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A Cultural Examination of the *DSM-5*: Research and Clinical Implications for Cultural Minorities

Martin J. La Roche
Harvard Medical School and Boston Children's Hospital, Boston, Massachusetts

Milton A. Fuentes
Montclair State University

Devon Hinton
Harvard Medical School and Massachusetts General Hospital, Boston, Massachusetts

The fifth edition of the *Diagnostic and Statistical Manual* (*DSM-5*) was recently released and it contains significant cultural revisions in comparison to the *DSM-IV*. In this article, the research, assessment, and psychotherapeutic implications of these changes for cultural minorities are examined. The *DSM-5*'s cultural revisions are categorized into 2 types: modifications that are an extension of previous revisions and changes that resulted from the *DSM-5*'s overall restructuring. A cultural framework is used to analyze these revisions. In addition, throughout this article suggestions for the development of a more culturally sensitive and inclusive *DSM* are discussed. To conclude some of the main research and clinical implications of *DSM-5*'s cultural revisions are underscored.

Keywords: *DSM-5*, diagnosis, culture, assessment

Culminating 14 years of research, preparation, and revisions, the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*—from herein referred to as the *DSM-5*—was published by the American Psychiatric Association (APA) in 2013. Since the *DSM–III* (1980), the *DSM*s have become the most influential texts in the psychiatric literature and the *DSM-5* is not expected to be an exception. The *DSM-5* is designed to facilitate characterization, communication, and research about mental health illness (APA, 2013). Although classification systems are indispensable for systematizing scientific observation and knowledge (Follette & Houts, 1996), there is an ongoing debate regarding the "universality" of these diagnostic categories. The *DSM-5*'s diagnostic categories are used across countries and cultures with relatively small cultural considerations. Critics using a cultural framework (e.g., Kleinman, 1988; La Roche, 2013; Sue & Sue, 2008) argue that the *DSM*'s nosological system is based on Western American beliefs (e.g., individualism, emphasis on biology) and practices (e.g., standardization) that limit their usefulness among different cultural groups. More specifically, when Western American standards are used to diagnose cultural minorities it is more likely that their cultural differences be misconstrued or overlooked (Kleinman, 1988; Hinton & Good, 2009; La Roche, 2013). Consistent with this cultural framework, throughout this article we identify *DSM-5*'s cultural assumptions and suggest how each applies to cultural minorities. To accomplish this goal, we start by briefly describing the *DSM-5*, followed by an analysis of the cultural revisions of the *DSM-IV* and *DSM-5*. We conclude by suggesting some clinical and research considerations and recommendations that can enhance the volume's cultural sensitivity and inclusiveness.

Although, there is much variability among "White Americans," we reluctantly use this term—partly because of a lack of a better

MARTIN J. LA ROCHE received his MA and PhD in clinical psychology from the University of Massachusetts at Boston. He has been director of mental health training at the Martha Eliot Health Center for the last 18 years. He is also an Assistant in Psychology at the Harvard Medical School, Department of Psychiatry at Boston Children's Hospital. His main areas of professional interest include psychotherapy and assessment with culturally diverse groups, evidence-based practice and research with ethnic minorities and he is the author of "Cultural Psychotherapy: Theory, Methods and Practice" (Sage Press).

MILTON A. FUENTES received his MA in Psychology with a focus on Latina/o Psychology from Montclair State University and his Psy.D. in clinical psychology from the Graduate School of Applied and Professional Psychology at Rutgers University. He completed a predoctoral fellowship in clinical and community psychology at Yale University and postdoctoral training in epidemiology at Columbia University. He is currently an Associate Professor in the Psychology Department at Montclair State University in Montclair, NJ. Dr. Fuentes' research interests are in the areas of Latina/o and multicultural psychology, child and family psychology, and pedagogy. He serves as a consultant to several programs, including the Puerto Rican Family Institute and the Violence Prevention Office of the American Psychological Association, where he directs the ACT Mid-Atlantic Regional Center.

DEVON HINTON, MD, PhD, is an anthropologist and psychiatrist, and is Associate Professor of Psychiatry at Harvard Medical School and Massachusetts General Hospital. His work has focused on culturally specific presentation of anxiety disorders and culturally sensitive treatment of PTSD. He is the Co-Editor, with Byron Good, of the volume "Culture and Panic Disorder" (Stanford University Press, 2009) and "Culture and PTSD" (Cornell University Press, 2015).

