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Diagnostic Criteria for Schizophrenia and Related Psychotic Disorders: Integration and Suppression of Cultural Evidence in DSM-IV

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Abstract This paper documents the work of the NIMH Culture and Diagnosis Committee on schizophrenia from its inception in 1991 through publication of the final version of DSM-IV. Detailed comparisons are made between the committee’s suggested text and the final published text of the manual, both for general cultural considerations regarding schizophrenia and for specific diagnostic criteria. The paper concludes with a critical assessment of the successes and failures of DSM-IV as a culturally relevant document and a restatement of the rationale for the centrality of culture to any understanding of schizophrenia.

Key words anthropology • culture • diagnosis • DSM-IV • schizophrenia

At the time of preparation of this review of DSM-IV diagnostic criteria for schizophrenia in 1996, we had just marked the centenary of Kraepelin’s distinction in 1896 between ‘dementia praecox’ and manic–depressive psychosis (Kraepelin, 1919/1971). While the 1911 reformulation of the category as ‘the schizophrenias’ by Bleuler (1950) served to elaborate Kraepelin’s phenomenological and prognostic formulations, the importance of a specifically ‘comparative psychiatry’ was already established by Kraepelin in the 1890s with his field observations of symptom differences in south-east Asia (Kraepelin, 1904). Since then, several decades of

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research, conducted largely at the interface of anthropology and cultural psychiatry, have empirically established the role of culture in nearly every aspect of schizophrenic illness: identification, definition and meaning of the illness during the prodromal, acute and residual phases (Jenkins, 1988a, 1988b); the timing and type of onset (WHO, 1979; Karno & Jenkins, 1996); symptom formation in terms of content, form and constellation (Kennedy, 1974; Murphy, 1978; WHO, 1979); the personal and social experience of schizophrenic illness (Jenkins & Karno, 1992; Strauss, 1994; Corin, 1996); the course and outcome of the disorder with respect to symptomatology, work and social functioning (WHO, 1979; Leff & Vaughn, 1985; Karno et al., 1987); and the utilization of and response to treatment (Edgerton, 1980; Telles et al., 1995; Schooler et al., in press). Thus 100 years after Kraepelin’s identification of the need for a comparative approach to the study of schizophrenia, the scientific imperative for cross-cultural research has become all the more compelling.

The reach of culture across all these domains mirrors the nature of culture as fundamental to all human experience, normal and psychopathological alike. Culture invariably shapes the emotional, cognitive and behavioral symptoms assessed in the diagnostic encounter. Yet, for many practicing clinicians and biological psychiatrists, the relevance of culture to schizophrenia has seemed remote at best. In addition to the common lack of familiarity with the transcultural psychiatric research record, the failure to grasp the immediate relevance of culture to schizophrenia may also stem in part from the notion that schizophrenia, perhaps more than any other psychiatric disorder, has been regarded traditionally as: (i) the most biogenetically based of disorders, on the one hand; and (ii) emblematic of the ‘alien other,’ on the other. These symbolic associations are observable not only in the dominant professional discourse of research and teaching but also in the popular discourse of communities, advocacy groups and families.

There are two limitations to these cultural representations. First, appraisal of schizophrenia as a biogenetically based disorder\(^1\) inevitably entails an appreciation of the critical difference between genotype and phenotype in the development and course of the disorder. However, such an appreciation has been slow in coming.\(^2\) This is troubling not only because specific biogenetic markers have yet to be reliably identified but also because the complex multifactorial process of heritability of schizophrenia is certain to be mediated by social and cultural factors. Second, representations of schizophrenia as ‘inherently bizarre’ and ‘fundamentally flawed’ are strongly influenced by Euro-American ethnopsychology. Standard psychiatric texts often prepare medical students and residents with the most bizarre of schizophrenic imagery and case materials. Thus, in the course of clinical work it may come as a surprise to observe that,
whatever truly strange and entangled symptomatology may be present, persons with schizophrenia can in many other respects appear quite normal. Focus on the pathological prompts the anthropologically informed counterpoint that persons with schizophrenia are inter alia no less cultural beings than their non-schizophrenic counterparts (Sapir, 1961; Sullivan, 1962). If the validity of this claim is granted, it follows logically that a cultural framework is integral to the diagnosis of persons with schizophrenia. These premises provide the basis for the specific cultural recommendations for DSM-IV summarized below.

