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Culture and Psychiatric Diagnosis

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Abstract

Since the publication of DSM-IV in 1994, a number of components related to psychiatric diagnosis have come under criticism for their inaccuracies and inadequacies. Neurobiologists and anthropologists have particularly criticized the rigidity of DSM-IV diagnostic criteria that appear to exclude whole classes of alternate illness presentations as well as the lack of attention in contemporary psychiatric nosology to the role of contextual factors in the emergence and characteristics of psychopathology. Experts in culture and mental health have responded to these criticisms by revising the very process of diagnosis for DSM-5. Specifically, the DSM-5 Cultural Issues Subgroup has recommended that concepts of culture be included more prominently in several areas: an introductory chapter on Cultural Aspects of Psychiatric Diagnosis –composed of a conceptual introduction, a revised Outline for Cultural Formulation, a Cultural Formulation Interview that operationalizes this Outline, and a glossary on cultural concepts of distress—as well as material directly related to culture that is incorporated into the description of each disorder. This chapter surveys these recommendations to demonstrate how culture and context interact with psychiatric diagnosis at multiple levels. A greater appreciation of the interplay between culture, context, and biology can help clinicians improve diagnostic and treatment planning.

The American Psychiatric Association (APA) is scheduled to release the 5th Edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) in May of 2013 after revision efforts lasting nearly a decade. The various iterations of the DSM have been important documents for cultural psychiatry. The specified descriptions of mental disorders in these manuals fix the accepted phenomenological boundaries of diagnosable conditions. The goal of this specification is to standardize the definitions of disorders in order to guide research and clinical practice. However, an unintended consequence has been to exclude the alternative symptom variants of these disorders, which occur worldwide as a result of cultural and contextual factors [1].

In fact, the shift in emphasis after DSM-III to descriptively-based assessment has meant less attention to several kinds of contextual information when making a diagnosis, not just cultural factors. By *context*, we refer to the social and environmental particularities of the local world in which individuals and groups develop. These elements include *culture* (e.g., meaning systems for interpreting human interactions and experience more generally), *social*

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structures that constrain and allow diverse possibilities of activity and access to resources across individuals in a society (e.g., the health consequences of structural discrimination, such as racism), the *local material environment*, which sets the parameters for the group's engagement with natural resources and technology (e.g., the availability of certain medications in low-resource settings), as well as *individual circumstances*, which vary from person to person and over time. When applied to the diagnostic process, this cultural/contextual information includes the person's interpretation of the condition; whether it is considered pathological by others in the person's local setting; if pathological, what is the perceived level of severity; the dependence of the symptoms on particular situations or precipitants; and the relationship between the persistence of the disturbance and the availability or non-availability of supports and interventions [2]. In order to maximize the validity and usefulness of diagnosis, these cultural/contextual elements need to be included in the design and implementation of our nosologies.

Contemporary diagnostic manuals in psychiatry, however, have not pursued this approach. Over the last few decades, mental disorders have persistently been reduced to symptom lists devoid of contextual information. The circumstances that precipitate an emotional disturbance being assessed for Major Depressive Disorder, for example, have become less important since the publication of DSM-III in 1980. By 1994, a patient presenting with two weeks of depressive symptoms could still be excluded from a DSM-IV diagnosis of Major Depressive Disorder if the symptoms occurred within two months after a particular precipitant –the death of a loved one. The implication of this exclusion is that, in the context of bereavement, the emotional disturbance does not represent a pathological condition – despite sharing the same symptoms—but instead a normal grief reaction. In DSM-5, by contrast, it appears that this bereavement exclusion will be eliminated, and just meeting the symptom list will be sufficient for a diagnosis of Major Depressive Disorder [3]. This almost exclusive reliance on clinical symptoms as the primary definition of the disorders argues for the importance of continuing to press for the inclusion of cultural and contextual factors in DSM-5.