CORRESPONDENCE CONCERNING THIS ARTICLE should be addressed to Martin J. La Roche, Harvard Medical School, 49 Hancock Street, Suite 104, Cambridge MA 02139. E-mail: Martin.Laroche@Childrens.Harvard.edu or Martinjlaroche@aol.com

one and to be consistent with the prevalent multicultural literature (Sue & Sue, 2008)—to refer to descendants of White-Europeans living in the United States. In addition, in this article the term *White Americans* is also used to refer to the dominant group that defines what is "normal" (e.g., heterosexual, Judeo-Christian, middle class) in the United States. In contrast, we use the term *cultural minority* to refer to ethnic or racial minorities and others who differ from White Americans in relationship to the dominant cultural characteristics (e.g., homosexual, Muslims, poor). Furthermore, the use of the term *cultural minority* is consistent with *DSM-5*'s broader understanding of culture. In the *DSM-5*, *culture* is defined as a group's particular interpretive system, such as their understanding of mind and body functioning, healing traditions, religious systems, as well as their social and economic structures that overall differ from others groups—although there is clearly much variability within groups.

The *DSM-5* is the newest classification system of mental health disorders with associated criteria designed to facilitate reliable diagnoses, which aims to serve clinicians as a guide to identify the most prominent symptoms that should be assessed when diagnosing mental health disorders (APA, 2013). After five successive editions over the past 60 years, it has become a standard reference for clinical practice in the mental health field. The *DSM-5* is intended to serve as a practical, functional, and flexible guide for organizing information that aids in the accurate diagnosis and treatment of mental disorders. The various versions of the *DSM* have played an important role in furthering our understanding and in defining mental disorders (Cushman, 1995; Hacking, 2002). As its predecessors, the *DSM-5* will very likely become the "law of the land." Managed care companies will mandate its use and clinicians who do not use it will not be reimbursed and/or face legal penalties.

The *DSM-5* is the product of 14 years of work by an expert panel of mostly physicians and researchers. The authors are often the principal investigators of landmark studies that have shaped the mental health field. This is a very illustrious group of mental health experts. Although an income cap was imposed from commercial sources, 75% of the main *DSM* authors reported commercial ties with psychopharmacological companies. Critics (e.g., Cosgrove & Wheeler, 2013) have claimed that the *DSM-5* is a result, or at least partly a result, of these financial interests. We are in no position to judge the veracity of these claims. It is, however, likely that as in any classification system, the DSM-5 was influenced by the political and financial interests of the groups that created it.

As means to promote transparency and diminish political and economic interests, the *DSM-5* panel sought feedback from many mental health organizations and the public in the development of the *DSM-5* (APA, 2013). Preliminary drafts with proposed diagnostic criteria were posted on the *DSM-5* website for public comment. Expert panels thoroughly reviewed over 8,000 comments. Feedback was, however, only sought after there was a public outcry in which the APA was accused of developing the *DSM-5* in secrecy. Despite this feedback, in 2013 over 80 mental health organizations (e.g., American Counseling Association) criticized and/or condemned its use. One of the most frequent criticisms is that the *DSM-5* expands the boundaries of abnormality by reducing the threshold of clinical significance (e.g., normal grief becomes major depression) and by creating new disorders (e.g., disruptive mood dysregulation disorder, minor neurocognitive disorder) so that it expands the number of potential mental health customers (Kleinman, 2012). Allen Frances (2013), the chairperson of the American Psychiatric Association *DSM-IV* Task Forces, warned that this medicalization of the *DSM-5* will lead to "massive overdiagnosis and harmful overmedication." Several mental health organizations concerned about *DSM-5*'s detrimental effects to the public have asked the American Psychological Association not to recommend its use. Although the changes in the *DSM-5* can be examined from many different perspectives, in this article we focus on its implications for cultural minorities. Many additional revisions are not herein discussed because they are not essential for this cultural examination. We examine the changes present in the *DSM-5* in two main sections: cultural revisions that are an extension of previous changes and cultural revisions that stem from *DSM-5*'s innovations. Throughout this examination we identify *DSM-5*'s cultural assumptions and their applicability with cultural minority groups. We conclude with a discussion of the research and clinical implications of the review in respect to the goal of optimizing the cultural sensitivity of the *DSM*.

Cultural Revisions That Are an Extension of Previous Changes

Many of the *DSM-5*'s cultural revisions are rooted in the pioneering efforts of the *DSM-IV* cultural working group (e.g., J. E. Mezzich, A. Kleinman, H. Fabrega, B. Good) who first introduced the cultural framework into a *DSM* (Mezzich et al., 1999). Overall, it can be said that the cultural group of the *DSM-5* has continued many of these cultural innovations and carried them a step further. In this article, first, we describe the cultural revisions that grew from *DSM-IV* revisions and second we discuss cultural revisions that are a result of *DSM-5*'s changes. Mezzich et al. (1999) described five of the most significant cultural revisions present in *DSM-IV*, which we will also use to examine changes in the *DSM-5*. The features of the *DSM-IV* noted by Mezzich et al. (1999) were as follows:

1. The *DSM-IV*'s introduction section includes a few lines underscoring the importance of culture in assessing individuals.
2. Axis-IV includes several cultural annotations that underscore the need for careful cultural consideration.
3. The ninth appendix includes an Outline of the Cultural Formulation.
4. The ninth appendix also includes a Glossary of Culture-Bound Syndromes.
5. Many disorders include a brief section of cultural features or considerations. In each of these sections information on cultural variation in modes of describing distress, symptom patterns, dysfunctions, course, and sociodemographic correlates of the disorder are summarized.