The Development of Cultural Criteria for DSM-IV: The Nature of the Process

The author has served on the NIMH-funded Committee on Culture and Diagnosis since the first meeting in Pittsburgh in 1991. At that time, cultural considerations of the diverse mental disorders were presented with commentaries by experts in the fields of cultural psychiatry and medical anthropology, including schizophrenia and psychotic disorders (Corin, 1996; Karna, 1996; Lin, 1996). Subsequent to this initial meeting, Karna and Jenkins (1993) served as authors of the specific text for inclusion as part of the culturally based diagnostic criteria for schizophrenia and psychotic-related disorders and a background paper summarizing the cross-cultural evidence for cultural recommendations (Karno & Jenkins, 1997). As a premier schizophrenenologist who has conducted extensive cross-cultural research, Karna provided expertise on key diagnostic and epidemiological issues. The present author, a psychiatric anthropologist with a long-standing research interest in schizophrenia, provided an anthropological orientation for recommendations in light of contemporary culture theory of self, emotion, cognition, gender and language.

It is useful to clarify the task put to us. Initially, the DSM-IV Task Force requested all diagnostic workgroups to provide a one page summary that would cover all recommended entries for each disorder. Such a severe space limitation curtailed the possibility for adequate cultural commentary. Subsequent meetings of the Committee on Culture and Diagnosis in Redondo Beach, California in 1993 and San Diego, California in 1994 provided opportunities to present the recommended changes and to appraise the extent of their incorporation into draft and final documents. During this phase, Jenkins reviewed and revised the multiple versions of the various sections for inclusion. Following the original submission (along with the documentary paper by Karna and Jenkins cited above), we were requested by the DSM-IV Task Force to provide cultural commentary on all portions of the sections on schizophrenia and related disorders for culturally pertinent materials. Thus the input requested from us was not
apparently to be restricted to the ‘Specific Culture, Age, and Gender Features’ but rather to cultural issues pertaining to all sections providing information on schizophrenia and related disorders as proposed. In addition, we were asked to comment on the Schizophrenia Subtypes, Simple Deteriorative Disorder, Delusional Disorder, Schizophreniform, Brief Reactive Psychosis and Induced Psychotic Disorders sections.

This second phase was essential for two reasons: (i) to respond to what had (and had not) been incorporated from our work; and (ii) to provide further cultural commentary in light of the final diagnostic criteria which were adopted. This second point is important because at the time of submission of our initial proposals we had not yet been provided with the actual diagnostic criteria which were to be ultimately included. Rather, we were given three separate possibilities under consideration. Our revised recommendations took into account the extent of the changes incorporated from our original proposal and the additional commentaries we designed in light of the final diagnostic criteria. This paper then summarizes this somewhat unwieldy process in light of our original and revised proposals.

Cultural proposals for schizophrenia were of two types, general and specific. First was a comprehensive statement for the overall chapter we felt was relevant for culturally appropriate diagnosis of schizophrenia. Secondly, we provided text for cultural application of each of the specific symptom criteria. Here I present the specific texts (‘Suggested text’) for cultural considerations submitted to the task force, and a status report on whether these entries were included or excluded from DSM-IV (‘final text’). I conclude with an analytic summary.

**General Considerations: Comprehensive Cultural Features**

Given our understanding of culture as an orientation for one’s feeling, thinking and being in the world, we determined that a comprehensive statement concerning cultural factors would be of value in the general introductory section for the chapter on schizophrenia and related disorders. We reasoned that this could be important for two reasons. First, many practicing clinicians may only refer to this chapter (rather than the informative ‘Cultural Formulation’ section which was ultimately published in the last of nine clinical information appendices to DSM-IV). First, we felt a brief, yet comprehensive, statement of how culture could be expected to relate specifically to schizophrenia was important to alert the diagnostician to potential problems which could be identified and addressed through consultation as necessary. Second, we had anticipated (incorrectly, as it turns out) that, like DSM-III-R, the new manual would include a
section describing characteristic symptoms involving multiple psychological processes. The introductory information for the schizophrenia section had provided clinicians with useful information on schizophrenic processes. For example, DSM-III-R (American Psychiatric Association, 1987: 189) included information that a loss of self in schizophrenia was thought to derive from ‘the sense of self that gives the normal person a feeling of individuality, uniqueness, and self-direction (which is frequently disturbed in Schizophrenia.’ Accordingly, we determined that anthropological and cultural psychiatric perspectives on such processes could help to avoid ethno psychological assumptions about the self which may not be culturally valid for non-Euro-American populations (Fabrega, 1989). The statement proposed read as follows:

Suggested text (Karno & Jenkins, 1993: 37).