In this chapter, we present recommendations from the DSM-5 Cultural Issues Subgroup that are designed to improve the assessment of culture and context within psychiatric diagnosis. The Cultural Issues Subgroup is part of the larger Gender and Cross-Cultural Study Group and is composed of experts in cultural mental health. The Subgroup is charged with making recommendations on racial, ethnic, cultural, and contextual issues to the all the Work Groups, such as differences in risk factors, precipitants, symptom presentations, prevalence, symptom severity, and course of illness. As part of this process, the Subgroup organized literature reviews of relevant topics as well as a field trial in five continents of a newly developed Cultural Formulation Interview. Several of these literature reviews and field trial reports have been published and others will be forthcoming [4-7]. This chapter summarizes key aspects of the work of these experts. Specifically, we review the following recommendations for DSM-5: 1) a comprehensive introductory chapter that provides conceptual and practical guidance on evaluating the role of culture and context in diagnosis and 2) culture-relevant material included in the descriptive text for each disorder. The introductory chapter would be composed of: a) a conceptual introduction, b) a slightly

revised version of the DSM-IV Outline for Cultural Formulation, *c*) the Cultural Formulation Interview, which operationalizes the Outline into a questionnaire, and *d*) a glossary on cultural concepts of distress. It is important to acknowledge at the outset that we write this chapter as the content of DSM-5 is under deliberation and it is possible that some of these Subgroup recommendations may not be included or ultimately modified. Final decisions on manual content reside with the DSM-5 Task Force and other supervisory bodies (e.g., the APA Board of Trustees). Therefore, this chapter also serves to document the interim history of the Subgroup and its interactions with other Work Groups and the DSM-5 leadership. Before describing the Subgroup recommendations, however, we briefly review critiques from both neuroscience and anthropology related to the diagnostic issues in DSM-IV.

Challenges of and to Diagnosis in DSM-5

As a subgroup tasked with reviewing cultural content for the entire Manual, the Cultural Issues Subgroup has maintained a dual focus on two allied disciplines that strongly inform cultural psychiatry: cultural anthropology and neuroscience. These fields have challenged central tenets of diagnosis in DSM-IV and informed the revision process for DSM-5. A survey of criticisms from these fields lays a foundation to illustrate how culture and context relate to psychiatric diagnosis.

To begin, neurobiologists have raised concerns that are fundamental to the very act of diagnosis. They contend that current DSM-IV diagnoses are similar phenotypic expressions of different underlying mechanisms [8]. In the case of Major Depressive Disorder, for example, only five symptoms are needed from a list of nine. In other words, two different Major Depressive Disorder phenotypes can overlap only on one symptom [9]. They also question the use of binary categories in DSM-IV, even though the underlying psychopathology is most likely dimensional [8]. Disorders likely develop in degrees, not as a yes/no condition, and cutoff criteria are somewhat arbitrary based on few studies trying to predict long-term outcomes [10]. Since DSM-IV adopts a categorical approach to diagnosis, this orientation may impede research exploring the relationship between neurobiology and the phenomenology of disorders, especially at sub-threshold levels [11]. Consequently, DSM-5 is exploring how to include dimensional aspects of disorders [12-16]. The fact that these debates may significantly alter the process by which diagnoses are established in DSM-5 represents a notable departure from DSM-IV.

Anthropologists have also leveled substantial arguments against DSM-IV. Anthropologists assert that psychiatrists have over-reified conditions based on the biomedical model and with the expectation of promoting research related to the biological factors of illness over social and cultural factors [17]. Psychiatrists have transformed reactions to adversity and complex dimensional experiences into fixed entities in conformity with the medical concept of diseases that are immutable. In contrast, anthropologists hold that many psychiatric conditions are more in the nature of reactions, experiences changing over time and place, with patterns of expression that are strongly determined by contextual factors that evolve historically. A reification of disorders mistakenly turns them into invariant diagnoses that ignore alternate possibilities of symptomatology. In addition, anthropologists dispute

psychiatry's predominant focus on the individual, a particularly North Atlantic medical perspective that leads to locating pathology inside the person [18-19]. This ignores the contribution of other health sciences, which show that social, cultural, and contextual determinants of health are equal if not more important contributors to psychopathology. This contextualization needs a place in clinical practice and research.

Both of these neurobiological and anthropological analyses point to a common direction: the current method of diagnosis in DSM-IV cannot account for varieties of illness presentations and experiences that lie outside of existing, categorical, symptom criteria. Neurobiologists may wish for more precision at the levels of molecular biology, genetics, or functional neuroanatomy. Anthropologists may wish for more attention to research on the social and cultural etiologies, courses, and healing processes of illness. These perspectives are united by dissatisfaction with a diagnostic system that excludes sub-threshold or alternate symptom expressions of mental disorders and that privileges descriptive, symptom-based approaches devoid of contextual information as the main way of defining psychopathology. As cultural psychiatrists, we believe that the relationship between biology and culture can be better understood through a greater examination of the contextual factors of illness. This tenet underlies the various proposals of the DSM-5 Cultural Issues Subgroup.

