SPECIAL ARTICLE

Culture, cultural factors and psychiatric diagnosis: review and projections

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This paper aims to provide conceptual justifications for the inclusion of culture and cultural factors in psychiatric diagnosis, and logistic suggestions as to the content and use of this approach. A discussion of the scope and limitations of current diagnostic practice, criticisms from different quarters, and the role and relevance of culture in the diagnostic encounter, precede the examination of advantages and disadvantages of the approach. The cultural content of psychiatric diagnosis should include the main, well-recognized cultural variables, adequate family data, explanatory models, and strengths and weaknesses of every individual patient. The practical aspects include the acceptance of "cultural discordances" as a component of an updated definition of mental disorder, and the use of a refurbished cultural formulation. Clinical "telescoping" strategies to obtain relevant cultural data during the diagnostic interview, and areas of future research (including field trials on the cultural formulation and on "culture bound syndromes"), are outlined.

Key words: Culture, psychiatric diagnosis, cultural formulation

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Diagnosis is probably the dominant topic of discussion and debate in the psychiatric field today. The announcement of the publication of new editions of the two best known classifications, the DSM-V and the ICD-11, for 2012 and 2014 respectively, has generated a predictable, at times heated exchange of opinions, suggestions, criticisms, and research initiatives. A variety of activities (conferences, meetings, symposia) across the world, and joint declarations of harmonious work at the international level, have kept a momentum that, most likely, will not cease until long after the actual publications.

It is expected that the new nomenclatures will incorporate significant changes in structure, diagnostic modalities, clinical evaluation approaches, definition and scope of disorders, and measurements of severity and level of functioning. Contributions from neurosciences and social sciences, clinical and epidemiological research, and a public health perspective will hopefully be included at realistic levels. Last but not least, national government agencies, insurance companies, the pharmaceutical industry, and worldwide medical and professional organizations as well as the public at large are keeping a close eye on the whole process (1-3).

The cultural perspective on psychiatric diagnosis has experienced uneven levels of reception and actual implementation (4), in spite of uniform pronouncements from the leading bodies of organized psychiatry and mental health across the world, professing respect and due consideration of cultural factors in the elaboration of previous, current, and future nomenclatures.

Assuming the sincerity of such statements, this article will attempt an objective examination of why, what, how and when should culture be an integral part of diagnosis in psychiatry. After a brief review of general basic concepts of diagnosis, the paper will focus on history, evolution and current status of the two main classification systems in today's psychiatry. An examination of basic concepts of culture and cultural factors in psychiatric diagnosis will, then, be followed by specific recommendations regarding a reasonable integration of cultural issues into the diagnostic enterprise.

DIAGNOSIS IN PSYCHIATRY: A BRIEF REVIEW

Understood as the processing of complex information regarding symptoms, behaviors, emotional correlates and eventual neurobiological substrates by means of history-taking and actual observation of psychopathological events, psychiatric diagnosis aims at reaching a comprehensive perspective of the patient's experience, so that the most appropriate treatment can be offered, and result in clinical improvement, more efficient personal functioning, and a more comfortable quality of life for the patient and his/her family.

Modern perspectives make diagnosis, in addition to all of the above, an essential component of epidemiological surveys, an important item in the elucidation of risk and protective factors for the clinical entity under study, a tool in the ascertainment of roles of families and communities, and the basis for policy-making and delivery of services to individuals and the general population (5). One could safely assume that the modern view of diagnosis would actively incorporate cultural elements in the structure, conduction and desired outcomes of the diagnostic process (6,7).

With all its imperfections and deficiencies, diagnosis is an essential step in the psychiatric encounter, perhaps more relevant than in any other field of medicine. It is mostly based on pure clinical components, i.e. the anamnestic dialogue between patient and psychiatrist, assessment of deeply subjective emotional states, and exploration of interpersonal issues and experiences (8). Diagnosis in psychiatry does not have the option of laboratory tests or the categorical (pathognomonic) ascription of symptoms or "biomarkers" utilized in medical or surgical specialties. It responds rather well to the characterization of a "work in progress".

