblical Law. Abstinence from most	Holy Piby (the "Blackman's Bible"). The

Source: http://www.religionfacts.com/big-religion-chart

	Adherents	History	Gods	Meaning of Life	Afterlife	Practices	Texts
		Jamaica in the 1920s and 30s History of Rastafarianism	black); Ethiopian Emperor Haile Selassie I was messiah.	and consists of liberation from oppression and return to Africa.	(physical immortality). Heaven is a return to Eden, which is in Africa.	or all meat, artificial foods, and alcohol. Use of marijuana in religious rituals and for medicine. Wearing of dreadlocks. Rastafarian Practices	Ethiopian epic Kebra Negast also revered. Rastafarian Texts
Satanism		The Church of Satan was founded in 1966 by Anton LaVey					
Scientology	70,000 or several million, depending on the source	Founded by L. Ron Hubbard, 1954, California History of Scientology	God(s) not specified; reality explained in the Eight Dynamics	Human consists of body, mind and thetan; capable of great things. Gain spiritual freedom by ridding mind of engrams.	Reincarnation	Auditing, progressing up various levels until "clear". Focus on education and drug recovery programs.	Writings of Hubbard, such as Dianetics and Scientology
Seventh-Day Adventism	25 million	Rooted in Millerite movement; founded 1863 in New England; early leaders: Ellen White, Hiram Edson and Joseph Bates	Trinitarian monotheism	Live in accordance with the Bible, including the Old Testament. The Second Coming will happen soon.	A "peaceful pause" after death until the coming of Christ, then resurrection to judgment, followed by eternity in heaven or nonexistence. No hell.	24-hour Sabbath observance starting Friday at sunset; adult baptism by immersion; church services emphasizing sermon	Christian Bible; writings of Ellen G. White as helpful supplement
Shinto	3-4 million	Indigenous religion of Japan Shinto History	kami: ancient gods or spirits	Humans are pure by nature and can keep away evil through purification rituals and attain good things by calling on the kami.	Death is bad and impure. Some humans become kami after death.	Worship and offerings to kami at shrines and at home. Purification rituals. Shinto Practices	Kojiki (Records of Ancient Matters); Nihon-gi (Chronicles of Japan) Shinto Texts

Source: http://www.religionfacts.com/big-religion-chart

	Adherents	History	Gods	Meaning of Life	Afterlife	Practices	Texts
Sikhism	23 million	Founded by Guru Nanak, c. 1500, Punjab, India. History of Sikhism	one God: Ik Onkar	Overcome the self, align life with will of God, and become a "saint soldier," fighting for good.	Reincarnation until resolve karma and merge with God.	Prayer and meditation on God's name, services at temple (gurdwara), turban and five Ks. Balance work, worship, and charity. No monasticism or asceticism.	Adi Granth (Sri Guru Granth Sahib)
Spiritualism	11 million	c.1850, USA, UK, France	Generally accepts the Christian God	Body and spirit are separate entities. Morality and contact with spirits affect afterlife.	A spiritual existence with access to the living. Condition depends on morality of life and advancement is possible.	Sunday services. Seances and other communication with departed spirits. Spirit healing.	No authoritative texts. Doctrine learned from spirit guides (advanced departed spirits).
Stoicism		Zeno in c.313 BC, Athens.	Pantheism: the logos pervades the universe.	Happiness, which is achieved by living reasonably.	Possible continued existence of the Soul, but not a personal existence.	Ethical and philosophical training, self-reflection, careful judgment and inner calm.	writings of Zeno, Seneca, Epictetus, Marcus Aurelius
Taoism	20 million specifically of Taoism (Chinese religion contains Taoist elements)	Based on teachings of Lao-Tzu, c. 550 BC, China.	Pantheism - the Tao pervades all. Taoist Pantheism	Inner harmony, peace, and longevity. Acheived by living in accordance with the Tao. meaning of life (Taoism)	Revert back to state of non-being, which is simply the other side of being. Afterlife in Taoism	General attitude of detachment and non-struggle, "go with the flow" of the Tao. Tai-chi, acupuncture, and alchemy to help longevity.	Tao-te Ching; Chuang-tzu Taoist Texts
Unification Church	over 1 million (3 million acc. to official sources)	Founded by Sun Myung Moon, 1954, South Korea.	Monotheism, with the duality of God (esp. masculine and feminine) emphasized. No Trinity.	True love and world peace instead of selfish love. True love and the kingdom of God on earth will be restored by the	Eternal life in a spirit world.	Blessing Ceremony	The Divine Principle (1954) by

