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CULTURAL FORMULATION OF PSYCHIATRIC DIAGNOSIS

This issue of *Culture, Medicine and Psychiatry* introduces a new regular feature to the Journal: a Section of Clinical Cases exemplifying the Cultural Formulation outlined in *DSM-IV*. The Cultural Formulation is a recent operationalization for clinicians of the process of cultural analysis as it relates to the clinical encounter that can be performed as part of the evaluation of every patient (Mezzich and Good in press; Mezzich 1995a). Its immediate origins lie in the recent process of revision of psychiatric nosology that resulted in *DSM-IV*. Responding to criticisms of prior insensitivity to cultural issues in past editions of the Manual, the National Institute of Mental Health (NIMH) supported formation of a Group on Culture and Diagnosis in 1991 composed mainly of anthropologists and cross-cultural psychiatrists (cf. Alarcón 1995 and Mezzich 1995b for a history of these events). The general goal of this Group was to advise the DSM-IV Task Force on how to make culture more central to *DSM-IV*. From the beginning, one of its specific aims was to devise a mechanism that would facilitate the application of a cultural perspective to the process of clinical interviewing and diagnostic formulation in psychiatry.

Early notions favored supplementing the five existing Axes of the Manual – those that organize diagnostic formulations into separate domains for pathological syndromes, personality disorders, medical conditions affecting the psychiatric picture, relevant stressors, and resulting levels of functioning – with a sixth or "Cultural Axis." Investigators had previously laid out some of the conceptual components that should be included in such a proposal, indicating that a cultural axis would only be viable if it represented illness from an 'emic' perspective, that is, from the perspective of the sufferer and his or her primary reference group (Good and Good 1986). The Group realized, however, that in order to fit the existing multiaxial format, a Cultural Axis would almost certainly be reduced to a standardized typology of brief cultural characterizations, a menu of key descriptors listed in the Manual for use as part of the clinical evaluation (Mezzich in press). These descriptors would most likely be used to hone but not fundamentally alter the basic diagnoses, following the model of other diagnostic modifiers, such as the specifier "with rapid cycling" used to characterize a subtype of Bipolar Disorder. Items in an Axis VI typology would include

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general specifiers for use in any cultural setting (such as "with prominent somatization") and indigenous labels for the presenting syndrome (such as "*nervios* illness" that describe patients' and family members' views of causation and pathophysiology. Some investigators proposed dealing with the constraints of the multiaxial schema by expanding Axis VI into a series of subaxes, covering topics such as language preference, levels of acculturation and biculturality, and religious belief and practice (Guarnaccia in press; Ramírez, via Mezzich in press). In general, the Cultural Axis proposal had the obvious advantage of fitting within the existing DSM structure, thus apparently facilitating its widespread acceptance by clinicians already familiar with the multiaxial format.

The Cultural Axis concept, however, soon came under criticism as unworkable and insufficient. From the beginning, a Cultural Axis faced what appeared to be significant technical objections. Doubts arose whether this format could ever yield any real clinical usefulness. How might one assemble a series of brief comments on culture that are universally applicable and non-stereoyping? How would the items forming the necessarily limited typology be selected? Would the typology simply make official clinical commonsense (any clinician knows when there is an "excess" of somatic symptoms) without adding any useful information? Would this format not contribute instead to the essentializing – or stereotyping – tendency of psychiatric assessments? Is there any difference between pulling indigenous illness labels out of context, without any processual analysis of how they emerge in particular settings, and the cultural essentializing involved in the psychiatric diagnoses themselves? Consider the inadequacy of the likely Cultural Axis evaluation of the rich contextual dynamics involved in a presentation of *taijinkyofusho*. The particular Japanese exigencies of self-definition within different social circles evincing distinct relational obligations, especially problematic during adolescence, patterned by gender roles and cultural rules of social trust and reciprocity (*amae*), and showing historical changes with the loosening of social bonds as a result of the growth of corporate capitalism in Japan (Russell 1989) would all be reduced to an Axis I diagnosis of Social Phobia and a Cultural Axis VI evaluation of "with other-directed shame features" or a similarly worded modifier. Using the axial format, cultural contextualization came to seem practically impossible. Initial technical objections gave way to more fundamental criticisms of the Cultural Axis proposal, and then led, by contrast, to alternative views regarding how to put together a clinically useful cultural analysis that could complement *DSM-IV*.