An essential feature of a culturally appropriate diagnosis of Schizophrenia is that all prodromal, actively psychotic, and residual symptoms be evaluated with reference to the patient’s cultural context. This includes the patient’s sense of self, cognitive style, beliefs, affects, perception, volition, behavioral repertoire, and language and communication.

Final text (APA, 1994). This general statement was not included in DSM-IV.

Next, we considered that a general statement about the substantial cross-cultural variation in both the frequency and form (e.g. auditory versus visual hallucinations) should be included:

Suggested text (Karno & Jenkins, 1993: 41).

Although the primary symptoms of schizophrenia have been reported in diverse parts of the world, there is evidence for substantial cross-cultural variation in the form and frequency of schizophrenic symptomatology.

Final text (APA, 1994). This general statement was not included in DSM-IV. Instead, a statement for symptoms (and course and outcome, discussed below) editorially abstracted by the task force was included in the section on Specific Culture, Age, and Gender Features: ‘Cultural differences have been noted in the presentation, course, and outcome of Schizophrenia’ (APA, 1994: 281).

To the extent that ‘cultural considerations’ were considered by the DSM-IV Task Force as relevant to the introductory section, they appear first on the second page of introductory materials in relation to the distinction between ‘bizarre’ and ‘non-bizarre’ delusions: ‘Although bizarre delusions are considered to be especially characteristic of Schizophrenia, “bizarreness” may be difficult to judge, especially across different cultures’ (APA, 1994: 275).
Culture is also introduced early on per a specific suggestion on our part, which cautions that: ‘Hallucinations may also be a normal part of religious experience in certain cultural contexts’ (APA, 1994: 275).

However, the fuller version of our suggested text for hallucinations was more complex, and is summarized below as part of the specific diagnostic symptom criteria.

**Analytic Summary**

Both our comprehensive statement of cultural relevance for self, cognition, emotion and behavior and our general statement of cross-cultural variation in the form and frequency of schizophrenic symptoms were excluded. Instead, culture is referenced in relation to: (i) ‘bizarre’ delusions, and (ii) hallucinations distinguished as potentially ‘a normal part of religious experience in certain cultural contexts’ (APA, 1994: 275).

The section on ‘characteristic symptoms involving multiple psychological processes,’ is deleted from DSM-IV, with new sections appearing as ‘Associated descriptive features and mental disorders,’ ‘Associated laboratory findings’ and ‘Associated physical examination findings and general medical conditions.’ Yet, as recognized by pioneers such as Kraepelin and Bleuler, a considerable challenge in treatment is the phenomenological complexity of schizophrenic process which may manifest, for instance, as an alteration of psychocultural processes such as sense of self. The decision to limit or delete complicated materials for what, in this historical era, appears to be regarded as psychiatric ‘soft signs’ (psychological process, cultural sense of self) demotes clinical information that for a century has been regarded as central to the treatment of schizophrenia. In sum, the task force appears to have excluded culture when culture is construed as: (i) the generalized context for schizophrenic experience; (ii) a source of structure for schizophrenic symptomatology (e.g. as type of hallucination, catatonia, etc.); and (iii) a source for substantial variation across societies.

**Specific Considerations: Cultural Features of Individual Symptom Criteria**

In DSM-IV, this section contains one paragraph each for cultural, age, and gender-related features. The paragraph on cultural features begins with a general statement, not suggested by Karno and Jenkins, that ‘Clinicians assessing the symptoms of Schizophrenia in socioeconomic or cultural situations that are different from their own must take cultural differences into account’ (APA, 1994: 285). Below I document the suggested text for cultural features in relation to: (i) each individual symptom criterion,
(ii) gender, (iii) socioeconomic status, and (iv) course and outcome. This is followed by a notation of how our recommendations were incorporated, modified or deleted. As with the general features above, an analytic summary concludes the review.

**Individual Symptom Criteria**

**Diagnostic Criterion A1: Delusions**

*Suggested text* (Karno & Jenkins, 1993: 41).

Delusions must be evaluated with reference to cultural and religious belief systems. For example, belief in witchcraft or sorcery is common cross-culturally. Caution should be exercised when probing these domains because patients may be reluctant to divulge their views if they expect an unsympathetic response.


Ideas that may appear to be delusional in one culture (e.g. sorcery and witchcraft) may be commonly held in another.

**Diagnostic Criterion A2: Hallucinations**

*Suggested text* (Karno & Jenkins, 1993: 37, 38, 41).

