

DSM IV, Culture and Child Psychiatry

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Abstract

Objective: The expanding cultural diversity of children and families with mental health needs raises questions about the cultural appropriateness of diagnostic classifications like the DSM IV. This paper briefly surveys the literature on culture and DSM-IV in child psychiatry, presenting ADHD as an example of the relationship between diagnostic categories and cultural issues, and illustrating some of the clinical dilemmas of differential diagnosis in a migration context. **Method:** A literature review was performed and analysed, and a case vignette was constructed to illustrate key points. **Results:** The literature does not provide a definite answer about the DSM IV cultural validity in child psychiatry. On the one hand it suggests that all diagnostic categories may be found universally. On the other, variations in prevalence rates support the hypothesis of a role for social and cultural factors in the diagnostic process. The clinical formulation may be a useful tool to address the validity issue by modulating the process of diagnosis with a cultural understanding of the symptoms, the patient-therapist alliance and the appropriateness of treatment recommendations. **Conclusion:** Although the DSM IV diagnostic categories may be found cross culturally, clinicians need to be aware of how culture may influence the diagnostic process in child psychiatry.

Key words: DSM IV, culture, child psychiatry, cultural formulation

Résumé

Objectifs: La diversité culturelle croissante des enfants et des familles qui ont besoin de services de santé mentale conduit à se demander si la classification des diagnostics du DSM IV est adaptée à la réalité culturelle de ces enfants et de leur famille. Le présent article passe rapidement en revue la littérature sur la culture et le DSM IV en pédopsychiatrie; il donne le TDAH comme exemple de relation entre les catégories de diagnostics et les questions culturelles, et illustre certains dilemmes cliniques posés par le diagnostic différentiel chez les immigrants. **Méthodologie:** La littérature a été analysée; des vignettes illustrent les principaux points. **Résultats:** On ne trouve pas, dans la littérature, de réponse précise sur la validité culturelle du DSM IV en pédopsychiatrie. D'une part, la littérature laisse entendre que toutes les catégories de diagnostics se retrouvent partout. D'autre part, les écarts constatés dans le taux de prévalence appuient l'hypothèse selon laquelle les facteurs socioculturels jouent un rôle dans le diagnostic. La formulation clinique peut être utile pour traiter de la validité en modulant le diagnostic par la compréhension culturelle des symptômes, de l'entente patient-thérapeute et de la pertinence du traitement. **Conclusion:** Bien que les catégories de diagnostics du DSM IV se retrouvent dans différentes cultures, les cliniciens doivent avoir conscience de l'influence de la culture sur le diagnostic en psychiatrie de l'enfant.

Mots clés: DSM IV, culture, psychiatrie de l'enfant, formulation culturelle

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In the field of adult psychiatry, the influence of cultural factors on the causes, course and outcome of major psychiatric disorders has been well established (Kirmayer et al, 2003; Lopez and Guarnaccia, 2000). The growing awareness of the role of culture and the need to address this issue within the clinical assessment has led the DSM-IV to propose an outline for a cultural formulation which could help us to understand cultural differences in the symptomatology, diagnosis and prognosis of mental health disorders, and to support the elaboration of an appropriate treatment plan (Lewis Fernandez, 2002). In the urban settings of North America, child psychiatrists have to respond clinically to the expanding cultural diversity of children in need of mental health services. At present, however, the literature addressing the universality or the cultural relativity of diagnosis in child psychiatry remains sparse (Canino and Alegria, 2008).

The aim of this paper is to briefly survey the literature on culture and DSM-IV in child psychiatry, to present ADHD as an example of the relationship between diagnostic categories and cultural issues, and to illustrate some of the clinical dilemmas of differential diagnosis of ADHD in a migratory context. In addition, some guidelines around the use of clinical formulation for clinicians working with children in a context of cultural diversity will be proposed.

