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SHORT REPORTS

Cultural Factors Considered in Selected Diagnostic Criteria and Interview Schedules

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Researchers have argued that diagnostic criteria and interview schedules inadequately reflect cultural influences in the definition and expression of psychopathology. In this study 11 widely used diagnostic criteria and interview schedules for schizophrenia, affective disorders, and personality disorders were examined to assess the extent to which they refer to cultural factors. The results indicated that 8 of 11 instruments referred to cultural influences in psychopathology at least once. The consideration of cultural factors, however, was primarily limited to the identification of delusions and hallucinations in schizophrenia. Very few cultural references were made in the diagnostic instruments of affective and personality disorders. The clinical implications of these findings are discussed with respect to the evaluation of cultural minority group members residing in the United States. Specific recommendations are offered to increase the attention given to culture in diagnostic instruments and to increase our understanding of how culture influences psychopathology.

This study assesses the extent to which frequently used diagnostic criteria and interview schedules consider cultural factors in the identification of schizophrenic, affective, and personality disorders. Although some authors have discussed how selected diagnostic instruments fail to address cultural influences (Alarcon, 1983; Egeland, Hostetter, & Eshleman, 1983; Klerman, Vaillant, Spitzer, & Michaels, 1984; Swartz, Ben-Arie, & Teggin, 1985), none have systematically looked at the extent to which a wide range of diagnostic instruments address the role of culture in psychopathology. Such an examination should reflect the relative importance given to culture in the classification of mental disorders.

Schizophrenic and affective disorders were chosen because much of the cross-cultural psychopathology research concerns these two diagnostic categories (Draguns, 1980, 1984; Kleinman & Good, 1985; Marsella, 1980). Personality disorders were selected because of the recent attention given to their cultural nature (Alarcon, 1983; Klerman et al., 1984). Moreover, subjects in current investigations of these disorders are at times drawn from cultural minority groups, including Blacks (Robins et al., 1984), Hispanics (Karno et al., 1987), and the Amish (Egeland et al., 1983). Given the use of these instruments with cultural minority groups as well as with international populations, questions of cross-cultural validity are raised.

This study was completed while Steven López was a recipient of a Ford Foundation postdoctoral fellowship. During this time he was affiliated with the Spanish Speaking Psychosocial Clinic, Neuropsychiatric Institute, University of California, Los Angeles.

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Method

Instruments

The diagnostic criteria and structured interview schedules selected for this study were the following: the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III;* American Psychiatric Association, 1980), the Feighner Criteria (Feighner et al., 1972), the Flexible WHO (Carpenter, Strauss, & Bartko, 1973), the New Haven Schizophrenic Index (NHSI; Astrachan et al., 1972), the Research Diagnostic Criteria (RDC; Spitzer, Endicott, & Robins, 1977), Taylor and Abrams (1975), the Diagnostic Interview Schedule (DIS; Robins, Helzer, Croughan, & Ratcliff, 1981), Present State Examination (PSE; Wing, Cooper, & Sartorius, 1974), the Schedule for Affective Disorders and Schizophrenia (SADS; Spitzer & Endicott, 1978), the Structured Clinical Interview for *DSM-III* (SCID; Spitzer & Williams, 1984), and the Structured Interview for *DSM-III* Personality Disorders (SIDP; Stangl, Pfohl, & Zimmerman, 1983). We chose these instruments because they are among the most frequently used in the study of schizophrenia, major affective disorders, and personality disorders. The *International Classification of Diseases: Clinical Modification* (U.S. Department of Health and Human Services, 1980) was considered for review, but we decided to exclude it because it is based on a classification scheme that offers no specific criteria for mental disorders. Self-report measures were also excluded because of their large number and because they frequently do not have explicit diagnostic criteria. Including such measures would have gone beyond the desired focus of this investigation.

Procedure

Joseph A. Núñez carefully read the diagnostic criteria and structured interview schedules and identified the instruments' direct references to possible cultural influences in judging the presence of symptomatology regarding schizophrenic, affective, and personality disorders. In addition, introductory comments about the perceived role of culture in psychopathology were noted. For the present study, *culture* generally refers to the distinctive body of customs, beliefs, and institutions characteris-

tic of a racial, ethnic, religious, or national group. Social factors (socioeconomic status) and patient variables (sexual orientation, age) are also important in the diagnosis of mental disorders and could be included in a broad definition of culture. For this investigation, however, these factors were not considered to be cultural in nature unless the authors of a given instrument referred to them as cultural (e.g., Taylor & Abrams, 1975). In general, we attempted to identify the instruments' perspective regarding how cultural factors should be considered in the identification and diagnosis of psychopathology.

