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Culture and psychiatric classification

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Abstract. *Culture shapes every aspect of patient care in psychiatry, influencing when, where, how, and to whom patients narrate their experiences of illness and distress, the patterning of symptoms, and the models clinicians use to interpret and understand symptoms in terms of psychiatric diagnoses. This article presents the rationale for the changes related to the role of culture in psychiatric diagnosis that were included in DSM-5 and describes examples of these changes. The DSM-5 Cross-Cultural Issues Subgroup took into account the recommendations of neurobiologists and anthropologists who have criticized the rigidity of DSM-IV diagnostic criteria, which exclude alternate illness presentations and do not account for the role of context in the emergence and characteristics of psychopathology. Revisions in DSM-5 include a Cultural Issues section in the introduction, the inclusion of culture in the definition of mental disorder, material related to culture that was incorporated into the criteria and description of selected disorders, a new chapter on Cultural Formulation that includes the Cultural Formulation Interview and a description of the revised construct of cultural concepts of distress, and a Glossary illustrating this revised construct. The intent of these revisions was to enhance the validity and reliability of psychiatric diagnosis across cultural groups in the United States and around the world.*

Keywords: DSM-5, culture, psychiatric classification, Cultural Formulation Interview (CFI).

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INTRODUCTION

Culture shapes every aspect of patient care in psychiatry, influencing when, where, how, and to whom patients narrate their experiences of illness and distress (Kirmayer, 2006), the patterning of symptoms (Kleinman, 1977), and the models clinicians use to interpret and understand symptoms in terms of psychiatric diagnoses (Kleinman, 1987). Culture also shapes patients' perceptions of care, including what types of treatment are acceptable and for how long (Lewis-Fernández et al., 2013). Even when patients and clinicians share similar cultural, ethnic or linguistic backgrounds, culture impacts care through other influences on identity, such as those due to gender, age, class, race, occupation, sexual orientation, and religion (Lu, Lim, and Mezzich, 1995). Cultural contexts and expectations frame the clinical encounter for every patient, not only underserved minority groups, and cultural formulation therefore is an essential component of any comprehensive psychiatric assessment (Lewis-Fernández, Aggarwal, & Kirmayer, 2016).

The influence of culture on psychiatric presentations can be profound. Nosologies that rely on symptom descriptions – such as DSM and ICD – are based on a "common denominator" approach to syndrome classification. This approach develops prototypes of psychiatric syndromes in order to encompass the diversity of presentations around the world within a "common" set of descriptors; these prototypes,

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however, are usually the product of symptom descriptions obtained in only a subset of cultural settings, typically tertiary care centers in large Western cities; empirically, Patel and Kim (2007) have shown that only 3.7% of psychiatric research is conducted in low and middle-income countries, where 80% of the world resides. DSM and ICD differ in the way they structure these prototypes, which take the form of lists of criteria in DSM and symptom narratives in ICD. Consistent with the nature of all prototypes, however, the disorder criteria and narratives in both nosologies tend to minimize the substantial variation of these clinical phenomena worldwide and over the historical record.

This cultural variation may help explain why psychiatric diagnoses map only partially to their putative biological substrates at the genetic or neurocircuitry level (Kirmayer & Crafa, 2014). It is more likely that these biological domains constitute dimensional vulnerability factors that pattern disorder expression more generally (e.g., mood dysregulation), and that specific syndromes arise from the interaction of this general vulnerability with other factors, including contextual elements such as culturally patterned illness expressions (Kirmayer & Young, 1999; Clark, Cuthbert, Lewis-Fernández, Narrow, & Reed, in press). In a way, the syndrome prototypes in ICD and DSM may be understood as placeholders for whole "families" of disorders, which show substantial internal variation within each "family." For example, major depressive disorder may be understood as a kind of nosological placeholder for a more diverse family of depression-like syndromes. Globally, depressive phenomena are characterized by very diverse combinations of multiple dimensions: cognitive experiences such as guilt and existential angst, somatic presentations characterized by vegetative symptoms and bodily complaints, a range of dysphoric affects that are variously described as sadness, emptiness, psychic pain, or "soul loss," and varying degrees of anxiety, dissociation, substance abuse, personality disturbances, and psychosis (Clark, Cuthbert, Lewis-Fernández, Narrow, & Reed, in press). As a result, what a given person experiences as "depression" depends on a host of factors, many of which stem from the person's idiosyncratic biology and psychology, but is also influenced by the person's sociocultural context, including the cultural expressions of illness that are normative in his or her local setting (Lewis-Fernández & Aggarwal, 2015). Even the way that disorder "families" are distinguished from each other varies over time and cross-culturally. DSM and ICD, for example, do not distinguish a set of "anger disorders" from, for example, mood or anxiety disorders, whereas examples of "anger illnesses" are included in folk nosologies of Korea and of several Latin American indigenous groups, as evidenced by cultural concepts such as hwa-byung (anger illness) in Korea (Lin, 1983) and muina or bilis in Latin America (APAL, 2004; Villaseñor Bayardo, 2008). In contrast, symptoms of anger are subsumed within other conditions in Western nosologies, rather than constituting a separate "family" of disorders, including experiences of irritability in bipolar disorder or of aggressive outbursts in intermittent explosive disorder.

