LIMITATIONS/BIASES OF DSM-IV IN TRINIDAD AND TOBAGO

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In fully addressing the context within which the current Diagnostic Statistical Manual (DSM-IV) is founded, it is necessary to demonstrate its attempts at achieving cultural significance but there is also a need to discuss with rigor the inherent biases that are present within it. This paper will firstly present a brief history of this statistical manual which will highlight that it is in a process of evolution as empirical research continues to reshape the manner in which mental disorders are classified. Furthermore, the basis for such an endeavour is the assumption that mental illness is a universal concept with the ability to be applied cross culturally and in a variety of settings. This will be challenged from a perspective that ethnocentric biases within the DSM, as well as factors specific to the Caribbean experience impact the manifestation and interpretation of mental illness in Trinidad and Tobago, proving it difficult to apply the DSM-IV “wholesale” without further adjustment suitable to the cultural context.

The Diagnostic Statistical Manual (DSM) was originally formulated to provide clear descriptions of diagnostic categories in order to enable clinicians and other investigators to diagnose, communicate, study and treat various mental disorders (APA, 1980). Despite this attempt at universality, the DSM in the past has adhered to a vague nomenclature of symptomatology without much if any consideration for variability across cultures. The DSM III was designed to provide comprehensive descriptions of the manifestations of disorders without regard to aetiology, except for those disorders that included aetiological statements as part of their definitions. This version also introduced multiaxial diagnosis with explicit diagnostic criteria for each of these disorders. The former allowed for the application of a biopsychosocial model, a characteristic which was directly attributed to its success in the extensive use of the DSM by clinicians both within the United States as well as the varying backgrounds in non-western societies.

In moving forward towards DSM-IV, this edition of the manual was intended to mirror its international counterpart, The International Classification of disorders in its tenth edition (ICD 10). There was a drive for improvement upon its former edition (ICD 9) which was determined to be necessary due to well established criticisms including, for example, presence of sex bias and ethnocentrism within the manual that prompted a thorough review of the available empirical evidence. Despite thorough research, preparation and effort that preceded the articulation of the DSM-IV, it is not without its own shortcomings. The current version of the manual has been extensively disparaged for various reasons, but the authors
(Frances, First & Pincus 1995) maintain a different opinion and have indicated that the controversies ensuing after its publication was primarily due to how the manual was interpreted and sequentially applied. They also note that DSM-IV was formulated in line with psychiatric diagnosis being self correcting and in a constant process of evolution; in line with their assertion that as societies change so do the classification of mental disorders. According to the editors of DSM-IV (Frances et al. 1995, 14), “this version of the manual attempted to forge some middle ground between naïve realism and a heuristically barren solipsism.” Simply put, “classification of mental disorders are meant to be used as heuristic constructs that, along with clinical judgement, form the basis for treatment response, predicting course and management decisions” (Frances et al. 1995, 14).

Despite attempts at improving the classification system, there are still biases that exist within DSM-IV, including ethnocentric biases that impact many clinicians who work outside of the United States. Various cross cultural researchers have written at length on this subject and, one of its leading researchers notes that “Much cross cultural research in psychiatry has been initiated with the desire to demonstrate that psychiatric disorder is like any other disorder and therefore occurs in all societies and can be detected if standardized diagnostic techniques are applied” (Kleinman 1988, 18).

This has far reaching implications as there is substantial empirical research that attests to differences in the expression of symptoms associated with the more severe disorders like Schizophrenia, but also the more commonly encountered mental illnesses such as depression, anxiety as well as somatoform disorders in developing countries. The literature has demonstrated that the latter has a unique clinical presentation that is specific to the society within which it is encountered. Therefore, it can be surmised that culture plays a pivotal role in variations within which stress or distress manifests itself.

Culture can be defined as “The values, beliefs and practices that pertain to a given ethno cultural group” (Betancourt & Lopez 1993). The strength of this definition has been debated where researchers have accepted a more pertinent description which states that the expression of distress is related to a specific belief and/or orientation. This has particular significance when applied to the cultural context that exists within Trinidad and Tobago, which will be discussed later in the discourse. Culture in itself is not a static phenomenon but a dynamic and creative process that changes over time (Greenfield 1997) and if researchers fail to recognize this, it will lead to a misrepresentation of what culture is. This therefore allows the clinician to conceptualize the aspects of culture that matter within a specific context (Lopez & Guarnaccia 2000). With relevance to this discussion, an accurate definition of culture is crucial to an understanding of how this factor affects the clinical presentation of some disorders.