The first major cultural revision of the *DSM-5* is in the introduction section, where the importance of culture is expanded from what it was in *DSM-IV*. It states that "culture provides interpretive frameworks that shape the experience and expression of the symp-

tom, signs and behaviors that are criteria for diagnosis" (p. 14). Even the definition of *mental disorder* has explicit cultural considerations: "Mental disorders are defined in relation to cultural, social and familial norms and values" (p. 14). Furthermore, in contrast to the *DSM-IV*, in Chapter 3 of the *DSM-5*, culture is explicitly defined as:

> Systems of knowledge, concepts, rules, and practices that are learned and transmitted across generations. Culture includes language, religion, and spirituality, family structures, life—cycle stages, ceremonial rituals and customs, as well as moral and legal systems. Cultures are open dynamic systems that undergo continuous change over time; in the contemporary world, most individuals and groups are exposed to multiple cultures, which they use to fashion their own identities and make sense of experience. These features of culture make it crucial not to overgeneralize cultural information or stereotype groups in terms of fixed cultural traits. Race is culturally constructed . . .. Culture, race and ethnicity are related to economic inequities, racism, and discrimination that result in health disparities. Cultural, ethnic and racial identities can be a source of strength and group support that enhance resilience, but they may also lead to psychological, interpersonal, and intergenerational conflict or difficulties in adaptation that require diagnostic assessment. (APA, 2013, p. 749)

Furthermore, in contrast to the *DSM-IV*, in the *DSM-5* the concepts of race and ethnicity are defined and differentiated. A more thorough definition of these concepts may prevent clinicians and researchers from equating and confusing them (La Roche & Christopher, 2009). Moreover, *DSM-5*'s elaboration of the concept of culture has significant assessment, psychotherapeutic, and research implications. First, it is insufficient to define culture solely through proxy and broadly defined variables such as skin color (i.e., race) or place of birth (i.e., ethnicity). It is necessary to take into account the ways in which people construct different cultural meanings, which are a result of a multiplicity of causes including religion, socioeconomic factors, and so forth (Schwartz, Unger, Zamboanga, & Szapocznik, 2010). An illustration of how cultural meanings influence diagnoses is presented in the "Culture-Related Diagnostic Issues" section of the posttraumatic stress disorder in which it is stated that the perceived severity of a traumatic event is influenced by the cultural meaning attributed to an event. Different cultural groups define the same event as more or less traumatic. For example, Tibetans consider witnessing the destruction of religious symbols as more upsetting than imprisonment or torture (for a review, see Hinton & Lewis-Fernández, 2011).

A significant departure from the *DSM-IV* is that the *DSM-5* no longer uses the multiaxial system. In the *DSM-5*, Axis I has been combined with Axis II and III. Clinicians can list as many medical conditions or personality disorder(s) as necessary. In addition, Axis V has been substituted for the more reliable Z codes included on the ICD-10-CM. Unfortunately, the *DSM-5* does not propose an equivalent substitute for Axis IV, which was designed to assess psychosocial and environmental stressors that could be affecting the assessment process. Psychosocial stressors could include poverty, racism, immigration and many other conditions that disproportionately affect cultural minorities (Hays, 2008). By deleting Axis IV, the influence of psychosocial stressors is deemphasized in the *DSM-5*.

A third revision is that the *DSM-5* includes an updated version of the Outline of the Cultural Formulation now called Cultural Formulation Interview (CFI) which is described in section III of the *DSM-5*, making it no longer relegated to the ninth appendix. The CFI is a semistructured interview composed of 16 questions that focuses on individual experience and social context. The objective of the CFI is to identify cultural and contextual factors relevant to the diagnosis and treatment of different problems; its main aim is to provide a cultural meaning to patients' symptoms by embedding them into a cultural context. Two CFI versions are available, one for the individual and one for an informant, such as a family member or caregiver. There are also 12 supplementary modules to the CFI, which provide additional questions to further assess other domains briefly explored in the 16-item CFI (e.g., cultural identity) as well as questions that can be used during the cultural assessment of particular groups, such as children and adolescents, older adults, immigrants and refugees, and caregivers. The CFI is a powerful tool to directly assess patients' beliefs, idioms of distress or meanings rather than simply categorizing individuals based on their skin color or place of birth. The information provided throughout the CFI can help practitioners avoid misdiagnosis, obtain clinically useful information, improve clinical rapport and therapeutic efficacy, guide research, and clarify cultural epidemiology. The cultural approach that informs the CFI enables it to explore and reveal symptoms as locally shaped by different cultural contexts, which is in contrast to the prevalent *DSM-5* conceptualization in which symptoms are independent of cultural context (Regier et al., 2011).

