

Gender and cultural issues in psychiatric nosological classification systems

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Much has changed since the two dominant mental health nosological systems, the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM), were first published in 1900 and 1952, respectively. Despite numerous modifications to stay up to date with scientific and cultural changes (eg, exclusion of homosexuality as a disorder) and to improve the cultural sensitivity of psychiatric diagnoses, the ICD and DSM have only recently renewed attempts at harmonization. Previous nosological iterations demonstrate the oscillation in the importance placed on the biological focus, highlighting the tension between a gender- and culture-free nosology (solely biological) and a contextually relevant understanding of mental illness. In light of the release of the DSM 5, future nosological systems, such as the ICD 11, scheduled for release in 2017, and the Research Development Criteria (RDoC), can learn from history and apply critiques. This article aims to critically consider gender and culture in previous editions of the ICD and DSM to inform forthcoming classifications.

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Introduction

It has been argued that culture and context are both integral when making a psychiatric diagnosis, and that a “greater appreciation of the interplay between culture, context, and biology can help clinicians improve diagnostic and treatment planning” (p. 15).¹ This position, which is espoused by the International Classification of Diseases (ICD) and Diagnostic and Statistical Manual of Mental Disorders (DSM) nosological systems, also argues for a more empathic understanding of a patient’s identity and a more comprehensive and accurate assessment of psychopathology.

This review aims to outline gender and cultural considerations in previous iterations of nosological systems and use these as stepping stones toward a gender- and culture-fair diagnostic future characterized as valid, reliable, and clinically useful. Throughout it is important to consider that progress does not always equate advancement to an ideal (static) end, as nosologies are rarely permanently fixed.^{2,3}

Defining Context, Culture, Gender, and Nosology

Gender refers to the complex psychological, biological, and behavioral processes that influence a person’s representation as *female* or *male*, or the psychosocial expression of living as a *man* or *woman*.⁴

Culture is broadly defined in the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5) 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. (p. 749)⁵

The DSM-5 acknowledges the dualistic relationship between culture and advantage and culture and disadvantage. Cultural identity can galvanize and enhance resilience but can also be a source of “psychological, interpersonal, and intergenerational conflict or difficulties in adaptation that require diagnostic assessment” (p. 749).⁵

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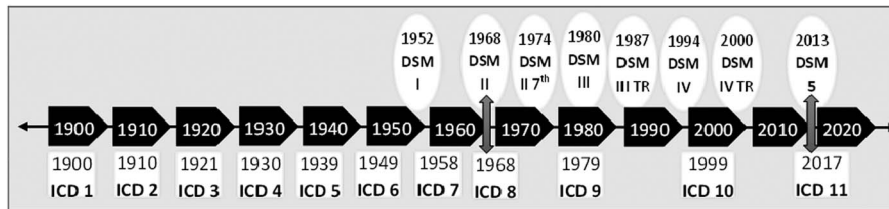


FIGURE 1. Comparative timeline of ICD and DSM publications. The publication dates of the *Diagnostic Statistical Manual of Mental Disorders* (DSM) and the *International Classification of Diseases* (ICD) are illustrated. Vertical arrows indicate attempts to harmonize the ICD and DSM.

Gender and culture are irrevocably entwined and play a major role in the idiomatic expressions of distress and definitions of normality and pathology.⁶ They influence all aspects of psychopathology, including the stressors and exposures that precede the onset of disease, symptom expression, help-seeking behavior, how one is treated in a system (eg, at the level of the local community or wider population), social support, economic status, cultural expectations, and other environmental factors that could influence individual vulnerability to mental illness.⁴

Context on the other hand gives consideration to local social and environmental factors. Culture and context influence how people experience and express emotional distress and how (and from whom) they seek help and receive treatment. A culturally and contextually sensitive psychiatric diagnostic evaluation includes a patient's interpretation of his or her emotional disturbance, the perceived level of severity, the role of social stressors and supports, and risk and protective factors in the onset and/or persistence of that disturbance.⁵

Nosology is the scientific classification of diseases,⁷ while nomenclature describes the names or labels of the disorders that make up the nosology. As a discipline, nosology aims to achieve a broad understanding of diseases, regardless of theoretical orientation.⁸ Diagnostic assessment informs clinical care by providing information on etiology, prognosis, and most importantly, treatment.⁹ Good diagnosis should, therefore, be based on up-to-date, reliable, and valid diagnostic models.¹⁰