DSM and ICD: history and evolution

The first edition of DSM was published in 1952. It was primarily a listing of clinical entities with a strong ideological twist, an almost paradoxical mix of psychoanalytic terminology and Mayerian "psychobiological" conceptualizations. Adolf Mayer, a Switzerland-born pathologist who came and work first in Chicago, had elaborated a pioneering integrative effort at defining mental illness. His influence in American psychiatry, as the first chair of the psychiatric department at Johns Hopkins Hospital in Baltimore between 1912 and 1960, was powerful, both as a symbol of the openness of a still young nation to the contributions from an immigrant scientist, and the permeability of American medicine and psychiatry to innovative ideas (9). Mayer considered mental illnesses as "reactions" to a variety of psychobiological factors and, like Freud did with the "unconscious" phenomena, conferred them a categorical, irrefutable etiological nature.

This approach persisted in the second edition of DSM (1968), regardless of the elimination of the term "reaction". The acceptance of an assumed or pre-established etiology, not even the consideration of a mediating pathogenic chain in response to still unknown etiological factors, presided the theoretical background of these classifications.

DSM-III came to light in 1980. Many within and outside psychiatry consider it a "revolution" in the nosology of mental disorders. It was, indeed, a drastic change in the approach to diagnosis, breaking away from psychoanalytic jargon and weak "psychobiological" concepts, adopting a phenomenological/descriptive/categorical approach (Jaspersian and Kraepelinian for the most part), seeking and using documented research findings, enumerating more precise criteria, and assigning coded quantifications. Before and after its publication, DSM-III generated abundant numbers of books, articles, and new research that, while supportive, emphasized reliability at the expense of a non-demonstrable validity (10).

The worldwide acceptance of DSM-III made it the *de facto* classification of mental disorders in practically all countries, as demonstrated by the translation of the manual into more than 30 languages. This happened in spite of a practically total omission of cultural factors, other than a few timid phrases here and there, or casebooks attempting to demonstrate the manual's applicability to cases from different areas of the world (11). This approach persisted in the DSM-III-R, published in 1987, that included broader criteria for some conditions but, most importantly, multiplied even further the total number of diagnostic entities.

The success of DSM-III and DSM-III-R brought diagnosis to the forefront of world psychiatry. There is no question about the new relevance that a well-based diagnosis acquired for research work, teaching activities, and actual treatment approaches. Lawyers, administrators, insurance companies, bureaucrats and politicians paid more attention to diagnoses and their implications. Reliability was not all that was needed, but was good enough for an acceptable diagnosis.

Some may say that DSM-IV represented a modest improvement in terms of recognition and acceptance of a cultural perspective. A distinguished group of cultural psychiatrists (clinicians and researchers) and social scientists submitted a series of suggestions and recommendations to the DSM-IV Task Force. Unfortunately, these contributions were drastically trimmed down, and resulted in just three additions: a mention of "cultural", together with "age" and "gender" considerations, as part of the text in some (not all) groups of disorders; the inclusion of a cultural formulation in Appendix I (next to last) of the manual; and the listing of an (incomplete) glossary of "culture-bound syndromes". The meagerness of DSM-IV's cultural content may have been just one of the reasons why medical schools, residency training programs, and practitioners in general have not paid to these concepts, and specifically to the cultural formulation, the same attention that was given, at the peak of the psychoanalytic influence on psychiatric practice in the US, to the then-called "psychodynamic formulation".

The fate of the cultural aspects of psychiatric diagnosis in the ICD is, in turn, ambiguous, if not nebulous. The nature of the World Health Organization (WHO) as an entity serving all the countries in the world (which, in turn, are officially committed to follow its rules, norms and recommendations), and its primary concern with the public health impact of all diseases, makes the consideration of culture in diagnosis a more likely occurrence, even if the deliberations may also have to pay attention to issues beyond nosology. Accordingly, one could think that the mention of cultural variants in some entities, the inclusion of "culture-bound syndromes", specific recommendations about interviewing styles and approaches, explanations of criteria and other aspects of the process would have a more focused presentation. Such has not always been the case, however, throughout decades and several versions of ICD, in spite of the scholarly and courageous examination of these issues made by Stengel, at WHO's request, fifty years ago (12), and several more recent publications (13,14).

Criticisms of psychiatric diagnosis

Representatives from different segments of the public and professional world have criticized the form and content of the current nomenclatures. This is, indeed, a reflection of the enormous importance that psychiatric diagnosis has in many quarters. Historically, psychoanalysts were the first in lamenting the disappearance, in DSM-III and subsequent editions, of many concepts and ideas precious to them. Their criticisms evolved around the omission of unconscious (or psychodynamic) phenomena as diagnostic criteria components, the deletion of some clinical or diagnostic terms, and the subjection to precise guidelines for interview, assessment and conclusions, instead of the lax "free-association" approach of the Freudian school (15).