Although the CFI "can be used in the initial assessment of individuals in all clinical settings regardless of the cultural/ethnic/racial background of a patient or clinician" (p. 751), it is differentiated from the "approach to clinical case formulation" that appears in the first section of the *DSM-5*. The approach to the clinical formulation is a short section in the introduction of the *DSM-5* that underscores the need to obtain information from different domains of a patient's life. By differentiating the CFI and the approach to clinical case formulation it seems to suggest that the CFI is mostly applicable to cultural minorities, whereas the "approach to clinical case formulation" is the major way to assess patients. In all fairness it is necessary to state that the approach to clinical case formulation is very broad and despite its brevity it states that the "ultimate goal of a clinical case formulation is to use the available contextual and diagnostic information in developing a comprehensive treatment plan that is informed by the individual's cultural and social context" (p. 19). However, a more complete understanding of the influence and importance of the cultural context could have been obtained if the CFI had been referenced or integrated in this introductory section.

A fourth revision is that instead of categorizing certain constellations of symptoms as "Culture-Bound Syndromes" as recommended by the *DSM-IV–TR* in the *DSM-5* these are understood in more complex and multifaceted manners. In the *DSM-5*, the term *cultural concepts of distress* is used, and this is further analyzed as to whether the cultural concept of distress is a "cultural syndrome," "idiom of distress," or locally explained "perceived causes of distress."

1. Cultural syndromes: "clusters of symptoms and attributions that tend to co-occur among individuals in specific cultural groups, communities, or contexts . . . that are recognized locally as coherent patterns of experience" (APA, 2013, p. 758);

2. Cultural idioms of distress: "ways of expressing distress that may not involve specific symptoms or syndromes, but that provide collective, shared ways of experiencing and talking about personal or social concerns" (APA, 2013, p. 758); and

3. Cultural explanations of distress or perceived causes: "labels, attributions, or features of an explanatory model that indicate culturally recognized meaning or etiology for symptoms, illness, or distress" (APA, 2013, p. 758).

The *DSM-IV–TR* listed 25 "culture-bound syndromes" in the ninth appendix. The use of the term *culture-bound* made these conditions appear highly localized and confined, almost like a museum of anthropological curiosities. The current use of the term *cultural concepts of distress* and the division into subtypes highlights the heterogeneity of these cultural understandings. Some "syndromes," including *nervios*, seemed to represent specific situational predicaments, or variations in the way people express their distress, rather than coherent collections of symptoms. This complex and multilevel understanding has significantly more clinical value than categorizing a set of behaviors as a specific "culture-bound syndrome." Furthermore, it is important to note that instead of having a glossary of cultural concepts segregated in an appendix as was the case for the *DSM-IV*, these concepts are occasionally—although not frequently—referenced through section II as possible manifestations of different symptoms.

A final change of the *DSM-5* is that many of the cultural considerations for specific disorders have been refined. Cross-cultural research during the last decade has allowed these cultural sections to benefit from significant findings in this area (e.g., Hinton & Good, 2009; Hinton & Lewis-Fernández, 2011; Matunga & Seedat, 2011). The above mentioned inclusion of cultural meanings on the PTSD "Culture-Related Diagnostic Criteria" section is an example of these refinements. Furthermore, in section II, specific diagnostic criteria were modified to better apply across diverse cultures. Many of the *DSM-IV* diagnostic criteria suffered from overinclusion and/or underinclusion. *Overinclusion* is defined as a reliance on items to define a diagnosis that do not apply equally well across cultural groups, whereas *underinclusion* is an absence of items that constitute key diagnostic elements in other cultures (Hinton & Good, 2015). Although it is likely that many *DSM-5* diagnostic criteria still suffer from overinclusion and underinclusion, it is important to note that some of the changes on these diagnostic criteria are a result of comparative research among different ethnic groups (e.g., Hinton & Lewis-Fernández, 2011) and a thorough and concerted effort to modify culturally determined criteria so that they would be more equivalent across different cultures. For example, the criteria for social anxiety disorder now includes the fear that an "individual makes other people uncomfortable (e.g., my gaze upsets people so they look away)" rather than solely focusing on self-evaluative (e.g., they will make fun of me) concerns. The inclusion of this criteria is derived of collectivistic values that emphasize peoples' understanding of themselves in relation to others, which is more prevalent in Eastern Asian, countries rather than solely focusing on individualistic concern or people's tendency to understand themselves in isolation from others, which is more prevalent in the United States than Eastern Asian countries (Oyserman et al., 2002; Triandis, 1995).