This paper focuses on DSM-5 to discuss the theoretical and empirical rationale for incorporating cultural variation into psychiatric nosology, illustrated by inclusions in the Manual at the level of criteria, prevalence statements, syndrome description, and risk and protective factors. It also describes how cultural aspects of psychiatric presentation can be explored using an assessment method introduced in DSM-5, the Cultural Formulation Interview (CFI). The paper concludes by describing the revision in DSM-5 of the construct of "culture-bound syndrome" into "cultural concepts of distress" to clarify details and the contextual nature of all psychiatric presentations.

LIMITATIONS OF DSM-IV

In the two decades since the publication of DSM-IV in 1994 it's the limitations have been repeatedly noted by anthropologists and neuroscientists, as well as by investigators in other disciplines. One of these limitations is an excessive focus on reliability of diagnostic assessments at the expense of validity (Andreasen, 2007), a fact even noticed. Even prior to DSM-IV, since 1980 when DSM-III was published, a main goal of the DSM series has been to increase the reliability of diagnostic assessments. That is, to Reliability enables clinicians to reach the same diagnosis when faced with the same patient whether assessed in the United States or in the United Kingdom, and at time 1 equally as at time 2.

Reliability is essential for attaining a valid classification system. It is difficult to imagine how an unreliable system can ever be valid. However, as suggested by anthropologists and neuroscientists, reliability is not enough; a classification system can be reliable and yet invalid.

The emphasis on reliability has eclipsed the equally important quest for validity in diagnosis (Kleinman, 1977; Hyman, 2007). Validity stands for a robust formal correspondence between the proposed nosological category and the pathological process it represents, whether described in cultural or biological terms. In anthropology, for example, for a mental disorder category to be valid, it should represent a form of illness that is conceptually and experientially coherent and meaningful in a given cultural setting, not just an imported syndrome that does not correspond to the way people get sick in that cultural context (Kleinman, 1988). In turn, according to neuroscience, a valid mental disorder should signal true interrelationships of abnormally functioning neural circuits, that is, stable, pathological patterns of brain function that can be traced back to neural substrates (Hyman, 2007).
Instead of emphasizing these aspects of nosological validity, however, the development and uses of the DSM series have been characterized, according to both anthropology and neuroscience, as a process of inadvertent reification (Hyman, 2010). Reification indicates the cognitive fallacy whereby the model is confused with the underlying reality, such as the logical mistake of taking the map as fully representative of the much more complex terrain of which it is a limited portrait. In other words, in the quest for reliable signs of disease, many mental health providers and researchers have come to use the nosology as if the list of symptoms was the disorder, as opposed to just an illustration of the underlying pathological process. From a cultural perspective, one practical implication of this critique is the realization that – at least given our current level of knowledge – any set of descriptive criteria for a disorder that attempts to be exhaustive (i.e., to portray all the important symptoms of the disorder) is likely to be incomplete and to a certain extent partial, derived from research on a minority of the world's population (Patel & Kim, 2007). In other words, the DSM criteria are to some extent "over-specified," in that they require that every patient fulfill a list of symptoms that are necessarily incomplete – and therefore over-precise – in order to receive a diagnosis (Hyman, 2010). To the degree that the accepted prototype is reified – so that it comes to assume in our minds the position that should be held by the underlying disorder of which the prototype is only a sign – then the diagnostician runs the risk of excluding patients from care who present with alternative forms of the disorder. The prototype is often also "de-contextualized," in the sense that, as a simple symptom list, it makes no allowance for variations in the complex process whereby the person's experience and expression of the disorder are shaped by the environmental context (Metzl & Hansen, 2013; Hinton & Simon, 2015). Everything about disorders – including the risk factors leading up to them, the timing of their onset, the way the pathology is experienced and expressed, the care sought and therefore its impact on course, and the definition of response and recovery – is shaped by the person's environment, including the sociocultural context (Henningsen & Kirmayer, 2000). These aspects of the illness are simply not included in the disorder prototype. DSM-5 is no exception, although it includes an assessment method, the CFI, for eliciting some of these contextual elements, and help guide the diagnostic process. The CFI – called the Cultural Formulation Interview, which is described later in the paper.