There are three areas in which culture must be taken into consideration in the psychiatric assessment of psychotic hallucinations: (i) the distinction between normal-range hallucinatory experience, on the one hand, and psychotic hallucinations, on the other; (ii) the content of hallucinations; and (iii) the form of hallucinations. In some cultural contexts, hallucinations may be a normal part of everyday experience (e.g., visual hallucinations of God, the Virgin Mary, or the Saints in Latin American cultures). However, culturally devalued psychotic states in which hallucinations are present have also been observed cross-culturally. Psychotic hallucinations may vary both in content (e.g., spirit, demon, popular performing artist) and form (e.g., visual, auditory, tactile, olfactory). (See Karno and Jenkins DSM-IV supporting paper for documentation)...Visual hallucinations are apparently more common in Asian, African and Latin American cultural contexts.... Such culturally normative experiences must be differentiated from culturally devalued psychotic states in which visual hallucinations are present.


In some cultures, visual or auditory hallucinations with a religious content may be a normal part of religious experience (e.g., seeing the Virgin Mary or hearing God's voice).
Diagnostic Criterion A3: Disorganized Speech (e.g. frequent derailment or incoherence)

Suggested text (Karno & Jenkins, 1993: 38).

Language barriers in the diagnostic process may present a challenge for the culturally appropriate assessment of disorganized speech. In addition, there may be cultural–linguistic variation in narrative styles that affect the logical form of verbal presentation.


In addition, the assessment of disorganized speech may be made difficult by linguistic variation in narrative styles across cultures that affects the logical form of verbal presentation.

Diagnostic Criterion A4: Catatonic Motor Behavior

Suggested text (Karno & Jenkins, 1993: 38).

Variations in catatonic symptomatology have been observed cross-culturally. For example, catatonic schizophrenic behavior has been reported as relatively common in some parts of Asia.


Catatonic behavior has been reported as relatively uncommon among individuals with Schizophrenia in the United States but is more common in non-Western countries.

Diagnostic Criterion A5: Negative Symptoms (i.e. affective flattening, alogia or avolition)

Suggested text (for general introductory statement) (Karno & Jenkins, 1993: 38).

The cross-cultural assessment of negative symptoms may be difficult since systematic data in this area are yet to be collected.

Final text (APA, 1994). Not included

Flat Affect

Suggested text (Original) (Karno & Jenkins, 1993: 41).

Flat affect must be carefully assessed to avoid the misdiagnosis of a psychotic disorder. Cultures vary in their typical styles of emotional experience and expression, and affective displays must be examined with reference to the patient’s cultural background. In addition, cultural styles may vary by gender within cultures, and implicit rules for interaction between men and women may differ. This could be especially relevant when clinical interviewers are not of the same gender as the patient . . .
**Additional suggested text** (Karno & Jenkins, 1993: 38).

Eye contact and body language are all strongly influenced by the patient’s gender and cultural background. Failure to adequately consider the patient’s cultural context with respect to variations in emotional experience and expression could lead to the misdiagnosis of flat or inappropriate affect. Cross-cultural data collected by the World Health Organization have indicated a very broad range in the frequency of flat affect.

**Final text** (in introductory section) (APA, 1994: 276).

Affective flattening is especially common and is characterized by the person’s face appearing immobile and unresponsive, with poor eye contact and reduced body language. Although a person with affective flattening may smile and warm up occasionally, his or her range of emotional expressiveness is clearly diminished most of the time. . . .

(in section on ‘Cultural, Age and Gender Features’) (APA, 1994: 281).

The assessment of affect requires sensitivity to differences in styles of emotional expression, eye contact, and body language, which vary across cultures.

**Alogia**

**Suggested text** (Karno & Jenkins, 1993: 39).

Sociolinguistic considerations may be relevant in the assessment of alogia. If the psychiatric assessment is conducted in a language different from that of the patient’s primary language, care must be taken to ensure that alogia is not related to linguistic barriers but is instead related to true psychotic confusion.

**Final text** (APA, 1994: 281).

If the assessment is conducted in a language that is different from the individual’s primary language, care must be taken to ensure that alogia is not related to linguistic barriers.

**Avolition**

**Suggested text** (Karno & Jenkins, 1993: 39).

Disturbances of volition must also be carefully assessed in light of the patient’s cultural and socioeconomic context. The cultural meaning of self-initiated, goal-directed activity can be expected to vary across diverse settings.