Interestingly, phenomenologists also criticized DSM-III

and its successors, in spite of the adoption of clear descriptive approaches in the new system. These critics pointed out that the manual had more or less "manipulated" the classic phenomenology, depriving it from its rich philosophical content, in the interest of a more pragmatic use of old terms, and choice of new ones (16). Similarly, neuroscientists and basic researchers objected to what they considered lack of recognition of basic science contributions to some diagnoses, particularly in the area known as "neuropsychiatry", that included age-related or genetically-based symptom sets (17,18). Last but not least, social and cultural psychiatrists have consistently denounced the undeclared ethnocentrism (Caucasian-oriented) of DSM and its "benign neglect" towards specific issues. This will be more elaborated below.

Society at large has not been indifferent to the debates about this topic. Lay organizations, while recognizing the need for psychiatric nomenclatures, tend to see them, at times, as potentially threatening or unduly instruments of control, intrusiveness, and oppression. The extremist views of the Church of Scientology about psychiatry are known (19). In the corporative world, insurance companies balk at the scope of clinical entities and their management; until recently, they plainly refused to provide any kind of coverage for mental disorders diagnosed and managed in inpatient or outpatient settings in the US. On its side, the pharmaceutical industry has welcomed the growing number of diagnosable conditions, has pushed for more clinical indications for existing compounds (including the proliferation of off-label use suggestions), and has favored – without acknowledging it – the use of "polypharmacy", which is, in any practical sense, a gross denial or rejection of formal diagnostic systems.

Two other players contribute to what some have called the "subculture" of psychiatric diagnosis debates: the legal profession and the media. Some legal firms and individual attorneys misinterpret or abuse the insanity issues derived from the hint of any diagnosis, to justify law violations of all kinds; in turn, they may criticize diagnoses as imprecise or "cruel", according to the particular features of the case. And, as background drummer or, at times, conductor of this truly cultural upheaval, the media sensationalize psychiatry-related incidents, criticize diagnostic errors or neglect, blame treatment failures, or exaggerate disagreements within the profession, in order to maintain sellable topics alive.

Current status of psychiatric diagnosis

From a strictly clinical and scientific vantage point, the current state of diagnosis in psychiatry can respond better to the label "in transition". The last 15 years have witnessed significant advances in epidemiological research, neuroscientific inquiries, and clinical management of many mental disorders. At the same time, the experience with the use of the existing diagnostic systems has led to well founded observations, both favorable and critical, as well as suggestions for improvement. For instance, it is clear that, while improving the levels of reliability and communication in general, descriptive diagnostic criteria reflect a lack of consistent information about the etiology and pathophysiology of mental disorders, which is partly due to the absence of reliable "biological markers". Furthermore, these criteria are a mix of behavioral features (some of them not necessarily "pathological") and true symptoms. This may lead, in part, to high levels of comorbidity (and its inherent imprecision, clouded by complicated family aggregations of psychopathologies) or to excessive numbers of "not otherwise specified" diagnoses (20).

There are unclear relationships between validity, severity, disability and desirable quantitative aspects of diagnoses (21). In turn, this quantitative component cannot be captured by the multi-axial approach. The "cross cutting points", or transition from normality to psychopathology, are not clearly established, making the clinical course of any condition pre-determined if not artificial (22). The "required" number of criteria for a given diagnosis generates heterogeneity even among patients who end up with the same label. The differential diagnosis can become, then, difficult and confusing. The reification of diagnostic criteria invites rigidity and opaqueness in a diagnostic exercise that must be active and lucid. Limited or biased research may emphasize the most frequently studied symptoms, not necessarily the most relevant or decisive in the clinical presentation, generating significant variations in epidemiological studies, among others. Subtypes and "subthreshold" diagnoses are subjective, unstable, arbitrary and, ultimately, non-empirical (23). Closer to the cultural perspective, age, gender and developmental variants are essentially ignored.