Principles Guiding Revisions on Culture and Diagnosis for DSM-5

In April 2010, the Cultural Issues Subgroup sent a memo to the DSM-5 leadership delineating how revisions relating to culture and psychiatric diagnosis can be integrated at several levels of the Manual. A proposal written by Roberto Lewis-Fernández, Renato Alarcón, Laurence Kirmayer, and Kimberly Yonkers on behalf of all Subgroup members recommended inclusion of an introductory chapter on *Cultural Aspects of Psychiatric Diagnosis*. This chapter, preferably included early and prominently in the Manual, would provide a theoretical introduction to cultural issues in psychiatry. It would emphasize the value of cultural/contextual information as a way of enhancing diagnostic accuracy, and would include general instructions for use of the DSM-5 with patients whose backgrounds may differ from clinicians, as well as with immigrants, refugees, and in cases where the clinician felt uncertain about the nature of the information. The interview version of the DSM-IV Outline for Cultural Formulation and a glossary on cultural concepts of distress would furnish clinicians with methods to obtain this cultural/contextual information.

In drafting the proposal, members of the DSM-5 Cultural Issues Subgroup recalled experiences with DSM-IV in which culture appeared to be included as an afterthought to diagnosis [20]. For example, the APA accepted only a modified set of recommendations from the National Institute of Mental Health's Group on Culture and Diagnosis to enhance the cultural validity of DSM-IV. These modified recommendations included an introduction without definitions for race and ethnicity; a combined section on Age, Gender, and Culture included in each disorder chapter, the Outline for Cultural Formulation placed in the next-to-last appendix; and a significantly shortened version of the Glossary of Culture-Bound Syndromes, also placed in the Appendix [19]. For DSM-5, the Cultural Issues Subgroup adopted an alternate approach: the centrality of culture within psychiatric diagnosis necessitates revisions that are implemented at all levels of the text. To draw upon spatial

metaphors, these revisions can be seen as *horizontal* in that they infuse a cultural/contextual perspective to the Manual as a whole as well as *vertical* in that they appear at various levels of the text.

Furthermore, the Cultural Issues Subgroup has operationalized theoretical developments from neurobiology and anthropology for clinical practice. For example, the need to account for social and cultural influences manifests in the Subgroup's emphasis on ascertaining cultural/contextual information to increase diagnostic accuracy. In addition, cultural factors are posited as potential explanations for symptom variability of disorders based on their settings. Moreover, the Subgroup's Cultural Formulation Interview also utilizes a dimensional approach to assessment as an analogue to the dimensional approach for diagnosis.

The remainder of the chapter summarizes the Subgroup recommendations. We will cover the proposed content of the introductory chapter first, followed by a brief description of how we suggested cultural/contextual information be included in the description of each disorder.

Introductory Chapter on Cultural Aspects of Psychiatric Diagnosis

Conceptual Introduction

The proposed draft of the introductory chapter began with the essential role of culture in diagnosis:

Understanding the cultural context of illness experience is essential for effective diagnostic assessment and clinical management. Mental disorders are defined in relation to social and cultural norms and values. Diagnostic assessment must therefore consider whether patients' experiences, symptoms, and behaviors differ from relevant sociocultural norms and lead to difficulties in adaptation in their cultures of origin and current social contexts. DSM-5 aims to help clinicians assess cultural features of clinical problems, and to support research on the influence of culture on mental health and illness (Proposed DSM-5 text).

This text begins to elaborate the Cultural Issues Subgroup's concept of the cultural/contextual approach. This perspective explicitly calls for situating mental disorders in relation to social and cultural norms and values. The conceptual introduction also provides a working definition of culture for clinicians. This definition focused on the following characteristics of culture: how it touches all aspects of daily experience (e.g., knowledge, practices; language, family structures); the fact that it is learned and transmitted; how culture organizes individual identities, interpersonal interactions, and social institutions; that cultures change over time and are open and dynamic; how individuals are exposed to multiple cultures, out of which individual identities and sense of experience are fashioned; and the need not to essentialize or stereotype cultures as unchanging.

