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VIEWPOINT IN CULTURE AND MENTAL HEALTH

Culture and mental health: Towards cultural competence in mental health delivery

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Abstract

The purpose of this paper is to highlight the role of culture in the conceptualization of mental illness and the phenomenology of mental illness across cultures. Mental health professionals are increasingly dealing with a multicultural patient population and there is an urgent need for awareness of the influence of culture in understanding patient's expression of distress, assigning symptoms to a diagnostic category and planning treatment in culturally appropriate ways. Cultural bias can lead to misdiagnosis and have devastating consequences on patients. This paper highlights the need for cultural competency in mental health service delivery and outlines ways mental health professionals can think about the issue of culture in their practice.

KEYWORDS: culture; cultural competence; cultural diversity; mental health; mental illness.

Riassunto

La finalità di questo lavoro è di evidenziare il ruolo della cultura nella concettualizzazione della malattia mentale e nella fenomenologia della malattia mentale attraverso le culture. I professionisti della salute mentale sono sempre di più alle prese con una popolazione di pazienti multiculturali e c'è un urgente necessità di acquisire maggiore consapevolezza dell'influenza

esercitata dalla cultura nella comprensione dell'espressione degli stati di distress vissuti dal paziente, assegnando sintomi ad una categoria diagnostica e pianificando il trattamento con modalità appropriate dal punto di vista culturale. Il bias culturale può portare ad errori diagnostici con consequenze devastanti per il paziente. Questo lavoro evidenzia la necessità di competenze culturali nella fornitura di servizi di salute mentale e sottolinea le modalità con cui i professionisti della salute mentale possono pensare al problema culturale nella loro pratica professionale.

TAKE-HOME MESSAGE: Culture is important in mental health service delivery. Cultural contexts help clinicians in understanding patients' expressions of distress, diagnosis and treatment planning. Clinicians are encouraged to undergo life-long cultural competency training in order to render the best care for their patients.

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INTRODUCTION

The concept of culture is vague, varied, multilayered and complex [1, 2], yet its impact on health outcomes is enormous, making it important to understand the relationship between culture and health, especially the cultural factors that affect health-improving behaviors [2]. The objective indicators of health and the subjective nature of what constitutes abnormal health vary with different cultures, as is the conceptualization, perception, health-seeking behaviors, assessment, diagnosis and treatment of illness [1]. Oftentimes, the definition of culture is limited to ethnic identity, national allegiance, and racial heritage, but the definition of culture goes beyond this.

Culture can be defined as "a set of practices and behaviors defined by customs, habits, language, and geography that groups of individuals share" [2]. These sets of collective behaviors underlie social agreement and cohesion, can limit the ability of those who share these behaviors to see the subjective nature of their values, perceived responsibilities, and assumptions about what is seen as objective knowledge [2]. Napier et al. expanded the definition of culture, drawing from the works of notable anthropologists (such as Emile Durkheim, Robert Redfield, Frederik Barth and Edward Burnett Taylor) in an attempt to facilitate the understanding of the broader dimensions of culture on health, as "the shared, overt and covert understandings that constitute conventions and practices, and the ideas, symbols, and concrete artifacts that sustain conventions and practices, and make them meaningful" [2].

The understanding of culture helps us to understand the daily behaviors on which good health and wellbeing depend [2]. In addition, improving health outcomes can only occur when we recognize the ways wellbeing is socioculturally generated and understood, and how cultural systems of value affect health and healthcare delivery [1, 2]. For example, among pregnant

women in Asia and Africa, the utilization of healthcare services was determined by the impact of culture on the meaning of care and informed choice [3, 4]. Although, culture in itself is neither good nor bad, ignoring the influences of culture on health and wellbeing can allow negative influences to go unchecked [2]. Also, understanding how cultural influences affect coping mechanisms and resilience can allow for the positive influences to be reinforced to maximize its beneficial effects and to inform new models of care [2].

The major attributes of culture that shape peoples' worldview and the extent to which they identify with their cultural group of origin are called variant characteristics of culture, some which may change while others remain stable over life [5]. These characteristics include race, gender, age, religious affiliation, educational status, socioeconomic status, physical characteristics, immigration status, etc. with gender and socioeconomic status being the two most extensively researched health-related aspects [1, 5, 6].