INCLUSION OF CULTURE IN DSM-5

Each DSM revision has paid more attention than the previous one to cultural factors affecting diagnosis. DSM-IV, in particular, noted the importance of cultural factors in its introduction and included a section entitled Specific Culture, Age, and Gender Features in each disorder chapter (Mezzich et al., 1999). It also included an Outline for Cultural Formulation and a Glossary of Culture-Bound Syndromes in its ninth Appendix. DSM-5 pushed forward the initial steps of DSM-IV in each of these areas, including changes to: a) the introduction, b) the definition of mental disorder, c) the disorder criteria, d) the descriptive text for each disorder, e) the method for developing a cultural formulation, f) and the description and exemplification of cultural concepts of distress (Lewis-Fernández & Aggarwal, 2013; Lu, Lewis-Fernández, Primm, Lim, & Aggarwal, 2014).

Introduction

The Cultural Issues section of the DSM-5 introduction succinctly sets the stage for the role of culture in the diagnostic manual as providing "interpretive frameworks that shape the experience and expression of the symptoms, signs, and behaviors that are criteria for diagnosis" (APA, 2013, p.14). In other words,

culture plays a key role in determining the level at which an experience becomes problematic or pathological. This section of the introduction clarified that culture is in fact the province of everyone, not only of minority racial/ethnic groups. All individuals and groups are cultural beings, and even scientific products such as the DSMs are based on cultural premises and have culturally relevant effects. The introduction outlined the multiple ways in which culture affects the diagnostic and treatment processes, including symptom expression (e.g., alternate symptoms), clinician assessment (e.g., diagnostic accuracy, evaluation of severity), and patients' responses (e.g., coping strategies, help-seeking choices and treatment adherence). The introduction also described how the older term "culture-bound syndrome" was replaced by three concepts that offer greater cultural utility: cultural syndromes, idioms, and explanations (Lewis-Fernández & Aggarwal, 2013), all to be described later in this paper.

Definition of a Mental Disorder

The section on the Definition of a Mental Disorder contained text to ensure that culturally normative experiences are not labeled as mental disorders, unless they also fulfill the general definition of disorder as a "clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning" (APA, 2013, p.20). Cultural norms were explicitly referenced: "An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder" (p.20). In addition, social deviance was likewise excluded from the definition: "Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders, unless the deviance or conflict results from a dysfunction in the individual, as described above" (p.20). The intent of the definition was clearly to ground pathological experiences in the individual's internal dysfunctions ("psychological, biological, or developmental") (Wakefield, 1992). Unfortunately, the extensive sociocultural patterning of these "internal" processes was left unmentioned (Littlewood, 1991).

