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## Issues for DSM-V

*The Role of Culture in Psychiatric Diagnosis*

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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,

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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.

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## REFERENCES

- Alarcón RD, Bell CC, Kirmayer J, Lin KM, Ustun B, Wisner KL (2002) Beyond the funhouse mirror: research agenda on culture and psychiatric diagnosis. In DJ Kupfer, MB First, DA Regier (Eds), *A Research Agenda for DSM-V* (pp 219–281). Washington (DC): American Psychiatric Association.
- American Psychiatric Association (2006) *Practice Guidelines on the Psychiatric Evaluation of Adults* (2nd ed). *Am J Psychiatry*. 163(suppl):3–36.
- Arnold LM, Keck PE Jr, Collins J, Wilson R, Fleck DE, Corey KB, Amicone J, Adebimpe VR, Strakowski SM (2004) Ethnicity and first-rank symptoms in patients with psychosis. *Schizophr Res*. 67:207–212.
- Betancourt JR (2004) Cultural competence—marginal or mainstream movement? *N Engl J Med*. 351:953–955.
- Brugha T, Jenkins R, Bebbington P, Meltzer H, Lewis G, Farrell M (2004) Risk factors and the prevalence of neurosis and psychosis methnic groups in Great Britain. *N Soc Psychiatry Psychiatr Epidemiol*. 39:939–946.
- Dutta R, Greene T, Addington J, McKenzie K, Phillips M, Murray RM (2007) Biological, life course and cross-cultural studies all point toward the value of dimensional and developmental ratings in the classification of psychosis. *Schizophr Bull*. 33:868–876.
- First MB (2006) Beyond clinical utility: Broadening the DSM-V research appendix to include alternative diagnostic constructs. *Am J Psychiatry*. 163:1679–1681.
- Flaherty JA, Meagher R (1980) Measuring racial bias in inpatient treatment. *Am J Psychiatry*. 137:679–682.
- Foulks E, Westermeyer J, Pa K (1998) Developing curricula for transcultural mental health for trainees and trainers. In SO Opkapu (Ed), *Clinical Methods in Transcultural Psychiatry*. Washington (DC): American Psychiatric Press.
- Gold I, Kirmayer LJ (2007) Cultural psychiatry on Wakefield's procrustean bed. *World Psychiatry*. 6:165–166.
- Hollan D (1997) The relevance of person-centered ethnography to cross-cultural psychiatry. *Transcult Psychiatry*. 34:219–234.
- Kirmayer LJ (2006) Beyond the 'new cross-cultural psychiatry': Cultural biology, discursive psychology and the ironies of globalization. *Transcult Psychiatry*. 43:126–144.
- Lewis-Fernandez R (1996) Cultural formulation of psychiatric diagnosis. *Cult Med Psychiatry*. 20:133–144.
- Muroff J, Edelsohn GA, Joe S, Ford BC (2008) The role of race in diagnostic and disposition decision making in a pediatric psychiatric emergency service. *Gen Hosp Psychiatry*. 30:269–276.
- Patel V, Sumathipala A (2001) International representation in psychiatric literature: survey of six leading journals. *Br J Psychiatry*. 178:406–409.
- Price RK, Shea BM, Mookherjee HN (Eds), 1995. *Social psychiatry across cultures: Studies from North America, Asia, Europe and Africa*. New York (NY): Plenum Press.
- Segal SP, Bola JR, Watson MA (1996) Race, quality of care and antipsychotic prescribing practices in psychiatric emergency services. *Psychiatric Services*. 47:282–286.
- Weiss MG (2001) Cultural epidemiology: An introduction and overview. *Anthropol Med*. 8:5–30.