Cultural influences on health can be viewed from 2 major perspectives: 1) Cultural variations in health (health disparities), and 2) cultural variations in approaches to health [1]. Health disparities exist across major physical and mental health indices in America: Among African-Americans, the infant mortality rate is double, mortality from cardiovascular conditions is 40%, compared with Whites [7]. Compared to Whites, African-Americans have higher rates of schizophrenia, have more severe and debilitating depression, and higher rates of psychological symptoms that impair their functioning [8].

These disparities are largely driven by policies that promote social inequalities and discrimination, reduction in opportunities and resources, distribution of health care services and access to scarce health services [2, 8–11]. Therefore, culture can determine the opportunities

people get, the resources available to them, and exposure to social determinants of health. Cultural variations also exist in the approach to health in terms of their beliefs and attitudes, health behaviors that may predispose to illness or be protective, their perception of illness and causation, which may affect pathway to care and treatment adherence [1].

The primary aim of this article is to explore the role of culture in mental health, how cultural factors interplay in the expression of distress, in diagnosis, and treatment planning, in order to highlight key issues in the ongoing debate on the current classification of mental illness and the exoticization of non-Western cultures and how it affects the definition of mental illness. The secondary aim is to discuss the deleterious effects of ignoring cultural context in patient encounters, to argue for the need to pursue cultural competence in delivery of mental health care.

DISCUSSION

Culture and mental health

Culture influences how individuals manifest symptoms, communicate their symptoms, cope with psychological challenges, and their willingness to seek treatment [1]. The majority of human behaviors are heterogeneous and the classification into signs and symptoms occur for the sake of diagnosis, treatment, prognosis, public health policies and to enhance professional communication [12, 13]. Culture is central to the etiology of mental disorders as it provides standards for normality and abnormality, and the definitions of what constitutes a mental disorder are socially and culturally negotiated [14, 15]. Culture determines the variations of normalcy in behaviors; while some cultures are tolerant of high levels of deviant behaviors, other cultures insist on conformity [15]. These differences can affect the rates of certain mental disorders. For example, Attention Deficit Hyperactivity Disorder diagnosis rates vary widely across countries

and these variations reflect the influence of culture on the tolerability of certain behaviors in children, and the perception and acceptance of the diagnosis [16].

Current diagnostic classifications of mental illness rely on western worldviews of what constitutes abnormal behaviors and assume a universalist view of mental illness [13, 16]. In reality, however, there are cultural variations in the phenomenology of mental illness and in psychopathology, which affects the reliability and validity of these diagnostic instruments [12, 17]. The DSM-IV to some extent and DSM-V to a larger extent have recognized the importance of cultural considerations in the manifestation of illness, diagnosis, and treatment of mental disorders [19, 20]. The DSM-V included a cultural formulation chapter that aims to help clinicians evaluate cultural aspects of the diagnostic procedure and added a Cultural Formulation Interview to aid the implementation [21]. Despite these improvements, the DSM-V has been criticized as being largely ethnocentric, having a western dominant view of abnormality, and not adequately allowing for social and cultural factors when making a diagnosis [21, 22].

Culture is an etiological determinant of mental disorder; it shapes the perception of self and reality [14, 15, 17]. Marsella and Yamada [17] identifies several ways in which culture influences psychopathology: 1) The patterns of physical and psychosocial stressors, 2) the types and parameters of coping mechanisms and resources used to mediate stressors, 3) basic personality patterns including, but not limited to, self-structure, self-concept, and need/motivational systems, 4) the language system of an individual, especially as this mediates the perception, classification, and organization of responses to reality, 5) standards of normality, deviance, and health, 6) treatment orientations and practices, 7) classification patterns for various disorders and diseases, 8) patterns of experience and expression of psychopathology, including such factors as onset,

manifestation, course, and outcome.

The phenomenology of mental disorders varies across cultures. The expression of depression, for instance, is typically limited to somatic and interpersonal domains in non-Western cultures, a reflection of the collective or socio-centric construct of identity in those cultures, compared to the expression of depression in Western cultures which is predominantly expressed as worthlessness and misery, reflecting the individualistic nature of the culture [15, 23]. Similar differences were observed in the expression of depressive, anxiety and somatoform disorders in India [24]. Among the study participants, the authors noted that while patients typically presented with somatic symptoms, clinicians more frequently diagnosed depression using the DSM-IIIR. And while patients tended to report somatic symptoms spontaneously, they identified depressive symptoms when probed using the DSM-IIIR. Using the Explanatory Model Interview Catalogue (EMIC) however (a semi-structured instrument that allowed for cultural meanings and perception of illness to be incorporated), they found a greater correlation between the presentation of somatic symptoms and the diagnosis of somatoform disorders among the patients. The authors highlight the role of culture in nosology and the need for incorporation of personal meanings and other aspects of phenomenological and subjective experiences of the patient into the psychiatric evaluation and practice [24].

