



Watson, Emily Louise (2017) A critical examination of the DSM as a multicultural diagnostic tool for depression among Asian Americans and Asian Indians. *Journal of Applied Psychology and Social Science*, 3 (1). pp. 19-32.

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A Critical Examination of the DSM as a Multicultural Diagnostic tool for Depression among Asian Americans and Asian Indians.

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Abstract

Depression has been examined from a Western, Asian American and Indian American- cultural, specific point of view. The purpose of this paper was to examine if the DSM can be used as a multicultural diagnostic tool for depression. Research suggests that ethnic and racial minority groups are often underserved by the mental health system (Snowden, 1996; Lewis-Fernández & Kleinman, 1994). Language, social construction, family, age, gender and religion have all been found to be barriers to treatment among different cultures (Blackmore, 1998; Ramisetty-Mikler, 1993). After reviewing the literature a strong argument can be made for the DSM being used as a multicultural diagnostic tool, as long as clinicians have the appropriate understanding of different cultures and their belief systems.

Keywords: Depression, DSM, culture, social constructionism

The Diagnostic and Statistical Manual (DSM) is a collection of mental disorders, published by the American Psychiatric Association (APA), which has been widely adopted for use in, research, health care and clinical practice (Vanheule & Devisch, 2014). The DSM continually evolves, throughout history as more evidence and new information becomes available, mirroring the cultural beliefs and political shifts of each time period (Kendler & First, 2010). This paper will discuss depression from a multiple cultural perspectives, to assess how the DSM may be changed and used to help clinicians treat depression among different cultures. A brief description of the history of depression and the DSM will be discussed, followed by descriptions of depression and how it is viewed from Asian Indian perspectives and Asian American perspectives. Asian Indian culture including: Hindus, Sikhs, Punjabis, Muslims and Christians, while Asian American includes individuals from the Far East, Southeast Asian and Indian Subcontinent.

The DSM, Fifth Edition, (DSM-5: American Psychiatric Association, 2013) is the most recent version of the manual, released in May 2013, it contains approximately 350 categories of disorders. The DSM “has become the official lingua franca for the entire culture and economy of the mental health establishment” (Sykes, 1995; p.25). Due to its wide spread adoption in diagnostic practice, it is crucial to have a rigorous manual based on empirical evidence (Warelow & Holmes, 2011). The DSM fundamentally affects patients’ lives, and it is the job of all those in relevant professions concerning the diagnosis of individuals to ensure that individuals lives are improved however this is not always the case (Fox & Prilleltensky, 2002). The construction of knowledge in the field of clinical psychology is based upon the orthodox notion that the researcher can be unbiased toward the observer. However social constructionism claims that this is unattainable, as researchers are subconsciously led by rules and assumptions about what is deemed to be the permitted way of interpreting the world we live in (Berger & Luckman, 1966). By illustration, language shapes our social reality and has the power to influence our beliefs, for example the way that an individual describes an experience they have had, structures our beliefs and attitudes toward that person and their experience (Dunn, 2008).

Despite the DSM being used world-wide, there has been little regard for culture specific variables within the various iterations of the diagnostic systems (Conrad, 2005). By illustration, the United States of America has such a multi-cultural

population, with an increase of Hispanic, Hindu, Sikh and Punjabi populations, it is essential that clinicians who use the DSM can diagnose, treat and understand the needs of people from different cultures (U.S Census Bureau, 2016). Hispanics have become the largest minority group in the United States and Asian Americans are the fastest growing minority group (U.S Census Bureau, 2016). Subgroups include Chinese Americans (0.9%), Filipino Americans (0.7%), Asian Indians (0.6%), Korean Americans (0.4%) and Japanese Americans (0.3%). From the census, the term “Asian” refers to any individual who originates from the Far East such as Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, The Philippine Islands, Thailand and Vietnam (Kalibatseva & Leong, 2011). Illnesses are constructed differently in different countries and within the different cultures; therefore it is illogical to treat different populations with different beliefs, using a ‘one-size fits all’ westernized biomedical model for mental disorders, which is foundation of the DSM-5 (Young, 2013). Historical research would suggest that racial and ethnic minority groups are often ignored by the mental health system, one could argue that this is still true today (Snowden, 1996; Lewis-Fernández & Kleinman, 1994).