Definitions of race and ethnicity were then provided as a contrast. These are related to racism and discrimination that results in health disparities, on the one hand, and to the development of cultural, ethnic, and racial identity on the other, which can be both a source

of resilience as well as of “psychological interpersonal, and intergenerational conflict or difficulties in adaptation that require diagnostic assessment” (Proposed DSM-5 text).

After providing these general definitions, the Subgroup turned to the act of diagnosis. The text focused on how culture plays a key role in determining the level at which an experience becomes problematic or pathological. Cultural factors can have the result of normalizing behaviors that may seem pathological in other contexts, e.g., intensely shy, socially reticent behavior in certain cultural settings may be experienced by the person and seen by others as respectful, rather than as a sign of Social Anxiety Disorder [21]. On the other hand, culture may also contribute to vulnerability and suffering, such as by amplifying fears that maintain panic disorder or health anxiety [22].

The text then turned to the cultural positioning of the DSM-5 itself:

As the distinction between mind, body, and spirit varies across cultures, the view that a problem is a mental disorder—as opposed to a physical illness or a social or moral predicament—depends on cultural modes of explanation and attribution. The DSM organizes disorders into broad categories (e.g., mood, anxiety, somatoform disorders) based on similarity in symptoms and putative underlying mechanisms. Across different cultural contexts, a problem may be organized differently on the basis of locally recognized symptoms and signs, presumed cause, course, or outcome. Furthermore, the correspondence between local culturally based nosology and DSM categories varies substantially. In general, there will be no one-to-one mapping of DSM and cultural categories; local nosology will provide additional information relevant to help-seeking, coping, and treatment expectations (Proposed DSM-5 text).

This conceptual introduction asserts the Subgroup's position on culture and diagnosis. Culture belongs to everyone, not just underserved or unfamiliar racial or ethnic minorities from a given society. Culture also frames the entire experience of mental health and illness for the patient and the clinician. For patients, culture molds the interpretations of thoughts, emotions, and behaviors that rise to the level of symptoms. Culture also influences the types and ways of seeking help. For clinicians, culture supplies the general assumptions and structural divisions of psychiatric classifications. In this way, diagnosis inherently represents a cross-cultural exercise given the possibility that patients and clinicians may not share the same understandings of illness.

The introduction is meant to orient clinicians to the relationship between culture and diagnosis. Within this framework, the Cultural Issues Subgroup has also provided tangible methods to increase cultural/contextual validity. The Cultural Formulation Interview exemplifies one approach.

Outline for Cultural Formulation and Cultural Formulation Interview

The Cultural Formulation Interview (CFI) is a DSM-5 innovation. It operationalizes the DSM-IV Outline for Cultural Formulation (OCF) into a set of questions and explicit instructions. The main goal of the OCF in DSM-IV was to help clinicians identify cultural-contextual factors affecting the patient that are relevant to diagnosis and treatment [23]. The

OCF organized the relevance of culture within the patient-clinician encounter around five dimensions: 1) the cultural identity of the individual, 2) the cultural explanations of the individual's illness, 3) the cultural factors related to psychosocial environment and levels of functioning, 4) cultural elements of the relationship between the individual and the clinicians, and 5) the overall cultural assessment for diagnosis and care [24-25]. An explicit function of the OCF has been to assist clinicians in diagnosing patients whose presentations do not correspond to DSM-IV diagnoses [17, 20]. An OCF composed of the same five dimensions was proposed for the DSM-5 chapter on *Cultural Aspects of Psychiatric Diagnosis*, but edited for comprehensiveness, clarity, and length (e.g., addition of other elements of cultural identity such as religious affiliation and sexual orientation).

The OCF has been called the most important contribution of anthropology to psychiatry [17, 26]. Journals such as *Culture, Medicine and Psychiatry* and *Transcultural Psychiatry* have regularly published cases on the benefits of its incorporation in mental health assessment. The OCF has been widely used within psychiatric education to impart cultural competency among trainees [27]. However, it has been criticized on several fronts: busy clinicians may not use it if it takes too much time [28], its dimensions may be too indistinct and overlapping [29], and use of the OCF may repeat information from the standard clinical assessment [30]. The Cultural Issues Subgroup has counted at least four versions of the OCF whose different formats may prevent the standardization of training and research [31]. Nonetheless, researchers from McGill University found that culture has a significant impact on psychiatric diagnosis through their use of the OCF within a cultural consultation service. Among a total of 323 patients referred over a ten-year period, 34 (49%) of 70 cases with a referral diagnosis of a psychotic disorder were rediagnosed as having a nonpsychotic disorder and 12 (5%) of the 253 cases with a referral diagnosis of a nonpsychotic disorder were rediagnosed as having a psychotic disorder [32]. These results demonstrated that the OCF is a useful adjunct to diagnosis and should be revised further to facilitate its use.