Cultural factors are both pathogenic and pathoplastic [25]. They may act as triggers of psychopathology, contribute to higher or lower levels of severity of psychiatric symptoms, and affect the pathway to care [25]. The macro-environment and micro-environment (the family unit, with its unique history, structure, and life) pose an inexhaustible source of potential (and sometimes preventable) harmful factors in the development of a disorder [25]. And while

advances in neuroscience and genetics have continued to localize psychopathology in the brain, social and cultural factors play a role in shaping neuronal circuitry that determines vulnerability and adaptability to stress, and ultimately predisposition to a mental disorder [17]. The pathoplastic effect of culture refers to the uniqueness of symptom expression; the description of symptoms, the word choices, and narrative are all reflections of the cultural context and dominant themes [25]. For example, variations in the content of delusions in schizophrenia across different eras and between cultures. The delusions in Western cultures are centered around technology-related themes (e.g., being implanted with a chip or alien abduction), while in non-Western cultures, the delusions revolve around themes of demon possession, witchcraft, and religion-related themes [26–29]. Even in Western cultures, the dominant contents of the delusions expressed by patients with schizophrenia in the 21st century differs from that of 200 years ago, reflecting the effect of cultural changes over time [25].

Certain mental illnesses are localized to certain cultures, and Yak coined the term ‘culture-bound syndromes’ to describe them [14]. Culture-bound syndromes have been a major area of concern in the study of mental health and culture, and have called into question the western ideas of mental illness and classificatory system [14, 15]. Marsella and Yamada [17] argued that if culture-bound syndromes were limited to specific societies, who defines what constitutes mental illness, and why do Western ideas of abnormality take precedence over non-Western definitions? Examples of these culture-bound syndromes include *Amok, Latah, Koro, and Taijin Kyofusho* [14]. *Amok* is a dissociative state characterized by an outburst of unrestricted violence, associated with homicidal attacks, and is prevalent among males from Malaysia. *Latah* presents with a startle reaction followed by an altered mental state, socially inappropriate speech, automatic

obedience and hyper-suggestibility, and is seen commonly among people from Malaysia and Indonesia, but has been reported in Africa and North America. *Koro* is an episode of sudden and intense anxiety that the genitals has receded into the body and possibly cause death, common parts of Africa, South Asia, United Kingdom and the United States of America. People with *Taijin Kyofusho* exhibit anxiety about social performance, have fear of smelling an offensive odor, or of having unpleasant or misshapen physical features. This syndrome occurs among individuals from Japan and Korea. Several commentators have noted that the term 'Culture-bound syndrome' reflects the ethnocentric views of the predominant Western influence in the current classification systems and that it tends to give the impression that cultural influences only apply to exotic cultures [15, 17, 21].

While the underlying assumptions behind the classification systems may be relevant and accurate in a Western cultural context, they do not necessarily remain relevant or accurate in other cultural contexts [17]. Recent researches have begun to find that certain 'culture-bound syndromes' are not limited to specific cultures but have a wide geographic range [30]. Also, most of the constructs described as 'culture-bound syndromes' in the DSM-IV were not 'culture-bound' nor were they syndromes (i.e. they lacked distinctive etiology or temporal course) [21, 30]. The DSM-V removed the adjective 'bound' from the descriptions of these disorders to recognize the exaggeration of the local uniqueness of these symptoms and to emphasize that clinically important cultural differences often involve an explanation of distress, not necessarily a distinct manifestation of illness [21, 30]. Certain mental disorders such as Anorexia Nervosa have been regarded as a culture-bound syndrome specific to Western cultures, however, they not located in the appendix of the DSM like the other culture-bound syndromes, providing further proof of

Western ethnocentrism and exoticization of other cultures with regards to disease definition and classification [21].