Moreover, there also has not been enough emphasis on the impact that the social world has on mental illness. The issue of gender, which is a social construction, and the manner in which this impacts the manifestation of symptoms among men and women and how it is classified in DSM-IV also needs to be addressed. Anorexia Nervosa is classified as a mental disorder in DSM-IV. From the research available, this disorder is mostly limited to western countries and the fact that it should
appear at all within the main body of DSM-IV is questionable. Cultural researchers and psychiatrists alike have argued that by the subjective nature in which this disorder presents itself, it should be included in a separate axis identified as "Culturally bound syndromes." It should be noted that 80% of the world's population comprise non-western societies; therefore one can posit the question as to whether the DSM-IV is simply a western classification of disease without due regard for mental illness in culturally diverse settings?

This debate is further exacerbated by the fact that there is little consensus on the extent to which psychiatric disorders or syndromes are universal in nature or the extent to which they differ in their core definitions and constellation of symptoms as influenced by cultural factors. Despite the substantial body of research on the latter, plaguing cross cultural research is a lack of biological markers, imprecise measurement and a lack of a gold standard for validating most psychiatric conditions (Robins 1985). Nevertheless, it can be argued that mental illness is not a biological given otherwise its presentation would be similar across societies. In some cases, this has been shown for disorders that have biological substrates such as Schizophrenia as core symptoms can be illustrated across cultures. However, schizophrenia in developing societies is most likely to have an acute onset rather than a chronic mode of onset which is more common in Western societies (Kleinman 1988). This would suggest that the DSM-IV continues to disregard such cultural differences as the diagnostic criteria currently speaks to continuous signs of disturbance over a six month period. Therefore, it can be argued there is still some level of ethnocentric bias present within the current edition of the Diagnostic Statistical Manual.

Hickling (2005) also elaborates on the above in his work which describes how the occurrence of schizophrenia differs in the United Kingdom as compared to Afro-Caribbean peoples in their native land. Hickling (2005, 257) notes that:

The reportedly low admission rates in Jamaica call into question the consistently reported higher rates of schizophrenia in African Caribbean populations living in England compared to white people. These studies indicated a risk ratio for schizophrenia more than threefold to sixfold as high as that in the white indigenous population, and up to eighteen times as high for the children of African Caribbean immigrants.

This brings to light one of two things for further consideration. The fact that mental illness is a universal phenomenon can be supported and contradicted by the above statement. This can be shown through the impact of culture and how this ties into the former by re-emphasizing that ethnocentric bias may well be present in such a system that proclaims one more at risk for a particular disorder in one country and less so for one in another country. The possibility that some of these individuals were misdiagnosed continues to suggest that mental illness may only be universal in certain respects, as clearly if mental illness were not a subjective phenomenon the diagnosis of such would prove to be consistent across countries. Hickling (2005) highlights this further in his study by showcasing how a black psychiatrist and a white psychiatrist differed in their diagnoses of clients. "Of 29 African and African Caribbean patients who received a diagnosis of schizophrenia, the diagnoses of the British and Jamaican
psychiatrists agreed in 16 (55%) and disagreed in 13 (45%))” (Hickling 2005, 258).

In addition, the argument that mental illness is a universal phenomenon can also be challenged by the fact that biological origins cannot be as convincingly demonstrated for Axis II disorders, nor does symptoms of depression and anxiety manifest itself uniformly in cross cultural research. Symptomatology of depression varies across societies where the marked predominance of somatic complaints is well documented among depressed and anxious patients in non-western societies. The prevalence of suicide has also been noted to be less common in Third World societies with some notable exceptions like Japan (Headley 1983). This further reiterates the importance of cultural consideration in the DSM and the fact that mental illness is universal in terms of its occurrence but the variance in expression would suggest that it is neither fully universal nor biological in nature.

With regard to the Caribbean experience, specifically in Trinidad and Tobago; culture is not the sole variable that accounts for differences in the display of mental illness among ethnic groups as religious affiliation also has a key role to play. Specifically, the mythical-magical dimension of mental illness is entrenched within the psyche of Caribbean peoples. There is no line drawn between religion and psychiatry where mental illness is often attributed to possession states (Maharajh 2001). Access to mental health care is affected because of these attitudes as the first port of call in most cases is often a visit to a priest or traditional healers regardless of religious persuasion. “Cultural, traditional and religious belief systems often delay contact with primary health care providers and often result in negative outcomes despite the establishment of well structured programs and attempts at strengthening community based care throughout the society” (Maharajh 2001, 45).