In order to be truly useful, a cultural assessment of a patient should alter the diagnostic process itself, affecting the way clinicians view all

five axes, not just add a sixth list of essentializing descriptors. Such an assessment should contextualize the multiaxial data within a processual view of social relations and institutions. The fundamental challenge that cultural analysis brings to diagnostic thinking is its capacity to render visible the socially constructed context that mediates key features of a patient's presentation and subsequent course. To fulfill this function, a cultural assessment must take into account intra-cultural as well as cross-cultural elements, paying special attention, for instance, to the complicated interactions of gender, class, race, and other intra-cultural factors affecting the clinical presentation (Lewis-Fernández and Kleinman 1994). It must go beyond explanations of cross-cultural differences in symptomatology to describe the cultural constituents of all clinical phenomenologies, as well as courses and outcomes, patterns of help-seeking and etiological attributions by patients and their social circles, and diagnostic practices, institutional pressures, and modes of research by clinicians.

Instead of facilitating these tasks, a Cultural Axis format would almost certainly contribute to the decontextualizing tendency of the DSM system by limiting the role of cultural analysis in clinical evaluation simply to its phenomenological component and even then to a secondary role, serving as an explanation of cross-cultural difference. At worst, a "cultural axis" so conceived might further the view that a cultural assessment of the patient is a last-minute phenomenological refinement, an ancillary and thus dispensable procedure, while leaving the rest of the diagnostic process unaffected. Given the pressures impinging on working clinicians, who already often bypass Axes IV and V and might ignore a sixth axis (Guarnaccia in press), a cultural axis as it would likely be accepted into the DSM-IV might paradoxically lessen the cultural contextualization of diagnostic practice. The Group saw that what was needed instead was a framework that helped clinicians realize how culture affects every aspect of the clinical encounter.

As the proposal for a Cultural Axis waned, in its place emerged a consensus in favor of outlining an approach that would complement and broaden the standard diagnostic work, leading clinicians to focus systematically on how culture influences psychiatric evaluation, which would be recorded in narrative rather than categorical terms. In place of the potential straightjacket of a nomothetic typology, this framework would permit an idiographic portrayal of the person and his/her relevant sociocultural environment (Mezzich 1995a). The use of narrative description came to be favored by the Group first because it obviously allows much greater operational flexibility than the fixed DSM format. More importantly, however, is that narratives make a different kind of truth claim than diagnostic typologies. Narrative creates a humanized account of suffering fundamen-

tally embedded in a particular setting through the assembling of telling contextual details as the signs of truth (Kleinman 1988; Herschbach 1995; Good 1994). Rather than focusing on patients as the "embodied signs of pathology," emphasis falls on "the horrible variety of suffering" experienced by particular human beings and those involved with them (Weir Mitchell, in Herschbach 1995: 189). The use of narrative also permits an accounting of the role of health institutions and practitioners in the evolution of the person's illness career and self-experience (Saris 1995). Turning the gaze of the profession back on itself is a major achievement of contemporary medical anthropology, as it clarifies the fluid and interactive process whereby diagnosis (and to a large extent, outcome) is reached in psychiatric practice (Good 1994). A humanized and ethnographic narrative of illness that includes a reflexive stance on the clinician-patient interaction would truly constitute a significant contribution to patient care.

Searching for a precedent for this kind of narrative analysis within clinical practice, the Group found one in the Psychodynamic Formulation, a complementary narrative to multiaxial diagnostics that follows a prescribed structure and is often included as part of the patient's chart next to other assessment procedures. It is employed by many psychotherapists and training centers instructing young clinicians in order to assess a patient's key psychological patterns of conflicts and defenses as rooted in the details of his/her life experience (Friedman and Lister 1987; Perry 1989). The Psychodynamic Formulation is then used to inform the choice and progression of psychological therapies. Because of its individual specificity, it is often considered superior for these purposes to the generic descriptions of the axial diagnoses (Perry et al. 1987). The Group came to see the Psychodynamic Formulation as a good model for complementing the standard diagnostic evaluation because it is a well-known format for clinicians, it is thought to convey useful information not already included in the axis system, and it is narrative and personalized. As a result, the resulting proposal for the mini-ethnographic narrative assessment came to be known as the "Cultural Formulation."