In light of these developments, the Cultural Issues Subgroup formed an international consortium of research collaborators to develop and test the CFI, a standardized 16-item questionnaire that operationalizes the OCF. The questions are intended for use at the beginning of a routine mental health evaluation and cover the same topical areas as the OCF. The CFI includes instructions that precede the questions and a guide to the interviewer on the type of content that can be generated by each question. The CFI is organized into four sections: 1) cultural definition of the problem (questions #1-3), 2) cultural perceptions of cause, context, and support (#4-10), 3) cultural factors affecting self-coping and past help seeking (#11-13), and 4) cultural factors affecting current help seeking (#14-16).

In order to avoid stereotyping, the CFI is personalized in that it focuses on the views of the individual patient, rather than inquiring generically about the views of the group(s) the person self-identifies with or is ascribed to by the clinician [2]. This allows the intra-cultural heterogeneity of views to emerge. It also accounts for hybrid identities in the person, since individuals typically hold views that stem from a diversity of cultural influences in their life, which can best be assessed on an individual basis [33]. To facilitate this use of the CFI, the concept of culture that informs the CFI is composed of the following three elements:

- a. the values, orientations, knowledge, and practices that individuals derive from membership in diverse social groups (e.g., ethnic groups, faith communities, occupational groups, and veterans)
- b. aspects of a person's background that may affect his or her perspective, such as geographical origin, migration, language, religion, sexual orientation, or race/ethnicity
- c. the influence of family, friends, and other community members (the person's *social network*) on the person's illness experience (Proposed DSM-5 text).

Cultural factors are subordinated to the information that can be elicited from individual patients, including their perspectives on the views of their social group.

Another aspect of the CFI that bears noting is that it is not intended exclusively for the evaluation of members of non-dominant cultural groups, such as racial/ethnic minorities. Instead, the CFI is intended for use by any clinician with any patient in any setting. Patients and clinicians who appear to share the same cultural background may nevertheless differ in ways that are relevant to care. At the same time, the CFI instructions suggest settings and patient-clinician matches for which the CFI may be most useful. These are:

...when there is difficulty in diagnostic assessment, owing to significant differences in the cultural, religious, or socioeconomic backgrounds of clinician and patient; when there is uncertainty about the fit between culturally expressed symptoms and diagnostic criteria; when it is difficult to judge illness severity or impairment; when patient and clinician disagree on the course of care; or in cases of limited treatment engagement and adherence (Proposed DSM-5 text).

The main goals of the CFI are to enhance the cultural validity of diagnostic assessment, facilitate treatment planning, and promote patient engagement. The CFI can be seen as operationalizing aspects of culture from the conceptual introduction. In particular, clinicians are encouraged to detect discrepancies in symptom presentation against DSM criteria, uncertainties in illness severity and impairment, differences of opinion on the course of care, and how clinician identities may interact with patient identities throughout the evaluation. The ascertainment of cultural/contextual information comprises an essential step of the diagnostic process and the CFI is an evidence-based method of obtaining this information. The CFI by itself does not result in a diagnosis, however. The information it obtains must be integrated with other available clinical material to produce a comprehensive clinical and contextual evaluation. Not only the information elicited by the CFI but also the process of conducting the Interview is expected to be helpful in this regard. Better patient engagement, for example, may result as much from greater diagnostic validity resulting from the information obtained as from the patient's perception of being attended to and understood that comes from the patient-centered nature of the CFI items. Which aspect of the CFI is useful for which outcome is a topic for further study.

As part of the development of the CFI for DSM-5 an APA-supported field trial is being conducted. With a targeted enrollment of 330 patients in six countries across five continents, the goal of the field trial is to test the feasibility (can it be done?), acceptability (do people

like it?), and perceived clinical utility (is it helpful?) of the CFI among patients and clinicians. Data on the first 200 patients was used to revise the initial version of the CFI into the final version to be included in DSM-5. Final field data results will be available in mid-2013.

