

From DSM-IV to DSM-5: an interim report from a cultural psychiatry perspective

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Summary In July 2012, the American Psychiatric Association (APA) closed its final commenting period on draft criteria for the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), slated for publication in May 2013. DSM-5 raises familiar questions about the cultural assumptions of proposed diagnoses, the scientific evidence base of these criteria and their validity in international settings. I review these issues since the publication of DSM-IV. I assess the cultural validity of DSM-5 and suggest areas of improvement.

Declaration of interest N.K.A. is an advisor to the DSM-5 Gender and Cross-Cultural Issues Study Group. He was also a study clinician for a DSM-5 field trial.

In 1992, Professor Roland Littlewood published an account of a conference, held in the USA a year earlier, on culture and psychiatric diagnosis, which had set out to improve the cultural validity of the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV).¹ He raised three interrelated issues from this conference: the cultural assumptions of psychiatric diagnosis, the scientific evidence supporting these diagnoses and their international, cross-cultural validity. He highlighted the challenges in making the DSM-IV a truly international diagnostic manual.

Since DSM-IV's publication in 1994, members of the National Institute of Mental Health (NIMH) Culture and Diagnosis Work Group have expressed disappointment about the DSM's cultural validity and reliability. The DSM-IV leadership recognised that the increasing ethnic diversification of both patients and physicians in the USA as well as the DSM's international dissemination required attention to cultural issues.² However, cultural suggestions were included in DSM-IV only after major adaptations: an introduction without definitions of culture and ethnicity, simplified text for specific disorders and the multi-axial format, a cultural formulation and glossary of culture-bound syndromes relegated to the last appendix, and no statement on the cultural construction of DSM-IV itself.³ In anticipation, members of the DSM-5 Cultural Issues Subgroup have called for a sociocultural perspective that guides manual revision through the inclusion of data on alternative symptom expressions, variations in syndrome boundaries, cultural differences in risk moderation, and cultural explanatory models different from DSM-IV.⁴

Littlewood's questions remain relevant today as DSM-IV and ICD-10 undergo revision. In an unprecedented move towards transparency, the American Psychiatric Association (APA) has publicised proposed changes ahead of DSM-5's publication. To what extent does DSM-5 display greater cultural validity and reliability than DSM-IV? This

article seeks to answer this question by examining DSM-5 proposals against Littlewood's criticisms of DSM-IV.

Cultural assumptions of psychiatric diagnosis

Littlewood observed that American cultural values appeared prominent in former editions of the DSM. For example, there were criticisms that late luteal phase dysphoric disorder could be misused against women and post-traumatic stress disorder did not specify 'normal' levels of stress among ethnic minority groups.¹ Historically, women and ethnic minority groups have been marginalised in American society and these disorders could reinforce marginalisation by pathologising the conditions of everyday life.

Littlewood's analyses belong to the 'new cross-cultural psychiatry'⁵ movement that has demonstrated the cultural bases of biomedical psychiatry. As a cultural system, psychiatric nosology reflects healing priorities, social values and professional ideologies.^{6,7} American psychiatric classification inherits a 19th-century European model that separates diseases based on unique symptoms, aetiology, course and treatment.⁸ Other societies may recognise alternative models, leading to doubts about DSM-IV's validity and reliability in these settings.

Members of the NIMH Culture and Diagnosis Work Group have since questioned the cross-cultural validity of DSM-IV. Articles in a 1998 issue of *Transcultural Psychiatry* compared the concordance of Work Group recommendations with final DSM-IV criteria. These articles can serve as a foundation to examine proposed changes for DSM-5.

- The relationship of mood to somatic disorders: DSM-IV separated depression, anxiety and somatoform disorders into distinct subgroups and then noted that these distinctions may be blurred in some cultures.⁹ This separation normalises the Cartesian mind–body distinction, which is

not shared worldwide.⁵ The proposed DSM-5 criteria for major depressive disorder continue to prioritise sadness and anhedonia as the principal symptoms of depression.¹⁰ Clinicians are not informed that somatic symptoms can predominate or that there may be cultural variability in whether and how patients discuss emotions with clinicians.

- The experience of psychosis: DSM-IV criteria for schizophrenia established subtypes as paranoid, disorganised, catatonic, undifferentiated and residual schizophrenia, based on Euro-American archetypes. DSM-IV assumed the validity and reliability of these subtypes worldwide without recognising cultural differences in symptom expression that challenge these distinctions.¹¹ For DSM-5, the proposed changes remove these subtypes and explicitly reference studies from Asia.¹²
- The varieties of dissociative pathology: DSM-IV criteria did not account for trance and possession states as cultural expressions of dissociation or indicate that dissociation can occur as part of normal practices across cultures (e.g. among Puerto Rican espiritistas, African American fundamentalist evangelicals.¹³ For DSM-5, the criteria for dissociative identity disorder include possession states and specify that the 'disturbance is not a normal part of a broadly accepted cultural or religious practice'.¹⁴ This change may increase the 'global utility' of DSM-5.¹⁴