Diagnostic prevalence and validity of DSM IV child psychiatric disorders across cultures

Most of the large studies on cultural dimensions of DSM child psychiatric diagnoses have focused on a comparison of the prevalence rates of diagnoses across ethnic groups or nations. They emphasize reliability, while usually paying little attention to validity, the latter of which is linked to the meaning of symptom patterns in a given social system

(Kleinman, 1988). The few North American surveys that have used DSM-IV criteria in a community sample to compare ethnic groups in terms of risk for child psychiatric disorders highlight the similarities in diagnostic prevalence rates between Indian, Mexican, European, African, Puerto Rican and American children (Angold, 2002; Costello, 1996; Canino et al., 2004). A large survey ($n = 4,175$) based on a sample of youth between the ages of 11 to 17 years provides comprehensive data on DSM diagnostic profiles for European, African and Mexican American youth in the U.S. Results show that African American youth had lower prevalence rates of disorder compared to other groups surveyed in spite of their disadvantaged minority status. These ethnic differences were however found to largely disappear when adjusting for impairment and covariates (Roberts et al., 2006a; Roberts et al., 2006b). The finding that disadvantaged social status does not appear, per se, to increase the risk for disorder among minority youth, is a finding which is consistent with the results of Canadian studies comparing emotional and behavioural difficulties between Khmer and Central American refugee adolescents, as well as between Caribbean and Filipino immigrant adolescents and their Canadian born peers (Rousseau and al, 2000; Rousseau and al, in press). Alongside this very global picture, studies examining discrete diagnostic entities tend to provide complex findings about the role of culture in child psychiatric disorders.

Attention Deficit/Hyperactivity Disorder as an example of the relationship between diagnostic studies and cultural issues

Attention Deficit/Hyperactivity Disorder (ADHD) is one of the child psychiatric diagnoses that has warranted considerable attention because of its importance in school performance and social adjustment, as well as the availability of effective psychopharmacological and behavioural treatments. Epidemiological studies in different countries have shown a great deal of variation in the estimated prevalence rates of ADHD. It has been suggested that the prevalence of ADHD in the United States in school-age children is between 3 and 5 percent (Cantwell, 1996; Reid et al., 2000). However, prevalence rates tend to vary accord-

ing to the population sampled as well as with the diagnostic criteria and instruments used (Scahill & Schwab-Stone, 2002). Even within Western cultures there is a wide variation in the frequency, recognition, diagnosis and treatment of ADHD (Anderson, 1996). In particular, there appears to be a clear discrepancy between the American and the European perspective on ADHD (Reid & Maag, 1997). In a study estimating the rate of school-age children treatment with stimulant medication, it was found that while the number of treated youth in the U.S. was estimated to be at 1.3 million in 1993, it was only 6000 when contrasted with 8 European countries whose combined population exceeds that of the US (Furman, 1996). Although the recognition and treatment of ADHD is increasing in the UK, its diagnosis and treatment is still reported to be lower in comparison to other western countries (Overmeyer & Taylor, 1999).

One explanation for this striking difference in the prevalence of ADHD is the fact that in the UK, the ICD-10 diagnostic framework is used to diagnose ADHD. The ICD-10 diagnosis of ADHD is much more restrictive than the DSM-IV and requires a higher degree of symptom expression (Rohde et al., 2005; Tripp et al, 1999). Furthermore, unlike the DSM-IV, the ICD-10 does not permit the co-morbidity of ADHD with certain disorders such as anxiety and mood disorders.

A number of epidemiological studies suggest that ADHD is not merely a disorder found in Western societies but that it can be identified in non-western societies such as Taiwan, Korea, Hong Kong, China and Lebanon (Yang et al, 2000; Bathiche 2008, Gingerich, 1998; Leung, 1996). It is difficult however to make any valid comparisons between international prevalence studies due to their diverse research methodologies including differences in rating scales, interview schedules and diagnostic constructs. In summary, the difference in rates are largely attributable to differences in methods and definitions used across studies, even within the same culture (Polanczyk and al, 2007). Given this, it remains a challenge to understand which part of the differences reported in cross cultural comparisons are due to cultural differences.