Source: http://www.religionfacts.com/big-religion-chart

	Adherents	History	Gods	Meaning of Life	Afterlife	Practices	Texts
				creation of "true families."			
Unitarian Universalism	800,000	Formal merger of Unitarians and Universalists in 1961, USA. History of Unitarian-Universalism	Has no set beliefs, which is its defining characteristic.	Salvation is "spiritual health or wholeness." Members seek "inner and outer peace," insight, health, compassion and strength.	Not specified. Some believe in an afterlife, some do not. Very few believe in hell - "Universalism" indicates the belief that all will be saved.	Ceremonies for marriages, funerals, etc. Church services have elements from various religions. Emphasis on civil rights, social justice, equality and environment. Most UUs are anti-death penalty and pro-gay rights. Unitarian Universalist practices	Many sacred texts are revered by various members; some none at all. The Bible is the most commonly used text. Unitarian Universalism Texts
Wicca	1-3 million	Based on ancient pagan beliefs, but modern form founded early 1900s. Founder generally said to be Gerald Gardner.	Polytheism, centered on the Goddess and God, each in various forms; also a belief in a Supreme Being over all	"If it harms none, do what you will."	reincarnation until reach the Summerland afterlife (Wicca)	Prayer, casting a circle, Drawing Down the Moon, reciting spells, dancing, singing, sharing cakes and wine or beer Wiccan practices	No sacred text; foundational texts include The Witch Cult in Western Europe and The God of the Witches
Zoroastrianism	200,000	Based on teachings of Zoroaster in 6th cent. BCE Persia. Official religion of ancient Persia. May have influenced Judaism and Vedic religion. History of Zoroastrianism	One God, Ahura Mazda, but a dualistic worldview in which an evil spirit, Angra Mainyu, is almost as powerful.	Humans are free to do good or evil, must choose the side of good.	Judgment followed by heaven or hell. Hell is temporary until final purgation and return to Ahura Mazda.	prayers; tending the sacred fire; coming of age rituals; burial by exposure in the Tower of Silence Zoroastrian rituals and practices	Zend Avesta Zoroastrian texts

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Cultural Formulation Interview (CFI)

Supplementary modules used to expand each CFI subtopic are noted in parentheses.

GUIDE TO INTERVIEWER	INSTRUCTIONS TO THE INTERVIEWER ARE ***ITALICIZED.***
The following questions aim to clarify key aspects of the presenting clinical problem from the point of view of the individual and other members of the individual's social network (i.e., family, friends, or others involved in current problem). This includes the problem's meaning, potential sources of help, and expectations for services.	*INTRODUCTION FOR THE INDIVIDUAL:* I would like to understand the problems that bring you here so that I can help you more effectively. I want to know about ***your*** experience and ideas. I will ask some questions about what is going on and how you are dealing with it. Please remember there are no right or wrong answers.

CULTURAL DEFINITION OF THE PROBLEM

CULTURAL DEFINITION OF THE PROBLEM

(Explanatory Model, Level of Functioning)

Elicit the individual's view of core problems and key concerns. *Focus on the individual's own way of understanding the problem.* *Use the term, expression, or brief description elicited in question 1 to identify the problem in subsequent questions (e.g., "your conflict with your son").*	1. What brings you here today? *IF INDIVIDUAL GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE:* People often understand their problems in their own way, which may be similar to or different from how doctors describe the problem. How would *you* describe your problem?
Ask how individual frames the problem for members of the social network.	2. Sometimes people have different ways of describing their problem to their family, friends, or others in their community. How would you describe your problem to them?
Focus on the aspects of the problem that matter most to the individual.	3. What troubles you most about your problem?

CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT

CAUSES

(Explanatory Model, Social Network, Older Adults)

This question indicates the meaning of the condition for the individual, which may be relevant for clinical care. *Note that individuals may identify multiple causes, depending on the facet of the problem they are considering.*	4. Why do you think this is happening to you? What do you think are the causes of your [PROBLEM]? *PROMPT FURTHER IF REQUIRED:* Some people may explain their problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes.
Focus on the views of members of the individual's social network. These may be diverse and vary from the individual's.	5. What do others in your family, your friends, or others in your community think is causing your [PROBLEM]?