**Final text** (APA, 1994: 281).

Because the cultural meanings of self-initiated, goal-directed activity can be expected to vary across diverse settings, disturbances of volition must also be carefully assessed.
GENDER

Suggested text (Karno & Jenkins, 1993: 41).

In addition, cultural styles may vary by gender within cultures, and implicit rules for interaction between men and women may differ. This could especially be relevant when clinical interviewers are not of the same gender as the patient.

Final text (APA, 1994). Not included.

ETHNICITY AND SOCIOECONOMIC STATUS

We suggested a general statement regarding the importance of evaluating socioeconomic status with reference to the patient’s particular cultural context, which was edited for inclusion as follows.


Clinicians assessing the symptoms of Schizophrenia in socioeconomic or cultural situations that are different from their own must take cultural differences into account.

Suggested text, specific statement (Karno & Jenkins, 1993: 41)

Failure to adequately consider an ethnic minority patient’s sociocultural context may result in misdiagnosis. Investigations have demonstrated that lower socioeconomic status African-American and Hispanic patients are more likely than non-Hispanic whites to be misdiagnosed with schizophrenia when a diagnosis of affective disorders (with psychotic features) may be appropriate.


There is some evidence that clinicians may have a tendency to over-diagnose Schizophrenia (instead of Bipolar Disorder) in some ethnic groups.

Quite independently of any of the committee’s recommendations on socioeconomic status, the following statement on ‘work functioning’ included in the final text requires some comment:

‘Many individuals are unable to hold a job for sustained periods of time and are employed at a lower level than their parents (“downward drift”). The majority (60–70%) of individuals with Schizophrenia do not marry, and most have relatively limited social contacts’ (APA, 1994: 277–278).

There is a considerable scientific problem with DSM-IV’s apparently casual acceptance of the ‘downward drift’ hypothesis while neglecting the equally well-supported competing hypothesis that adverse social conditions may contribute to the disproportionate development of schizophrenia
among lower socioeconomic segments of the population. The monumental and rigorous NIMH-sponsored Epidemiological Catchment Area studies provide the best data we have on this issue, as summarized by Keith, Regier and Rae:

A dramatic difference in prevalence of schizophrenia emerges between the lowest and the highest socioeconomic classes. . . . The difference is consistent across all time intervals (one month, six months, one year, and lifetime diagnosis) and for schizophrenia, schizophreniform disorder, and the combined diagnoses. The lifetime prevalence of the combined diagnosis for the lowest SES group (level V) is 2.5%; for the highest (level I), 0.5%; thus, schizophrenia is almost five times more common at the bottom of the socioeconomic ladder than it is at the top. With respect to the socioeconomic status prevalence data, the findings are consistent with studies done 50 years ago, showing that schizophrenia was overrepresented in the lowest classes . . . While the debate between the ‘downward drift’ hypothesis and the psychotogenic property of lower class life seems to have been muted over the past decade, the finding of increased prevalence in the lower classes persists. Cause or effect resolution must await further research. (1991: 46–47)

It is not clear to me why this puzzle could not be quickly resolved by comparing parental SES level with that of patients. While there can be little doubt that persons with this illness do indeed ‘drift downward’ from parents’ higher socioeconomic status, the ‘dramatic differences’ can hardly be accounted for through that mechanism alone. This suggests that, among those who are vulnerable, stressful living conditions and events inevitably play a key role in the onset and development of the disorder. Among lower socioeconomic segments of society, the primary difficulty may not be so much in holding down a job but rather in finding one.

**Course and Outcome**

_Suggested text_ (Karno & Jenkins, 1993: 41).

Cross-cultural evidence suggests a better course and outcome for Schizophrenia in developing nations.

_(Revised, Karno & Jenkins, 1993: 39)._  

Better outcome for schizophrenia in developing nations is likely related to factors of the social and cultural environment. Family factors which have been identified include non-critical, tolerant attitudes and behaviors.


Individuals with Schizophrenia in developing nations tend to have a more acute course and a better outcome than do individuals in industrialized nations.
Also noteworthy is the apparent responsiveness of the task force to delete text not suggested by us regarding an interpretation of better course and outcome cross-culturally:

Deleted text (as earlier suggested by task force).

This (cross-cultural difference in course/outcome) may reflect greater tolerance for deviant behavior in these countries because of a greater family cohesiveness and lower levels of stress to perform at high occupational levels.

Our commentary on text above (Karno & Jenkins, 1993: 39).