Not including somatic complaints a key aspect of trauma-related disorders in many cultural groups in the PTSD criteria is an example of an error of underinclusion (Hinton & Good, 2015; Hinton & Lewis-Fernández, 2011). Similarly, catastrophic cognitions seem to be a key aspect of panic disorder in many cultural contexts, but these are not evaluated in any depth in the *DSM-5*. Of note, these problems might be addressed through a dimensional approach in which somatic symptoms and catastrophic cognitions—and dimensions like panic attacks—are assessed dimensions (Hinton & Lewis-Fernández, 2011).

The *DSM-5* continued overreliance on checklists of symptoms may lead clinicians and researchers to miss or misunderstand cultural meanings. Methodological standardization does not guarantee diagnostic and cultural validity. To prevent these "category errors" or the misguided application of a construct only found in a particular Western culture at a certain historical time (Kleinman, 1988), we recommend that the CFI be more systematically incorporated in the *DSM*s' text. In addition, to expand the inclusiveness of the *DSM-5* criteria it is beneficial to systematically incorporate "cultural syndromes, cultural idioms of distress and their explanations of distress" in the *DSM* text and future cross-cultural research.

Cultural Revisions That Are a Result of *DSM-5*'s Innovations

The *DSM-IV* is based on the neo-Kraepelinian assumption that mental illnesses are discrete diseases that are distinct from normality and each other (Klerman, 1978), which means that any particular diagnosis is either present or absent. However, research has consistently not supported the boundaries established for many mental health disorders (APA, 2013). Most disorders have shared symptoms, genetic environmental risk factors, and neural substrates (APA, 2013). Many disorders are virtually inseparable from each other (Hyman, 2011). In the *DSM-5* it is finally acknowledged that it is not possible to achieve diagnostic homogeneity by progressive subtyping within disorders. Mental disorders, like most illnesses, are heterogeneous at multiple levels, ranging from genetic risk factors to symptoms. Many of the most significant innovations in the *DSM-5* (e.g., dimensional approach to diagnosis and a more pronounced used of specifiers) are an attempt to reflect the reality that mental health disorders are more complex, diverse, and heterogeneous than as categorized on the *DSM-IV*. As a result of this finding, the *DSM-5* aimed to have more porously defined boundaries than previous *DSM* editions. Consistent with this finding, transdiagnostic evidence-based approaches (e.g., Barlow et al., 2011) are being developed to treat several mental health disorders. Unfortunately, most of these promising evidence-based approaches have yet to be validated with culturally diverse groups or to include cultural variables in their validation processes (La Roche, 2013).

Although the *DSM-5* remains largely categorical it starts to move toward a dimensional approach in which some diagnostic categories are continuous and more heterogeneously defined—fewer boundaries between disorders. An example of the *DSM-5* dimensional approach is in the Assessment Measure section that lists 13 cross-cutting symptom measures. The Patient Health

Questionnaire-9 is an example of these scales in which each of the nine depression criteria are rated as "not at all," "several days," "more than half the days," and "nearly every day." This scale provides a quantifiable indicator of the depression diagnosis and its severity, while also including valuable descriptive information. These measures were developed to be administered both at the initial interview and over time to track patients' symptom status and response to treatment. Each individual can end up with a dimensional profile in which distinct patterns among measures reflect different psychiatric disorders. By facilitating and standardizing the monitoring of treatment response, profiles might serve eventually as an indicator of prognosis. Similar systems are used for blood pressure, cardiac risk scales, renal failure rating scales, and other medical conditions. Hempel (1961) suggested that scientific nosologies often begin with categorical classifications and move toward dimensions when measurements improve, which would suggest that the *DSM-5* psychiatric nosology is still in its infancy. Unfortunately, most of these measures have yet to be validated with different cultural groups.

Having continuous scales permits the development of normal distributions of mental health disorders for the general population. Eventually, this will allow researchers to examine what is "normal" according to the number of standard deviations from the mean or specific cut-off points. As a result normal distributions for specific groups such as ethnic/racial groups can be created which will allow for more culturally sensitive comparisons assuming that invariant measurements are valid across group (La Roche & Christopher, 2008). Nevertheless, it is likely that ethnic differences will be construed as a result of inherent biological or genetic deficits as was the case when ethnic differences were identified on academic performance (Helms, 1992). Some authors (e.g., Herrnestein & Murray, 1994) argued that ethnic differences on academic performance were the result of inherent biological and genetic deficiencies that are difficult—and very expensive if not impossible- to modify or treat. Consequently, they questioned the benefit of investing in the education of ethnic minority children. Similar harmful policy recommendations could be supported by a *DSM-5* that overlooks environmental stressors (e.g., deletion of Axis IV) and emphasizes biology. To prevent this risk, it is necessary that future *DSM* revisions underscore a cultural model that explain differences within specific cultural contexts that includes various ecological variables such as prejudice and various types of insecurity like financial ones and threats of violence (Hays, 2008; Hinton & Good, 2009; La Roche, 2013).