STRESSORS AND SUPPORTS

(Social Network, Caregivers, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Cultural Identity, Older Adults, Coping and Help Seeking)

Elicit information on the individual's life context, focusing on resources, social supports, and resilience. May also probe other supports (e.g., from co-workers, from participation in religion or spirituality).	6. Are there any kinds of support that make your [PROBLEM] better, such as support from family, friends, or others?
Focus on stressful aspects of the individual's environment. Can also probe, e.g., relationship problems, difficulties at work or school, or discrimination.	7. Are there any kinds of stresses that make your [PROBLEM] worse, such as difficulties with money, or family problems?

ROLE OF CULTURAL IDENTITY

(Cultural Identity, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Older Adults, Children and Adolescents)

	Sometimes, aspects of people's background or identity can make their [PROBLEM] better or worse. By ***background*** or ***identity***, I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, or your faith or religion.
Ask the individual to reflect on the most salient elements of his or her cultural identity. Use this information to tailor questions 9–10 as needed.	8. For you, what are the most important aspects of your background or identity?
Elicit aspects of identity that make the problem better or worse. *Probe as needed (e.g., clinical worsening as a result of discrimination due to migration status, race/ethnicity, or sexual orientation).*	9. Are there any aspects of your background or identity that make a difference to your [PROBLEM]?
Probe as needed (e.g., migration-related problems; conflict across generations or due to gender roles).	10. Are there any aspects of your background or identity that are causing other concerns or difficulties for you?

CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING

SELF-COPING

(Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors)

Clarify self-coping for the problem.	11. Sometimes people have various ways of dealing with problems like [PROBLEM]. What have you done on your own to cope with your [PROBLEM]?

Past Help Seeking

(Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship)

Elicit various sources of help (e.g., medical care, mental health treatment, support groups, work-based counseling, folk healing, religious or spiritual counseling, other forms of traditional or alternative healing). *Probe as needed (e.g., "What other sources of help have you used?").* *Clarify the individual's experience and regard for previous help.*	12. Often, people look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing have you sought for your [PROBLEM]? *PROBE IF DOES NOT DESCRIBE USEFULNESS OF HELP RECEIVED:* What types of help or treatment were most useful? Not useful?

Barriers

(Coping and Help Seeking, Religion and Spirituality, Older Adults, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship)

Clarify the role of social barriers to help seeking, access to care, and problems engaging in previous treatment. *Probe details as needed (e.g., "What got in the way?").*	13. Has anything prevented you from getting the help you need? *PROBE AS NEEDED:* For example, money, work or family commitments, stigma or discrimination, or lack of services that understand your language or background?

CULTURAL FACTORS AFFECTING CURRENT HELP SEEKING

Preferences

(Social Network, Caregivers, Religion and Spirituality, Older Adults, Coping and Help Seeking)

Clarify individual's current perceived needs and expectations of help, broadly defined. *Probe if individual lists only one source of help (e.g., "What other kinds of help would be useful to you at this time?").*	Now let's talk some more about the help you need. 14. What kinds of help do you think would be most useful to you at this time for your [PROBLEM]?
Focus on the views of the social network regarding help seeking.	15. Are there other kinds of help that your family, friends, or other people have suggested would be helpful for you now?

Clinician-Patient Relationship

(Clinician-Patient Relationship, Older Adults)

Elicit possible concerns about the clinic or the clinician-patient relationship, including perceived racism, language barriers, or cultural differences that may undermine goodwill, communication, or care delivery. *Probe details as needed (e.g., "In what way?").* *Address possible barriers to care or concerns about the clinic and the clinician-patient relationship raised previously.*	Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations. 16. Have you been concerned about this and is there anything that we can do to provide you with the care you need?

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Cultural Formulation Interview (CFI)—Informant Version

