Systematic inclusion of culture-related information in ICD-11

The experience and presentations of mental disorders are affected by culture and the social milieu, not only of patients and families, but also of the individuals and health systems providing care. These cultural views impact what is considered normal or pathological. The salience of cultural considerations has therefore been increasingly reflected in modern classification systems.

The two dominant classification systems in psychiatry, in their earlier editions, took somewhat different approaches to reflecting cultural influences on diagnosis. The Clinical Descriptions and Diagnostic Guidelines (CDDG) for ICD-10 Mental and Behavioural Disorders did not include a classification of culture-specific disorders, but rather noted the presence of cultural variations in expression under broad disorder groupings (e.g., somatoform disorder) and in help-seeking and illness-related behaviour. However, consideration of culture was not systematically incorporated in the manual. In contrast, the DSM-IV incorporated brief descriptions of cultural features under specific disorders, outlined components of a cultural formulation approach, and listed twenty-five "culture-bound syndromes"[1].

The development of the ICD-11 has emphasized the principle of global applicability, i.e., the need for the diagnostic guidelines to function well across global regions, countries and languages[2]. Reflecting the cultural context in which clinical encounters take place is likely to enhance this goal. However, there is an inevitable tension between the incorporation of locally relevant material and the essential purpose of an international classification system, which is to reliably convey clinical information across diverse boundaries. Responding to this challenge requires a pragmatic balance that involves recognizing cultural differences where these are clinically important without allowing them to detract from the goal of a common global diagnostic language[3].

As a way of including meaningful consideration of culture in the diagnostic process, the World Health Organization (WHO) Department of Mental Health and Substance Abuse constituted a Working Group to develop guidance on cultural considerations for the ICD-11 CDDG, based on the current state of clinically applicable information for individual disorders and/or disorder groupings.

The focus was on providing pragmatic, actionable material to assist clinicians in their evaluation of patients using the ICD-11 guidelines and reduce bias in clinical decision-making by facilitating diagnostic assessment in a culturally informed manner. Thus, for example, while recognizing that specific idioms relating to mental illness are always influenced by culture, what the guidance describes are emotions, cognitions or behaviours that are broadly universal and therefore not "culture-bound" in the sense of being unique.

The Working Group developed the following set of questions to guide the generation of the material on culture:

- Is there evidence that culture exerts a strong influence on the presentation of the disorder? For example, is there notable cross-cultural variation? Is a mechanism known for how culture might influence the symptoms or presentation of the disorder?
- Is there evidence that the prevalence of the disorder is particularly high or low in specific populations? What caveats should be considered in interpreting these data (e.g., misattribution of symptoms by clinicians unfamiliar with cultural expressions of distress)? Is it possible to link prevalence variation to information on mechanisms (e.g., available data suggesting that prevalence of anorexia nervosa is higher in societies where thinness is idealized)?
- What are the cultural concepts of distress (idioms, syndromes, explanations/causes) identified in various cultural groups that are related to the disorder?

To generate the guidance, the Working Group conducted extensive consultation with experts and reviewed the literature on cultural influences on psychopathology and classification of each diagnostic grouping as well as the texts provided in the ICD-10 CDDG and the DSM-5. Information was also derived from materials produced by various ICD-11 Working Groups as part of their generation of ICD-11 content forms[4]. The resulting guidance is designed to help the clinician make informed decisions which are likely to foster patient-centered care that is sensitive to the cultural and social milieu of the clinical encounter.

The following is an example of the resulting material on cultural considerations for adjustment disorder:

- Adjustment disorder may be exacerbated by limited family or community support, particularly in collectivistic or sociocentric cultures. In these societies, the focus of the worry may extend to stressors affecting close relatives or friends.
- Adjustment disorder reactions that include dissociative symptoms may be more prominent in some cultural groups.
- Symptoms of the disorder may be influenced by local idioms (e.g., *susto* or *espanto* (fright) in Central America) that are associated with fear or subsequent worry regarding a stressor with strong cultural connotations (e.g., becoming suddenly frightened when crossing an unpopulated area alone at night). These idioms are also applicable to anxiety disorders.

While the guidance can enhance the global applicability of ICD-11, it is not sufficient to meet this goal. The limitation of current scientific knowledge means that robust validating data for most diagnostic categories is lacking[5,6]. Classification of mental disorders has therefore entailed best judgment of existing information, usually by groups of experts. The data on which such judgment is commonly based are largely derived from the West, with large sections of the world contributing very little to the information pool. Just as we know that psychiatric diagnosis is not

value-free[7], there can be little doubt that psychiatric nosology is embedded in the culture of its derivation and that where the data come from is important.

One way of alleviating the limitation of the sources of data is to ensure that diverse cultural groups bring their experiences to the decision-making process[8]. Within the constraints of our imperfect present state of knowledge, the WHO has sought to address this need by ensuring that all ICD-11 Working Groups included members from all global regions, with a substantial proportion from low- and middle-income countries, and through the flexible design of the ICD-11 CDDG, which allows more scope for clinical judgment to take account of contextual, including cultural, factors[4].

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1. Lewis-Fernández R, Kleinman A. Psychiatr Clin North Am 1995;18:433-48.
2. Reed GM, Sharan P, Rebello TJ et al. World Psychiatry 2018;17:174-86.
3. Sartorius N, Ustün TB, Costa e Silva JA et al. Arch Gen Psychiatry 1993;50:819-24.
4. First MB, Reed GM, Hyman SE et al. World Psychiatry 2015;14:82-90.
5. Kendler KS, Gardner CO. Am J Psychiatry 1998;155:172-7.
6. Hyman SE. Nat Rev Neurosci 2007;8:725-32.
7. Fulford KWM, Broome M, Stanghellini G et al. World Psychiatry 2005;4:78-86.
8. Gureje O, Stein DJ. Int Rev Psychiatry 2012;24:606-12.

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