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CULTURE AND DSM-IV: DIAGNOSIS, KNOWLEDGE AND POWER

The new section of *Culture, Medicine and Psychiatry* announced and described by Roberto Lewis-Fernández in the pages that follow grew out of the work of the National Task Force on Culture and Psychiatric Diagnosis. In April, 1991, a national conference was held in Pittsburgh under the sponsorship of the minority affairs office of the National Institute of Mental Health. The gathering brought together researchers with an interest in culture and psychiatry and several members of the committee that was already hard at work on producing the up-dated diagnostic and statistical manual, DSM-IV. Participants were charged with providing critical assessments of specific categories within the DSM-IIIR from the perspective of culture and ethnicity, and were invited to discuss the advisability of formal participation in the scientific and political process of revising the manual. The most powerful realization to emerge from the gathering in Pittsburgh was the extent of our current knowledge about cultural data relevant to psychiatric diagnosis, particularly, knowledge of the phenomenology of mental illnesses across cultures and diverse social environments in our own society. Here were assembled researchers and clinicians – psychiatrists, epidemiologists, psychologists, anthropologists – with personal experience in attempting to apply the criteria of the DSM-IIIR among patient populations for whom some aspects of the manual were wholly inadequate. While the evidence necessary for evaluating some DSM categories is quite limited, for many of the most critical categories a large body of empirical data from many culturally diverse populations could be marshalled. Furthermore, the consensus of the group was that these findings are important for contemporary psychiatric practice and could be integrated into the body of the new manual. A decision was thus made to establish a national task force and to join the process that would lead to the writing of DSM-IV.[1]

Looking back today, I think nearly all participants in that gathering in Pittsburgh would agree that the results fell far short of what we, at times, dared to hope. Under the leadership of Dr. Juan Mezzich, enormous effort was put into analyzing the cross-cultural literature relevant to broad classes of psychopathology and recommending explicit language for the criteria and narrative text of the new manual, to be considered by specific DSM-IV

subcommittees. In spite of these efforts, there was seldom evidence our position papers had been understood and incorporated into the deliberations of most of the committees. There were welcome exceptions, individuals and committees who grappled with the difficulties of introducing considerations of cultural diversity into the rather inflexible structure of the DSM. In most cases, however, there was little evidence that the concerns we raised had been understood. When cultural issues were acknowledged in the early draft statements of committees, they too often appeared as a caricature of that which had been drafted; in place of careful scientific data, we found ethnic and cultural stereotypes that reflected almost nothing of the scientific literature. At several moments, the task force strongly considered formally withdrawing from the process. Although the editors made serious attempts to incorporate recommendations from the task force into the DSM text, to the very end our efforts at engagement with the DSM committees were nearly always one-sided.

While this is not the space to assess the outcome of these efforts to influence the DSM-IV, several things are apparent. On the one hand, culture was not added as an afterthought to this manual, as was the case with the DSM-III, where the only mention of cultural issues was in one or two paragraphs of the Introduction lifted from a letter from Prof. Kleinman criticizing the original draft. Cultural concerns are represented in a significant manner in the text of DSM-IV – in the Introduction, in the introduction to the multi-axial structure, in the text associated with particular categories (as "cultural considerations"), in a glossary of cultural terms ("culture-bound syndromes"), and in an "outline for cultural formulation" appearing in Appendix I. On the other hand, many of the substantive recommendations made by the task force – the wording of particular symptom criteria, variations in duration criteria, the inclusion of new or revised categories (a mixed anxiety-depression category, culturally distinctive forms of dissociative disorders, neurasthenia as seen and diagnosed in many Asian cultures), significant revisions of the definition of personality disorders – were not incorporated into the body of the manual, in spite of strong empirical data from the cross-cultural research literature. The primary thrust and philosophic commitments of the DSM-IV remained largely impervious to the empirical and ultimately political claims of those at the cultural margins of American society.

There are obvious reasons for the problems faced by members of this task force in gaining a hearing by those who devised the DSM-IV. There are generic difficulties in attempting to make a diagnostic manual truly reflect the diversity of a multicultural society. Particular cultural commitments are inevitable: there can be no 'God's eye point of view,' free of culture, from

which to assess a person suffering a mental illness. Furthermore, any efforts to represent psychiatric disorders as unique to particular 'cultures' leads rapidly to cultural essentialism, stereotyping, and increased possibilities of stigmatization. The glossary of cultural terms developed by the task force for inclusion as an appendix is almost certain to be interpreted in this way by some. There are no easy means to incorporate what we know about cultural diversity within a document such as the DSM.

