Current themes

DSM–IV and culture: is the classification internationally valid?

ROLAND LITTLEWOOD, Reader in Psychiatry and Anthropology, University College London, Gower Street, London WC1E 6BT

Although relatively neglected in Britain, the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* has been widely adopted in both Western and non-Western countries (Spitzer, Williams & Skrodol, 1983). The descriptive and multiaxial approach used in DSM-III (1980) and in its revised edition DSM-III-R (1987), together with the introduction of specific criteria for allocating each diagnosis, would seem particularly useful when comparing psychopathologies across societies. In addition to Axes I, II and III (Clinical Syndromes, Developmental and Personality Disorders, Physical Disorders and Conditions), the Manual has two more obviously 'social' axes – (IV) Severity of Psychosocial Stressors and (V) Global Assessment of Functioning.

The comparative value of a multiaxial approach is that each class of information is rated independently, striking a compromise in clinical assessment between a bare and decontextualised diagnostic category and a cumbersome clinical and social formulation which is difficult to use in comparative epidemiology and which may be excessively bound to local medical practice and theoretical assumptions. In clinical work, however, the last two axes are often omitted, and only the first three (together forming "the official diagnostic assessment") are used; they have now taken on a particular formal significance in American medico-legal and insurance considerations.

Concern has been expressed as to whether DSM-III-R is really the appropriate instrument for use in societies other than the United States, the country for which it was developed and field-tested, from which comes the bulk of the epidemiological and phenomenological data (eg. Spitzer *et al*, 1981) and the questionnaire responses on which it is based (Hughes, 1985; Prince & Tcheng-Laroche, 1987). The DSM-III manual or its shortened form – the *Quick Reference to the Diagnostic Criteria* (the "Mini-D") – are now available in 13 languages including Japanese. In Third World countries, where funds for libraries are limited, it has become virtually a textbook: quite inappropriately so, given that it is expressly a descriptive check-list alone and contains no details on aetiology or clinical management.

The United States is now under a treaty obligation with the World Health Organisation to maintain coding and terminological consistency with the WHO's *International Classification of Diseases*. The first edition of DSM in 1952 employed a glossary of descriptions which reflected the then current influence of Adolf Meyer in the United States. The second edition (1968) was developed in association with the eighth edition of the ICD, and by 1980 a relatively close 'translation' could be effected from the first three axes of the now multiaxial DSM-III to ICD-9; this was done by using an expanded form of the ICD four-digit code known as the five-digit ICD-9-CM (for Clinical Modification). This is now contained in an appendix to the Manual, and since 1979 has been the American national system for recording psychiatric illness.

DSM-III-R

DSM-III-R did recognise some criticism on the grounds of gender and ethnicity (Loring & Powell, 1988). Late luteal phase dysphoric disorder ("premenstrual tension") and self-defeating personality disorder were placed in a separate appendix entitled Proposed Diagnostic Categories Needing Further Study because of their "high potential for misuse, particularly against women". Homosexuality had already been dropped earlier after the famous APA vote. Under a heading entitled *Cautions*, a short paragraph warned against use of the DSM-III-R when "evaluating a person from an ethnic or cultural group different from the clinician's" unless it was "culturally valid". It was not clear what this meant, nor how any translation should "provide equivalent meanings, not necessarily dictionary equivalence." That old concern of cultural psychiatrists, the culture-bound syndromes, were dealt with in a single sentence: "Culture-specific symptoms of distress, such as particular somatic symptoms associated with

distress in members of different ethnic and cultural groups, may create difficulties in the use of DSM-III-R, because the psychopathology is unique to that culture or because the DSM-III-R categories are not based on extensive research with non-Western populations." And that was all: there were no guidelines for how to rate these 'atypical' patterns.