Furthermore, the life of a psychiatrist/psychologist in the Caribbean is worsened by the rule of supernatural phenomena and divine apparitions’ at all socio-economic levels in Trinidad and Tobago (Maharajh 2001). These define a society deep-rooted in spiritual tradition where the solution to one’s problems can often be found in the local church or by consulting “obeah” for help. This perpetuates the frustration of the mental health professionals in the Caribbean, because there are many people who are convinced that through religious means they can “cure” their loved ones.

The reality becomes clear when innocent, mentally ill individuals die due to the complete disregard of the families who believe that they can find a solution without consulting professional help. This can be illustrated through two case studies discussed in the Caribbean literature, where one case in particular of a sixteen year old girl that was suspected of being possessed by a demon was not taken to a mental health clinic for further evaluation; despite the fact that she was exhibiting signs of personality disintegration prior to the violent chain of events that resulted in her stabbing her mother to death (Maharajh 2001). The above demonstrates that in the Caribbean, the religious affiliation factor impacts how a client’s relatives interpret the origins of mental illness; how and if they access mental health care and most importantly how the inaccurate interpretation of the observed mental disturbance can lead to undesirable outcomes. The DSM-IV-TR (APA 2000) makes mention of demon possession as well as the behaviours that are likely to be exhibited but does not give sufficient guidance towards interpretation or adequately acknowledges the pervasiveness of such belief systems outside of the United States.
Following from the above, the bigger picture in this debate appears to centre on the applicability of the DSM to the Caribbean society and questions in what way the clinician should modify his/her conceptualization of established diagnostic criteria in the face of contradictory evidence with regard to observed mental disturbances. The fact that religious affiliation is such a predominant factor in the mindset of individuals within the Trinidad and Tobago society should also bear significance in the manner in which mental health professionals approach treatment, in addition to the families who interpret the aetiology of mental illness as the result of a spiritual precursor.

Cultural relations among ethnic groups in Trinidad and Tobago and the role that sociocultural differences play upon the expressions of mental illness is another factor that must be taken into consideration. It is important also to put in context the fact that when the DSM-IV is consulted for guidance on diagnosis, there is a higher risk of inaccurate classifications of behaviours in some cases. For instance, traditional Indo-Trinidadian females are noted for their reliance on the males in their family to be the primary breadwinner while they take care of the home and children. Similarly, dependence on their spouse to make decisions for the family and children is also well known among traditional Indo-Trinidadian families.

The behaviour of many Indo-Trinidadian women is such that it can be interpreted as unduly submissive and dependent on their spouse, if the cultural context of these behaviours is not considered. In the DSM-IV, this dependence or extreme reliance could be identified as criterion matching the classification of Dependent Personality Disorder, which states that excessive passivity, need for others to assume responsibility and make decisions in one’s everyday lives, difficulty in disagreeing with others due to loss of perceived support and approval and discomfort may seem similar to the experience of some Indo-Trinidadian women. Therefore, the likelihood of diagnosis for this ethnic group may be much greater than Afro-Trinidadian women; who may not display classic “dependency” behaviours as historically they are the “Matriarch” figurehead in single parent families in the Caribbean.

Social Construction theory states that the culture within a particular ethnic group shapes the shared values and norms of behaviour displayed by its members (Singh 1997). Culture is socially constructed and there are expectations of conformity within each group where certain behaviours are accepted and others rejected because they violate the cultural norms of the ethnic group. Therefore, in the case of Indo-Trinidadian women described above, they can be seen as conforming to what is expected of them as their cultural orientation is focused on collectivism which focuses primarily on what is best for the group as a whole rather than on the needs of the individual. As suggested by Rollocks, Dass, Mohammed and Seepersad (2007), Indo-Trinidadians tend to adhere more towards a collectivistic cultural orientation and this shapes their behaviour where they are not likely to display the same behavioural characteristics as Afro-Trinidadians. Clinicians must therefore be cautious when diagnosing individuals from other ethnic groups because without consideration of the culture within which the individual operates, there will be misclassifications of behaviours that are culturally appropriate.

Besides the phenomenon of culture and ethnocentric biases, there has been substantial debate on gender bias within the DSM and whether the proposed misclassification of
behaviour of Indo-Trinidadian women is a good example of such, has yet to be sufficiently tested in the Caribbean. This example seems to be fuelled more by cultural misinterpretation rather than gender bias. However, further investigation is needed before this can be stated with any level of certainty.