To date, the DSM and ICD remain the prominent mental health classification systems.¹¹ Despite criticism of the descriptive, categorical approach of the DSM and ICD in its use by researchers^{12–15} and clinicians,¹⁶ there is general agreement that these classification systems have benefitted the field of psychiatry by providing a common language for clinicians to communicate more effectively with one another, and for researchers to reliably define diagnostic samples for study.¹⁷ In response to the criticisms around the need for 2 different diagnostic systems,^{18,19} the process of harmonizing the DSM-5 and *The International Classification of Diseases*, 11th Revision (ICD-11) has been a more thoughtful and systematic process in comparison to earlier versions.²

Figure 1 illustrates a timeline depicting DSM and ICD publications and previous attempts at synchronization.

Gender and Culture in Nosology—Why Do They Matter?

Given the complexities of culture and society, there are a number of challenges to creating acceptable, harmonized guidelines in mental health diagnostic systems. These challenges include etiological (biological causes) vs descriptive (symptoms you can see) diagnoses, collectivistic vs individualistic cultural viewpoints/experiences, and the importance of viewing mental illness within context (ie, culture: societies are still largely patriarchal and heteronormative). In the increasingly multicultural world in which we live, it is, however, essential to strive for an effective balance, eg, between universalism, that facilitates professional communication across centers and continents, and local realities and needs, which address the individual in his/her particular context.²⁰

Current healthcare practices are often based on an assumption of sameness, rather than ensuring equal access to services while taking into account the needs of different people and groups. Culture, race, and gender, of clinician and patient, may therefore influence diagnostic practice.²¹ For example, clinicians assume that patients trust and accept the interview process regardless of cultural (racial and ethnic) differences in the notion of time (history-taking, thoughts about the future), cultural sanctions, and courtesy norms (what you might say and what you might say to whom).²² Unhelpful and disempowering interactions between clinician and minority clients are often a consequence.²³

Another example is *Tajin Kyofusho*, a Japanese, culture-specific syndrome similar to social anxiety disorder (SAD). While SAD focuses on the fear of being embarrassed in front of others, individuals with *Tajin Kyofusho* (or *Taein Kong Po* in Korea) are afraid of embarrassing others by being in their presence, a fear that is occasionally of delusional intensity and may fulfill criteria for a delusional disorder. This highlights the tension between biology (Is it an example of disordered biology?), the individual (Is it an example of individual

psychology and experience?), and social context (Is it an example of the social context of behavior?) in nosology.²⁴ It also illustrates the difference between individualistic and collectivist cultures. The DSM-5 has revised the criteria for SAD to reflect this culturally nuanced presentation, as there is mounting evidence that the fear of offending others is present in other (non-Asian) cultural settings.²⁵

A Historical Review of Cultural Considerations in Nosology

Over time, psychiatric nosologies have oscillated in their opinion regarding the pertinence of etiological explanations of disease (as first presented by Kraepelin). The first 2 editions of the DSM were criticized for being heavily guided by the Freudian tradition with the DSM-I (1952) task team sporting 10 (of 28) members with psychoanalytic sympathies, and 6 (of 10) in the DSM-II, published in 1968.²⁶ Furthermore, the DSM II was criticized for using mental illness to disguise moral conflicts and for society to label nonconformists, similar to religious myths, such as witchcraft, that acted as “social tranquilizers” (p. 116).²¹

The ICD spent the 1960s on improving diagnosis after discovering that the US and UK were out of sync. Influenced by psychoanalytic tradition, practitioners in the US were overdiagnosing schizophrenia in comparison to practitioners presented with the same symptoms in the UK.^{20,27,28} A task team of participants from various disciplines and traditions across the world³ tested criteria with joint ratings of videotaped interviews.²⁹ Recognizing that the importance of standardization on a multilingual basis was essential for conformity, the ICD-8 (1968) included a standardized glossary of psychiatric terms. The influence of Karl Jasper’s principles of descriptive psychopathology and phenomenology were evident in this, and future iterations of both DSM and ICD.³⁰

In the late 1960s, a daring group of scholars, who became known as neo-Kraepelinians, displayed interest in the unfashionable topics of brain chemistry and biology, and classification.²⁶ This movement pulled away from psychoanalysis and followed the nosological model of disease as a set of identifiable symptoms in an attempt to ensure the more exact correlation of diagnoses with natural disease entities.^{26,31}

The DSM-III exhibited a new task team weighted toward biological psychiatry, a scientific rather than theoretical orientation.²⁶ The National Institute of Mental Health (NIMH) sponsored field trials, between 1977 and 1979, for 500 psychiatrists, who used DSM-III drafts to diagnose 12,000 patients, and 300 psychiatrists were paired to evaluate consistency of

diagnoses in an attempt to create a scientific classification system.²⁶ Although it is not always possible to focus on empirical evidence exclusively, the changes in the DSM over time are indicative of advancement. Some examples are listed below.