Depression in the DSM

During the early twentieth century, the term “melancholia” was the term used for depression, and it was considered a rare disorder (Kendell, 1971). Anxiety disorder was a more prevalent diagnosis, reflecting the psychodynamic influence of the time (Thompson, 2005). The discovery of the tricyclic antidepressant imipramine and the monoamine oxidase inhibitor (MAOI) occurred in 1957 (Davidson, 1982). The pharmaceutical companies did not take an interest, as clinicians did not encounter depression often (Shader & Greenblatt, 1981). In 1961 the book *Recognizing the depressed patient* (Ayd, 1961) became a large hit with psychiatrists, from then on Amitriptyline became a large selling group of drugs (Beasley, 1998).

The early editions of the DSM reflected a psychoanalytic view of mental illness (Thompson, 2005). The DSM-III-R (1987) engendered the rise of the term ‘Depression’ along with the rise of pharmaceutical treatment (Luhmann, 2000), signifying a paradigmatic shift in Western society. This paradigm shift led to a procedural change in the DSM; processes such as structured interviews, were included which aimed to increase the validity and reliability of diagnosis by obtaining information such as patient history and social functioning (Klerman, 1989). Despite

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this being a significant step forward, it could be argued that this renewed focus on positive practice, obscured information vital to diagnosis, such as ethnic heritage and cultural background.

For example, depression has a range of different symptoms associated with it, some universal and others transcultural (Draguns, 1988). Universal symptoms have included; loss of enjoyment and low mood, and symptoms that have been found to vary across cultures include; previous depressive episodes and loss of sleep (Mindham, 1984). According to the World Health Organization (WHO), depression is one of the leading causes of disability world-wide and the fourth largest contributor to the global burden of disease (WHO, 2016). The focus on universal generalizable symptoms, increases the chances of misdiagnosis and poor treatment, as specific cultural nuances are dismissed (Marecek, 1993). This is particularly problematic, as patient accounts are not always viewed neutrally, events which are accounted are chosen based on the therapist's beliefs (Harris, 1993). Much of the research providing the evidence for the generalizations, were drawn and then accumulated in the DSM, however researchers often refrain from using and studying participants who may be difficult to access or who are thought of as being unreliable (Reid, 1993). This means there was a considerable lack of understanding among clinicians of how to help treat those who fall into the minority group or those who may pose difficult to treat (Brown, 1995).

As Indian Americans and Asian Americans fall into the minority group, the DSM may not have been effective (Conrad, 2005). However, the DSM-5 constantly updates itself, and contains vignettes, which give details on more challenging patients, which can support clinicians when treating those in a minority group. The criteria for "Major depressive disorder" in the DSM-5, states that five or more of the following symptoms must be experienced by an individual to result in a diagnosis (American Psychiatric Association, 2013). One of the symptoms must include; depressed mood or a marked diminishment in interest or pleasure. Other symptoms are as follows; significant weight loss/weight gain without dieting; Insomnia or Hypersomnia; psychomotor agitation or retardation; fatigue or loss of energy; feeling worthless or excessive guilt; diminished ability to think or concentrate, or indecisiveness and recurrent thoughts of death or suicidal ideation with or without a plan (APA, 2013). These symptoms must appear to cause marked impairment in an individual's occupational, social or emotional life (APA, 2013).

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A Western conceptualization of mental health is contingent on the notion of Cartesian dualism, which views the mind and the body as separate entities (Kalibatseva & Leong, 2011). By dividing the 'psyche' and 'soma' it means that somatic medicine is used to treat the body and illness while psychology and psychiatry treat disorders of the mind (Holroyd, 1997). Although in contrast to this, the DSM diagnostic criteria relies on somatic and physiological symptoms, it has been found that Westerners relate depression to guilt, self-control and individualism (Berntzen, Stiles & Sletvold, 1990). The predominant symptom of major depression in the West is sadness/depressed mood, however it is often symptoms such as insomnia, loss of appetite and headaches, which would lead a person to consult their general practitioner (Warren, 2013).