CULTURE AND CULTURAL FACTORS IN PSYCHIATRIC DIAGNOSIS

Culture is defined as a set of behavioral norms, meanings, and values or reference points utilized by members of a particular society to construct their unique view of the world, and ascertain their identity. It includes a number of variables such as language, traditions, values, religious beliefs, moral thoughts and practices, gender and sexual orientation, and socio-economic status (24). Keeping pace with the times, this definition has also incorporated elements such as financial philosophies, and the ever-changing realities imposed by technological advances. The range of possible interactions between culture and its components with clinical phenomena in general, and psychiatric diagnosis in particular, is broad and multifaceted. The latter certainly requires familiarity with the growing discipline of cultural psychiatry.

Cultural psychiatry deals with the description, definition, assessment, and management of all psychiatric conditions, inasmuch as they reflect and are subjected to the patterning influence of cultural factors. It uses concepts and instruments from the social and biological sciences, to advance a full understanding of psychopathological events and their management by patients, families, professionals and the

community at large (25,26). The boundaries of this discipline are better delineated by defining what cultural psychiatry is not. It cannot be restricted to being a psychiatric subspecialty, because culture impregnates every clinical and non-clinical event in any and all diseases. It is not a new name for other disciplines (in fact, cultural psychiatry is the result of a historical evolution of areas called in the past comparative psychiatry, cross- or trans-cultural psychiatry, social psychiatry and others, avoiding precisely the "rehashing" of old ideas). Cultural psychiatry is not an anti-biological psychiatry, simply because it recognizes the difference between etiology (probably biological) and pathogenesis (probably psycho-socio-cultural) of mental phenomena, and accepts contributions of neurosciences as both reinforcing and clarifying factors in normality and pathology. In the same context, cultural psychiatry is neither a political ploy nor a mere piece of rhetoric (27,28).

Closer to its dealings with diagnosis, cultural psychiatry should not be considered only a psychiatry of ethnic minorities or of exotic lands, because that would deny the impact of cultural factors in the everyday life of majority populations in any country or continent, or reduce them to existing only in places far from urban centers, developed countries or, more precisely, Western nations. While it is true that, due to clinical convenience, the presentation and discussion of cultural issues in health, disease, diagnosis and treatment may utilize examples of ethnic minorities, immigrants, refugees, or the so-called "special populations" (children, adolescents, the elderly, women, homosexuals, or members of cults and religious sects, all of them considered "minorities"), it would be a great mistake to assume that culture exists only in and for these groups. Actually, the recognition of cultural components in psychiatric diagnosis *for all* would be a great step forward in correcting this erroneous view. It goes without saying that cultural psychiatry is not the same as international psychiatry, nor it is limited to race, gender and ethnicity as its leading indicators.

The patient's cultural background and identity must be thoroughly understood by the clinician, and its impact duly recognized and evaluated. Involving a crucial set of factors, culture plays several roles in the diagnostic process (29). Cultural factors may have a powerful pathogenic impact as triggers of psychopathology (e.g., the role of violence in television shows in the development of violent behavior among probably predisposed children or adolescents (30)). They can also contribute to higher or lower levels of severity of psychiatric symptoms (e.g., delayed help-seeking response to the appearance of acute psychotic symptoms in a family member). They can be agents in the expression of clinical symptoms, reflecting the dominant themes of the historical period in which the illness occurs. They are certainly decisive elements in treatment.

How is culture being used in current psychiatric diagnostic practice? The short answer is, very poorly. Declarations on the importance of cultural factors in diagnosis are not scarce, to be sure. But the use of the cultural formulation is limited, culture in clinical assessments is reduced to mentions of race, ethnicity, language or migrant status at the most, and in most training programs, cultural psychiatry didactics covers a few hours, most frequently during the senior year or in elective periods, when its impact may be minimized by the residents' forthcoming expectations or plans. Even in programs where these requirements are intended to be met, the demands of a growing body of knowledge relegates cultural psychiatry to marginal consideration. In practical terms, the message is condescending: "yes, cultural factors are important in psychiatric diagnosis, so check about race and ethnicity of your patients; if you have language difficulties, call an interpreter (if there is any available), be respectful, and move quickly to your next case".