- Homosexuality was included as a disorder in the DSM-I, but was later subsumed under various other conditions (“Sexual Orientation Disturbance” in DSM-II 7th ed.; “Ego Dystonic Homosexuality” in DSM-III; “Sexual Disorder NOS” in DSM III-TR) to keep up with cultural and political pressure, and today is no longer a diagnostic entity.
- To appease psychoanalysts, the DSM-III included “neurosis” in brackets after the word “disorder.”²⁶ This could be considered an attempt to mark the transition toward a new way of thinking nosologically.
- Feminists pressured the task team to remove “self-defeating personality disorder,” initially included in the section “Conditions for Further Study.”²⁶

Despite criticisms, the DSM-III could be seen as a major step forward in international psychiatric nosology, eg, by improving inter-clinician communication and the reliability of diagnosis.¹¹ By 1980, the DSM-III was translated into 13 languages for widespread international use.

The 1980s also showed movement in the ICD process toward cultural sensitivity. ICD-8 included a glossary to provide definitions of diagnostic concepts that may have been unclear, while the ICD-9 incorporated this text into classification itself.²⁹ In preparation for the ICD-10, diagnostic criteria from ICD-9 were converted into algorithms to identify inconsistencies, overlaps, and ambiguities.³ The Composite International Diagnostic Interview was used as a standardized basis for epidemiological studies of mental disorders across 17 countries and, along with the International Personality Disorder Examination and Schedules for Clinical Assessment and Neuropsychiatry, was instrumental in refining ICD-10 criteria for Chapter V (F).³ These criteria were implemented in field trials across 40 countries (Egypt being the only African hub included in the field trials); at that time, this was the largest ever research effort of its type to improve psychiatric diagnosis.³ This required classification and diagnostic guidelines to be produced and tested in many languages, with equivalent translations, and also led to the improvement (clarity, simplicity, logical flow) of texts in English and other languages.³ By including researchers and clinicians from 32 countries, the ICD-10 demonstrates a distinctive international character and contains a list of 12 culture-bound disorders.³

A Historical Review of Gender in Nosology

Diagnostic criteria should, ideally, not exhibit bias based on possible prejudices within society. As the DSM and ICD nosological systems became more culturally sensitive, there was also a growing interest in gender considerations in psychopathology. Growing scientific productivity relating to sex and gender in psychiatry was fueled by a rising critical mass of investigators across diverse scientific domains, and increased globalization and global inclusivity of mental health research.⁴ The DSM, similarly, followed this trend, starting with a lack of research linking gender and psychopathology in the 1950s and 1960s to heated debates regarding sex bias and the potential harms of diagnosing women with “late luteal phase dysphoric disorder” (LLPDD) in the 1970s and 1980s.⁴

- The DSM-I did not include any sex-related findings (eg, sex ratios), despite highlighting the increasing need for sufficient statistical information (including sex) regarding the American mental hospital population and providing suggested tabulations for reporting demographic and related information for statistics.
- The DSM-II included sex-ratios for “delinquent reaction of childhood” (more prevalent in boys) and discussed gender differences in the expression of the disorder.
- The DSM-III added in-text sex ratios, and some gender-specific information regarding presentation. These data, however, varied widely, with some being specific and others vague, and some acknowledging that there was no available information. Although a number of disorders provided gender-specific criteria sets, the increased gender focus must be seen in the context that many of these disorders were not included in the previous edition.
- During the DSM-III-R revision process, gender debates concerning the proposed diagnosis of LLPDD and its potential harm to women became heated. The DSM-III-R included more precise sex ratios, but now no reference was made to gender differences in the presentation of “conduct disorder” (in comparison to II and III). “Gender identity disorder” included separate diagnostic criteria for children, but not adolescents or adults, non-transsexual type or for transsexualism.
- The DSM-IV expanded the manual text to include information on gender-specific differences in the course and expression of disorders under the heading “Specific Culture, Age and Gender Features.” The workgroup for LLPDD changed the name to “premenstrual dysphoric disorder.” Concerns were raised regarding inconsistency in the quantity and quality of the sex ratio information in the DSM-IV, as no published empirical data were available on which to base conclusions.