A review of the literature on the subject shows that there are distinct differences in male-female prevalence rates for disorders such as Dependent, Histrionic and Borderline Personality Disorders where females are diagnosed more frequently (APA 1994). Narcissistic, Compulsive and Anti Social Personality disorders are more frequently observed in males, sometimes overwhelmingly so (APA 1994). Kaplan (1983) has suggested that there is gender bias codified within the diagnostic criteria of the DSM and that society’s sexism also fuels this misconception; in terms of how one envisions the role of women and the classification of excessively feminine traits as maladaptive. Widom (1984, 5) defines these sex role expectations and stereotypes as “shared expectations and beliefs about appropriate behaviour and characteristics for men and women in a given society.” This can be illustrated by the examples given within the DSM to highlight how one might recognise such behaviours. In other words, traits that are stereotypically feminine traits are seen as disordered (Sprock, Blashfield & Smith 1990). A key point in this debate is a consideration of “the manner in which males and females are socialized as well as their biological and psychological differences may be related to their development of psychopathology” (Widom 1984, 5).

Kass, Spitzer and Williams (1983) have responded to this debate, stating that like Kaplan’s description of disorders that occur more frequently in females, there are disorders that are more often diagnosed in men due to maladaptive variants of stereotypic masculine traits. However, researchers such as Funtowicz and Widiger (1999) have argued that if the diagnostic thresholds for stereotypic feminine traits disorders are lower than those for disorders for variants of stereotypic male traits then this would be evidence supporting the existence of sex bias within the DSM. However, the results from their study suggested that any gender differences that were expected were not found to be significant. This is a general finding when a cross section of studies examining gender biases is consulted: if there are gender differences they are small and are virtually non-existent when further data analysis is employed.

Unlike previous editions, the DSM-IV has made significant advancements in recognizing the influence of culture upon the expression, assessment and prevalence of psychiatric disorders within non-western societies. DSM-IV notes differences in presentation and linguistic categories in Appendix I of the manual known as “Outline for cultural formulation and glossary of Culturally Bound Syndromes” as well as a note on culture, age and gender specific considerations in some disorders including Schizophrenia, depression and anxiety. Some would argue that not enough was done to highlight the impact of culture on the diagnosis of mental illness. Some background on how this occurred is necessary to put things into perspective.

Through the funding of the National Institute of Mental Health, a working group was created where such pioneers in cross cultural research (e.g., Good 1996; Kleinman 1988) formed a task force to present the body of research in the area and how best to integrate a cultural perspective. The results of their efforts
were not fully integrated, particularly the request by Good (1996) to include a cultural axis where this will be a complement to clinical judgement in a multiaxial diagnosis. In addition, a full glossary of culturally bound syndromes was not created but instead an appendix was inserted where these syndromes were given the connotation that the extent of its applicability was to members of ethnic minorities.

The illustrative case examples that were formulated to assist in diagnosticians’ assessment were also not included and the little that were may give the user the impression that they have the knowledge required to make such distinctions between what is culturally bound and what is not. However, the reality is that without such illustrations, the likelihood of misclassification increases due to a lack of true understanding of the intricate relationship shared between culture and the social world and how it reveals itself in other societies. Despite this, there has been significant progress made in this area and the look ahead towards what DSM-V will bring is much anticipated by cultural anthropologists, cross cultural researchers and psychologists alike who know the value of incorporating this information into their clinical assessment.

Therefore, it can be demonstrated that the DSM-IV has made significant progress in broadening the classification of mental disorders where there has been some consideration of culture and how this manifests itself in non-western societies. This emphasizes the fact that mental illness is not a biological given but universal to an extent in its occurrence but with considerable variability in structure. In the Caribbean, this manual should be used as a guide for standard clinical presentation of core symptoms but is one that must be applied with caution; noting that much of what is observed and interpreted must be tempered by clinical judgement. While the social construction of gender is important in this debate, gender bias in itself is not as significant as the impact of culture, religious affiliation and societal norms in the Caribbean context. These shape the manner in which mental illness presents itself and how individuals within the society address mental health problems. The notion of religion and the mythical-magical dimension of mental illness are of real importance to clinicians in gaining a greater understanding of what challenges they are likely to encounter as mental health professionals in the Caribbean.

In looking forward towards DSM-V, there is hope that continued progress is made where an explicit nomenclature will be maintained, one that is rigorous in its attention to empirical data, encompassing a biopsychosocial model validating the variance in expression, onset, duration and prevalence of mental disorders in areas outside of the United States. Only then can there be a manual where there is true representation of the majority of the world’s population in the sphere of mental illness.
References