The transactions between teachers and trainees, or between clinicians and patients, do not always have such a hasty, or cynic-sounding flavor. The staff of busy hospital units, outpatient clinics, emergency rooms, or private practice offices do their best to cover intense demands of time and professional skills. Those that find ways to provide decent cultural information, and gather solid cultural data, learn to recognize what is cultural in the clinical area generally called "environment". If and when this is done, the diagnosis will then be truly comprehensive, individualized and, for all these reasons, will also possess the humanistic seal that must always be at the core of any clinical interaction in medicine and, more particularly, in psychiatry.

Unfortunately, these advantages meet disadvantages resulting from the criticisms discussed above (31). Culture is said to be too broad a concept, too complex in content, and too heterogeneous in nature (the hundreds, even thousands of cultural and subcultural groups, languages and dialects all over the world are frequently cited as proof) to be covered by relatively simple clinical interactions (32). Literature contributions dealing with culture in clinical practice and diagnosis are mostly descriptive, narrative, and/or colored by sociological, anthropological or even ecological viewpoints (33), therefore labeled and dismissed as "soft science" by clinicians and scientists. Many authors insist that cultural factors are important *only* for treatment and management issues, perhaps preventive measures, but not for diagnosis *per se*. Finally, the disadvantages are rounded up by logistic difficulties in the instrumentation of cultural diagnostic inquiries: their proponents do not seem to agree on the content of such inquiries, there are not too many well proven tools, and even if they are, their use is time-consuming and complicated (21,32,33).

The so-called "culture-bound syndromes" deserve special comments. These are clinical pictures said to be uniquely related to specific cultural characteristics of the human groups in which they occur; as such, their etiological, pathogenic and clinical manifestations do not correspond to the conventional entities included in mostly Western-based nomenclatures. Culture-bound syndromes have, indeed, a venerable history enriched by contributions of notable clinicians and researchers in the last four or five decades (34,35). A

partial list of culture-bound syndromes was included in the Appendix I of DSM-IV, but it did not do justice to the extensive literature on the topic. Practically every region of the world has a set of culture-bound syndromes, yet it has to be said that, at times, the descriptions are quite similar, and at others, too generic or vague to be appropriately characterized. The basic question about culture-bound syndromes dwells on yet another dilemma: are they nosologically autonomous entities, or do they have enough similarities with existing clinical conditions currently listed in DSM or ICD?

WHAT SHOULD BE CULTURAL IN A MODERN PSYCHIATRIC DIAGNOSIS?

The purpose of including cultural elements in the diagnosis is neither to homogenize diagnostic procedures to the point of vague generalizations, nor to accentuate heterogeneity in the name of an ill-conceived thoroughness. The cultural components of modern psychiatric diagnosis cover a variety of areas. The following is a list of the main aspects about which information must be gathered in the process of a well-structured clinical interview.

Cultural variables

They should be recognized and duly described, thus setting the stage for more comprehensive information. Specifics about language (and how it is mastered), religion and spirituality (with possible mention of main rules, as understood and described by the patient and family members), gender and sexual orientation, traditions and beliefs (those that, together with ethnicity, confer a sense of personal and group identity), migration history and level of acculturation (when necessary and applicable) would conform the minimal set of variables to be covered in the initial phase of a clinical evaluation (24).

Family data

Information about family, being in itself another cultural variable, appears to be sufficiently important as to deserve a special focus. Family history, structure and life provide data about what are called "micro-cultural" or "micro-environmental" segments in the patient's story. Areas such as raising modalities, roles and/or hierarchies, value-infusing activities, eating habits, and social interactions (e.g., community celebrations) must be inquired about, as part of the whole assessment process. Last but not least in this section, help-seeking patterns, while not being strictly a diagnostic component, represent a useful context-revealing factor reflecting a great deal of family mentality about interactions with the outside world in general, and the health professions in particular (36).

Pathogenic and pathoplastic factors

The environment (or "macro-environment", to be more precise) is an almost inexhaustible source of both benign (or preventive) and harmful factors in the development of any clinical condition. For the purposes of a culturally-based diagnosis, the identification of environmental pathogenic factors is essential. Such factors include family life (deserving a special focus, as done above), but also estimates of the impact of broader agencies such as media, socio-political structures, rules and values of public behavior, church affiliation, schedules, rituals, schooling norms, and the like.