- The DSM-IV-TR included independently critiqued systematic reviews to provide written documentation for the sex and gender variation and also included potential explanations for reported sex ratios (eg, help-seeking behavior, study setting, inaccurate assessments, culture and age differences).

Recent Gender and Cultural Considerations

The last attempt to align the 2 diagnostic systems was in 1968 (DSM-II with ICD-8), but poor diagnostic reliability was a major concern.¹¹ Prior to DSM-5, recommendations from Hartung and Widiger³² and Narrow *et al*⁴ encouraged that both gender and cultural considerations toward diagnosing mental illness should attempt to create the most neutral criteria possible. In the event that gender neutral criteria are not possible, Narrow *et al* provide a number of suggestions.⁴

Social context and cultural considerations were embraced in the DSM-IV and 5. Table 1 summarizes some pertinent examples.

The development of the DSM-5 demonstrated a commitment to being more gender and culturally sensitive. Specific task teams and subgroups were employed to address gender, cultural, and cross-cultural issues, including diverse representation in the development process.³³⁻³⁵ This process resulted in fairly significant changes to diagnostic labels and culture-specific diagnoses.

TABLE 1. Cultural considerations in DSM-IV and DSM-5

DSM-IV	DSM-5
Outline of cultural formulation as a narrative tool in appendix	Field trials in 5 continents to test culture formulation interview (clinical interview tool for comprehensive assessment included in section III)
25 culture-bound syndromes in glossary: criticized for not being inclusive of culture-bound syndromes in children, for creating the impression that these culturally specific experiences were esoteric and unusual, and that they were included simply to placate cultural critics instead of being based on science ^{6,57,58}	Replaced with 3 constructs: cultural syndrome, idiom of distress, explanation of cause
Discussion of gender/culture sporadic (79 of 400 disorders) ³⁰	Text includes “culture related diagnostic issues” for each diagnosis and “other specified” gives examples of cultural concepts of distress
Sensitive v-codes and Axis IV	Culturally balanced task force actively considered evidence of racial, ethnic, or gender bias

More specifically, the DSM-5 included a work group specifically focused on gender and culture issues.^{36–40} This group reviewed epidemiological datasets from the US and other countries, and conducted meta-analyses to determine if there were significant differences in the incidence of mental illness among different subgroups (race, gender) that might indicate a bias in currently used diagnostic criteria.^{36–38} Field trials were conducted in multiple sites across 5 continents to test the Culture Formulation Interview.¹ It has since been included in section III of the DSM-5 as a valuable tool to be used across the world.

Praise and Criticism Regarding Changes in Diagnostic Criteria

Changes to diagnostic criteria elicited mixed reports, some of which are listed below:

- Gender identity disorder: Gender identity disorder has been renamed “gender dysphoria.” The new name has been praised, similar to the removal of homosexuality from the DSM in 1973.⁴¹
- Mood and anxiety disorders: Response to the inclusion of a mixed anxiety and depression diagnosis has been varied, and there is concern of the possible increase in false positive diagnoses.⁴² There has also been criticism of the DSM-5 for not incorporating empirical findings regarding the role of culture in the accurate diagnosis of mood symptoms, given that culture influences observable behavior, somatic complaints, and the verbal description of symptoms.⁴²
- Trauma- and stressor-related disorders: Bensimon *et al.*, for example,⁴³ have criticized criterion A in the DSM-5 posttraumatic stress disorder (PTSD) diagnostic criteria for including elements of cultural bias. This criterion refers to single traumatic incidents rather than to chronic national traumatic stress, “where exposure to terror is persistent, constant and of national proportions” (p. 81),⁴³ which is more likely in non-Westernized societies.
- Personality disorders: Gender and cultural concerns fueled a lot of debate. The alternative model of personality disorders, which is based on multidimensional aspects of personality functioning and traits, was rejected by the DSM-5 committee and relegated to section III of the manual.⁵