DSM-V introduced the term 'cultural concepts of distress' (CCD) which encompasses three areas: culture syndromes (very similar to culture-bound syndromes in DSM-IV), idioms of distress and cultural explanations with the intent to stimulate further understanding of the constructs and to aid its application in clinical practice and research [30]. CCDs are local verbal and non-verbal modes of expression of distress and sometimes resilience and they differ from mental disorders [30–32]. According to Lewis-Fernandez et al. [30], CCDs cover a wide range of distress that ranges from responses to everyday stress to severe psychopathology; represent the expressions of distress using local idioms that can be distilled into categories by clinicians to arrive at a diagnosis. CCDs can also be useful in re-contextualizing formal nosologies and biological mechanisms of mental disorders in individual narratives of distress and the dynamic practices of meaning-making through interpersonal processes and social systems; can lead to the recognition of certain phenomenological aspects or psychopathology missing from current psychiatric nosology and can be a pointer to new symptoms, signs or syndromes that can help refine current nosology for enhanced global reliability and validity [31]. CCDs can also provide a more sensitive screening mechanism superior to diagnostic screens, in predicting individuals at risk for a mental disorder (especially in low resource settings) [30, 31]. The use of CCDs can prevent overmedicalization as it identifies people with mild forms of mental distress that can be amenable to psychosocial interventions; can inform patient-centered care by overcoming the decontextualization that comes with an exclusive emphasis on diagnosing disorders, helping clinicians appreciate the uniqueness of the patient's illness experience and struggles for meaning;

and can be useful in identifying and addressing social inequalities and structural violence which may be drivers of the mental disorders [30].

Culture and misdiagnosis in mental health

Culture is the royal road to understanding a patient [14]. When the social and cultural factors are neglected in the assessment of patients, misdiagnosis and perpetuation of clinical stereotypes based on race, ethnicity, gender, among other factors occur, leading to disparities in mental healthcare [33]. Indeed, in the US there is a long history of misdiagnosis of schizophrenia and other psychosis related disorders among African-Americans, dating as far back as the early 1900s [15, 33]. Similar misdiagnosis has been observed among people of African and Caribbean descent in the UK [34]. While rates of schizophrenia are disproportionately high among African-Americans in the US, the rates of depression were found to be disproportionately low [15]. Because there is a well-established link between negative life experiences, lower socioeconomic status, stress, and depression, Plant et al. [35] found the low depression prevalence among African-Americans odd given the accumulation of social and economic disadvantages among them. On further investigation, they found that African-Americans scored higher on measures of depression compared to Whites and Hispanics suggesting that depression was being underdiagnosed among African-Americans [35]. Their research also highlighted the role of cultural factors in coping; African-Americans with depression compared to their White counterparts had higher levels of interpersonal functioning. This was attributed to the collectivist culture among African-Americans compared to the more individualistic culture among Whites [35]. Cultural factors therefore play an important role not only in diagnosis, but should be considered when planning treatment— identifying and strengthening culture specific ways of

promoting resilience.

The consequences of the diagnostic disparity between African-Americans and Whites include higher rates of hospitalizations, higher antipsychotic dosages, and more frequent use of restraints among African-Americans compared with Whites [36–38]. African-Americans are also perceived to be more dangerous and more severely ill which may be one reason why there is a higher rate of hospitalizations among them [15].

Clinicians' cultural influences, as well as situational and attributional factors, play a role in the diagnostic interview of patients even when they use standardized diagnostic instruments; non-American clinicians were found to be more likely to give a diagnosis of schizophrenia to African-American patients compared to an African-American clinician [39, 40]. African-American clinicians utilize situational and cultural context more often than non-African-American clinicians when faced with diagnostic ambiguities [39].

Clinical diagnosis of a mental disorder requires clinicians to fit patient information into existing diagnostic categories, and the weaker the fit between the available information about the patient and the diagnostic criteria, the greater the uncertainty regarding clinical diagnosis [39]. In these situations, clinicians often rely on cognitive heuristics in making clinical judgments based on underlying assumptions about the patient within the context of the general population, and failure to take into account the patient's cultural context leads to misinterpretation of the patient's behaviors resulting in diagnostic inaccuracies [33, 39]. This underscores the need for cultural sensitivity and knowledge of the cultural context in every patient encounter to provide a more contextualized perspective – that integrates patients' personal, social, and clinical data with an explanatory model of the meanings attributed to symptoms – to enhance diagnostic accuracy and

to identify local markers of severity and ongoing vulnerability [25, 33].