Additional clinical and diagnostic concerns could emerge because of the dimensional approach. First, the common presence of a behavioral feature (e.g., smoking) in the general population or subgroup does not mean that it is "normal" or healthy; it just means that it is not necessarily rare. Studies are required to examine the cultural and clinical meaning of statistical findings among different cultural groups. Some pathological behaviors may not exist in the "normal" or White American population, yet they may be normally distributed in different cultural groups. In some cultures certain behaviors may be adaptive (e.g., workaholic), whereas they may be pathological in other cultures. Clearly much cultural research is needed to examine the meanings attributed to distinct behaviors in different cultures.

The *DSM-5* benefits from more sophisticated and complex medical/biological formulations than the *DSM-IV*; unfortunately it seems that these advances are at the expense of the cultural view. For example, in the neurodevelopmental disorders section the biological etiologies are substantially more elaborated than cultural and contextual influences. Important neuroimaging, genetic and physiologic studies inform this section. *DSM-5*'s reliance on biological evidence reveals the importance and credibility of this discipline. In addition, this emphasis seems to suggest that there are biological vulnerabilities underlying all *DSM-5* disorders and that sociocultural influences are less relevant to understand these disorders.

The ways in which disorders are constructed have powerful clinical, political, and economic ramifications for different disciplines (Cushman, 1995). If disorders are defined biologically physicians are justified to prioritize psychopharmacological treatments while social, economic and psychological issues become secondary and less valuable, which can lead to the neglect of the oppressive effects of racism, gender inequality and colonization among many other sociocultural variables. Furthermore, if symptoms are assumed to reside within patients then individualistic interventions that do not question or challenge sociopolitical and economic injustices are supported (La Roche, 2013).

Although the cultural revisions of the *DSM-5* are more integrated and developed than those of the *DSM-IV*, many of the *DSM-5* cultural revisions (e.g., CFI) remain divorced from the text. At times it seems that the *DSM-5* promotes two opposing mental health approaches. First, a largely universalist and predominantly biological model in which diagnostic algorithms are valid for all independently of their cultural context (e.g., neurodevelopmental disorders); and second a cultural model that emphasizes the importance of understanding symptoms within specific cultural contexts. Regier et al. (2011) explained the many—not just two—incongruous frameworks had to be taken into account in designing the *DSM-5*. However, the *DSM-5* allegedly adheres to a model in which disorders are fundamentally biological in origin with superficial cultural variations—though changes suggested as the emphasis on the CFI highly a cultural context approach. Nevertheless, in comparison to the *DSM-IV*, the *DSM-5* seems more explicit in presenting some of its theoretical assumptions (e.g., personality disorders and conditions for future study).

In the *DSM-5* an alternative personality disorder model is proposed in which specific disturbances of self and interpersonal functioning are the basis of pathology. The *healthy self* is defined as that in which the identity of oneself is unique and has clear boundaries between self and others. This understanding of self—and interpersonal functioning—is consistent with individualistic Western assumptions. Numerous authors (Cushman, 1995; Oyserman, Coon, & Kemmelmeier, 2002; Triandis, 1995) define the prevalent Western American individualistic self-orientation, which is diametrically opposed to that of many cultural minorities who tend to define themselves through a collectivistic self-orientation or in relationship to others (Oyserman et al., 2002; Triandis, 1995). Crafting a personality model that underscores individualistic standards may not only undermine its applicability with ethnic minorities, but also with women and other cultural minority and international groups who define themselves through relationships.

Conclusions

In comparison to the almost 1,000 pages of the *DSM-5*, the discussion of cultural factors is relatively small, though much improved from *DSM-IV*. The cultural revisions are a significant departure and improvement in comparison to the rest of the *DSM-5* in which disorders are treated as universally valid across cultures with only superficial cultural variations noted in the cultural sections. Instead of understanding symptoms in a cultural vacuum as much of the *DSM-5* does, these cultural revisions underscore the need to examine the meaning of symptoms within cultural contexts. As patients' cultural contexts are included in the assessment process, the risk of misconstruing and not assessing patients' cultural differences is diminished. An inadequate or incomplete understanding of such cultural factors and interactions interferes with accurate clinical inferences (Kleinman, 1988; Hinton & Good, 2009; La Roche, 2013).