There are more fundamental issues at stake, however, in the resistance to incorporating the messages of social and cultural psychiatry into the text of the DSM-IV. Members of the culture and diagnosis task force as a group are deeply committed to a view of psychopathology as social and cultural. This in no way implies a discounting of the role of human biology, but it does represent a basic critique of the dominant vision of psychopathology and psychiatric practice. It represents a critique of a too sharp distinction between 'disease' and 'illness,' between psychiatric diseases viewed as universal biological entities and the forms of experience and cultural interpretations of that experience that occur in individuals and social groups. It represents a critique of the hegemony of particular forms of science, of the failure to match the nation's (and profession's) commitment to furthering knowledge of the neurobiology of mental illnesses with an equal commitment to recognizing and understanding the social origins of psychopathology and to developing effective social interventions. And it represents a critique of all too easy assumptions about universality, assumptions that what one learns from an upper middle class Euro-American population in a tertiary care anxiety disorder clinic is generalizable to all humans.

Some readers of this journal will surely view the efforts of the task force as naive or misplaced. It was not for naivete, however, that many devoted such energy to a process that from the outset was certain to have limited effects, but because we believed that so much is at stake. At stake is not only the integrity of psychiatry's claims to knowledge as a science of the human mind, but more importantly the care of many of the most disadvantaged members of American society – psychiatric patients who are recent immigrants, members of minority populations, and persons who are poor and living on the margins of our society. Research provides strong evidence for high rates of psychiatric misdiagnosis among such persons (Neighbors et al. 1989; cf. Good 1993 for a summary review of the literature). Although the full implications of these data are not known, the inappropriate prescription of some medications (such as neuroleptics) and the failure to prescribe potentially effective medications (such as antidepressants) appears to be all too common. Misdiagnosis is almost certainly associated with inordi-

nately high rates of involuntary confinement of African American men and with poor care in outpatient settings, inpatient units, and substance abuse treatment centers (see Lindsey and Paul 1989, Nordhoff and Bates 1989). If the evidence that supports these claims is indeed valid, the cultural gulf between many clinicians and their clients, a divide formalized in apparently trivial issues of wording in the DSM, may turn out to be very crucial for the integrity of psychiatric practice.

It is because we accepted the claim of those central to the development of the DSM-IV that diagnosis matters, that it matters for the care of patients whether a diagnostic assessment is formulated well (or 'correctly') or badly, that members of the task force devoted such energy to this process. It is troubling that concern about the development of reliable research instruments by much of the leadership of the psychiatry profession should not be matched by concern about the sensitive and reliable use of diagnostic instruments in community practice. To engage these issues, however, takes psychiatric research out of the laboratory and to the social margins, to clinicians who are struggling under adverse conditions to care for homeless men and women who are mentally ill, to providers caring for persons suffering both from mental illness and the effects of use of alcohol or addictive drugs, to American Indian patients in emergency rooms of rural hospitals, to poor Latino or African American men and women in crowded urban clinics, to recent arrivals to our country suffering the traumatic effects of state violence who live in continuing terror that they will be deported, to clinicians attempting to provide care for a broad range of disadvantaged Americans within the constraints of for-profit managed care organizations. And it takes psychiatric research to everyday uses of language, to the pragmatic effects of diagnostic judgements, to the effects of employing the label 'antisocial personality disorder' or 'conduct disorder' for minority youth (while refusing to label racism as a personality disorder).

Members of the task force, who continued to attempt to influence the text of the DSM-IV, were scholars whose primary concern is not for finding a biological marker for a specific subtype of anxiety, but who link their concerns for scientific accuracy with a commitment to human rights. It is for this reason that we recognize that our struggle to be heard, that the disqualification of certain forms of scientific evidence and the reluctance to incorporate knowledge generated at the social margins, are issues of power and what the French social theorist Bourdieu calls 'symbolic violence.' And it is for this reason that those who contributed to this process see their work not as engaging in debates over trivial issues of language but as an effort to confront power relations that contribute to the marginalization of many persons and groups in our society.

Only time will tell whether we chose wisely in selecting psychiatric diagnosis and the DSM-IV as a site for engaging what we believe are crucial issues of our day. Clearly it is a small part of what must be done if psychiatric care is to be improved for many of the least powerful members of our society. And it is a small part of what must be done if psychiatry and psychiatric research are to respond to the multicultural and social challenges of our contemporary society.

In the following pages, Dr. Lewis-Fernández outlines one of the projects devised by the task force as an on-going dimension of its work. All too often, the group argued, psychiatric knowledge and prototypes of psychiatric disorders derive from work with middle class 'majority' clients or patients – those with enough power and resources to be seen in research clinics. The task force has therefore called for the development of and reflection on new prototypes, cases of illness typically seen in the community clinics which serve the poor and disadvantaged, cases in which the divide between clinician and client is often the greatest. It has called for the development of a 'minority casebook' to illustrate the diagnostic dilemmas faced in these settings, and for the elaboration of an approach to 'cultural formulation' that might contribute modestly to bridging that divide. We join in this effort by making available pages of this journal for critical analyses of cases under the broad rubric of cultural formulation.

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NOTE

1. Members of the Steering Committee of the Task Force included Drs. Juan Mezzich, Arthur Kleinman, Horacio Fábrega, Delores Parron, Byron Good, Keh-Ming Lin, Spero Manson, and Gloria Johnson-Powell. Over 50 additional persons were active in the work of the task force. Their names are listed on pp. 861–862 of the DSM-IV.

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