Disorder criteria

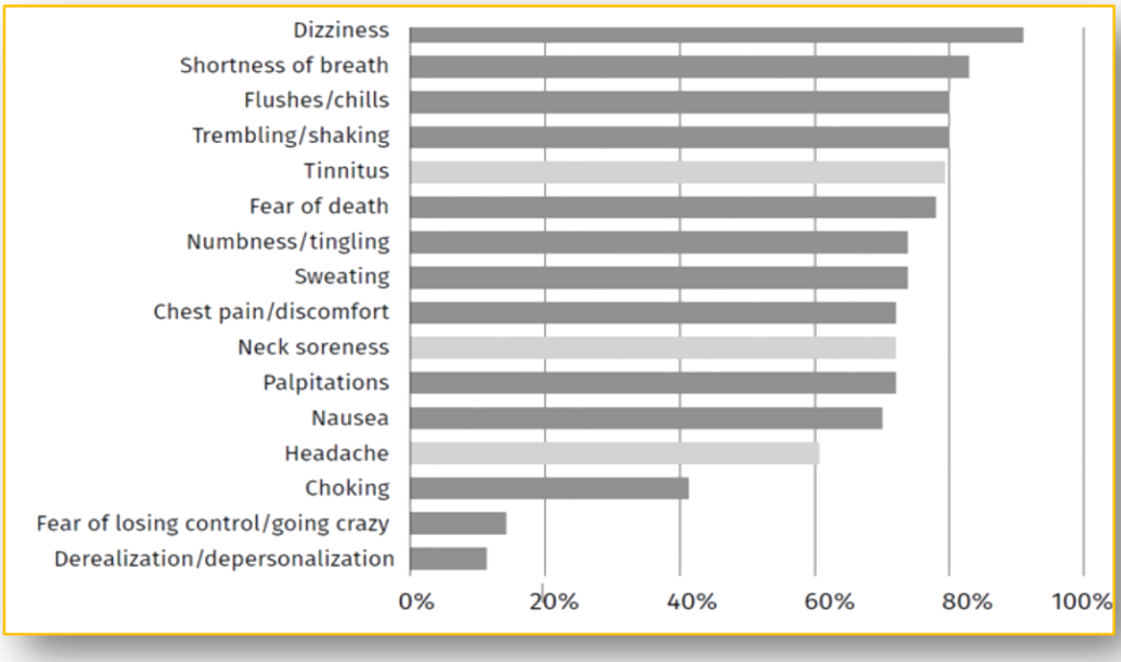
Several of the DSM-5 work groups prepared literature reviews on the influence of culture on each disorder (e.g., Becker, Thomas, & Pike, 2009; Lewis-Fernández et al., 2010; Hinton & Lewis-Fernández, 2011; Brown & Lewis-Fernández, 2011). The first step was to review the quality of the existing data on cultural variation for each DSM-IV disorder in order to recommend revisions for DSM-5. Sometimes, the data were robust enough to warrant proposed revisions at the level of criteria sets. This was the case for panic attack, social anxiety disorder, agoraphobia, specific phobia, posttraumatic stress disorder, and dissociative identity disorder, among others (Lu, Lewis-Fernández, Primm, Lim, & Aggarwal, 2014).

The case of panic attacks is worth examining, as it constitutes an example of an "over-specified" criteria list, in the sense that the DSM "common denominator" prototype leaves out cultural variants of disorder expression. Conceptually, the main characteristics of panic attacks are a sudden autonomic storm (characterized by palpitations, dizziness, etc.), which is linked to catastrophic cognitions (e.g., I am dying), and dissociative symptoms (e.g., depersonalization). DSM-IV criteria required at least 4 out of 13 specified symptoms to define a panic attack (Craske, Kircanski, Epstein, Wittchen, Pine, Lewis-Fernández, & Hinton, 2010).

The literature review revealed that the symptoms indicating an autonomic storm are not identical across cultural groups (Lewis-Fernández et al., 2010). Some cultures may prioritize certain symptoms over others or report symptoms that are not on the list (e.g., blurry vision). The priority given to specific symptoms is due in part to cultural understandings of pathophysiology, including perceptions of which symptoms are considered particularly dangerous (Craske, Kircanski, Epstein, Wittchen, Pine, Lewis-Fernández, & Hinton, 2010; Hinton & Simon, 2015). For instance, the DSM-IV panic attack criteria included several cardiac-related symptoms (e.g., palpitations, chest pain or discomfort, shortness of breath). The salience given to these symptoms in DSM-IV may be related to the widespread concern about heart attacks seen in developed countries. This in turn is likely due to the rise in morbidity and mortality associated with cardiovascular diseases in developed countries as a function of their having undergone an "epidemiological