This interpretive comment on the cross-cultural data documenting better outcome in developing nations is problematic. Our concern here is that this statement is too hypothetical and quantitatively modeled. There is insufficient empirical evidence that better outcome cross-culturally is due to greater tolerance for deviance. This statement may be too general, since it is more likely that there are different kinds of tolerance for different kinds of symptoms. The (above) reference to ‘lower levels of stress to perform at high occupational levels’ is also too hypothetical and runs the risk of characterizing work in developing countries as not of a ‘high occupational level.’ We simply recommend that the statement . . . be eliminated.

Finally, we had also suggested changing an earlier draft which suggested that ‘complete remission, i.e., a return to full premorbid functioning in this disorder is probably not common – perhaps 10%.’ Our response to this assertion was to point to the cross-cultural record to conclude that such a statement is not empirically defensible. The issue becomes, as we stated, ‘whose 10%?’, urging that if psychiatric science is to become a global science (i.e. concerned with the whole of human populations), comparative data must be incorporated into basic scientific models of schizophrenia (Karno & Jenkins, 1993: 39).

In commenting on the ‘subtypes’ of schizophrenia, we noted that catatonia is apparently common in some parts of the world (as incorporated, below) but also that

Suggested text (Karno & Jenkins, 1993: 40).

It is important to note that all of the ‘types’ reviewed in this section appear to be formulated on the basis of North American and European symptom profiles. These may or may not cohere similarly as subtypes of schizophrenia cross-culturally.

Final text (APA, 1994). This does not appear.

With respect to other psychotic disorders and psychiatric disorders not otherwise specified, we referred the reader to the Cultural Considerations section of the Schizophrenia section. Given the multitude of such disorders, we can only briefly review these further.
For schizophreniform disorder,

Suggested text (Karno & Jenkins, 1993: 41–42).

The temporal boundary distinguishing Schizophreniform disorder from Schizophrenia is more problematic in the cultural contexts of many developing nations where studies have indicated a generally greater prevalence of rapid recovery from psychotic disorders. . . . There is almost no data on culture and delusional disorders (and) induced psychotic disorders are customarily diagnosed within the context of family or equivalent relationships, however some cultures apparently value hallucinatory experiences which are generally not psychopathologic . . . although large-scale and careful epidemiologic studies are still lacking in most of the developing world, numerous clinical reports strongly suggest that acute psychotic disorders, often reactive to stressful situations and subject to rapid resolution, may be more common than in industrially developed cultures. Moreover, evidence for better prognosis of psychotic disorders of gradual onset has been noted in lesser developed countries.

Final text (under Specific Culture, Age and Gender Features) (APA, 1994: 291).

There are suggestions that in developing countries, recovery from Psychotic Disorders may be more rapid, which would result in higher rates of Schizophreniform Disorder than of Schizophrenia.


Some cultures have widely held and culturally sanctioned beliefs that might be considered delusional in other cultures.


It is important to distinguish symptoms of Brief Psychotic Disorder from culturally sanctioned response patterns. For example, in some religious ceremonies, an individual may report hearing voices, but these do not generally persist and are not perceived as abnormal by most members of the person’s community.

An additional disorder under consideration and for which we provided critical commentary was Simple Deteriorative Disorder. As proposed, this disorder was associated with poverty, ‘though probably as a result of downward drift.’ Persons with the disorder were described as ‘eccentric drifters at the margins of society’ and ‘superstitious.’ We challenged the downward drift hypothesis and recommended deletion of language we considered to be problematic. Finally, we noted that there was a ‘lack of data and hence generalizability of the characterization of Simple Deteriorative Disorder cross-culturally’ (Karno & Jenkins, 1993: 40). In the final version of DSM-IV, Simple Deteriorative Disorder does not appear.
**Analytic Summary**

For a summary analysis of delusions and hallucinations, it is useful to reproduce our response to the first draft returned to us subsequent to the submission of our original proposal:

**Specific Problems with the Text on Delusions and Hallucinations (or Criteria A1-2)**

1. Whereas cultural considerations are included for symptom criteria A1 or ‘delusions,’ they are not included for criteria A2 or ‘hallucinations.’ This is a problem because: (i) an erroneous impression may be conveyed that culture is relevant for ideational symptoms but not for perceptual symptoms; and (ii) both the content (e.g. spirits, demons) and form (e.g. visual, auditory, tactile, olfactory) of hallucinations have been observed to vary cross-culturally (see Kano & Jenkins, 1997). Culture must therefore be taken into consideration for both the content and form of hallucinations.