An outline of this proposal was prepared (Mezzich et al. 1993) and submitted to the DSM-IV Task Force. In addition, clinicians associated with the Group on Culture and Diagnosis undertook a "Field Trial," testing the applicability of the Cultural Formulation on actual patients. This process involved developing case analyses from the four main ethnic minorities in the United States (African Americans, American Indians, Asian Americans, and Latinos) and revealed that the Cultural Formulation could be used very successfully as currently proposed (Mezzich 1995a). Short and long versions of the Cultural Formulation were envisioned, to meet the needs of

different clinical professionals. Social workers and psychotherapists, for example, might require the completeness and detail of the full Formulation, whereas psychopharmacologists could make use of an abbreviated version. The final draft of the Outline included the short versions of four cases from the field trial for inclusion in *DSM-IV* as models of completed formulations. The Group recommended that the Outline be prominently placed at the front of the Manual, immediately following the section on Multiaxial Assessment. The Editors of the *DSM-IV* agreed to publish an edited and shortened version of the proposed text, but only as an appendix rather than in the central text. The relevant portion of Appendix I reads as follows.

OUTLINE FOR CULTURAL FORMULATION

The following outline for cultural formulation is meant to supplement the multiaxial diagnostic assessment and to address difficulties that may be encountered in applying DSM-IV criteria in a multicultural environment. The cultural formulation provides a systematic review of the individual's cultural background, the role of the cultural context in the expression and evaluation of symptoms and dysfunction, and the effect that cultural differences may have on the relationship between the individual and the clinician.

As indicated in the introduction to the manual (see p. xxiv), it is important that the clinician take into account the individual's ethnic and cultural context in the evaluation of each of the DSM-IV axes. In addition, the cultural formulation suggested below provides an opportunity to describe systematically the individual's cultural and social reference group and ways in which the cultural context is relevant to clinical care. The clinician may provide a narrative summary for each of the following categories:

Cultural identity of the individual. Note the individual's ethnic or cultural reference groups. For immigrants and ethnic minorities, note separately the degree of involvement with both the culture of origin and the host culture (where applicable). Also note language abilities, use, and preference (including multilingualism).

Cultural explanations of the individual's illness. The following may be identified: the predominant idioms of distress through which symptoms or the need for social support are communicated (e.g., "nerves," possessing spirits, somatic complaints, inexplicable misfortune), the meaning and perceived severity of the individual's symptoms in relation to norms of the cultural reference group, any local illness category used by the individual's family and community to identify the condition (see "Glossary of Culture-Bound Syndromes" below), the perceived causes or explanatory models that the individual and the reference group use to explain the illness, and current preferences for and past experiences with professional and popular sources of care.

Cultural factors related to psychosocial environment and levels of functioning. Note culturally relevant interpretations of social stressors, available social supports, and levels of functioning and disability. This would include stresses in the local social environment and the role of religion and kin networks in providing emotional, instrumental, and informational support.

Cultural elements of the relationship between the individual and the clinician. Indicate differences in culture and social status between the individual and the clinician and problems that these differences may cause in diagnosis and treatment (e.g., difficulty in communicating in the individual's first language, in eliciting symptoms or understanding

their cultural significance, in negotiating an appropriate relationship or level of intimacy, in determining whether a behavior is normative or pathological).
Overall cultural assessment for diagnosis and care. The formulation concludes with a discussion of how cultural considerations specifically influence comprehensive diagnosis and care. (American Psychiatric Association 1994: 843–844)

The DSM-IV Task Force elected to publish the Cultural Formulation not at the front of the Manual but instead as one of the last appendices of the *DSM-IV* (pp. 843–844). Furthermore, rather than highlighting it in a space of its own, as recommended by the Group on Culture and Diagnosis, they combined it with what they titled the "Glossary of Culture-Bound Syndromes," a glossary which had been prepared by the Group as a separate submission under the title "Glossary of Cultural Syndromes and Idioms of Distress." The effect of joining these two disparate proposals is to exoticise the Cultural Formulation, which now seems relevant only to "culture-bound" presentations among non-Western ethnic groups, rather than as an evaluation process applicable to every patient in every cultural setting. Moreover, the illustrative cases were removed, thereby decreasing the persuasiveness and the pedagogic effect of the Outline. These alterations to the Cultural Formulation proposal were not unique; they formed part of an admittedly conservative editorial policy (Frances et al. 1990) of simplifying or rejecting many of the Group's cultural proposals in order to maintain the universalistic position of *DSM-IV* (Lewis-Fernández & Kleinman 1995).