Members of the NIMH Work Group expressed additional apprehensions about DSM-IV's cross-cultural validity and reliability for child and adolescent disorders, sexual and gender disorders and the glossary of 'culture-bound syndromes'. These criticisms focused mostly on the descriptive text that accompanies diagnostic criteria. The APA has not yet publicised this accompanying text for DSM-5. It would be premature to claim major victories for cultural psychiatry, and a full analysis awaits the publication of DSM-5. Nonetheless, changes to diagnostic criteria indicate that cultural psychiatrists have succeeded in revising the psychotic and dissociative disorders. This success may owe to the official status of the Gender and Cross-Cultural Issues Study Group. An official study group improves on the marginal role of cultural psychiatry experts in the DSM-IV process.^{1,3}

Definition of scientific evidence

DSM diagnoses may be biased towards American values owing to the nature of the evidence that supports revisions. Littlewood pointed out that most epidemiological and phenomenological data in the DSM came from the USA.¹ Members of the Work Group further characterised DSM-IV study populations largely as White and upper- and middle-class with sufficient resources to enrol in longitudinal research at academic centers.¹⁵ Ethnographic and qualitative data were dismissed as 'anecdotal' when they challenged established disorders or did not include quantitative designs.² It has been contended that certain disorder criteria such as levels of social and occupational functioning, course of illness and subjective distress are best studied through ethnography since they do not lend themselves easily to quantitative methodologies and exhibit

cross-cultural variations.¹⁶ In sum, the evidence base for DSM-IV consisted mostly of clinical trials with White Americans, without studies, particularly qualitative, on how symptoms vary in other cultural groups.

The DSM-5 leadership has adopted another approach in its *Guidelines for Making Changes to DSM-V*.¹⁷ This report instructs that 'recommendations should be guided by research evidence' and declares 'impractical' specifications on sample size and the quality of studies needed for revisions. The report guides work groups to summarise 'the overall strength of evidence across all validators'. Validators are assigned relative importance, with 'high priority' reserved for studies on familial aggregation (family, twin or adoption studies), diagnostic stability, course of illness and response to treatment. Less prioritised validators include studies on sociodemographic and cultural factors, environmental risk factors, psychiatric history, psychological correlates, biological markers and comorbidity patterns. Major changes such as an addition of a new specifier or subtype, a 'meaningful' change to a widely studied DSM-IV diagnosis or an addition of a new diagnosis to DSM-5 must cite research from high-priority validators. This research must be of 'high methodological quality' such as phenomenology, genetic epidemiology and neural circuitry. Protocols for DSM-5 field trials notably do not include qualitative methodologies in data analysis.^{18,19}

The *Guidelines for Making Changes to DSM-V* report does not explicitly exclude qualitative research. One could argue that the inclusion of studies on sociodemographics, cultural factors and environmental risks is an improvement from DSM-IV. However, the report emphasises the 'strength of evidence' and 'high-priority validators' based on biological factors or clinical epidemiology. Both research traditions take for granted the existence of DSM diagnoses and criteria such as diagnostic stability and treatment response. This vocabulary also draws on the language of evidence-based medicine to reform psychiatric classification. Sceptics argue that psychiatric classification produces evidence that reinforces its own claims about diagnosis, prognosis and treatment specificity without accounting for counter-claims.²⁰ Most studies are conducted for short periods in Western, middle-class, educated young people without medical or psychiatric comorbidities, but then generalised to other populations.²⁰ This quantitative focus excludes the particularities of local context in which this knowledge is produced. We are left with a dilemma: qualitative research in non-Western populations is excluded owing to a lack of scientific rigour, but quantitative research in Western populations is generalised for other contexts.

Littlewood emphasised that medical anthropologists and cultural psychiatrists needed to employ quantitative methods to better present their findings.¹ We have not learnt this lesson fully for DSM-5, despite methods that render qualitative research into quantitative results. For example, meta-ethnography, akin to the systematic review and meta-analysis, synthesises research that interprets social and cultural events from the perspectives and experiences of those studied. Through an established procedure, meta-ethnography translates concepts across studies by determining whether they are directly comparable, in opposition, or constitute a single argument. Synthesis

then proceeds through multiple discrete steps to offer hypotheses for future researchers.²¹ Other examples of methodologies that synthesise qualitative data include cross-case analysis, the case survey method and the multiple exemplar strategy.²² The Human Relations Area Files (HRAF) at Yale University, USA, a non-profit consortium of hundreds of educational and research institutions, sponsors a database of ethnographies with topics devoted to medical anthropology. This and other databases such as Anthropology Plus and AnthroSource provide a starting point for literature reviews, but may not address immediate clinical concerns. Social scientists and cultural psychiatrists may need to jointly establish parameters that translate social science findings for clinical research and practice.