The related question of what constituted 'normal stress' in American culture (is minor depression consequent on bereavement pathological?) was dealt with at greater length. Post-traumatic stress disorder (PTSD) on Axis I was rated if the "psychologically distressing event was outside the range of usual human experience". Examples of this normal range included "simple bereavement, chronic illness, business losses, and marital conflict" yet appeared to specifically exclude military conflict and traffic accidents. Axis IV, the scale for the severity of psychosocial stressors, was to be rated allowing for "the stress an 'average' person in similar circumstances and with similar sociocultural values would experience": potentially rateable problems included unemployment and "lack of parental guidelines or excessively harsh or inconsistent parental control". It was again not clear how the stressors should be rated in minority groups if, from the dominant American perspective, they were particularly common there: culturally normative and hence not rateable? or did the group in question simply have a high level of experienced stress? Similarly, Axis V (Global Assessment of Functioning) made assumptions about nuclear family life, occupation and education. The problem is less that these two axes are quite inappropriate outside Anglo-American culture – they are not and it is easy to modify them or construct analagous scales – but rather that it is not clear how and when this is to be done.

Criticism of DSM has come from some anthropologists and Third World psychiatrists who are worried about procrustean attempts to fit local categories into a schema which presumes (and is tacitly marketed as having) some international validity (Chakraborty, 1990; Honda, 1983; Hughes, 1985; Lock, 1987; *cf.* Wig, 1983, Westermeyer, 1988). Together with the theoretical critique of psychiatry known as 'the new cross-cultural psychiatry' (Kleinman, 1987; Littlewood, 1990), these questioned the relevance of citing 'culture' only when the particular clinical instance involved a non-European or non-dominant group. The descriptive and individualistic focus of DSM did not allow for the cultural background of *any* patient, for its notion of psychopathology was one of difference between individuals within a culture taken as invariate and therefore not itself specifically pathogenic.

A particularly poignant issue was the question of PTSD and overwhelming political terror. In a situation where not only were a whole population subject to arbitrary murder and torture but the total emotional and moral context of such terror was directed by the state over a number of years, what was the 'normal' baseline, what the stressor (Jenkins, 1991)? And what of the potential for misuse of DSM among black and minority groups (Guarnaccia *et al*, 1990)? If one used DSM categories among Puerto Rican schoolchildren, an extraordinary total prevalence rate of 46% for all categories together was found (Bird *et al*, 1987).

Concerns were also expressed about the universality of those DSM patterns described principally in the West, notably anorexia nervosa, multiple personality disorder (MPD) and PTSD itself (Young, 1988; Littlewood, 1990). Were these consequent on local socio-political contingencies and the medicalisation of everyday American life to the extent that they could have no proper place in an international system of classification? If, as seems likely, the social induction of MPD and 'possession states' were remarkably similar, should anthropological critics be so concerned that 'normative possession' should not then be rated diagnostically? Or was the distinction to be made in terms of social attitude – in one case disapprobation, in the other (variously) approval? Would this not however cut across the descriptive and phenomenological intentions behind DSM-III?

Towards DSM-IV: the 1991 Conference on Cultural Issues and Psychiatric Diagnosis

In 1988 the American Psychiatric Association appointed a DSM-IV Task Force to prepare a revised manual to coincide with the anticipated publication of ICD-10 in 1993. The intention was to move beyond the existing technical consistency with the *International Classification of Diseases* to one that would be "conceptually compatible". This was facilitated by the intention of the WHO to move to a multiaxial approach for ICD-10, and the representation of each organisation in the other's working party.

Currently a series of draft revisions for each of the DSM syndrome groups is in circulation for comment, and the existing data sets are being reanalysed, together with 11 field trials sponsored by the National Institute for Mental Health. While the "threshold for revising" DSM-III-R has been set higher than for DSM-II or DSM-III, NIMH sponsored a meeting in Pittsburgh in April 1991 to "enhance the cultural suitability of DSM-IV".

This conference involved over 50 cultural psychiatrists and anthropologists who were already involved in the debate, together with APA and Task Force Representatives. While only two participants

came from outside North America, the meeting was arguably the most significant to date on examining the relevance of sociological and anthropological work to formal psychiatric criteria. While the papers and conclusions are likely to be publised, I shall briefly sketch out in the remainder of this article a personal view of the proceedings.