2. In addition, culture is important to the diagnostic assessment of hallucinations for distinguishing between normal-range hallucinatory experience, on the one hand, and psychopathological hallucinatory experience, on the other (Karno & Jenkins, 1993: 37–38; and see Kano & Jenkins, 1997).

For criteria A3–A5, much of the language suggested by us was retained. An important deletion of our suggested text, however, occurred for negative symptoms, which we cautioned may be difficult to assess in light of scant published cross-cultural data comparable with data available for North America. Not included was our suggestion that *both culture and gender* may mediate affective communication and that failure to observe this could result in the misdiagnosis of flat or inappropriate affect. We also cited data from the WHO IPSS (1979) which documented quite an extraordinary range in the presence of flat affect cross-culturally. This also was deleted from the final DSM-IV document. Finally, while we specifically advised that the assessment of avolition be considered in light of both the patient’s socioeconomic and cultural contexts, only the cultural meaning of self-initiated, goal-directed activity was listed as variable across diverse settings.

Our suggested statements of better course and outcome for schizophrenia cross-culturally were not adopted in the form that we had recommended. By reinterpreting the cross-cultural data as ‘more acute course’ (a curious phrase since ‘acute’ is generally used more for onset than course), the cross-culturally more favorable course of illness may be interpreted as reducible to a premorbid factor such as type of onset. The WHO data
specifically ruled out variance in relation to type of onset; cases with an acute onset generally had a favorable course (WHO, 1979). The cross-cultural differences were found among those cases with insidious onset (see Edgerton’s 1980 summary and analysis). The conclusion by the WHO (as well as numerous other transcultural psychiatric investigators), that the variance is likely to be due to social and cultural factors, was not included. Also deleted was our note that the various ‘sub-types’ of schizophrenia may or may not cohere similarly cross-culturally. In sum, there appears to be a bias toward: (i) excluding relevant data which supports substantive cross-cultural variation in schizophrenic disorders; (ii) statements of gender and socioeconomic status in relation to culture and psychopathology; and (iii) the interpretation of better outcome for schizophrenia in developing countries as probably linked to sociocultural factors. It also seems possible that a hypothesis which has long since been rejected in transcultural psychiatry in the wake of empirical evidence to the contrary – that is, better outcome in developing nations is simply due to higher rates of schizophreniform disorder – has yet to be supplanted in DSM-IV.

Assessing the Outcome: Shortcomings, Accomplishments and Challenges for the Future

Here, I appraise the overall outcome of this long, challenging and experimental process. The task force is to be congratulated for an appreciation that cultural factors are requisite to psychiatric practice in the 1990s both in the U.S. and globally. Investigators working at the interface of psychiatry and anthropology must collectively take pride in what we have accomplished. As we have seen, the section on ‘Cultural, Gender, and Age Features’ included a general statement of cultural differences in the presentation, course and outcome of schizophrenia (APA, 1994: 281). Much of the specific language for individual symptom criteria for delusions, disorganized speech, goal-directed activity, and affective, linguistic and narrative styles was published as originally suggested. Having acknowledged these significant steps, a discussion of the particular ways in which DSM-IV can be said to fall short is required. Failure to incorporate the general statements misses an opportunity to convey a broader understanding of how culture may structure schizophrenic disorders. As recommended, this would have included one’s sense of self, perception, cognitive style, emotion and behavioral repertoire (Jenkins, 1991). In addition, the substantial cross-cultural variation in both the form and frequency of schizophrenic symptoms was not adequately represented. The primary way in which culture is represented in the manual is not with respect to the structure of symptomatology (as in auditory or visual or tactile hallucinations) but rather in the content. Specifically, there appears to have been a
consistent tendency among the DSM-IV Task Force to take culture as relevant in relation to ‘beliefs’ (for a critique of ‘belief’ as an analytic category, see Good, 1994) but not to take culture as of broad relevance for the organization of schizophrenic experience. Recall also that DSM-IV introduces culture in the general descriptive materials for schizophrenia in association with the ‘bizarre,’ that is, the distinction between what constitutes bizarre and non-bizarre delusions. While there was inclusion of our suggestion that hallucinations may be a part of normal religious experience in some cultural contexts, the other incorporation of culture occurs in relation to the tenacious Euro-American ethnopsychological representation of schizophrenia as a cultural emblem of the bizarre, analyzed in the introduction to this paper.

