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Cultural Diversity and the DSM-III-R: Can a Barking Man be Diagnosed?

Edward F. Foulks, M.D., Ph.D.

The case of the Barking Man (JJP 9(1):82-88, 1991) raises once again the question whether some mental disorders are "Culture Bound Syndromes" or are merely cultural manifestations of basic mental disorders which plague humankind wherever they live. Bernstein and Gaw (1) have recently made a compelling argument for the former position using the example of Koro. Koro affects a variety of ethnic groups throughout Southeast Asia and is characterized by an acute, morbid panic accompanied by the idea that the penis is retracting and will disappear, at which time, the patient fears, he will die. The disorder is widespread, affecting many people, and has been prevalent in the region for generations. As Bernstein, Gaw, and the numerous responses to their article have discussed (2,3), Koro is not easy to pigeonhole in the DSM-III-R. Panic disorder, body dysmorphic disorder, delusional disorder are all possibilities but each requires additional essential criteria to accommodate the symptoms of Koro. Thus, American psychiatrists debate whether Koro is an anxiety disorder, a somatoform disorder, or a psychotic disorder. South-East Asians on the other hand are convinced that Koro is simply, Koro, a disorder that occurs so rarely in the U.S. that it has not deserved a place as a diagnosis in the DSM-III-R. Whereas, anorexia nervosa, a disorder exceedingly rare in South-East Asia, but commonly encountered in the United States rates a place. The DSM's apparently include those culture-bound syndromes found commonly in the United States, but not those from other diverse cultures of the world, and in the minority populations in the United States.

In all fairness to the developers of the DSM's, their intent has been to create categories based on the phenomenology of those mental disorders encountered by American psychiatrists. They never proposed that this classification should be applied elsewhere. Nevertheless, the DSM-III-R has by now become international (4), and has been translated into Chinese, Japanese, Danish, Dutch, Finnish, French, German, Greek, Italian, Spanish, Portugese, Swedish, Norwegian, Russian, and has been extensively evaluated for its use in many societies around the world and within the United States. The W.H.O. International Pilot Study of Schizophrenia (IPSS) and the N.I.M.H., Epidemiological Catchment Area Program (E.C.A.P.) (5) are such attempts, and are based on the assumption that mental health problems are strikingly similar across cultures. The W.H.O.'s International Pilot Study of Schizophrenia (IPSS) attempted to systematically verify this assumption by utilizing the Present State Examination (PSE) on hospitalized psychotic patients in seven different nations across the world. Research psychiatrists from India, Nigeria, Columbia, Denmark,

the U.K., the U.S.S.R. and the United States were trained to use this instrument in their own languages and were able to obtain high levels of inter-rater reliability at home and abroad. The study was able to find in each national research center a group who manifested core symptoms of the schizophrenic syndrome. However, most significant was the fact that most of the psychotic patients in each of these research centers failed to meet the diagnostic inclusion criteria for the study. One might conclude therefore that the study demonstrated that schizophrenia does exist across cultures, but other types of psychosis, perhaps more culturally specific, also exist.

Which brings us back to Goldwasser's case of R.W., the "Barking Man." R.W. presented one intriguing diagnostic and treatment dilemma for Dr. Goldwasser, who insightful and mindful of possible cultural factors in R.W.'s symptomatology had great difficulty finding an appropriate DSM diagnosis for him. Previous psychiatrists, witnessing R.W.'s bizarre hallucinations and barking noises were not so puzzled, and categorized R.W. as a "chronic undifferentiated schizophrenic" and tried to treat him for years (unsuccessfully) with phenothiazines. Dr. Goldwasser carefully developed a differential diagnosis and systematically went about excluding one DSM diagnostic possibility after the other. He discovered that R.W. "had been on neuroleptics for years, with many changes in types of medication, but none had any lasting therapeutic effect." He decided to stop all medications except lorazepam, and proceeded with R.W.'s work-up. He found R.W. had no thought disorder and a clear sensorium between his barking spells! He considered a seizure disorder and Tourette's Syndrome but ruled them out with neurological examinations and tests. Goldwasser discovered fascinating cultural factors in R.W.'s history which included an abrasive father who had hexed him with "roots" when he was a young boy. Goldwasser concluded that R.W.'s most likely diagnosis according to DSM-III-R was Dissociative Disorder.

R.W.'s symptoms are however not easily accommodated by any of the specific Dissociative Disorders. R.W. was clearly not a typical Multiple Personality Disorder (unless his "other personality" might be that of his dog). R.W. was not a Psychogenic Fugue, nor was he Amnesic, nor Depersonalized. Perhaps Dissociative Disorder Not Otherwise Specified could be considered for R.W. and perhaps several other culture-bound syndromes (Arctic Hysteria, Zar, Susto, and other spirit loss and possessive states), but such conditions are not mentioned in the diagnostic manual.

The fact is that the DSM-III-R does not accommodate well to many United States "non-majority" groups, nor to many diverse ethnic populations elsewhere. While not designed for cross-cultural use, the DSM's are nevertheless being used so, and future versions will require a major cultural component. In order to prepare such a cultural component for future versions of the DSM a number of important preliminary field studies are required:

1. Studies to discover the gamut of mental disorders in diverse ethnic groups that are not contained in the DSM-III-R.
2. Ethnic research to discover whether a core group of DSM-III-R diagnostic categories are seen as pathological or dysfunctional in diverse ethnic groups.
3. Ethnic research using SIDP or a comparable culturally-linguistically adapted

instrument across ethnic groups in the United States and abroad to verify previous findings of constant life-time prevalence rates for each disorder.

4. Research to discover the cultural variability along gaussian personality trait continuum which indicate unique points of pathology demarcation for the ethnic group.

The results of such studies might convince the developers of the next version of the DSM to include:

1. An additional rating requirement or Axis VI for each diagnosis that would use a point on a Likert scale 1–10, for degree of socio-cultural dystonicity for the symptoms required to diagnose a disorder.
2. An additional category of potential culture bound disorders based on taxons of trait expressions such as fright, running, dissociative, etc. reactions, which are not included in the present taxonomy of DSM-III-R, Axis I or Axis II disorders.

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