In addition, eleven supplementary modules to be used in conjunction with the CFI have been created to further help clinicians conduct a more comprehensive cultural assessment for patients who require it. Topical modules cover explanatory models, level of functioning, influence of social network on illness course, psychosocial and economic stressors, role of spirituality, religion, and moral traditions, cultural identity, coping and help seeking, and the patient-clinician relationship. Population-specific modules address the special needs of school-age children and adolescents, older adults, immigrants and refugees, and caregivers. Clinicians may choose to utilize all modules for a full assessment or apply selected modules if they wish to expand a particular component of the CFI.

Glossary of Cultural Concepts of Distress

The Cultural Issues Subgroup has proposed a thorough revision of the DSM-IV *Glossary of Culture-Bound Syndromes* into a new *Glossary of Cultural Concepts of Distress* that would be included in the introductory chapter. The new Glossary substitutes the older formulation of *culture-bound syndromes* with three concepts of greater clinical utility:

Cultural syndromes are clusters of symptoms and attributions that tend to co-occur among individuals in specific cultural groups, communities, or contexts and that are recognized locally as coherent patterns of experience. *Cultural idioms of distress* are ways of expressing distress that may not involve specific symptoms or syndromes, but that provide shared ways of experiencing and talking about personal or social concerns (e.g., everyday talk about “nerves” or “depression”). *Cultural explanations* or *perceived causes* are labels, attributions, or features of an explanatory model that indicate culturally recognized meaning or etiology for symptoms, illness, or distress [5, 34, 35] (Proposed DSM-5 text).

Although worth distinguishing conceptually, in common practice the same cultural term frequently denotes more than one kind of cultural concept. A familiar example of this usage may be the concept of “depression”, which can describe a syndrome (e.g., Major Depressive Disorder), an idiom of distress (e.g., as in the common expression “I feel depressed”), or a perceived cause (similar to “stress”). Despite this overlap, the distinctions between syndromes, idioms, and causes can help clinicians recognize how cultural concepts are deployed by patients and thus facilitate diagnosis and treatment negotiation. The Glossary provides nine examples of cultural concepts of distress from around the world that typify syndromes, idioms, and causes and their inter-relationship. Only high-prevalence concepts that have received considerable research attention are included, and for each concept, the Glossary lists the related psychiatric diagnoses. These examples are intended to assist clinicians in the evaluation and treatment of individuals who present for care reporting these nine specific cultural concepts, but they are also meant to illustrate the process by which providers can translate from local expressions to DSM diagnoses.

In fact, the Glossary devotes considerable attention to explaining the relationship of cultural concepts to the conventional diagnoses in the body of the Manual. One way to understand the cultural concepts presented in the Glossary is that many DSM disorders started out as local expressions which over time became operationalized prototypes of disorder, based on a process of abstraction and generalization. Yet these prototypes do not exhaust cultural diversity in presentation, not only for cultural expressions that are closely related to DSM diagnoses (e.g., alternate versions of panic attacks), but especially for entirely different ways of organizing the classification of psychopathology (e.g., alternate types of disorder, such as anger-related conditions). As a result, clinicians may be exposed to local phenomena of distress that do not conform easily to conventional diagnoses. In fact, most of the cultural concepts included in the Glossary cut across DSM diagnoses, so that the relationship between concepts and disorders is not one-to-one, but instead one-to-many in either direction [36]. Symptoms or behaviors that might be sorted by DSM-5 into several disorders may be included in a single folk concept, and diverse presentations that might be classified by DSM-5 as variants of a single disorder may be sorted into several distinct concepts by an indigenous diagnostic system (Proposed DSM-5 text). In effect, the existence of these alternate presentations suggests that *all* forms of distress are locally shaped [36].

In order to deliver culturally appropriate care, it can be very useful to understand the association between locally patterned differences in symptoms, ways of talking about distress, and locally perceived causes, on the one hand, and coping strategies and patterns of help-seeking, on the other. Therefore, the Glossary explains in some detail the various ways in which knowledge of the cultural grounding of cultural concepts of distress can be important to diagnostic practice and clinical care generally. These include: to avoid misdiagnosis, to obtain clinically useful information, to improve rapport and engagement, to improve therapeutic efficacy, to guide clinical research, and to clarify the cultural epidemiology (Proposed DSM-5 text). Each of these uses of the cultural material is clarified, and particular illustrations are provided by the nine examples.