transition" over the last century (Omran, 1971), characterized by a decrease in the prevalence of infectious diseases and a rise in chronic behavioral and lifestyle-related illnesses (Hinton & Simon, 2015).
In developing countries, by contrast, other signs of an autonomic storm may be more salient during panic attacks, as a result of different conceptions of pathophysiology and of the perceived dangerousness of specific symptoms (Hinton & Simon, 2015). The Figure shows data on 100 consecutive Cambodian outpatients seen in a mental health clinic in Massachusetts, who reported at least one panic attack during the last month (Hinton, Pich, Marques, Nickerson, & Pollack, 2010). The three symptoms shown in red (tinnitus or ringing in the ears, neck soreness, and headache) evince autonomic arousal, are not included in DSM-IV or DSM-5 but are very common among Cambodians, as seen in the Figure. These three symptoms are attributed, in Cambodian ethnophysiology, to the abnormal circulation of khyâl, a wind-like substance that is understood to flow inside the body and that, when dysregulated, can cause physical symptoms, sometimes catastrophically. In some cases, the attribution of khyâl causality is inherent in the description of the symptom itself: the Khmer word for tinnitus, for example, translates as "khyâl exits from the ears." Panic-related catastrophic cognitions, common among Cambodians, often relate to developing dire physical consequences from abnormally flowing khyâl, such as becoming deaf or dying from stroke (Craske, Kircanski, Epstein, Wittchen, Pine, Lewis-Fernández, & Hinton, 2010; Hinton, Pich, Marques, Nickerson, & Pollack, 2010). The presence of these culturally specific symptoms during panic attacks indicates how cultural constructions of the body can shape the symptoms of autonomic arousal and also the content of the panic-related catastrophic cognitions.

Figure 1 Proportion of symptom endorsement among Cambodian psychiatric outpatients with at least one panic attack during the previous month (N=100)



Adapted from: Hinton, Pich, Marques, Nickerson, & Pollack, 2010

Options discussed by the work group for revising the panic attack criteria to include these cultural variants ranged from incorporating additional symptoms into the criteria list (e.g., adding tinnitus to the list of 13 symptoms) to "stepping back" from a specified list of symptoms and instead requiring three types of symptom clusters: an autonomic storm, catastrophic cognitions, and dissociative symptoms. Each cluster

would be illustrated by a list of potential symptoms (which could more easily incorporate new examples, such as tinnitus), of which a minimum number may be required. However, the list of symptoms would not be closed (in the sense that only the listed potential symptoms would qualify for a diagnosis) but rather open to alternative symptoms that are characteristic of the particular cluster in local settings (Lewis-Fernández et al., 2010). In the end, however, the revised DSM-5 criteria contained the same 13 symptoms as in DSM-IV but a note was added to the criteria mentioning the possible presence of alternative symptoms. This note read: "Culture-specific symptoms (e.g., tinnitus, neck soreness, headache, uncontrollable screaming or crying) may be seen. Such symptoms should not count as one of the four required symptoms" (APA, 2013, p.214). This addition, while suboptimal, at least highlights the existence of cultural variation in disorder expression.

Descriptive text

Often, evidence on the impact of cultural factors on diagnosis did not warrant a revision of diagnostic criteria but was considered a useful addition to the textual description of the disorder (e.g., its diagnostic features, associated features, prevalence, etc.). The intent was to help clinicians and researchers identify individuals suffering from the disorder and facilitate assessments of severity, comorbidity, and prognosis as well as treatment options (Lu, Lewis-Fernández, Primm, Lim, & Aggarwal, 2014). To this end, the section in each disorder chapter on culture, age, and gender in DSM-IV was disaggregated into separate subsections in DSM-5. A dedicated section on Culture-Related Diagnostic Issues contained most of the data on the explicitly cultural features of each disorder, such as on the cultural variation in symptomatology that did not warrant criterial revision, as well as in the development and course of the disorder, risk and prognostic factors, interpretation of stressors, impairment, and severity. Information on cultural labels, explanatory models, and cultural syndromes associated with the disorder were included in this section and cross-referenced with individual entries in the Glossary of Cultural Concepts of Distress. Data on cross-national prevalence were not placed in the Culture-Related Diagnostic Issues section but instead were incorporated into the primary section on prevalence. In addition, in an effort to limit the ethnocentricity of the text, the geographic and cultural origin of the data presented was provided. For example, if studies were only available from certain regions of the world (e.g., the US and Europe), this was noted in each pertinent section of the text (e.g., under Development and Course or Risk and Prognostic Factors) (Lewis-Fernández & Aggarwal, 2013).