Cultural competence in mental health service delivery

Cultural competence is defined as the capacity to render quality services to different cultural groups because of increased knowledge of their culture's history, knowledge, ways of life [17]. It is a means to address organizational, structural, and clinical barriers to healthcare access and provision faced both patients and physicians; it seeks to bridge the cultural distance between providers and the people they serve, emphasizing on physicians' knowledge, attitudes, and emerging skills, and on the creation and growth of meaningful relationships [2]. Cultural competence does not apply only to healthcare professionals but to all involved in healthcare delivery including social workers, receptionists, telephone and internet respondents, and care administrators who serve as service gatekeepers [2].

In developing a framework for cultural competence, both patients' and caregivers' explanatory models and perceptions of illness and wellbeing should be taken into account and divergent perspectives reconciled [2]. It is also important that when physicians and patients share similar backgrounds, shared knowledge is not taken for granted in order to avoid leaving patients with incorrect assumptions and incomplete understanding of their disorders [2, 41]. Cultural competence removes barriers to care by promoting effective communication between caregivers and patients and therefore is a necessary skill set for every patient encounter and not just when there is a perceived cultural difference (i.e. when dealing with immigrants or an individual from a foreign culture) [42–44].

Cultural competence is caring competence, and goes beyond competence training; it is a lifelong journey of acknowledging the unknowns and engaging cultures with a willingness to learn [2].

Culturally competent clinicians learn that respect and esteem are important in assisting their patients to discover new meaning through the suffering that illness creates [2]. While it is important for clinicians to take culture competence courses, it must be known that the process of culture change takes time [2]. At its worst, cultural competency training can create the idea that culture is synonymous with ethnicity, nationality, and language, thereby promoting stereotypes that result in mediocre care [2, 45, 46]. Teaching culture as a fixed perspective on illness and behaviors can lead to false attribution of cultural reasons to patient's issues rather than considering other economic, logistic or social inequalities and lead to the development of poor strategies to address difficulties that emerge in socially complex environments [2, 45].

All human perceptions and social interactions occur within the context of culture, therefore in all aspects of the mental health service, providers must take patient's culture and perspectives into consideration in defining problems and planning interventions [15]. However, it is impossible to personalize service for every single culture within the mental health service given the increasingly diverse nature of the demographics [15]. In addition, an in-depth understanding of specific groups does not confer competency as every individual is unique in terms of cultural identity, and it is not possible to fully master culture, one's own or another's [2, 5, 15]. Therefore, an integrated approach is needed that incorporates general techniques (based on commonalities across all cultures) and specific skills relevant to specific cultural groups within a particular mental health service [15].

Attaining cultural proficiency is a lifelong endeavor and is a personal quality that lies along a continuum and not 'all or nothing' [15]. Training in cultural competence is based on two models: The Cultural Competence Continuum and the Three Domains of Multicultural Competence. The

Cultural Competence Continuum assesses the degree of culturally appropriate responsiveness to identified needs of individuals and families, on a dimensional scale ranging from 'cultural destructiveness' to 'advanced cultural competence'; the Three Domains of Multicultural Competence assesses 3 domains: Awareness, Knowledge, and Skills [15]. These tools are useful in the evaluation, reflection, and training of providers in delivering culturally competent care. Also, the DSM-V provides a Cultural Formulation Interview to help clinicians evaluate cultural aspects in every patient interaction. This will help in recognizing the phenomenological diversity of core diagnostic criteria, understanding symptoms in the context of patient's culture, providing context to local idioms of distress to avoid diagnostic errors, and incorporating culturally relevant strategies into the treatment plans to improve patient outcomes and enhance compliance [21, 25, 33, 47].

CONCLUSION

In this paper, the importance of culture in mental health has been highlighted and the dangers of not paying attention to cultural context in interactions with patients with mental illness explored. Current diagnostic systems are beginning to advocate for clinicians to be aware of the cultural context of each individual that is interacted with. This work raises the need for cultural competency training for all persons involved in the mental health system and not just the clinicians. Cultural competence is to be seen not as a one-off training but as a life-long process.

References

1. Gurung RAR. Cultural influences on health. Cross−Cultural Psychol Contemp Themes Perspect. 2019;451–466.

2. Napier AD, Ancarno C, Butler B, Calabrese J, Chater A, Chatterjee H, et al. Culture and health. Lancet. 2014;384(9954):1607–1639.