Despite its efforts, therefore, the Group on Culture and Diagnosis was only able to exert a slight influence on *DSM-IV*. Nevertheless, the need for the cultural expansion of DSM categories remains and can be illustrated with great force. To this end, two strategic fronts may acquire greater relevance in the future. The first is the intensification of research on the epidemiology of indigenously defined syndromes, heralded by Rubel's work on *susto* in Mexico (1964) and Carstairs and Kapur's investigation of possession and other forms of psychopathology in India (1976), and developed by Manson on models of depression among the Hopi (1985), by Guarnaccia and Canino on *ataques de nervios* among Puerto Ricans (Guarnaccia et al. 1993), and by Kleinman (1986) and later by Lin and Weiss on neurasthenia in Chinese communities (Lin 1995), among others. Documenting alternate nosologies affecting whole nations and ethnic groups that account for much of the variance in validity assessments of standard epidemiologic surveys by indigenous clinicians is a powerful way of problematizing the universality of the established Western nosologies used in those surveys (Guarnaccia et al. 1990).

The second front in the struggle to make culture more central to the process of clinical evaluation and treatment consists of the systematic

development of case-based clinical ethnography as operationalized by the Cultural Formulation (cf. Kleinman's [1988] recommendations for the place of "mini-ethnographies" in clinical work). Marshalling the empirical evidence of many case analyses will reveal the contextual embeddedness of illness, and thus the limited usefulness of purely descriptive diagnostics and the fallacy of universalistic course predictions and outcome measures (Canino et al. in press). It will also establish the impact of cultural factors on clinical phenomenology by revealing the poor fit between existing nosologies and many non-Western presentations of psychopathology.

The new Clinical Cases Section initiated here in the pages of *Culture, Medicine and Psychiatry* constitutes part of the vanguard of this second front. This Section will be a testing ground for the Cultural Formulation, where the current proposal will be honed in practice, and improved by critique and elaboration. These developments should help inform the subsequent work of the Group on Culture and Diagnosis. The Group has already begun to push forward the Formulation proposal by preparing a Booklet that describes the Formulation guidelines and contains two illustrative cases. Entitled *Introduction to the Cultural Formulation*, it will be distributed to most medical schools and training programs for mental health professionals. Following the Booklet, planning is underway for a *Cultural Casebook* of hundreds of cases canvasing the application of different Cultural Formulation formats to diverse psychopathology categories and cultural populations. The *CMP* Section will continue in the tradition of the Booklet and pave the way for the *Casebook*, so that Formulation refinements obtained through the Section will inform the *Casebook*, and cases published first in *CMP* will be available for subsequent republication.

The Section's editorial policy will give priority to psychiatric cases in which cultural elements make a difference to illness phenomenology, to diagnostic assessment, to patients' outcome, to health services utilization, or to a combination of these factors. The two cases published in this edition of the Journal illustrate these tendencies. The Puerto Rican case highlights some of the diagnostic difficulties involved in assessing the phenomenology of *nervios* and *ataques*. It also discusses the impact on illness outcome of different cultural conceptualizations of the patient's presentation. A shorter version of this case was one of the four illustrations of the Cultural Formulation Outline submitted to *DSM-IV* that were not included in the published Manual. The American Indian case disentangles the complicated effects of ethnicity and of different explanatory models of illness on the health-seeking behavior and the clinician-patient interactions of a young woman suffering from depression, alcoholism, and the sequelae of sexual abuse.

The Section will publish case discussions of patients from any cultural or ethnic group, including those that highlight the cultural aspects of clinical presentations by Euro-Americans or majority European populations. Since child and adolescent cases are generally underrepresented in cross-cultural work, their submission is encouraged. We are also interested in cases where clinical variables are significantly affected by intra-cultural differences, for instance, class, gender, or sexual orientation. In general, we find that the best cases are those that aim to expand the boundaries of the established nosology or that show how cultural information clarifies a complex phenomenological, treatment or health services picture.