As an example of the kind of material included in the section on Culture-Related Diagnostic Issues, we can consider posttraumatic stress disorder (PTSD). The culture-related section included information on variation in the risk of onset and severity of PTSD as a result of various cultural-contextual factors. These included: variation in the type of traumatic exposure (e.g., genocide), the impact on the disorder's severity of the meaning attributed to the traumatic event (e.g., inability to perform funerary rites after a mass killing), the ongoing sociocultural context (e.g., residing among unpunished perpetrators in post-conflict settings), and other cultural factors (e.g., acculturative stress in immigrants APA, 2013). The section also noted that the clinical expression of the individual symptoms or symptom clusters of PTSD may vary cross-culturally, particularly with respect to avoidance and numbing symptoms, distressing dreams, and somatic symptoms (e.g., dizziness, shortness of breath, heat sensations) (Hinton & Lewis-Fernández, 2011). Other information in this section included the role that cultural syndromes and idioms of distress play in the expression of PTSD and the range of comorbid disorders. These cultural concepts of distress provide behavioral and cognitive templates that link traumatic exposures to specific symptoms (Hinton & Lewis-Fernández, 2010). The section calls for comprehensive evaluation of local expressions of the disorder by including, for example, an assessment of cultural concepts of distress via the Cultural Formulation Interview (Lewis-Fernández & Aggarwal, 2013).

The Outline for Cultural Formulation and the Cultural Formulation Interview

The Cultural Formulation Interview (CFI) is a DSM-5 innovation. It operationalized the DSM-IV Outline for Cultural Formulation (OCF) into a set of questions and explicit instructions (Lewis-Fernández et al., 2014). The main goal of the OCF in DSM-IV was to help clinicians identify cultural-contextual factors affecting the patient that are relevant to diagnosis and treatment (Mezzich, Caracci, Fábrega, Kirmayer,

2009). The OCF organized the relevance of culture within the patient-clinician encounter around four domains: (1) cultural identity of the individual, (2) cultural explanations of the individual's illness, (3) cultural factors related to psychosocial environment and levels of functioning, (4) cultural elements of the relationship between the individual and the clinicians; a fifth domain summarized this information for use in clinical care (Lu, Lim, & Mezzich, 1995; Lewis-Fernández, 1996). An explicit function of the OCF has been to assist clinicians in diagnosing patients whose presentations do not correspond to DSM-IV diagnoses or whose treatment expectations clash with those of the provider (Good, 1996; Lewis-Fernández & Díaz, 2002).

In order to make the OCF more user-friendly, the DSM-5 Cross-Cultural Issues Subgroup developed the semi-structured Cultural Formulation Interview to operationalize the OCF (Aggarwal, Nicasio, DeSilva, Boiler, Lewis-Fernández, 2013). The three components of the CFI are: a core 16-item questionnaire that can be used with any patient and forms the nucleus of the assessment, an informant version of the core CFI to obtain collateral information from caregivers, and 12 supplementary modules that expand on these basic assessments as part of a more comprehensive evaluation. Together, all three components cover all of the topic areas in the OCF; the interviewer may choose one, several, or all components of the CFI depending on the desired depth of assessment. The questions in the core CFI are intended for use at the beginning of the standard assessment with any patient, since all patients are influenced by their culture(s). The CFI includes instructions that precede the questions and a guide to the interviewer on the type of content that can be generated by each question. The core CFI is organized into four sections: (1) cultural definition of the problem (questions #1-3), (2) cultural perceptions of cause, context, and support (#4-10), (3) cultural factors affecting self-coping and past help seeking (#11-13), and (4) cultural factors affecting current help seeking (#14-16) (Lewis-Fernández, Aggarwal, Hinton, Hinton, & Kirmayer, 2016).