GUIDE TO INTERVIEWER	INSTRUCTIONS TO THE INTERVIEWER ARE ***ITALICIZED.***
The following questions aim to clarify key aspects of the presenting clinical problem from the informant's point of view. This includes the problem's meaning, potential sources of help, and expectations for services.	*INTRODUCTION FOR THE INFORMANT:* I would like to understand the problems that bring your family member/friend here so that I can help you and him/her more effectively. I want to know about ***your*** experience and ideas. I will ask some questions about what is going on and how you and your family member/friend are dealing with it. There are no right or wrong answers.
RELATIONSHIP WITH THE PATIENT	
Clarify the informant's relationship with the individual and/or the individual's family.	1. How would you describe your relationship to [INDIVIDUAL OR TO FAMILY]? *PROBE IF NOT CLEAR:* How often do you see [INDIVIDUAL]?
CULTURAL DEFINITION OF THE PROBLEM	
Elicit the informant's view of core problems and key concerns. *Focus on the informant's way of understanding the individual's problem.* *Use the term, expression, or brief description elicited in question 1 to identify the problem in subsequent questions (e.g., "her conflict with her son").*	2. What brings your family member/friend here today? *IF INFORMANT GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE:* People often understand problems in their own way, which may be similar or different from how doctors describe the problem. How would ***you*** describe [INDIVIDUAL'S] problem?
Ask how informant frames the problem for members of the social network.	3. Sometimes people have different ways of describing the problem to family, friends, or others in their community. How would ***you*** describe [INDIVIDUAL'S] problem to them?
Focus on the aspects of the problem that matter most to the informant.	4. What troubles you most about [INDIVIDUAL'S] problem?
CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT	
CAUSES	
This question indicates the meaning of the condition for the informant, which may be relevant for clinical care. *Note that informants may identify multiple causes depending on the facet of the problem they are considering.*	5. Why do you think this is happening to [INDIVIDUAL]? What do you think are the causes of his/her [PROBLEM]? *PROMPT FURTHER IF REQUIRED:* Some people may explain the problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes.
Focus on the views of members of the individual's social network. These may be diverse and vary from the informant's.	6. What do others in [INDIVIDUAL'S] family, his/her friends, or others in the community think is causing [INDIVIDUAL'S] [PROBLEM]?

Stressors and Supports

Elicit information on the individual's life context, focusing on resources, social supports, and resilience. May also probe other supports (e.g., from co-workers, from participation in religion or spirituality).	7. Are there any kinds of supports that make his/her [PROBLEM] better, such as from family, friends, or others?
Focus on stressful aspects of the individual's environment. Can also probe, e.g., relationship problems, difficulties at work or school, or discrimination.	8. Are there any kinds of stresses that make his/her [PROBLEM] worse, such as difficulties with money, or family problems?

Role of Cultural Identity

	Sometimes, aspects of people's background or identity can make the [PROBLEM] better or worse. By ***background*** or ***identity,*** I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, and your faith or religion.
Ask the informant to reflect on the most salient elements of the individual's cultural identity. Use this information to tailor questions 10–11 as needed.	9. For you, what are the most important aspects of [INDIVIDUAL'S] background or identity?
Elicit aspects of identity that make the problem better or worse. *Probe as needed (e.g., clinical worsening as a result of discrimination due to migration status, race/ethnicity, or sexual orientation).*	10. Are there any aspects of [INDIVIDUAL'S] background or identity that make a difference to his/her [PROBLEM]?
Probe as needed (e.g., migration-related problems; conflict across generations or due to gender roles).	11. Are there any aspects of [INDIVIDUAL'S] background or identity that are causing other concerns or difficulties for him/her?

CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING

Self-Coping

Clarify individual's self-coping for the -problem.	12. Sometimes people have various ways of dealing with problems like [PROBLEM]. What has [INDIVIDUAL] done on his/her own to cope with his/her [-PROBLEM]?

Past Help Seeking

Elicit various sources of help (e.g., medical care, mental health treatment, support groups, work-based counseling, folk healing, religious or spiritual counseling, other alternative healing). *Probe as needed (e.g., "What other sources of help has he/she used?").* *Clarify the individual's experience and regard for previous help.*	13. Often, people also look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing has [INDIVIDUAL] sought for his/her [PROBLEM]? *PROBE IF DOES NOT DESCRIBE USEFULNESS OF HELP RECEIVED:* What types of help or treatment were most useful? Not useful?

BARRIERS	
Clarify the role of social barriers to help-seeking, access to care, and problems engaging in previous treatment.	14. Has anything prevented [INDIVIDUAL] from getting the help he/she needs?
Probe details as needed (e.g., "What got in the way?").	*PROBE AS NEEDED:* For example, money, work or family commitments, stigma or discrimination, or lack of services that understand his/her language or background?