Depression among Indian Americans

'Illness and disease occur within a cultural and social context and human groups use their conceptuality embedded meanings to explain these phenomena' (Kleinman, 1988; p.237). In order to treat people who consider depression differently, it is important to relate to their cultural beliefs, so that appropriate treatment can be fully understood (Blumenthal & Endicott, 1996). For example, Hinduism is the dominant religion throughout India; Hindus consider psychological issues to be explained through a religious framework. Many Indians share the belief of fatalism and animism (Leininger & McFarland, 2002). The belief is that individuals have an unchangeable self (Atama) and an inner self (Jeevatma), which is shaped and moulded by past experiences, which is known as Karma (Jambunathan, 2009). The notion of Karma represents the individual's own responsibility for their actions. Physical and mental issues are explained as an expression of God's will and is considered to be a punishment of a sin they have committed (Ramisetty-Mikler, 1993). Depression is often viewed as being a good thing as it provides an insight as to how God would like an individual to act (Conrad & Pacquiao, 2005). This poses a major barrier to treatment and seeking treatment as it could rouse feelings of shame or guilt, or it may not be considered a problem that is needed to be told to a clinician as it is God's will (Blackmore, 1998).

A further barrier to treatment may be family; family within a Western society is considered important however in India, family is considered to be the most prevalent social institution (Parashar, 1997). Gender and age play an important role as

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men are often regarded more highly than women as it is men who carry the family name (Khera & Nakamura, 2016). People look up to their elders in Indian society, as there is a strong sense of social hierarchy. Elders are held in high regard and are believed to be experienced and knowledgeable (Moberg, 1978). Help and treatment is likely to be sought from the Elders of a community rather than clinicians. One reason why depression may be disregarded in Asian Indian society is to do with gender and arranged marriage (Palriwala, 2005). Due to arranged marriage, a woman who is suffering from depression may be disregarded because she is expected to marry someone in order to benefit the family, and by being labelled with an illness of some sort would bring shame to the family and make a marriage less likely to take place (Ramisetty-Mikler, 1993).

Repressing or not acknowledging a mental health issue may result in somatic symptoms; somatization refers to the presentation of physical symptoms as an explanation of psychological distress (Brody, 1968). This is common among non-Western cultures due to disapproval of expression of emotion. It has been found that individuals from minority groups may not access help because it is seen as being a product of a white, Western culture, and clinicians often hold stereotypes of that religion or culture (Mallinson & Popay, 2007). A study of patients diagnosed with depression in South India found that they were more likely to visit their doctors and report somatic symptoms than a Western comparison group, however they are less likely to report depressive symptoms (Latalova, Kamaradova & Prasko, 2014).

Often, if Indian Americans believe they may be suffering from depression the first support network they will turn to for help will be their family, families of strong Indian American communities often do not believe in hospitalization or a follow up of treatment (Conrad & Pacquiao, 2005). More education is needed for families of patient care and the need for prolonged treatment. However, in the same way, more education is also needed for clinicians so they are able to explain this to Indian American families and understand their culture in order to offer alternative ways to the families without pushing a Westernised view of treatment (Khera & Nakamura, 2016). If treatment is relevant to treating issues in a way that fits in with the Indian American culture then it is less likely to be dismissed and being a Westernised view with no relevance.

Depression among Asian Americans

An Eastern experience of depression composes of an integration of the body and the mind as they hold a more holistic view (Hussain & Cochrane, 2003). There is more emphasis placed on somatic symptoms; people from a Chinese culture have been found to be more likely to report somatic symptoms even if they are aware of a psychological issue (Lu, Bond, Friedman & Chan, 2010). Although many studies have been done debating Eastern cultures over emphasising somatic symptoms of depression, it must be considered that Westerners may over emphasise psychological aspects of depression, this is known as the ‘psychologization’ of depression (Ryder, Yang & Heine, 2002).

Studies have suggested that Asian Americans have reported higher rates of depression than their overseas counterparts, however they are significantly lower than European Americans (Von Zerssen & Weyerer, 1982). This indicates a difference in reporting of distress or possibly differences in family and social support. Recent Chinese immigrants and Asian American women are at a higher risk of encountering major depressive disorders, which could be due to acculturative stress (Hussain & Cochrane, 2003).