3. Dormandy E, Michie S, Hooper R, Marteau TM. Low uptake of prenatal screening for Down syndrome in minority ethnic groups and socially deprived groups: a reflection of women's attitudes or a failure to facilitate informed choices? Int J Epidemiol. 2005;34(2): 346–352.

4. Ndidi EP, Oseremen IG. Reasons given by pregnant women for late initiation of antenatal care in the Niger Delta, Nigeria. Ghana Med J. 2010;44(2).

5. Purnell LD, Fenkl EA. Transcultural Diversity and Health Care BT - Handbook for Culturally Competent Care. In: Purnell LD, Fenkl EA, editors. Cham: Springer International Publishing; 2019. p. 1–6. Available from: https://doi.org/ 10.1007/978-3-030-21946-8_1.

6. Ruiz JM, Prather CC, Steffen P. Socioeconomic status and health. 2012;

7. | Healthy People 2020 [Internet]. [cited 2019 Oct 22]. Available from: https:// www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Injury-and-Violence/data#homicides.

8. McGuire TG, Miranda J. New evidence regarding racial and ethnic disparities in mental health: policy implications. Health Aff (Millwood) [Internet]. 2008;27(2):393–403. Available from: https://www.ncbi.nlm.nih.gov/pubmed/18332495.

9. Wilkinson RG, Marmot M. Social determinants of health: the solid facts. World Health Organization; 2003.

10. Sen A. Human rights and capabilities. J Hum Dev. 2005;6(2):151–166.

11. Farmer P. Pathologies of power: Health, human rights, and the new war on the poor. Vol. 4. Univ of California Press; 2004.

12. Manderson L, Aagaard-Hansen J, Allotey P, Gyapong M, Sommerfeld J. Social research on neglected diseases of poverty: continuing and emerging themes. PLoS Negl Trop Dis. 2009;3(2):e332.

13. Fabrega JR H. Psychiatric Diagnosis: A Cultural Perspective. J Nerv Ment Dis. 1987;175(7):383–394.

14. Aderibigbe YA, Pandurangi AK. The neglect of culture in psychiatric nosology: The case of culture bound syndromes. Int J Soc Psychiatry. 1995;41(4):235–241.

15. Paniagua FA, Yamada AM. Handbook of multicultural mental health: Assessment and treatment of diverse populations. Academic Press; 2013.

16. Hinshaw SP, Scheffler RM, Fulton BD, Aase H, Banaschewski T, Cheng W, et al. International variation in treatment procedures for ADHD: social context and recent trends. Psychiatr Serv. 2011;62(5):459–464.

17. Marsella AJ, Yamada AM. Culture and psychopathology: Foundations, issues, directions. J Pacific Rim Psychol. 2010;4(2):103–115.

18. Gold I, Kirmayer LJ. Cultural psychiatry on Wakefield's procrustean bed. World Psychiatry. 2007;6(3):165.

19. Mezzich JE, Berganza CE, Ruiperez MA. Culture in DSM-IV, ICD-10, and evolving diagnostic systems. Psychiatr Clin North Am. 2001;24(3):407–419.

20. Mezzich JE, Kirmayer LJ, Kleinman A, Fabrega H, Parron DL, Good BJ, et al. The place of culture in DSM-IV. J Nerv Ment Dis [Internet]. 1999;187(8):457–464. Available from:

https://journals.lww.com/jonmd/Fulltext/1999/08000/The_Place_of_Culture_in_DSM_IV.1.aspx.

21. Bredström A. Culture and Context in Mental Health Diagnosing: Scrutinizing the DSM-5 Revision. J Med Humanit [Internet]. 2019 Sep;40(3):347–363. Available from: https://doi.org/10.1007/s10912-017-9501-1.
22. Whooley O. Nosological reflections: The failure of DSM-5, the emergence of RDoC, and the decontextualization of mental distress. Soc Ment Health. 2014;4(2):92–110.
23. Marsella AJ. Culture, self, and mental disorder. Cult self Asian West Perspect. 1985;281–307.
24. Weiss MG, Raguram R, Channabasavanna SM. Cultural Dimensions of Psychiatric Diagnosis: A Comparison of DSM–III–R and Illness Explanatory Models in South India. Br J Psychiatry. 1995;166(3):353–359.
25. Alarcón RD. Culture, cultural factors and psychiatric diagnosis: review and projections. World psychiatry. 2009;8(3):131–139.
26. Maslowski J, Jansen Van Rensburg D, Mthoko N. A polydiagnostic approach to the differences in the symptoms of schizophrenia in different cultural and ethnic populations. Acta Psychiatr Scand. 1998;98(1):41–46.
27. Patel V. Explanatory models of mental illness in sub-Saharan Africa. Soc Sci Med. 1995;40(9):1291–1298.
28. Campbell MM, Sibeko G, Mall S, Baldinger A, Nagdee M, Susser E, et al. The content of delusions in a sample of South African Xhosa people with schizophrenia. BMC Psychiatry. 2017;17(1):41.