Pathoplastic factors refer to the uniqueness of symptom expression. The clinician should be prepared to recognize that the description of the symptoms by patient and relatives, the words and terms used, and the context in which the clinical story evolves (in short, the "narrative" component of the professional-patient transactions) respond to the particular moment in time when they are occurring. Environment shapes the form (not only the substance) of the symptoms: a delusion is a firm, unchangeable (in many cases, unusual and bizarre) belief identified in the psychopathological assessment of any patient, now and ever since clinical psychiatry became an established discipline; the delusion's content (of prominent cultural facture), however, will be different in a 21st century patient growing up in an urban, technologically-dominated world from that of a patient from 200 years ago, living in a predominantly rural, much less complicated environment. The distinction between the appearance of the symptom, its verbal description, and the patient's surrounding reality continues to be the key element of this part of the evaluation.

Explanatory models

A critical component in any cultural framing of psychiatric diagnosis, explanatory models offer the idiosyncratic perspective of patient and relatives about the origin (cultural etiology?) of the symptoms, why they occur, and how the process of "getting ill" has evolved (cultural pathogenesis?). The exploration could expand into why has the particular patient become the "target" of such symptoms, and what should be done to overcome them (37). The cultural stamp of these explanations should not be underestimated, as the information is valuable and relevant for both the diagnosis itself, and for aspects of the eventual multidisciplinary (multi-conceptual or multi-dimensional) management process.

Patient's strengths and weaknesses

The mental status examination part of a clinical history includes now a section outlining the individual patient's strengths and weaknesses as reported by him/her and/or by

family members. The cultural nature of this piece of information is undeniable: being the product of self-observation, it reflects issues of self-image and subsequent self-esteem, interaction styles, social disposition and skills, level of performance, even subtly disguised yearnings for change, or clear therapeutic targets (38). Furthermore, strengths and weaknesses (the latter considered barriers against treatment approaches) configure what is known as "coping styles" of the patient *vis-à-vis* the adverse events originating, leading to, or aggravating the pathological symptoms.

PRACTICAL ASPECTS OF THE INTEGRATION OF CULTURAL FACTORS IN PSYCHIATRIC DIAGNOSIS

The logistics of the process to incorporate cultural factors in both ICD and DSM is not simple. It has several steps or components that entail conceptual integration, ideological coherence, pragmatic vision, and even political commitment. It includes the incorporation of culture in the definition of mental disorder, a review and improvement of the cultural formulation, and specific steps in the processes of interview, instrumentation, clinical documentation, and needed research.

Definition of mental disorder

A first step should be the unequivocal recognition that cultural discordances play as important a role in the definition of mental disorder as maladaptive behaviors and subsequent functional inadequacy. It is not enough to limit this recognition to bland phrases such as "in contrast with accepted cultural norms of the individual's community or society of origin". The definition of mental disorder, or mental illness/disease, should be explicit about such discordances (i.e., against rules of coexistence, respect or solidarity in the culture of origin), enumerating them succinctly but comprehensively. That the definition of mental disorder will be in one of the opening pages of the new manuals seems to be generally accepted; that it should include a cultural component remains to be seen. It would certainly be a clear demonstration that the leaderships of WHO, American Psychiatric Association, World Psychiatric Association and other organizations involved in the effort really intend to materialize a long-expected feature for the process' final product (39,40).

Cultural formulation

The cultural formulation, as outlined in DSM-IV-TR, is a valuable tool that, however, has not been systematically tested. Its content includes most, but not all, the concepts discussed in this article. It has the advantage of being already a known instrument, usable by both mental health specialists and non-specialists, enhancing the value of ethnography as a clinical data-gathering method, covering the patient-owned perspective, and including data on the patient's identity, explanatory models, psychosocial environment and functioning, relationship with the diagnostician, and an overall cultural assessment for diagnosis and care (41). It provides a better understanding of symptoms, therefore increasing the accuracy of conventional clinical assessments.

As disadvantages of the current cultural formulation, imprecision and subsequent heterogeneity of the narrative data are mentioned. In an era of quantitative approaches to the clinical assessment of individual and groups of patients, and use of "evidence-based" documentation, some authors have suggested devising a scale to convey more objectively the qualitative nature of the cultural formulation's information. This is certainly a doable project. Be that as it may, there is consensus about the fact that the cultural formulation must be considered a formally sanctioned tool for use in clinical evaluations leading to a more comprehensive diagnosis (42).

Cultural axis? Cultural dimension?