Eastern Asian societies place a large emphasis on selfless subordination which, could lead to different manifestations of depression, where loss of control and helplessness may not be expressed as a symptom (Beng-Huat, 1999). As studies concerning Korean culture have found that women often describe their experience with the term “Suffering” which is a reflection of the collectivist society (Bernstein, Lee, Park, & Jyoung, 2008). In Korea it is seen as being socially unacceptable to express negative effect, this could also pose as a barrier to treatment as they are less likely to express any negative emotional feelings (Kang & Yoo, 2012).

The “foreigner stereotype” can be linked to depression, especially among adolescents, and may be a barrier to treatment for certain individuals (Hussain & Cochrane, 2003). Those who were found to have internalized the perpetual foreigner stereotype reported more depressive symptoms than those who did not identify as perpetual foreigners (Hwang & Seo, 2010). English language may play a role in this as proficiency plays an important role in communicating symptoms of depression, another reason may be that the lower the language proficiency among the adolescents the more likely they are to identify as perpetual foreigners (Bernstein et.al, 2008).

More research needs to be done to further understand the relationship between

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English proficiency and depression. One way to improve this would be to have trained interpreters on hand who would have knowledge and sensitivity to address specific cultural needs of patients and their families (Goldberg & Steury, 2001).

Using the DSM-5

The DSM-5 still uses a mostly categorical approach to diagnosis with the exception of Autism (American Psychiatric Association, 2013). This could pose a problem when diagnosing an individual from different cultures; as being categorised and defined as having depression could affect the entire family. Many studies have found that strong family involvement is a barrier to treatment in Western and other cultures (Palriwala, 2005; Kang & Yoo, 2012). Family involvement is much stronger in Eastern and Indian cultures and it was found that families often do not believe in continued follow-up treatment, there is an expectation of a quick fix (Khera & Nakamura, 2016). Language is also considered a barrier to treatment as an exact translation is not always possible as terminology, that is associated with depression does not exist in the same context (Khera & Nakamura, 2016). The language used might represent scientific knowledge and holds a certain power however it should be used with care. Such as the DSM-5 states that diagnosticians must use their own abilities and intuition when examining the patients (American Psychiatric Association, 2013). This could lead to misinterpretations and is ultimately reflective of personal beliefs and ideologies, which is not absolute as science promises (Vanheule & Devisch, 2014). An individual is unlikely to question, therefore clinicians must be aware of the impact their diagnosis can have on an individual (Warelow & Holmes, 2011). Over diagnosis can occur because certain experiences and behaviors which, may be normal for some are considered as symptoms of psychological disorders, for example 'being withdrawn' may be a person's personality and they may enjoy spending a lot of time alone (Franks, 1981).

Empirical evidence has been reviewed to try and understand if psychiatric disorders are etic (Culture-universal phenomena) or emic (culture-specific; Fawcett, 2012). In the case of depression and the DSM it takes an etic view as it assumes that depression is expressed the same universally and the DSM criteria can be applied to all cultures (Holmes & Warelow, 1999). Future research is needed on separate ethnic groups rather than grouping Asian Americans and Indian Americans together, which will allow for differences in depression to be more clearly defined (Kalibatseva & Watson, E. (2017) A Critical Examination of the DSM as a Multicultural Diagnostic tool for Depression among Asian Americans and Asian Indians. *Journal of Applied Psychology and Social Science*, 3 (1), 19-32

Leong, 2011). To increase validity depression could be measured based on; Affective, Somatic, Interpersonal, Cognitive and Existential factors. By using a multidimensional framework to examine different depressive symptoms and their relevance to individuals from different cultures will help clinicians to assess, diagnose and treat depression (Vanheule & Devisch, 2014). Culturally appropriate communication and understanding of clinicians could help to develop trust and understanding between practitioners and patients. To conclude, used correctly the DSM is a helpful manual and can improve the wellbeing for many, however it should be used as a guideline along with professional interpretations rather than being viewed as the law of mental disorders (Fox & Prilleltensky, 2002). Practitioners must have relevant understandings of mental illness and social norms from culture specific points of view.

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