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Renato D. Alarcón

Anne E. Becker

Roberto Lewis-Fernández

Robert C. Like

Prakash Desai

See next page for additional authors

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Authors

Renato D. Alarcón, Anne E. Becker, Roberto Lewis-Fernández, Robert C. Like, Prakash Desai, Edward Foulks, Junius Gonzales, Helena Hansen, Alex Kopelowicz, Francis G. Lu, María A. Oquendo, and Annelle Primm

Issues for DSM-V

The Role of Culture in Psychiatric Diagnosis

Renato D. Alarcón, MD, MPH,* Anne E. Becker, MD, PhD, ScM,†‡ Roberto Lewis-Fernández, MD,§¶
 Robert C. Like, MD, MS,|| Prakash Desai, MD,** Edward Foulks, MD, PhD,†† Junius Gonzales, MD, MPH,‡‡
 Helena Hansen, MD, PhD,§§ Alex Kopelowicz, MD,¶¶ Francis G. Lu, MD,||| María A. Oquendo, MD,***
 and Annelle Primm, MD, MPH†††‡‡‡ for the Cultural Psychiatry Committee of the Group for the
 Advancement of Psychiatry

The development of DSM-V represents a renewed and critical opportunity for the integration of sociocultural data into psychiatric nosology and diagnostic practice. Although DSM-IV provided more guidance on culturally informed diagnostic assessment than its predecessors, it still fell short in this domain, and there is much more to add. The cross-cultural utility of DSM-IV was hampered by its limited attention to culturally patterned diversity in phenomenology, risk moderation, and course through excessive reliance on decontextualized epidemiological data (Gold and Kirmayer, 2007). It was further constrained by insufficient emphasis on approaches that integrate pertinent sociocultural contextual data into the diagnostic process, such as the cultural formulation. The oversimplified framing of sociocultural processes as merely epiphenomenal to mental disorders eclipses their constitutive role, resulting in essentialism, reductionism, and ethnocentrism (Alarcón et al., 2002) that can preempt detailed inquiry into their complex etiologic pathways.

Globalization, widespread migrations, and the international use of DSM-IV demand greater clinical expertise and sensitivity in responding to cultural diversity (Kirmayer, 2006). This is an eminently pragmatic call to action given that the United States is rapidly becoming a multiethnic and pluralistic society. Moreover, careful attention to the sociocultural dimensions of mental illness serves both a scientific and social justice agenda. For example, when assessment fails to attend to sociocultural factors, it risks misdiagnosis and the perpetuation of clinical stereotypes based on race, ethnicity, gender, religion, or sexual orientation, among other factors, which can lead to mental healthcare disparities. Data demonstrating elevated rates of misdiagnosis of schizophrenia among African Americans provide a sobering illustration of the costs of culturally uninformed practice. The consequences of this diagnostic disparity are enormous—more hospitalizations, higher antipsychotic dosages, and greater use of restraints among persons of African descent compared with whites (Flaherty and Meagher, 1980; Segal et al., 1996; Muroff et al., 2008). But correspondingly, differential risk relating to social adversity presents opportunities to advance models of etiologic pathways for mental disorders (Arnold et al., 2004; Grugha et al., 2004; Dutta et al., 2007; Muroff et al., 2008).

These aims can be achieved through infusion of a sociocultural perspective into the entire manual, for example, comparable to the developmental approach that is currently planned. Every diagnostic encounter should consider the sociocultural context of illness, not only those involving migrants or racial/ethnic minorities. Majority patients also express distress in culturally embedded ways, which differ by region, age, gender, and local conditions and traditions. Elaborating on the existing DSM cultural formulation—that is, attending to sociocultural aspects of identity, phenomenology, explanatory models, stressors, supports, and clinician-patient relationship—would help integrate contextual data into a comprehensive diagnostic assessment for every patient (Hollan, 1997; Lewis-Fernandez, 1996). Moreover, relocating it from the last appendix in DSM-IV-TR to the section on diagnostic assessment in the main text will give it the visibility and prominence it merits,