What appears to be most at stake is a conceptual gap between the nature of culture as understood by cultural anthropologists and as understood by non-anthropologically trained psychiatrists. The inclusion of culture as primarily pertaining to ‘beliefs’ runs the risk of trivializing or minimizing the relevance of cultural theory and data for our understanding of schizophrenia. As such, DSM-IV may have missed the opportunity to more fully represent cultural information useful to the diagnostic endeavor in North America and elsewhere. The specific decision to cite a tendency to overdiagnose schizophrenia generally for ‘some ethnic groups’, but not specifically for African Americans as had been recommended, results in a missed opportunity to alert practitioners to cultural and socioeconomic factors that should be reflected upon carefully.

I am convinced that the most serious problem with DSM-IV information on schizophrenia and other psychotic disorders is the task force’s selective relegation of cultural information to the ‘Specific Culture (Age and Gender) Features’ paragraph as opposed to the general descriptive section. This decision results in the template for schizophrenia being derived from North American and European clinical data. One example from the course and outcome data will illustrate my point. While in the ‘Cultural Features’ section it is acknowledged that ‘Cultural differences have been noted in the presentation, course, and outcome of Schizophrenia’ and ‘Individuals with Schizophrenia in developing nations tend to have a more acute course and a better outcome than do individuals in industrialized nations’ (APA, 1994: 281), the ‘general’ and presumably universally applicable information on ‘Course’ is summarized as ‘Complete remission (i.e., a return to full premorbid functioning) is probably not common in this disorder.’ Thus we have one set of data for the West (or as some prefer, the ‘North’) and one for the ‘Rest’ (i.e. non-Western, or population ‘pockets’ when referencing variations in prevalence rates, see APA, 1994: 282 (emphasis added)). It would seem obvious that these two versions of the research and clinical construct we call ‘schizophrenia’ are not compatible with one another.
Equally evident is which version is the default or ‘primary’ model and which is shunted to the empirical sidelines. As became clear at the initial meeting of the Committee on Culture and Diagnosis in dialogue with the DSM-IV Task Force representatives, the representation of DSM-IV as a document of global application is seriously undermined by neglecting to incorporate cross-cultural data into diagnostic models. Similarly, culture in relation to gender and socioeconomic status is seriously neglected for the epidemiological, symptom presentation and course of schizophrenic disorders. While we made suggestions for text to be included on both of these fronts, the disproportionate emphasis on culture as independent of these other critical contextual variables must be corrected as part of our future efforts. The initial one page limit for listing cultural considerations played a significant role in this regard. To address these problems, the process of interchange between the task force and the Committee on Culture and Diagnosis must be vastly improved to ensure that dialogue and debate unfold in a way that can better serve the millions of patients and families who live daily with schizophrenic illness. As is evident from the commentaries of other members of the Committee on Culture and Diagnosis in this volume, the level of frustration over opportunities missed at times ran high. The process of writing DSM-IV does indeed provide a paradigm case for the sociology of knowledge in which the hegemonic forces of biological psychiatry at times overwhelmed the voices of culturally oriented psychiatrists and anthropologists. There was at times some collective sentiment by our committee that such forces threatened to co-opt what might otherwise have been good faith efforts of scientists working together to represent the state of the art for psychiatric research in relation to cultural theory and empirical data. My own position, certainly tested at numerous times along the way, remains that DSM-IV is culturally a much improved document when set alongside its predecessor. Commitment to the interdisciplinary endeavor through the historical tides of paradigm shift in psychiatric science is a challenge certainly faced regularly by all on the Cultural Committee. However, the strong conviction that psychiatric science can and indeed must become a global science (see Kleinman, 1988) which takes into account the diversity of human groups is the fuel for the engine of a committee such as ours. Our work suggests that appreciation of the impressive strides of cultural psychiatry will be furthered by empirical research programs which maintain an interdisciplinary dialogue with research in aligned fields.

Notes

1. The perception of schizophrenia as ‘the most’ biogenetic of disorders is not borne out by current research findings which, while still controversial, suggest
that some affective disorders, for example, may have a higher genetic loading
than schizophrenia.

2. For a sophisticated appreciation of the complexity of issues pertaining to
phenotype and genotype across diverse populations in the case of psycho-
pharmacology, the research of Keh-Ming Lin and colleagues (Lin, 1995; Lin,
Poland & Anderson, 1996) has served to advance our understanding of why
different groups require differing optimal doses of medications. Increasingly,
the field can no longer endorse that idea that ‘one size fits all’ whether
symptom formation, medication, or course of illness be our concern.

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