A short-lived initiative fostered the idea of adding a cultural axis to the five included since DSM-III. Its proponents remarked the "visibility" that cultural issues would reach by being incorporated in one exclusive axis. However, it soon became clear that it would be enormously laborious and ineffective to pretend an inclusion of all that is cultural about the mentally ill person's experience in just one axis. Moreover, it would go against the universalistic nature of cultural assessments, and create a pseudo-independence that would further even more the isolation of culture as a diagnostic factor. Rather, the critics opined, culture should be at the forefront of all clinical interactions leading to a diagnosis, and preside the overall assessment of all patients, with specification of its impact on symptoms, syndromes and the whole illness experience (4).

The discussion about a cultural "dimension" is more current, given the debate about categorical vs. dimensional approaches in psychiatric diagnosis in general (43). It is true that culture implies (and plays) a greater role from a dimensional perspective, with factors (facets? traits?) that are also impacted by external realities such as poverty, unemployment, legal and political circumstances, "isms" of all kinds. Yet, the dimensionalization of culture could also create isolation and eventual neglect, its implementation would be time-consuming, and the information thus obtained would be fragmented. Once again, the reasonable response to this call should be a renewed effort to make the cultural evaluation a fluid component of the clinical interview, with easy-to-use instruments, and cohesive, encompassing views and procedures.

Clinical interview procedures

With a clear perspective on relevant cultural variables in mind, etiopathogenic factors and explanatory models to be inquired about in the course of the conventional clinical interview, a simple but informative scoring scale, and the cultural formulation's components handy, the clinician will be in a good position to integrate these factors in his/her routine work. This sense of alertness, however, is critical in that it would allow an early detection of what can be "cultural" in the patient's story (e.g., the ubiquitous topic of somatization (44)). If such content is mild, it will remain in the clinical documentation as a specific reminder that, later on, can be relevant or useful. If the clinician's intuition (or "suspicion") is moderate or even strong, he/she could use a sort of "telescoping" method that allows him/her going from broad to narrow (more precise, in this case) estimates, using now the tools at hand, to make either perception similarly clear. As telescoping requires not only "zooming", but also a variety of lenses with increasingly finer views and adjustment possibilities, this "clinical telescoping" *vis-à-vis* the assessment of cultural diagnostic factors can make use of new approaches, including questions to relatives, friends, neighbors, coworkers or acquaintances, or additional clinical instruments to ascertain true "cultural discordances" in the story being gathered (45,46). There may be a point in which referral to or assistance by an experienced colleague in this area is necessary.

This process can go on to the identification of, for instance, a "culture-bound syndrome" (35,47) or of a well defined culture-related aspect of a conventional clinical entity, e.g., consideration and assessment of concept, severity, and explanation of suicidal risk in a given patient (48). All this will be duly documented in the final clinical history. Obviously, this effort may ultimately lead to a more inclusive diagnosis, and an expected comprehensive set of treatment recommendations. Contrariwise, the exercise may end with a rational ruling out of cultural etiopathogenesis, while maintaining value as part of the general management recommendations, e.g. strengthening of family ties, group therapy, or spiritual counseling. The clinician will, again, make this clear in the medical record.

SUGGESTED FUTURE RESEARCH

The next few years offer a significant opportunity for research on culture and psychiatric diagnosis (32,33). There may be a better disposed set of funding sources as the need to fulfill old promises reaches compelling levels. The field remains substantially unexplored, in spite of culture's ubiquitous presence in all areas of research on psychiatric diagnosis. The American Psychiatric Association's launching volume on a research agenda for DSM-V (49) recognized the role of culture in practically all its chapters. Neuroscientists commented on the pervasiveness of ethnic and cultural issues in the interpretation of most genetic studies, and their influence on vulnerability and resilience, coping styles, cognitive responses to stress, and the nature of social support. The presence of ethnocultural components in endophenotypic manifestations of psychiatric conditions, and the realities of pharmacological epidemiology, ethnopsychopharmacological and pharmacogenomics findings (50), are now undeniable. It was also said that the new nomenclature should include clear delineation of core criteria, and recognition of cultural and cross-cultural variants in symptom definition, and behavioral and symptomatic manifestations.