In many cultures, children display 'hyperac-

tive' and disruptive behavior, which is considered by adults to be unacceptable. The extent to which a behavior is unacceptable influences the way it gets labeled, the diagnostic criteria eventually adopted and the treatment or action undertaken (Gingerich et al., 1998). A study by Mann et al. (1992), compared the ratings of mental health professionals in four different countries on hyperactive-disruptive behaviors. The results indicated that the definition of and attitudes towards hyperactivity are subject to cultural variation. It was found that Chinese and Indonesian clinicians provided higher ratings of hyperactivity than the clinicians from Japan and the United States. Consequently, although uniform and identical rating criteria may be used in different countries, being considered as hyperactive may vary depending on the perception of the clinician.

In addition to the prevailing 'professional culture', societies may differ with respect to the existing Explanatory Model which families put forward to explain illnesses (Kleinman, 1987). Problems that parents or teachers perceive as being serious and warranting attention are shaped by prevailing cultural beliefs and values. For example, in a research study carried out in Lebanon on ADHD symptoms (Bathiche, 2008), key informants (parents and teachers) were shown vignettes of children with the different ADHD subtypes (ADHD-Combined, ADHD-Hyperactive/Impulsive and ADHD-Inattentive) and asked to comment on them. When parents were asked to explain the ADHD-like behavior, none referred to the child in the vignettes as having a condition corresponding to a medical label. For the ADHD-Combined and ADHD-Hyperactive/Impulsive vignette the majority of parents considered the behavior presented to be normal and they were accepting of such behavior, especially in boys. Most of the parents used a behavior problem label but did not consider the behavior to be negative or bad; thus it did not require any kind of intervention. They described the child as being 'wiry' in Arabic, which translates to 'hyperactive' or 'rough' in English. Another term used was 'dammo hammy' which translates to 'hot blooded' and is endorsed with a rather positive meaning of masculinity. For the ADHD-Inattentive vignette, the child was labeled as being 'lazy', 'spoilt', and having a 'slow brain'.

Although the children may have symptoms consistent with ADHD as defined by the DSM-IV they do not appear to be conceptualized by parents as a syndrome or a diagnosis that warrants clinical treatment. Thus the recognition of ADHD symptoms and the labeling of distress as being deviant or pathological depend on the norms of behavior accepted in a particular culture. The latter raises important questions: to what degree is a non-recognized problem pathological? What is the relative importance of a limit in learning capacity, which may be associated with the ADHD like symptoms, versus the stigma and self image problems that may result from a diagnosis? These are complex validity issues which need to be addressed in every specific socio-cultural context in order to avoid category fallacy which, according to Kleinman (1988), is the projection of a diagnostic category in another culture where this category lacks coherence.

The Complexity of Diagnosis and Treatment in a Transcultural Context

Very often culture interacts with a migratory context, which further complicates the diagnostic process though a number of factors including language, development and premigratory history. A young child presenting with ADHD-like behaviour difficulties may pose particular challenges in the diagnostic assessment and treatment process within a transcultural context. This is particularly the case for young refugee children. These youngsters have been exposed to organized violence and are adapting with their families to a new cultural context in the host country. The assessing psychiatrist faces particular challenges in trying to identify and understand the biopsychosocial contributors to the child's difficulties. In addition, the family is in a period of adaptation and the tasks of forming a therapeutic alliance need to take into account the family's readiness to cope with the possibility of their child having a difficulty, as well as their understanding of its cause and their feelings about proposed solutions.