Plenary sessions alternated with parallel meetings on the eight major syndrome groups of DSM-IV plus one on 'culture-bound syndromes'. Overview papers were of a high theoretical quality and had been previously circulated, together with responses to them from 'cultural' (anthropologists) and 'DSM-IV' (APA) positions. The anthropologists took a surprisingly benign view of psychiatric diagnosis, and if any theoretical tensions developed they were between the anthropologists and cultural psychiatrists on the one hand (who had often previously sparred together) and the APA Task Force who acted as 'minders' for each syndrome session. The latter constantly reigned in the social scientists and reminded them that the existing work on DSM-IV and its two predecesors had been so extensive that only the hardest epidemiological evidence would have any effect on the circulated DSM-IV drafts. These revisions of DSM-III were indeed modest and any ambitious intentions to mount a critical assault on the status of DSM soon dissipated.

The overview papers, each prepared by the leading authorities, were thus of greater scope than the ensuing discussions which were rapidly channelled into discussing the value of inserting or deleting single words or phrases in the revisions proposed by the APA. We did not pursue the interesting suggestion that DSM-III-R could not justify its claim to be simply descriptive rather than aetiological (which was its objection to the inclusion of 'folk illnesses') because its diagnostic hierarchy already presumed a distinction between primary and secondary syndromes. There was certainly a sense for the anthropologists of being lucky to have been invited, alternating with an anxiety that our presence would merely provide an *imprimatur* for marketing a highly culture-bound manual in the Third World. It was noteworthy that the non-White participants were all working in the United States; inevitably the anthropologists served (quite inappropriately) as representatives for non-Western societies. Their contributions, although frequently political, were seldom grounded in the practicalities of everyday clinical work in the developing world. The psychiatrists from American minority groups, however, gave papers on racism and psychiatric insensitivity, and discussed the relevance of current diagnoses for their communities (African-American, Native American, Asian and Hispanic).

The tendency of anthropologists and cultural psychiatrists to favour an interpretative rather than an empirical model was evident: it was clear that future work needed to employ more quantitative methods if a psychiatry-anthropology dialogue was to be sustained in the area of diagnosis. The anthropologists needed to continue clarifying whether their locally-described patterns are actually observable complexes of action and behaviour, or merely local aetiologies of little specificity. A dispute which might have been expected between the 'lumpers' (psychiatrists, universalists) and the 'splitters' (anthropologists, relativists) did not emerge, largely because of the long and tiresome history of the dichotomy: most participants agreed the distinction was merely one of heuristic level, and we were now on universalist terrain.

Radical options such as removing anorexia nervosa to a new 'culture-bound' category were soon abandoned, as was the suggestion by Hughes and Good for a new 'cultural axis' in DSM. Many participants agreed that a cultural axis, even if it could be operationalised, would have little chance of being introduced into the Manual and, if it was, it would be seldom used. Here the newer anthropologically-inspired view that all psychiatric categories are (even at an Axis I level) culturally constructed and embedded notions gelled rather well with the APA Task Force's insistence on maintaining DSM in essentially the existing form: the latter, of course, had its own (conventional) epistemological assumptions exemplified by talk on "the interaction of cultural factors with mental illness" (Sabshin). Additionally, it was uncertain if the new axis would be epidemiological, dealing with differential patterns, or whether it would be an 'emic' axis reflecting local conceptualisations, recognition and response.

While the immediate effects of the meeting on the Task Force and its international advisory board are still to be seen, it is possible that some field projects may be funded on specifically 'cultural' concerns or on the inappropriate use of certain diagnostic categories in African-Americans and other minority groups. Another possibility was the inclusion of a 'cultural statement' at the beginning of DSM-IV, together with short paragraphs under each syndrome dealing briefly with any cultural aetiology, universality and variation in the occurrence of the syndrome or of its defining criteria, and listing local variants and analogues, recognition and response. Clearly this threatened to become a small ethnography for each syndrome, but there are precedents in the existing short paragraphs under each DSM-III syndrome which detail age of onset, associated features, course, and so on.