29. Suhail K, Cochrane R. Effect of culture and environment on the phenomenology of delusions and hallucinations. Int J Soc Psychiatry. 2002;48(2):126–138.

30. Lewis-Fernández R, Kirmayer LJ. Cultural concepts of distress and psychiatric disorders: Understanding symptom experience and expression in context. Transcult Psychiatry. 2019;56(4):786–803.

31. Lewis-Fernandez R, Kirmayer LJ, Guarnaccia PJ, Ruiz P. Cultural Concepts of Distress. Compr Textb Psychiatry. 2017;2443–2460.

32. Wooyoung Kim A, Kaiser B, Bosire E, Shahbazian K, Mendenhall E. Idioms of resilience among cancer patients in urban South Africa: An anthropological heuristic for the study of culture and resilience. Transcult Psychiatry. 2019;56(4):720–747.

33. Alarcón RD, Becker AE, Lewis-Fernández R, Like RC, Desai P, Foulks E, et al. Issues for DSM-V: The role of culture in psychiatric diagnosis. Vol. 197, J Nerv Ment Dis. 2009;197:559–560.

34. McKenzie K. Improving mental healthcare for ethnic minorities. Adv Psychiatr Treat. 2008;14(4):285–291.

35. Plant EA, Sachs-Ericsson N. Racial and Ethnic Differences in Depression: The Roles of Social Support and Meeting Basic Needs. J Consult Clin Psychol. 2004;72(1):41–52.

36. Segal SP, Bola JR, Watson MA. Race, quality of care, and antipsychotic prescribing practices in psychiatric emergency services. Psychiatr Serv. 1996;47(3):282–286.

37. Muroff J, Edelsohn GA, Joe S, Ford BC. The role of race in diagnostic and disposition decision making in a pediatric psychiatric emergency service. Gen Hosp Psychiatry. 2008;30(3):269–276.

38. Flaherty JA, Meagher R. Measuring racial bias in inpatient treatment. Am J Psychiatry. 1980;137(6):679–682.

39. Trierweiler SJ, Muroff JR, Jackson JS, Neighbors HW, Munday C. Clinician race, situational attributions, and diagnoses of mood versus schizophrenia disorders. Cult Divers Ethn Minor Psychol. 2005;11(4):351–364.

40. Trierweiler SJ, Neighbors HW, Munday C, Thompson EE, Jackson JS, Binion VJ. Differences in patterns of symptom attribution in diagnosing schizophrenia between African American and non-African American clinicians. Am J Orthopsychiatry. 2006;76(2):154–160.

41. Helman C. Culture, health and illness. CRC press; 2007.

42. Betancourt J, Green AR, Carrillo JE. Cultural competence in health care: Emerging frameworks and practical approaches. New York: The Commonwealth Fund, Quality of Care for Underserved Populations New York, NY; 2002.

43. Betancourt JR. Cultural competence and medical education: Many names, many perspectives, one goal. Acad Med. 2006;81(6):499–501.

44. Kripalani S, Bussey-Jones J, Katz MG, Genao I. A prescription for cultural competence in medical education. J Gen Intern Med. 2006;21(10):1116–1120.

45. Kleinman A, Benson P. Anthropology in the clinic: The problem of cultural competency and how to fix it. PLoS Med. 2006;3(10):1673–1676.

46. Taylor JS. Confronting “culture” in medicine’s “culture of no culture.” Acad Med. 2003;78(6):555–559.

47. Adeponle AB, Groleau D, Kirmayer LJ. Clinician Reasoning in the Use of Cultural

Formulation to Resolve Uncertainty in the Diagnosis of Psychosis. Cult Med Psychiatry [Internet]. 2015 Mar;39(1):16–42. Available from: https://doi.org/10.1007/s11013-014-9408-5.