My intention is not to favour any specific technique. Instead, I wish to point to the possibilities for quantifying the largely ethnographic record of cultural psychiatry on cross-cultural differences in symptom presentations.² Quantified results can then be included for DSM revision. Questions on how disorders are variably expressed across cultures or on cross-cultural responses to depression, anxiety and other clinical states could be answered through these methods. These questions fall within the DSM-5 research agenda.¹⁷ Cultural psychiatrists have now been involved in revising DSM-IV and DSM-5, but with similar constraints on evidence. We must evolve methods in this research tradition to truly advance our perspectives.

International validity and application of the DSM

Based on the largely American evidence base, Littlewood questioned DSM-IV's international validity. He noted that DSM-III had been translated into 13 languages and essentially became a textbook in many places.¹ He also criticised the paradox of the DSM establishing universal definitions for each disorder, but reluctantly acknowledging cross-cultural variation. Non-Western illness categories were omitted or consigned to a glossary on 'culture-bound' syndromes; in contrast, Western diagnoses such as anorexia and bulimia were deemed universal.

These criticisms have persisted with the international dissemination of DSM-IV. Surveys show that most psychiatrists in East Asia and many in Latin America find problems in applying the DSM-IV and ICD-10.^{23,24} I have found translations of DSM-IV into Arabic, Bulgarian, Chinese (Mandarin), Dutch, French, German, Greek, Hungarian, Italian, Japanese, Korean, Polish, Portuguese, Romanian, Spanish, Swedish and Turkish. These translations may demonstrate linguistic validity, but their validity with local populations is unknown.

Again, Littlewood's call for anthropologists and psychiatrists to cultivate more quantitative research methods is relevant.¹ The previous section addressed the translation of extant qualitative studies into quantitative results. How can DSM-5 stimulate novel research related to cross-cultural validity and reliability? Cultural epidemiology may provide an answer as a mixed-methods framework that integrates professional concepts of disorders with local experiences of illness, meanings and behaviours.²⁵ Semi-structured interviews on patient illness representations can accompany surveys of DSM disorders to

assess patterns of distress, perceived causes and help-seeking. This information is essential since it frames the therapeutic encounter for patients: biomedical evaluations may guide clinicians and researchers, but local cultural knowledge determines illness behaviours and responses for patients.²⁵

Experiences with DSM-III and DSM-IV suggest that DSM-5 may spawn its own epidemiological instruments. Through cultural epidemiology, cultural psychiatrists can collaborate with epidemiologists by adding ethnographic questionnaires that situate psychiatric disorders in local experience. Just as traditional psychiatric epidemiology clarifies the distribution of diagnoses, cultural epidemiology clarifies the distribution of illness representations.²⁵ This approach may help us understand cultural differences in the expression of disorders, perceived severities and illness courses. Research methods that join global psychiatric knowledge with local cultural experience can create the quantitative evidence base for improving the cultural validity and reliability of the DSM.

Littlewood's article called attention to the gap between DSM-IV's universal truth claims and their uncertain fit with local lived experiences around the world. Here, anthropologist Margaret Lock's idea of 'local biologies' may help resolve this dilemma. In tracing the relationships among global scientific and local cultural knowledge, she writes that 'the biological and the social are coproduced and dialectically reproduced, and the primary site where this engagement takes place is the subjectively experienced, socialized body'.²⁶ She originated this concept to reconcile how textbooks on menopause produced in North America and Europe did not match the lived experiences of Japanese women. She concluded that biological differences such as environment, diet or genetics may explain such differences.²⁶ The scientific knowledge produced in North America was not incorrect – it was based on biological studies of local populations that did not match the lived experiences of people elsewhere.

We may similarly conceive of 'local psychiatries' in which the DSM is but one of many psychiatric classification systems. For two rounds of revisions, cultural psychiatry experts have succeeded in contextualising the DSM as a largely American enterprise. We have also shown that this evidence comes from American samples. However, we have not made qualitative research as pertinent to DSM revision or suggested biological mechanisms for cultural differences related to psychiatric diagnoses. We have also not assessed how alternative classification systems construct scientific knowledge based on other forms of evidence or how differences in psychiatric classifications reflect disparate evidence bases. As negotiations over DSM-5 come to a close, we should reflect how these pending contributions can continue to improve the cultural validity and reliability of international classification systems. In 1988, anthropologist and psychiatrist Arthur Kleinman advocated a dynamic, bi-directional relationship among psychiatry and the social sciences as a cooperative, interdisciplinary solution.²⁷ Twenty-five years later, the DSM leadership still chases advances in cultural psychiatry despite leading developments in clinical psychiatry. Perhaps the real cultural story of the DSM is its hesitation in treating findings from

cultural psychiatry and the social sciences with the same authority accorded to 'evidence' in other disciplines.

About the author

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