Vignette

M was referred for psychiatric assessment at the age of 8 by his neighborhood school. They were concerned that as a grade 2 student he was not communicating in French, the language

of instruction, he was socially isolated from the other children, he did little work in class and was not progressing academically, and he was disruptive in class. M came with his mother as a refugee to Quebec at the age of 4. The school was not aware of M's history, and were initially concerned that he may have been experiencing some kind of maltreatment. In a psychiatric assessment, mother shared that the family had experienced many traumas, while she was reluctant to share this information with the school for fear that her son may be stigmatized. She explained that M's father had been killed in their country of origin prior to migration, and mother and son were socially isolated in their new host country. M had had little opportunity to learn French prior to attending school. Mother described him as having been an active and agitated child since his toddler years and said that some family members had considered that his difficulties may in part be due to an evil spell. M participated in a psychiatric and psychoeducational assessment and was found to have a normal IQ, learning disabilities and ADHD. Pediatric examination revealed that he may have some fine and gross motor delays, and M was referred for an occupational therapy assessment. Speech and language evaluation was also recommended to consider the possibility of a language disorder. These latter assessments would take some time to access given long waiting lists, and the school felt that M would be best served by being referred to an assessment and treatment setting which could more readily access these services and where teaching was conducted in small classes designed to help youth with learning and behavioural difficulties. M's mother expressed a great deal of resistance to the idea of treatment in a specialized setting. Joint meetings with school personnel and an interpreter led the mother to share some aspects of her refugee experience with them and a strong alliance developed. The school organized a special play group to help this youngster make friends. In addition, individual support and behavioural interventions were introduced at the school for his behavioural difficulties. A trial of stimulant medication was also introduced. Mother also began to take French classes, and was able to help M more with his homework. Finally, mother consulted a traditional healer about her concern that an evil spirit was affect-

ing her son, and she was recommended to say some specific prayers on his behalf. Extended family members in her country of origin did the same. M's behaviour improved at school and at home, he made some friends, and he began to invest more in his academic work. Ongoing family meetings were held conjointly with the school to address M's progress and while M continued to have some academic difficulty, he was no longer oppositional and disruptive.

This case illustrates some of the challenges of diagnostic assessment and treatment of behavioural and learning difficulties in a transcultural context. In this case, the differential diagnosis suggested a picture of comorbidities including anxiety symptoms, oppositional difficulties, ADHD symptoms, learning difficulties, motoric delays and communication difficulties. A specialized multimodal assessment and treatment program in an educational setting was suggested, while this was considered unacceptable by mother, who was concerned that this would be stigmatizing for her child. Our case vignette also illustrates the importance of taking into account the family's migration history and how this can influence both the host country's understanding as well as the family's understanding of a child's difficulties.

Finally, in terms of assessment and treatment provision, this vignette illustrates a finding that we have often encountered in our work with migrant families. While the recommendation of special classes and specialized treatment facilities may technically be quite helpful for a youngster's needs, these are often perceived as stigmatizing. Families often express a wish to maintain their children in their current environment and to receive treatment in close proximity to their neighbourhoods. This can present a challenge to the family, school, and treating team, as specialized knowledge and treatment networks are less readily accessed from these sites. This has led to the development of shared care and proximity-based services to help attempt to address the mental health care needs of immigrant youth (Nadeau and Measham, 2005).