Similarly, the work group on developmental issues elaborated on the topics of meaning and context and their effects on the expression of particular behaviors, and on the risks for psychopathology throughout the different developmental phases. The need to provide explanations about social, cultural and neurophysiological mechanisms at play in the impact of adaptive and maladaptive personality traits was also emphasized. The pertinent chapter pointed out typological and behavioral differences among cultures, and commented on the uneven results of well-known measurement instruments in different ethnic groups. Cultural psychiatry research must pay attention to the "desirability factor" in diagnostic processes, a prelude to the vast field on stigma and its diagnostic impact, as well as the ethnocultural and linguistic biases in mental health evaluations (51,52). The areas of cultural epidemiology (a potentially rich mix of anthropological and descriptive epidemiological variables), and comparative studies (urban vs. rural, DSM-ICD, international, and interhemispheric) are equally relevant (53,54).

Similarities and differences between ethnicity and identity, religiosity and spirituality are topics of worthy connections with psychiatric diagnosis in a variety of cultural settings (55). The connections between biology and culture in psychopathology may have a powerful repercussion in diagnostic factors such as resilience, response to traumatic events, violence, treatment susceptibility, and creativity among others (56,57). Cultural factors in specific diagnoses such as chronic pain, phobias, dissociative and eating disorders, as well as personality disorders, are prominent, yet not totally dissected (58). The same applies to the assessment of culture in the perception of severity of symptoms (by patients and clinicians), functional disturbances, and the all-encompassing area of quality of life (59). The consideration of studies about dimensionalization of cultural factors could set the stage for future diagnostic and nosological systems (43).

In the field of culture-bound syndromes, potential research items are abundant and in high need of implementation. The first and foremost area of inquiry has to do with their validity as clinical entities to be considered on their own, or be included as part of the existing groups of disorders, i.e. *"ataque de nervios"* being a form of panic disorder, *"amok"* a violently acute psychotic episode, *"susto"* a dissociative disorder, or *"koro"* a variant of obsessive-compulsive disorder (47, 60). In turn, how much is cultural in well established "Western" disorders such as anorexia nervosa or

pathological gambling? (61-63). Needless to say, the intense debates about this could only be solved by means of well conceived comparative research projects.

Prominently closer to current developments in psychiatric nosology, field research on the cultural formulation could test validity, feasibility (utility) and reliability of the tool. Gender- and racially/ethnically diverse samples would be required in order to include the much sought-after cultural variability in symptom presentation, and clarify the issues of under- or over-diagnosis of some entities in different ethnic groups (42,43). Input of the "cultural reference group", impact of factors such as sector of care, or the practitioner's personal and professional cultural background, must be adequate subjects of research. Applying the cultural formulation to and comparing it between different, comorbid or difficult-to-differentiate disorders, would make it more rigorous and reliable (60). Finally, the cultural formulation can and should be administered and tested in a variety of clinical settings, i.e., general medicine, primary care, and psychiatry clinics, as well as specialty medicine and psychiatry units.

CONCLUSIONS

The universality vs. distinctiveness dilemma implicit in the elaboration of diagnostic and classification systems across history has an emblematic angle in the debate about incorporation of culture and cultural factors in the forthcoming editions of DSM and ICD. The internationalization of the health and mental health fields due to globalization, nourished, in turn, by seemingly unstoppable migrations, has led to the acceptance and practical concerns of diversity in clinical settings around the world. While generally accepted, this effort is not free of difficulties in many areas: conceptual, methodological, clinical, financial, administrative, and political. Nevertheless, a historical opportunity for the materialization of old promises is now present, and must be decisively grabbed by all individuals, groups and organizations involved.

The trajectory of today's two main nosological systems has made clear that culture, as an etiopathogenic and pathoplastic factor, and as a contributing component of severity, has a significant impact on psychiatric diagnosis. But, such impact goes even beyond: every clinician needs to know about, and assess pertinent cultural variables, family data, explanatory models, strengths and weaknesses of individual patients and their communities of origin. Cultural psychiatry, as a young but robust discipline, helps in the systematization of these pieces of knowledge, thanks to its growing connections with both neurobiological and social sciences.

Together with an explicit declaration of a cultural referent ("cultural discordances") in a new definition of mental disorder, the use and refinement of, and additional field research on tools such as DSM-IV-TR's cultural formulation are needed for a new and pragmatic clinical interview, that should include an exploration of cultural factors in both history-taking and diagnosis-building phases. This article has elaborated on the theoretical/conceptual and logistic/pragmatic components of the effort.

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