To facilitate use of the CFI, a definition of the concept of culture that informs the CFI was provided in DSM-5. It is composed of three elements: a) "the values, orientations, knowledge, and practices that individuals derive from membership in diverse social groups (e.g., ethnic groups, faith communities, occupational groups, veteran groups);" b) "aspects of an individual's background, developmental experiences, and current social contexts that may affect his or her perspective, such as geographical origin, migration, language, religion, sexual orientation, or race/ethnicity;" and c) "the influence of family, friends, and other community members (the individual's social network) on the individual's illness experience" (APA, 2013, p.750). The intent of this definition is to describe an individual's experience of culture as a dynamic, constantly changing distillation of multiple engagements with all the communities (s)he belongs to, whether based on gender, spirituality, age, language, race/ethnicity, occupation, geographic region, leisure activities, national origin, or any other element of the person's background and collective life (Lewis-Fernández & Aggarwal, 2013). In U.S. health care practice, notions of culture are frequently paired exclusively with racialized/ethnic categories, which may lead to the unintended consequence of stereotyping patients. The CFI challenges this view, guiding clinicians to see the contextual frame of each patient's experience – seeking to use information about the collective to understand an individual's perspective and to clarify how local environments impinge on the person's situation, including how sociocultural contingencies help pattern a set of events. The goal is to understand the patient's predicament – both the aspects (s)he is aware of, and those that are outside his or her awareness. The CFI enables clinicians to construct a cultural formulation genuinely based on the person's self-identified group, freeing the clinician from the burden of incorrectly guessing group markers of identity – such as race and ethnicity – or offering treatment recommendations based on inaccurate stereotypes (Lewis-Fernández, Aggarwal, & Kirmayer, 2016).

The main goals of the CFI are to enhance the cultural validity of diagnostic assessment, facilitate treatment planning, and promote patient engagement. The CFI can be seen as operationalizing aspects of culture from the DSM-5's introduction. In particular, clinicians are encouraged to detect discrepancies in symptom presentation against DSM criteria, uncertainties in illness severity and impairment, differences of opinion on the course of care, and how clinician identities may interact with patient identities throughout the evaluation. The ascertainment of cultural-contextual information comprises an essential step of the

diagnostic process, and the CFI is an evidence-based method of obtaining this information (Aggarwal, Nicasio, DeSilva, Boiler, Lewis-Fernández, 2013; Lu, Lewis-Fernández, Primm, Lim, & Aggarwal, 2014).

Cultural concepts of distress

The DSM-5 thoroughly revised the DSM-IV Glossary of Culture-Bound Syndromes into two related sections: a description of Cultural Concepts of Distress at the end of the Cultural Formulation chapter in Section III, and a Glossary of Cultural Concepts of Distress in the Appendix that illustrated the new concepts with nine examples. These two sections describe how DSM-5 substituted the older formulation of culture-bound syndromes with three concepts of greater clinical utility (APA, 2013). Two main limitations of the older term led to the change. First, early investigations tended to exaggerate the cultural "boundedness" of local presentations of psychopathology, which appeared distinctive and unique to the (usually) Western observers. Instead, all forms of mental and emotional distress (including the DSM syndromes) originate in particular settings and spread to other cultural areas and are incorporated into local concepts of illness and expressions of distress. Whatever boundedness they have inheres not in specific locales but in their adoption by ethnic or linguistic groups and links to the sociocultural patterns of which they form part, whether within or outside their countries of origin or in new homes. Second, the term "syndrome" implies a relatively fixed pattern of symptoms. Only a subset of culture-specific expressions of distress around the world shows this level of organization. Many are typified instead by a more diffuse set of complaints, symptoms, and predicaments that vary across situations and settings, age cohorts, and social subgroups. Rather than representing separate illnesses, they constitute a general category of distress, part of an indigenous system of classifying suffering, sometimes encompassing not only illness but also other forms of misfortune or adversity (Lewis-Fernández, Kirmayer, Guarnaccia, Ruiz, in press).