Culture-Relevant Material Included in the Descriptive Text for Each Disorder

The sections above summarized the proposed DSM-5 revisions that address what we have called a *horizontal* approach to infusing a cultural/contextual perspective to the manual as a whole. The following section covers the recommendations by the Cultural Issues Subgroup and individual members of each Work Group that we have labeled *vertical*, that is, they appear in each disorder chapter at various levels of the text. While the DSM-IV limited the explicitly culture-related material for each disorder to a single section on Specific Culture, Age, and Gender Features, the DSM-5 is planning to separate this section into three independent sections on Age, Culture, and Gender. Some Work Groups took this opportunity to pursue a comprehensive revision of cultural factors relevant to each disorder. In the interest of space, we illustrate this approach with examples from the Work Group on Anxiety, Obsessive-Compulsive Spectrum, Posttraumatic, and Dissociative Disorders.

The first step in this more comprehensive approach was to review the quality of the existing data on cultural variation for each DSM-IV disorder in order to recommend revisions for

DSM-5. This involved answering the following questions: For each disorder, what level of integration is needed for cultural information within DSM-5? Is the evidence strong enough to warrant changes to disorder criteria? Or, instead, should cultural data go only in the descriptive text to help the clinician apply existing criteria across cultural presentations? Alternatively, should nothing be changed from DSM-IV? The basis for this approach is the view that every disorder description is incomplete until it includes the full range of cultural variation of the syndrome worldwide. Clearly, an institutionalized process with multiple stakeholders, such as the DSM revisions, is inherently resistant to change, sometimes appropriately so. It can be destabilizing, for example, to make too many changes at once in a nosology that has clinical, social, forensic, and fiscal implications. Not only these socio-political processes but also the shortcomings of the existing datasets limited the extent of cultural variation that could be proposed. But within these constraints, the Work Group marshaled the evidence for change.

Sometimes, the data were robust enough to warrant proposed revisions at the level of criteria sets. This was the case for Social Anxiety Disorder, Agoraphobia, Specific Phobia, Posttraumatic Stress Disorder, and Dissociative Identity Disorder, among others. Social Anxiety Disorder may serve as an example [37]. Decades of cross-cultural research have noted that the fear of negative evaluation by others, which is the hallmark of Social Anxiety Disorder, can take the form of fear that the individual will offend others, in addition to or instead of the fear that the person will feel embarrassed or humiliated as a result of engaging in the social behavior [38-39]. Labeled “other-directed” or “allocentric” fear, this type of fear is a characteristic symptom of certain forms of culturally described distress in East Asia, such as *taijin kyofusho* in Japan and *taein kong po* in Korea. However, fear of offending others is also observed among individuals with Social Anxiety Disorder in many cultural settings, such as Australia and the US [39-40]. In fact, in many cases cross-culturally, the fear of offending others and the fear of embarrassment or humiliation occur together, rather than being mutually exclusive, indicating that they are related presentations [37]. The Work Group felt that the cross-cultural evidence was sufficiently robust to revise Social Anxiety Disorder criteria to indicate this relationship, which is intended to help reduce misdiagnosis in settings where “other-directed” fear is the primary or initial presentation. The revised Social Anxiety Disorder criterion B would now read: “The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (e.g., be humiliated, embarrassed, rejected, *or offend others*)” (italics added) (Proposed DSM-5 text).

At other times, evidence on the impact of cultural factors in diagnosis was not felt to warrant a revision of diagnostic criteria but was considered a useful addition to the fuller description of the disorder, e.g., its diagnostic features, associated features, and prevalence. The intent was to help clinicians and researchers identify individuals suffering from the disorder and facilitate assessments of severity, comorbidity, and prognosis as well as treatment options. Cultural contributions to the text took several forms:

- a. In light of the growing international use of the DSM revisions, an effort was made throughout the text to limit its ethnocentricity. Clear notation was made of the geographic and cultural origin of the data provided. For example, under the section for prevalence, data reported US racial/ethnic, and international variation. If studies

were only available from certain regions of the world (e.g., the US and Europe), this was noted in the relevant sections of the disorder chapter, e.g., under Risk and Prognostic Factors. The goal is to advance toward a truly international nosology that can more easily be integrated with ICD-11. A first step is to clarify the limitations of the existing data; if most of the information comes from only a few geographic regions, this raises the question of its generalizability and also identifies the logical next areas for research.