The session on eating and sexual disorders, for example, argued that recent work in India and China suggested that DSM-III-R anorexia nervosa could be said to be found there but only if one omitted the 'fear of fatness' which is a defining DSM-III-R criterion. Prince noted that pica, considered as a developmental

disorder in DSM and defined as the "persistent eating of a non-nutritive substance", begged many questions of cultural appropriateness in ritualised adult settings. There has been a welcome shift in the various editions of DSM to recognising paraphilias, not as pathological variants of some universal psychology but as cultural, locally reinforced, possibilities; given the growth of various 'paraphilia activist groups' in the United States, we predicted that the sexual disorders section would remain controversial. Certainly those of us in this session welcomed the proposed DSM-IV revision which would specify that the paraphilias would only be rated if they "caused marked distress or interpersonal difficulty". The sessions on psychoses, mood disorders and substance use followed relatively expected lines of psychiatric epidemiology: if negative symptoms and a chronic course were more typical of schizophrenia among Europeans, do we need to alter the diagnostic criteria? How can we avoid such circular arguments as that of comparing the course of this illness in different societies when DSM-III-R schizophrenia is defined in part by its course?

The session on culture-bound disorders demonstrated the more radical concerns of cultural psychiatrists as to what constituted psychopathology. Japanese psychiatrists have objected that the common (up to 40% of their out-patients) local syndrome of *taijin kyofushu*, generally glossed as 'interpersonal phobia', has no obvious DSM-III coding (Honda, 1983). It is not the same as social phobia in that the experienced concern is not recognised by the individual to be unreasonable, and its focus is not the individual's avoidance of others because of the personal feelings thus generated but the individual's concern that it is others who are avoiding them. Should social phobia in DSM-IV then have a 'cultural footnote' to describe this as a variant, or does the increasing influence of Japan in international affairs demand a separate category? Are *koro* and the various semen loss syndromes to be considered as sexual dysfunctions or perhaps more appropriately as somatoform disorders? Weiss pointed out that the current understanding of somatoform disorders placed them akin to dissociative disorders yet cross-cultural work argued a closer similarity to mood disorders. The argument was not simply a choice between an (etic) medical approach and an (emic) popular category: 'neurasthenia' was a once common medical diagnosis in the West, now disregarded there but still used extensively by psychiatrists of the Western Pacific Basin. Did this make it a culture-bound syndrome or not?

Culture-bound syndromes returned us to the question of aetiology as a defining characteristic. To what extent are local conceptualisations of distress actually part of the symptomatology? ("Yes" –

Kleinman; "No" – Prince.) Was there a place for them on a cultural axis if that went ahead? The best that could be achieved, argued some in the culture-bound session including myself, was that we press for the introductory 'cultural statement' in DSM-IV, together with a provisional appendix with some such title (in DSM-speak) as Syndromes Usually Specific to Particular Societies Which May Come to Medical Attention and Which Require Further Study. The appendix would list the best-known 'culture-bound syndromes' for which there was reasonable epidemiological and phenomenological data, and which in later editions of DSM might claim their place in the main body of the text, either as sub-types of currently listed syndromes or as separate syndromes. If this seemed too much of a concession to Western psychiatry, we could at least point to the dubious status of anorexia nervosa and multiple personality disorder. A widely supported idea was that the new edition of the DSM Case Book (the 'how to do it' companion to the Manual) should certainly contain a wide variety of clinical examples from different societies and cultural contexts, and should deal frankly with cross-cultural diagnostic difficulties. Or a separate 'international' Case Book should be prepared.

The responsibilities of the conference were enormous given the likely impact of DSM-IV in the Third World. The extent to which the anthropologists can back up their perspective with quantitative data remains to be seen – as does the readiness of the American Psychiatric Association either to downplay the cross-cultural value of their manual or to radically transform it into a valid international instrument.

Acknowledgements

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Lecture

The British Association for Social Psychiatry (BASP) will be holding its VIth Joshua Bierer Memorial Lecture to be given by the Right Reverend David Jenkins, Bishop of Durham, on 27 May 1992 at 7.30 p.m. at London Bridge Hospital. Its title is 'Souls, Structure, Sickness and Society'. There is no charge and all are welcome. Would those attending, please inform Professor A. H. Crisp, Chairman, BASP, Department of Mental Health Sciences, St George's Hospital Medical School, London SW17 0RE (telephone 081 672 9944, extension 55540).

Erratum

Dr Thomas Bewley. Dr Bewley has noted that in a recent "In conversation with ..." article he was referred to alternately as Dr Tom Bewley and Dr Thomas Bewley. He would like to make clear that "Thomas" is his correct name and that he intensely dislikes the diminutive "Tom".