The diagnostic process and the therapeutic alliance

The DSM IV nosology may provide a common professional reference which can be

useful in different cultural settings to evaluate the prevalence of specific problems and to advocate for mental health services, even if the validity of some diagnostic constructs in specific settings is often unknown. However, child scholars are worried about the limited emphasis given to cultural specificities in the application of the DSM IV classification. According to Harper (2001) DSM-IV is a culture-blind classificatory system in which cultural and religious variables are mainly considered as clinical afterthoughts or exotic considerations which have little influence on the treatment plan (Storck and Vander Stoep, 2007). Beyond specific diagnosis, each clinical encounter needs to take into account the cultural context of the family and of the service providers in order for the assessment process to be culturally sensitive and for the treatment plan to be acceptable to the family. Ecklund (2007) advocates for the use of the DSM cultural formulation to organize and conceptualize the role of culture in child intake assessments. The cultural formulation proposed by the DSM IV to complete the axial diagnosis is structured around 5 main categories: (1) identity of the individual; (2) explanations of the illness; (3) psychosocial environment and levels of functioning; (4) relationship between the individual and the clinician; and, (5) overall assessment with implications for diagnosis and care. Although useful as an outline, the cultural formulation is not child oriented and child psychiatrists need to adapt it for children and youth. The developmental history, which has a minor importance in the general cultural formulation is a key issue in a child psychiatry diagnostic assessment and needs to take into account the wide variations in cultural norms of child development. These include, for example, differences in developmental milestones and in the expected age of acquisition of autonomous behaviours (for example in terms of sleeping and eating), as well as divergent methods of parenting and disciplining. The relative importance of intergenerational differences in all of the categories evoked by the cultural formulation (such as identity, explanatory models, perception of the environment) is another key issue in child psychiatry. Much more than in adult psychiatry the elements of the formulation should be considered as dynamic and fluid entities, which are

constantly being reworked by personal, familial and social events as development proceeds.

The cultural formulation cannot be considered as the only solution to the dilemma posed by the cultural context in the diagnostic process. This useful tool needs to be handled by a sensitive clinician. The concept of cultural competence is used to describe the skills needed by clinicians to improve clinical services by taking into account culture. Lo and Fung (2003) propose that we need to develop both generic cultural competency, which includes the knowledge and skills set to work in any cross-cultural encounter as well as specific cultural competences which will enable clinicians to work effectively with specific ethno cultural groups. They suggest that the DSM cultural formulation needs to be completed by a cultural analysis which guides the adaptation of the psychotherapeutic process. Kleinman and Menson (2006) underline the potential problems embedded in the idea of cultural competence – the notion of cultural competence may introduce the idea that culture can be reduced to technical skills, which can be transmitted through a structured training program just like any other expertise. This may lead to stereotyping and simplistic cultural assumptions which may hinder clinical understanding. In order to provide a hands-on training in cultural competence and to support clinicians in the process of adapting the delivery of mental health services for patients and families from diverse cultural backgrounds, Kirmayer et al (2003) suggest that we organize cultural consultation services for mental health practitioners and primary care clinicians. Little is yet known about the efficacy of these forms of training and consultation in improving the outcome of children and youth with mental health problems.

Conclusion

Our professional attempts to destigmatize mental illness are not always successful. In many migrant communities a psychiatric diagnosis is associated with isolation and social exclusion from the reference group. Clinicians who value cultural resources without idealizing them can open up room for negotiation and allow the family to share their doubts about diagnosis, treatment or the effects of medica-

tion. The family often perceives mainstream knowledge and in particular a diagnosis as an imposed certainty; giving them the opportunity to present their perspective paves the way to a therapeutic relationship in which the family and the child feel empowered.

Frequently a refusal to accept a diagnosis and subsequent non-compliance with treatment is associated with difficulties in coming to terms with the implications of a diagnosis, as it has been presented. This sometimes generates a great deal of tension in the therapeutic relationship. The recognition of other systems of knowledge and of their potential value in the evolution of the child's condition may minimize the power imbalance often associated with a minority position in a host society and also create a space where the family and the child can express their concerns about the experience of illness and their interpretation of it.

Clinical observations suggest that taking culture into account in the assessment and subsequent treatment of children and youth does not aggravate the gap existing between the different cultural worlds they belong to but rather transforms the gap into a transitional space where multiple meanings can be constructed to account for the child's experience. This transitional space allows for an interplay between a number of interpretations and strategies to deal with the problem. This introduces a powerful therapeutic tool, as families and clinicians work through the tensions generated by differing perspectives with the goal of reaching some shared understandings of pathways to healing.

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