Reliability Check

To assess the reliability of the rater's judgments, an advanced undergraduate psychology student, blind to the study's purpose, was instructed to carefully read the instruments and available instructions and to identify the direct cultural references. The two raters concurred on 29 of 34 cultural references (85%). Except for *DSM-III*, the following pairs of ratings were based on the entire set of criteria or interview schedule: *DSM-III* (American Psychiatric Association, 1980, pp. 1–35, 181–194, 205–224, 305–330) (1:2), Feighner Criteria (0:0), Flexible WHO (0:1), NHSI (1:1), RDC (3:3), Taylor and Abrams (1:1), DIS (0: 0), PSE (18:20), SADS (4:5), SCID (1:1), and SIDP (0:0). This level of interrater agreement was judged adequate for this research.

Results

Overall, the selected diagnostic instruments minimally recognized how cultural factors can influence the expression and definition of schizophrenic, affective, and personality disorders. Of the six sets of diagnostic criteria, the RDC makes three cultural references, the Feighner Criteria makes none, and the remaining four sets of criteria (*DSM-III*, Flexible WHO, NHSI, and Taylor and Abrams) make only one cultural reference each. The review of interview schedules revealed similar findings; the PSE and SADS refer to cultural factors on six and five occasions, the SCID refers to culture only once, and the DIS and SIDP fail to acknowledge cultural influences altogether. Considering the sets of diagnostic criteria and interview schedules as a group, 8 of the 11 instruments consider culture at some level. However, the number of references are very few relative to the total number of symptoms designated for a particular disorder.

An examination of the diagnostic criteria and interview schedules by disorder revealed the type of cultural references made. In the diagnosis of schizophrenia, 6 of the 10 diagnostic instruments (*DSM-III*, NHSI, PSE, RDC, SADS, and SCID) that offer criteria for the disorder contain some reference to culture and its potential role in properly identifying delusions and hallucinations. The main point of these cultural references is that diagnosticians should make sure that the patient's particular belief or perceptual experience is not shared by other members of his or her cultural group. The RDC and its companion structured interview (SADS) also point out cultural factors that should be taken into account when assessing formal thought disorder. Interviewers are cautioned that some speech or thinking patterns considered to be representative of thought disorder could be representative of normal speech or thinking for some groups. With respect to the 7 diagnostic instruments that have criteria for affective disorders, only the RDC, SADS, and SCID refer to possible cultural influences. The cultural basis of hallucinations and delusions is again mentioned here. In addition, RDC and SADS indicate that bereavement may not represent a depressive disorder if all features of the bereavement are commonly seen in members of the subject's subcultural group in similar circumstances. In regard to personality disorders, none of the 7 diagnostic instruments makes reference to possible cultural influences.

Two of the 11 diagnostic instruments (Flexible WHO and PSE) make explicit the assumption that a transcultural description of mental disorders can be formulated. Although the authors of these instruments indicated that cultural factors can affect nuances in the expression of mental illness, they stated that diagnostic criteria can be used cross-culturally because there are enough common elements across cultures.

Discussion

Overall, these findings indicate that the lack of attention given to cultural factors in diagnostic instruments goes beyond what has been previously noted for *DSM-III* (Alarcon, 1983; Klerman et al., 1984), RDC (Egeland et al., 1983), and the PSE (Swartz et al., 1985). It is fair to say that the currently used sets of diagnostic criteria and interview schedules for schizophrenic, affective, and personality disorders pay little attention to cultural factors.

Some general recommendations are offered in an attempt to address the limited consideration of culture. At the very least, each set of diagnostic criteria and each interview schedule should have a general statement pointing out that cultural values, beliefs, and practices can influence the definition and expression of psychopathology. The need for such a statement is supported by the growing cross-cultural psychopathology literature (Al-Issa, 1982; Draguns, 1980; Fabrega, 1974, 1982; Kleinman & Good, 1985; Marsella & White, 1982) as well as by the more limited U.S. minority group research (Adebimpe, 1981; Cuellar & Roberts, 1984). The inclusion of this statement should alert diagnosticians and interviewers to seriously consider the cultural background of the patient. We also recommend that references to cultural factors be made for specific disorders and symptoms, and whenever possible, examples pertaining to specific cultural groups be cited. Comments such as the following might be included in diagnostic instruments: Black patients' depressive symptoms may not be properly identified as depressive in nature (Adebimpe, 1981; Simon, Fleiss, Gurland, Stiller, & Sharpe, 1973), and pressured speech may be inaccurately perceived as thought disorder among the Amish (Egeland et al., 1983). These and related comments may prompt evaluators to be more cautious in applying the available criteria when evaluating these patient groups.

In terms of research, we recommend that investigators examine the phenomenology, course, and outcome of the major disorders for U.S. minority groups. Cross-cultural studies to date indicate the important role culture plays in the definition and expression of psychopathology. However, we are only just beginning to understand how cultural factors influence the psychopathology of the major minority groups in the United States—Blacks (Adebimpe, 1981), Hispanics (Cuellar & Roberts, 1984), Asians (Chin, 1983), and American Indians (Manson, Shore, & Bloom, 1985). In addition, it is important that investigators and clinicians who work with specific cultural groups follow the lead

of Egeland and her colleagues in systematically assessing whether available criteria are appropriate. If criteria or interview schedules are not appropriate, then ways to modify these instruments should be explored.

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