In DSM-5, three new categories replaced the older construct of culture-bound syndromes and were defined in Section III. Cultural syndromes are clusters of symptoms and attributions that tend to co-occur among individuals in specific cultural groups, communities, or contexts and that are recognized locally as coherent patterns of experience. Cultural idioms of distress are ways of expressing distress that may not involve specific symptoms or syndromes, but that provide shared ways of experiencing and talking about personal or social concerns (e.g., everyday talk about "nerves" or "depression"). Cultural explanations or perceived causes are labels, attributions, or features of an explanatory model that indicate culturally recognized meaning or etiology for symptoms, illness, or distress (Nichter, 1981; Groleau, Young, & Kirmayer, 2006; Lewis-Fernández & Aggarwal, 2013).

Although worth distinguishing conceptually, in common practice the same cultural term frequently denotes more than one kind of cultural concept. A familiar example of this usage may be the concept of "anxiety", which can describe a syndrome (e.g., generalized anxiety disorder), an idiom of distress (e.g., as in the common expression "I feel anxious"), or a perceived cause (similar to "stress"). Despite this overlap, the distinctions between syndromes, idioms, and causes can help clinicians recognize how cultural concepts are deployed by patients and thus facilitate diagnosis and treatment negotiation (Lu, Lewis-Fernández, Primm, Lim, & Aggarwal, 2014). The Glossary in the Appendix provided nine examples of cultural concepts of distress from around the world that typify syndromes, idioms, and causes and their inter-relationship. Only high-prevalence concepts that have received considerable research attention were included, and for each concept, the Glossary listed the related psychiatric diagnoses. These examples are intended to assist clinicians in the evaluation and treatment of individuals who present for care reporting these nine specific cultural concepts, but they are also meant to illustrate the process by which providers can translate from any local expression to DSM diagnoses.

In fact, the description of Cultural Concepts of Distress in Section III devoted considerable attention to explaining the relationship of cultural concepts to the conventional diagnoses in Section II. One way to understand the cultural concepts is that many DSM disorders started out as local expressions which over time became operationalized prototypes of disorder, based on a process of abstraction and generalization. Yet, as noted earlier, these prototypes do not exhaust cultural diversity in presentation. As a result, clinicians may be exposed to local phenomena of distress that do not conform easily to conventional diagnoses. In fact, most of the cultural concepts included in the Glossary cut across DSM diagnoses, so

that the relationship between concepts and disorders is not one-to-one, but instead one-to-many in either direction (Kleinman, 1996). Symptoms or behaviors that might be sorted by DSM-5 into several disorders may be included in a single folk concept, and diverse presentations that might be classified by DSM-5 as variants of a single disorder may be sorted into several distinct concepts by an indigenous diagnostic system (APA, 2013). In effect, the existence of these alternate presentations suggests that all forms of distress are locally shaped (Kleinman, 1996). The description explained in some detail the various ways in which knowledge of the cultural grounding of cultural concepts of distress can be important to diagnostic practice and clinical care generally. These include: to avoid misdiagnosis, to obtain clinically useful information, to improve rapport and engagement, to improve therapeutic efficacy, to guide clinical research, and to clarify the cultural epidemiology (APA, 2013; Lu, Lewis-Fernández, Primm, Lim, & Aggarwal, 2014).

CONCLUSION

This paper briefly presented the rationale for the changes related to the role of culture in psychiatric diagnosis that were included in DSM-5 and described examples of these changes. The DSM-5 Cross-Cultural Issues Subgroup took into account the recommendations of neurobiologists and anthropologists the rigidity of DSM-IV diagnostic criteria which exclude alternate illness presentations and do not account for the role of context in the emergence and characteristics of psychopathology. The Subgroup's revisions can be conceptualized horizontally as a cultural/contextual orientation throughout the entire manual, and vertically as a collection of revisions at various levels of the text (Lewis-Fernández & Aggarwal, 2013). These revisions included a Cultural Issues section in the introduction, the inclusion of culture in the definition of mental disorder, material related to culture that was incorporated into the criteria and description of selected disorders, a new chapter on Cultural Formulation in Section III that includes the Cultural Formulation Interview and a description of the revised construct of cultural concepts of distress also in Section III as well as a Glossary illustrating this revised construct in the Appendix. The intent of these revisions was to enhance the validity and reliability of psychiatric diagnosis across cultural groups in the United States and around the world.

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