- b. Two sections of the text included culture-relevant information directly, those on Diagnostic Features and on Prevalence. The former described any symptom variation in disorder presentation that led to a revision of disorder criteria. An example is the Social Anxiety Disorder revision of criterion B mentioned above. The section on Prevalence included prevalence variation by race/ethnicity in the US and the range of prevalence internationally. For example, most of the Anxiety Disorders have been examined in many countries with the same instrument, the Composite International Diagnostic Interview, yielding comparable 12-month prevalence. The values from countries with the highest and lowest estimates of prevalence were reported as the endpoints of a range for each disorder.
- c. The rest of the cultural material went into a dedicated section on *Culture-Related Diagnostic Issues*. This section contained most of the data on explicitly cultural features of each disorder, such as on cultural variation in disorder symptoms that did not warrant criterial revision, as well as in development and course of the disorder, risk and prognostic factors, interpretation of stressors, impairment, and severity. More fine-grained information on cultural, racial, or ethnic variations in disorder prevalence (e.g., by nativity status, or sub-ethnicity) was included in this section. Finally, information on cultural labels, explanatory models, or cultural syndromes associated with the disorder were included here and cross-referenced with individual entries in the *Glossary of Cultural Concepts of Distress* in the introductory chapter. An example is the complex association between *ataques de nervios* (attacks of nerves), a cultural syndrome common among Latinos, and several DSM-5 disorders [4, 41]. Individual presentations of *ataque* can be variously diagnosed as Panic Disorder, Dissociative Disorder Not Elsewhere Classified, and Functional Neurologic Symptom (Conversion) Disorder, among others. That is, the cultural label unifies presentations that are considered psychiatrically diverse.

As an example of the kind of material that has been proposed for the explicit “culture-related” section of each disorder chapter, we can consider Posttraumatic Stress Disorder. This section includes information on variation in the risk of onset and severity of Posttraumatic Stress Disorder as a result of various cultural/contextual factors. These include: variation in the type of traumatic exposure (e.g., genocide), the impact on disorder severity of the meaning attributed to the traumatic event (e.g., inability to perform funerary rites after a mass killing), the ongoing sociocultural context (e.g., residing among unpunished perpetrators in post-conflict settings), and other cultural factors (e.g., acculturative stress in immigrants) [42]. The section also notes that the clinical expression of the individual symptoms or symptom clusters of Posttraumatic Stress Disorder may vary

culturally, particularly with respect to avoidance and numbing symptoms, distressing dreams, and somatic symptoms (e.g., dizziness, shortness of breath, heat sensations) [42-45]. Other information in this section includes the role that cultural syndromes and idioms of distress play in the expression of Posttraumatic Stress Disorder and the range of comorbid disorders. These cultural concepts of distress provide behavioral and cognitive templates that link traumatic exposures to specific symptoms [5]. For example, Panic Attack symptoms may be salient in Posttraumatic Stress Disorder among Cambodians and Latin Americans due to the association of traumatic exposure with panic-like *khyâl* attacks and *ataque de nervios* [42]. The section on Culture-Related Diagnostic Issues calls for comprehensive evaluation of local expressions of each disorder by including assessment of cultural concepts of distress, such as via the Cultural Formulation Interview.

Conclusion

This chapter has summarized many of the proposals from the DSM-5 Cultural Issues Subgroup that relate to the role of the culture and context in psychiatric diagnosis. The Subgroup has taken into account the recommendations of neurobiologists and anthropologists who have criticized the rigidity of DSM-IV diagnostic criteria that exclude alternate illness presentations and that do not account for the role of context in the emergence and characteristics of psychopathology. The Subgroup's revisions can be conceptualized horizontally as a cultural/contextual orientation throughout the entire manual and vertically as a collection of revisions at various levels of the text. These recommendations include an introductory chapter on Cultural Aspects of Psychiatric Diagnosis—composed of a conceptual introduction, the revised Outline for Cultural Formulation, a Cultural Formulation Interview that operationalizes this Outline, and a glossary on cultural concepts of distress—as well as material directly related to culture that is incorporated into the description of each disorder. The intent of these revisions is to enhance the validity and reliability of psychiatric diagnosis across cultural groups in the United States and around the world.

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