The *DSM-5* includes significant cultural improvements over the *DSM-IV*, nevertheless, we argue that much work still remains ahead of us if it is truly to become a more inclusive description of the range of psychopathology for all individuals in the United States and beyond. The *DSM-5* contains many Western American assumptions (e.g., universalism, individualism) that limit its applicability with cultural minorities. The following research and clinical considerations include recommendations to further refine the cultural sensitivity of the *DSM* and to more effectively use it with cultural minorities.

1. Research Considerations and Recommendations:

   1.1. Researchers should consistently include a more precise measurement of complex cultural and contextual variables (e.g., self-orientation, racism, community violence) that foster the development of a more thorough understanding of these influences in the research, assessment, and the psychotherapeutic process.

   1.2. It is necessary to identify the influence of different variables (e.g., genes, cultural variables) so that researchers/clinicians may start to define what is universal or culturally specific about distress presentations, thereby increasing the likelihood that more effective assessment and intervention strategies be selected for each patient.

   1.3. Instead of aiming to develop a *DSM* through an atheoretical taxonomy—in which universalist biologic assumptions are veiled-we propose that it explicitly be based on a cultural framework in which behaviors are understood within sociocultural contexts. This would allow researchers to understand scientific evidence within cultural contexts and to move to a more complex epigenetic model that underscores the relationships between patients, assessors, biology, and contexts.

   1.4. The explicit use of a cultural framework will permit clinicians and researchers to clearly identify cultural assumptions and tensions and their effects on assessment, treatment and research. As cultural assumptions and tensions are identified, they can be more effectively discussed and tested. It is important to note that the authors of this article are not immune to these tensions and interests as our proposals reflect our own research agendas.

   1.5. Research is needed to understand the varying prevalence rates and symptom manifestations (e.g., underinclusion and overinclusion of symptoms) of mental health disorders across cultural groups and in different countries.

   1.6. The *DSM-5*'s move to a dimensional approach is a promising step forward in refining cultural assessments that could be expanded further if symptom continuums were embedded in cultural contexts that clarify their meanings. However, studies that link symptom continuums and cultural influences are needed to accomplish this goal. It is necessary to consider the inclusion of cultural variations in each and all the *DSM* dimensions and/or consider the inclusion of cultural contextual dimension(s) or more complex axes.

   1.7. A complex understanding of culture requires a conceptualization other than that of an independent variable, and rather a testing of culture through several more complex statistical procedures (e.g., interactional and moderator analyses) as well as through multimethod strategies (i.e., quantitative and qualitative).

   1.8. The cultural validity of the diagnostic scales and questionnaires included in the *DSM-5* need to be more thoroughly investigated and such assessment tools should incorporate cultural variables to increase validity for minorities and in other countries.

   1.9. An enhanced cultural understanding of patients' symptoms and the development of cultural psychotherapies should be a key strategy to reduce ethnic minority health disparities.

2. Clinical Considerations and Recommendations:

   2.1. Clinicians should continuously assess and use patients' complex cultural variables (e.g., understanding of symptoms such as catastrophic cognition and type of self-orientation) rather than assuming stereotypic characteristics or making therapeutic recommendations solely because of patients' race or ethnicity.

   2.2. The CFI should more consistently be used in the assessment and psychotherapeutic process. However, future studies with more specific variables, cultural (e.g., LGTB) and international groups are required to refine its applicability.

   2.3. Instead of deleting Axis IV as the *DSM-5* did we would encourage that it be expanded and refined to include more precise contextual stressors such as racism, and community violence. Symptoms have meanings and repercussions in specific ecological contexts.

2.4. The *DSM-5* notes the complex and multifold comorbidity existent within different diagnostic constellations suggesting the need to develop and consider transdiagnostic psychotherapies for culturally diverse groups.

2.5. Diagnoses are hypotheses in need of more evidence including the influence of cultural contexts.

2.6. Not only do cultural minorities have a "culture" but rather all of us live in cultural contexts that profoundly shape our way of being in the world and our experiences. It is therefore important to assess and address cultural meanings and contextual variables for each and all of us.

References

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Barlow, D., Farchione, T., Fairholme, C., Ellard, K., Boisseau, C., Allen, L., & Ehrenreich-May, J. (2011). *Unified protocol for transdiagnostic treatment of emotional disorders*. New York, NY: Oxford University Press. http://dx.doi.org/10.1093/med:psych/9780199772674.001.0001

Cosgrove, L., & Wheeler, E. E. (2013). Industry's colonization of psychiatry: Ethical and practical implications of financial conflicts of interest in the DSM-5. *Feminism & Psychology, 23,* 93–106. http://dx.doi.org/10.1177/0959353512467972

Cushman, P. (1995). *Constructing the self: Constructing America: A cultural history of psychotherapy*. New York, NY: Adison-Wesley.