*Department of Psychiatry and Psychology, Mayo Clinic College of Medicine, Rochester, MN; †Department of Global Health and Social Medicine, Harvard Medical School, Boston, MA; ‡Department of Psychiatry, Massachusetts General Hospital, Boston, MA; §Department of Psychiatry, Columbia University, New York, NY; ¶New York State Center of Excellence for Cultural Competence, and Hispanic Treatment Program, New York State Psychiatric Institute, New York, NY; ||Department of Family Medicine, University of Medicine and Dentistry of New Jersey-Robert Wood Johnson Medical School, New Brunswick, NJ; **Department of Psychiatry, University of Illinois at Chicago, Chicago, IL; ††Department of Psychiatry, Tulane University, New Orleans, LA; ‡‡College of Behavioral and Community Sciences, Louis de la Porte Florida Mental Health Institute, University of South Florida, Tampa, FL; §§Department of Psychiatry, New York University, New York, NY; ¶¶Department of Psychiatry and Biobehavioral Science, David Geffen School of Medicine at UCLA, Los Angeles, CA; |||Department of Psychiatry and Behavioral Sciences, University of California, Davis, Sacramento, CA; ***Department of Psychiatry, Columbia University and New York State Psychiatric Institute, New York, NY; †††Office of Minority and National Affairs, American Psychiatric Association, Arlington, VA; and ‡‡‡Department of Psychiatry and Behavioral Science, Johns Hopkins University, Baltimore, MD.

Send reprint requests to Roberto Lewis-Fernández, MD, Department of Psychiatry, Columbia University, NYSPI, Rm 3200 (Unit 69), 1051 Riverside Drive, New York City, NY 10032.

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ISSN: 0022-3018/09/19708-0559

DOI: 10.1097/NMD.0b013e3181b0cbff

as supported by the Second Edition of the APA Practice Guideline for the Psychiatric Evaluation of Adults (American Psychiatric Association, 2006).

Recognition of phenomenological diversity is essential to complement our understanding of core commonalities and both are required for a nosology that is comprehensive and has broad national and international relevance. Available sources of empirical socio-cultural data must be incorporated into the forthcoming manual, including literature on alternative symptom expressions, variations in the boundaries between syndromes, risk moderation, and explanatory models of illness (Price et al., 1995). The use of sociocultural information can provide a more contextualized perspective—integrating essential personal, social, and clinical data from the patient's lifeworld—and also offer valid comparative parameters to enhance diagnostic accuracy and to identify local markers of severity and ongoing vulnerability.

Finally, the last 2 versions of DSM have had unprecedented global distribution. This new era of leadership in global mental health brings both opportunity and responsibility for thoughtful presentation of universal and culturally particular dimensions of mental disorders. The APA's collaboration in this regard with regional and international health organizations, the inclusion of cultural and international experts in DSM-V individual Work Groups, and the assembly of a Gender and Culture Study Group have been commendable and essential initial developments. We advocate 3 next steps to broaden the geographic and epistemological scope of the DSM. First, greater global representation should be proactively sought for secondary data analysis to avoid mistaking culturally homogeneous populations as representative of the Rest of the World (Patel and Sumathipala, 2001). Field trials should include sufficiently large and socioculturally diverse clinical and community samples to assess both the generalizability and specificity of proposed changes. These findings will augment text guiding clinical interpretation. Second, greater use of dimensional approaches to diagnosis would enable the incorporation of sociocultural findings on etiology, therapeutics, and prevention (Betancourt, 2004; First, 2006; Foulks et al., 1998). And third, enhanced integration of social sciences methodological and theoretical approaches as well as augmentation of clinical and epidemiological perspectives with ethnographic and narrative data will safeguard against the reification of diagnostic prototypes that result from inflexible and oversimplified criteria (Hollan, 1997; Weiss, 2001).

The clinical utility of the new Manual depends on its socio-cultural validity. Comprehensiveness of any diagnosis, but much more so psychiatric diagnosis, makes plain omission, "benign neglect" or minimal recognition of sociocultural factors clearly unacceptable. Clinical practice should include realistic ways of cultural consultation or assistance, from the establishment of a consultation service (including tele-psychiatry) to a directory of useful websites or other technological resources. Yet, clear sociocultural diagnostic guidelines are essential. A central role for sociocultural factors in DSM-V will continue to build upon the promising historical trend that began with DSM-IV, and will render the newly revised manual a better instrument for understanding human distress and suffering and for guiding culturally responsive, effective, and equitable care.

ACKNOWLEDGMENTS

All of the authors are members of the Cultural Psychiatry Committee of the Group for the Advancement of Psychiatry. Dr. Alarcón is the Project Coordinator and Dr. Lewis-Fernandez is the Committee Chair. In addition, Drs. Alarcón, Becker and Lewis-Fernandez are members of The American Psychiatric Association (APA) DSM-V Work Group. Information or views expressed in this editorial do not necessarily represent the views of either the APA or any of the DSM-V Work Groups.

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