CULTURAL FACTORS AFFECTING CURRENT HELP SEEKING

PREFERENCES	
Clarify individual's current perceived needs and expectations of help, broadly defined, from the point of view of the informant. *Probe if informant lists only one source of help (e.g., "What other kinds of help would be useful to [INDIVIDUAL] at this time?").*	Now let's talk about the help [INDIVIDUAL] needs. 15. What kinds of help would be most useful to him/her at this time for his/her [PROBLEM]?
Focus on the views of the social network regarding help seeking.	16. Are there other kinds of help that [INDIVIDUAL'S] family, friends, or other people have suggested would be helpful for him/her now?
CLINICIAN-PATIENT RELATIONSHIP	
Elicit possible concerns about the clinic or the clinician-patient relationship, including perceived racism, language barriers, or cultural differences that may undermine goodwill, communication, or care delivery. *Probe details as needed (e.g., "In what way?").* *Address possible barriers to care or concerns about the clinic and the clinician-patient relationship raised previously.*	Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations. 17. Have you been concerned about this, and is there anything that we can do to provide [INDIVIDUAL] with the care he/she needs?

Exploring Culture in CLAS: Religion and Spirituality

https://www.thinkculturalhealth.hhs.gov/resources/presentations/6/exploring-culture-in-clas-religion-and-spirituality

Culture is defined as the integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics. Culture is dynamic in nature, and individuals may identify with multiple cultures over the course of their lifetimes.

* * * * *

Examples from questionnaires:

PATIENT RIGHTS:

Is there anything we need to know about your religion or culture in order to care for you?

If YES, explain _____

* * *

Religion/Spirituality

Do you have a religious affiliation? _____

Is religion/spirituality important in your life? *Yes* *No*

Would blood transfusion be an option for you? *Yes* *No*

* * *

Do you have any beliefs or practices from your religion, culture or otherwise that your doctor should know? For example

- ☐ I am a Jehovah's Witness and do not accept blood blood product
- ☐ I do not use birth control because of personal or religious beliefs.
- ☐ I fast (go without food) for periods of time for personal or religious reasons
- ☐ I am a vegetarian (do not eat meat).
- ☐ I am a vegan (do not eat anything that comes from an animal).
- ☐ Other special diets or eating habits. Please describe _____
- ☐ I use traditional medicines or treatments, such as acupuncture or herbs.
- ☐ Other beliefs _____
- ☐ No, I have no beliefs or practices that need to be included in my care.

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https://www.thinkculturalhealth.hhs.gov/resources/presentations/6/exploring-culture-in-clas-religion-and-spirituality

One spirituality assessment tool is the HOPE questionnaire

H: Sources of hope, meaning, comfort, strength, peace, love and connection
O: Organized religion
P: Personal spirituality/ practices
E: Effects on medical care and end-of-life decisions.

- *We have been discussing your support systems. I was wondering, what is there in your life that gives you internal support?*
- *What are your sources of hope, strength, comfort and peace?*
- *What do you hold on to during difficult times?*
- *What sustains you and keeps you going?*
- *Do you consider yourself part of an organized religion? How important is this to you?*
- *What aspects of your religion are helpful and not so helpful to you?*
- *Do you belong to a religious or spiritual community? Does it help you?*
- *Has being sick (or whatever your current situation is) affected your ability to do the things that usually help you spiritually? (Or affected your relationship with God?)*
- *As a doctor, is there anything that I can do to help you access the resources that usually help you?*
- *Are you worried about any conflicts between your beliefs and your medical situation/care/decisions?*

Another spirituality assessment tool is the FICA tool. **FICA represents faith, the importance and influence, community, and address.** Some specific questions you can use to discuss during these activates are:

F: What is your faith or belief?

- Do you consider yourself spiritual or religious? and
- What things do you believe in that give meaning to your life?

I: Is it important in your life?

- What influence does it have on how you take care of yourself?
- How have your beliefs influenced in your behavior during this illness? and
- What role do your beliefs play in regaining your health?

C: Are you a part of a spiritual or religious community?

- Is this of support to you and how?
- Is there a person or group of people you really love or who are really important to you?

A: How would you like me, your healthcare provider to address these issues in your healthcare?

Table 5.1 HOPE Approach to Spiritual Assessment

H **Spiritual Resources**	What are your sources of **hope** or comfort? What helps you during difficult times?
O **Organized Religion**	Are you a member of an **organized religion?** What religious practices are important to you?
P **Personal Spirituality**	Do you have **spiritual beliefs,** separate from organized religion? What **spiritual practices** are most helpful to you?
E **Effects on Care**	Is there any conflict between your beliefs and the **care** you will be receiving? Do you hold beliefs or follow practices that you believe may affect your **care?** Do you wish to consult with a religious or spiritual leader when you are ill or making decisions about your **healthcare?**

Source: Anadarajah, G., & Hight, E. (2000). *Spirituality and medical practice: Using the HOPE questions as a practical tool for spiritual assessment.* www.aafp.org/.