Follette, W. C., & Houts, A. C. (1996). Models of scientific progress and the role of theory in taxonomy development: A case study of the DSM. *Journal of Consulting and Clinical Psychology, 64,* 1120–1132. http://dx.doi.org/10.1037/0022-006X.64.6.1120

Frances, A. (2013). DSM5 in distress: The DSM's impact on mental health practice and research. *Psychology Today*. Retrieved from http://www.psychologytoday.com/blog/dsm5-in-distress

Hacking, I. (2002). *Historical ontology*. Cambridge, MA: Harvard University Press. http://dx.doi.org/10.1007/978-94-017-0475-5_13

Hays, P. (2008). *Addressing cultural complexities in practice: Assessment, diagnosis, and therapy* (2nd ed.). Washington DC: American Psychological Press.

Helms, J. (1992). Why is there no study of cultural equivalence in standardized cognitive ability thinking? *American Psychologist, 47,* 1083–1101. http://dx.doi.org/10.1037/0003-066X.47.9.1083

Hempel, C. G. (1961). Introduction to problems of taxonomy. In J. Zubin (Ed.), *Field studies in mental health disorders* (pp. 3–22). New York, NY: Grune & Straton.

Herrnestein, R., & Murray, C. (1994). *The bell curve: Intelligence and class structure in American life*. New York, NY: Free Press.

Hinton, D., & Good, B. (2009). *Culture and panic disorder*. Stanford, CA: Stanford University Press.

Hinton, D. E., & Good, B. J. (Eds.). (2015). *Culture and PTSD: Trauma in historical and global perspective*. Philadelphia: University of Pennsylvania Press.

Hinton, D. E., & Lewis-Fernández, R. (2011). The cross-cultural validity of posttraumatic stress disorder: Implications for DSM-5. *Depression and Anxiety, 28,* 783–801. http://dx.doi.org/10.1002/da.20753

Hyman, S. (2011). Diagnosis of mental disorders in light of modern genetics. In D. Regier (Ed.), *The conceptual evolution of the DSM-5* (pp. 3–18). Arlington, VA: American Psychiatric Publishing.

Kleinman, A. (1988). *The illness narratives: Suffering, healing & the human condition*. New York, NY: Basic Books.

Kleinman, A. (2012). The art of medicine: Culture, bereavement, and psychiatry. *The Lancet, 379,* 608–609. http://dx.doi.org/10.1016/S0140-6736(12)60258-X

Klerman, G. (1978). The evolution of a scientific nosology. In J. C. Shershow (Ed.), *Schizophrenia: Science and practice* (pp. 1–121). Cambridge, MA: Harvard University Press.

La Roche, M. (2013). *Cultural psychotherapy: Theory, methods and practice*. Los Angeles, CA: Sage.

La Roche, M., & Christopher, M. (2008). Culture and empirically supported treatments: On the road to a collision? *Culture and Psychology, 14,* 333–356. http://dx.doi.org/10.1177/1354067X08092637

La Roche, M. J., & Christopher, M. S. (2009). Changing paradigms from empirically supported treatment to evidence-based practice: A cultural perspective. *Professional Psychology: Research and Practice, 40,* 396–402. http://dx.doi.org/10.1037/a0015240

Matunga, H., & Seedat, S. (2011). Obsessive-compulsive spectrum disorders: Cross national and ethnic issues. In E. Hollander & J. Zohar (Eds.), *Obsessive-compulsive spectrum disorders: Refining the research agenda for DSM-5* (pp. 205–221). Arlington, VA: American Psychiatric Publishing.

Mezzich, J. E., Kirmayer, L. J., Kleinman, A., Fabrega, H., Jr., Parron, D. L., Good, B. J., . . . Manson, S. M. (1999). The place of culture in *DSM-IV*. *Journal of Nervous and Mental Disease, 187,* 457–464. http://dx.doi.org/10.1097/00005053-199908000-00001

Oyserman, D., Coon, H. M., & Kemmelmeier, M. (2002). Rethinking individualism and collectivism: Evaluation of theoretical assumptions and meta-analyses. *Psychological Bulletin, 128,* 3–72.

Regier, D., Narrow, W., Kuhl, E., & Kupfer, D. (2011). *The conceptual evolution of DSM-5*. Arlington, VA: American Psychiatric Publishing Inc.

Schwartz, S. J., Unger, J. B., Zamboanga, B. L., & Szapocznik, J. (2010). Rethinking the concept of acculturation: Implications for theory and research. *American Psychologist, 65,* 237–251. http://dx.doi.org/10.1037/a0019330

Sue, D. W., & Sue, S. (2008). *Counseling the culturally diverse: Theory and practice* (5th ed.). NY: Wiley & Son Press.

Triandis, H. C. (1995). *Individualism and collectivism*. Boulder, CO: Westview Press.

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