ICD 11 and Beyond

ICD-11 is scheduled for presentation to the World Health Assembly in 2017. The Working Groups, in consultation with the World Health Organization (WHO), have developed a standard format for Clinical Descriptions and Diagnostic Guidelines, to conform to the way in

which clinicians make psychiatric diagnoses.⁴⁴ This format includes a definition of the disorder, essential features of the disorder, the boundary with normality, the boundary with other conditions (*viz.*, differential diagnosis), course features, associated features, and developmental presentations. In addition, culture- and gender-related features are included. In line with the DSM-5, culture-related features are defined as “culturally sanctioned and recognised expressions or idioms of distress, explanatory beliefs, and cultural syndromes” (p. 88).⁴⁴ In PTSD, for example, these may be a prominent element of the trauma response, with cultural idioms presenting differently in different populations. Also, similar to the DSM-5, gender-related patterns in prevalence and symptom presentation in clinical and community settings are a focus.⁴⁴

The ICD-11 is expected to provide clearly organized, consistent information across disorders that is flexible enough to allow for cultural variation and the exercise of clinical judgment. In doing so, clinical utility should be enhanced, and identification and treatment improved.^{44,45} Improved healthcare throughout the world requires international cooperation in establishing standards and collecting and disseminating statistical information.⁴⁵ Although based on research findings (ensuring validity), clinical utility is as much a requirement. The clinical utility of the ICD-11 (and DSM-5) and any future iterations may be improved by making its structure more compatible with the common conceptual organization of mental disorders observed across diverse global contexts.⁴⁶

Alternate ways of understanding pathology that have been espoused include moving from a categorical toward a dimensional or spectrum approach.⁴⁷ Similarly, the Research Domain Criteria (RDoC) developed by the NIMH⁴⁸ has been proposed as a more biologically valid framework for understanding psychiatric disorders and developing a more precise taxonomy. While there is concern that the reductionistic approach of the RDoC may reify disorders on neurobiological and behavioral dimensions over social and experiential dimensions,^{49,50} others have argued that the emphasis should be on developing a more mechanistic understanding of how environmental factors, such as life events and the social environment, interact with development to produce a range of observed outcomes.^{48,51}

We suggest that diagnostic criteria be based on distress and impairment, rather than on differences based on gender and cultural stereotypes/nonconformity.⁵² Building on previous recommendations, we concur that diagnostic systems could consider weighting criteria that are not gender or culturally equivalent, while being cognizant of the need to measure the same disorder. Some criteria, such as crying in women and aggression in men, are biased in that that they are endorsed more

easily by one gender. One way of weighting criteria is employing a standardized approach to measure whether men with these attributes would have more trouble functioning than women displaying the same symptoms (and inversely). This, then, indicates the likelihood that the gender-specific behavior is, in fact, problematic.

We emphasize the need to de-pathologize gender and cultural differences and provide care for distressed individuals even in the absence of a clinical diagnosis.⁵³ Additionally, we agree that diagnostic criteria without contextual reference loses validity.⁵⁴ Each measurement system can rather be used to complement instead of replace the others.^{55,56} Whichever system is followed, one can only hope that the thread of increased validity, reliability, and clinical utility can be continued, in the further upcoming, regular revisions of these documents.

Conclusion

We have attempted in this manuscript to critically analyze historical gender and cultural considerations in nosological systems and provide suggestions for a more culturally attuned approach to psychiatric diagnosis. Nosological systems are constantly evolving, with changes often based on “shifts in the loci of power, social and technological experience, theoretical orientation and financial resource” (p. 12).² Attempts to revise/harmonize these systems will hopefully encompass a variety of complementary constructs (ICD/DSM/RDoC), be scientifically based, and increasingly gender and culture sensitive. To navigate the complexity of culturally sensitive diagnoses, diagnostic systems should be based on impairment and distress rather than nonconformity. While standardizing information across clinicians and toward increasing clinical utility, these systems should aim for criteria that exhibit respect, understanding, and acceptance of diversity. Weighting criteria that are not gender or culturally equivalent, while being cognizant of the need to measure the same disorder, can also be considered. In sum, appreciation of the diversity of cultural influences and diagnostic categories—a move toward an affirmative approach—will better enable mental health clinicians to assign more effective and individualized treatment plans for their patients.

Disclosures

The authors do not have an affiliation with or financial interest in any organization that might pose a conflict of interest.

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