Table I lists the features that each case submitted to the Clinical Cases Section must contain. A submission should start with a standard brief psychiatric description of the patient that includes a full multiaxial assessment. Authors should present a level of detail necessary to establish the diagnoses and to anticipate any obvious questions regarding relevant rule-outs. The latter is obviously especially important when standard categories are challenged by the case data: nosologists will want to know that all the established categories have been explored before entertaining NOS or mixed-category diagnoses. Both DSM-IV and ICD-10 categories may be applied, but the DSM-IV multiaxial structure must be utilized throughout, including the standard format for Axes IV and V and the use of diagnostic codes. If comparison between the two nosologies is pertinent, it could become a very interesting aspect of the case. Attention to help-seeking strategies and explanatory models is requested, particularly when these affect outcome. Information on long-term treatment and follow-up is especially desirable, as these validate initial diagnoses: readers may suspect that presentations appearing culturally particular at first will be revealed over time to conform to established nosologies. In order to avoid unnecessary repetition, authors are generally advised to present only "the bare facts" in the Clinical History section and then discuss the topics in detail in the Cultural Formulation.

The Cultural Formulation should compose the bulk of the submission. The main goal of every Formulation should be to enable the reader to locate the sufferer within his/her most relevant cultural context and to clarify the essential cultural determinants that shape the form of the clinical variables. To this end, succinct summaries of pertinent ethnic group history and of past research on the indigenous idioms of distress or the help-seeking options used by the patient may be useful at times, especially for purposes of comparison. Some Formulations will also require a subtle reflexive analysis of the author-patient interaction, including a discussion of cultural factors impacting the process of diagnostic assessment and ethnographic

TABLE I

Items to be included in *CMP* clinical cases

I.	CLINICAL HISTORY
1.	Patient identification
2.	History of present illness
3.	Psychiatric history and previous treatment
4.	Social and developmental history
5.	Family history
6.	Course and outcome
7.	Diagnostic formulation (Axes I-V)
II.	CULTURAL FORMULATION
A.	CULTURAL IDENTITY
1.	Cultural reference group(s)
2.	Language
3.	Cultural factors in development
4.	Involvement with culture of origin
5.	Involvement with host culture
B.	CULTURAL EXPLANATIONS OF THE ILLNESS
1.	Predominant idioms of distress and local illness categories
2.	Meaning and severity of symptoms in relation to cultural norms
3.	Perceived causes and explanatory models
4.	Help-seeking experiences and plans
C.	CULTURAL FACTORS RELATED TO PSYCHOSOCIAL ENVIRONMENT AND LEVELS OF FUNCTIONING
1.	Social stressors
2.	Social supports
3.	Levels of functioning and disability
D.	CULTURAL ELEMENTS OF THE CLINICIAN-PATIENT RELATIONSHIP
E.	OVERALL CULTURAL ASSESSMENT

writing. Every submission should discuss all the elements in Table I, but the relative length and importance of each Formulation item will of course vary with the case. Some cases will present a diagnostic dilemma exclusively, or mostly an issue in health services utilization, and each Cultural Formulation should also emphasize the main aspect of the case. Readers should expect to find in the Formulation specific cultural commentaries on the key facts

mentioned in the Clinical History. The *DSM-IV* outline reproduced above and the two cases published below may serve as further guides for future submissions.

Finally, we are especially interested in cases that justify the need for improvements to the Cultural Formulation format itself. Perhaps the main benefit the Section can produce is to develop an iterative process of revision around the Formulation proposal. Tentative areas for exploration may be: how can we make the Formulation more responsive to the particular exigencies of working with children? Do some sections, like the one on cultural identity, require a framework that distinguishes the information obtained from the child from the input received from additional sources, such as parents and teachers? Also, how can the Formulation move beyond the person in order to focus more directly on the social environment that structures differential exposures and responses to stress and trauma (Manson 1995)? Authors are encouraged to think critically about the Formulation as currently elaborated and to develop their ideas in the form of cases.

In sum, the Cultural Formulation presents an exciting challenge: will it provide the space for some of the "thick description" (Geertz 1973) that raises the real-world cultural complexity of clinical work? With more elaboration, the Formulation could grow into a comprehensive format that facilitates many of the goals of cultural psychiatry and psychology: expanding the established nosology used for diagnostics and epidemiology; providing clinicians with a concrete methodology for incorporating cultural analysis into evaluations and treatments; teaching psychiatric residents and other mental health trainees how to develop a contextualizing and processual understanding of their patients' suffering; and operationalizing the cultural assessment of clinical effectiveness required for valid outcome research. The *CMP* Clinical Cases Section invites you to participate in the evolution of this promising new framework for clinical cultural analysis.

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