

# 02 - Culture and Psychiatric Diagnosis

## Culture and Psychiatric Diagnosis

859

**Culture and Psychiatric Diagnosis** This chapter provides basic information on integrating culture and social context in clinical diagnoses, with sections on key terms, cultural formulation, and cultural concepts of distress. The first section defines terms that are essential to the rest of the chapter: culture, race, and ethnicity. The Cultural Formulation section presents an outline for a systematic person-centered cultural assessment that is designed to be used by any clinician providing services to any individual in any care setting. This section also includes an interview protocol, the Cultural Formulation Interview, that operationalizes these components. Symptom presentations, interpretations of the illness or predicament that precipitates care, and help-seeking expectations are always influenced by individuals' cultural backgrounds and sociocultural contexts. A person-centered cultural assessment can help improve the care of every individual, regardless of his or her background. Cultural formulation may be especially helpful for individuals who are affected by healthcare disparities driven by systemic disadvantage and discrimination. The Cultural Concepts of Distress section describes the ways individuals express, report, and interpret experiences of illness and distress. Cultural concepts of distress include idioms, explanations or perceived causes, and syndromes. Symptoms are expressed and communicated using cultural idioms of distress—behaviors or linguistic terms, metaphors, phrases, or ways of talking about symptoms, problems, or suffering that are commonly used by individuals with similar cultural backgrounds to convey a wide range of concerns. Such idioms may be used for a broad spectrum of distress and may not indicate a psychiatric disorder. Common contemporary idioms in the United States include “burnout,” “feeling stressed,” “nervous breakdown,” and “feeling depressed,” in the sense of experiencing dissatisfaction or discouragement that does not meet criteria for any psychiatric disorder. Culturally specific explanations and syndromes are also common and distributed widely across populations. This section also provides some illustrative examples of idioms, explanations, and syndromes from diverse geographic regions. The examples were chosen because they have been well studied and their lack of familiarity to many U.S. clinicians highlights their specific verbal and behavioral expressions and communicative functions. **Key Terms**

Understanding the cultural context of illness experience is essential for effective diagnostic assessment and clinical management. Culture refers to systems of knowledge, concepts, values, norms, and practices that are learned and transmitted across generations. Culture includes language, religion and spirituality, family structures, life-cycle stages, ceremonial rituals, customs, and ways of understanding health and illness, as well as moral, political, economic, and legal systems. Cultures are open, dynamic systems that undergo continuous change over time; in the contemporary world, most

individuals and groups are exposed to multiple cultural contexts, which they use to fashion their own identities and make sense of experience. This process of meaning-making derives from developmental and everyday social experiences in specific contexts, including health care, which may vary for each individual. Much of culture involves background knowledge, values, and assumptions that remain implicit or presumed and so may be difficult for individuals to describe. These features of culture make it crucial not to overgeneralize cultural information or stereotype groups in terms of fixed cultural traits. In relation to diagnosis, it is essential to recognize that all forms of illness and distress, including the DSM disorders, are shaped by cultural contexts. Culture influences how individuals fashion their identities, as well as how they interpret and respond to symptoms and illness. Race is a social, not a biological, construct that divides humanity into groups based on a variety of superficial physical traits such as skin color that have been falsely viewed as indicating attributes and capacities assumed to be inherent to the group. Racial categories and constructs have varied over history and across societies and have been used to justify systems of oppression, slavery, and genocide. The construct of race is important for psychiatry because it can lead to racial ideologies, racism, discrimination, and social oppression and exclusion, which have strong negative effects on mental health. There is evidence that racism can exacerbate many psychiatric disorders, contributing to poor outcome, and that racial biases can affect diagnostic assessment. Ethnicity is a culturally constructed group identity used to define peoples and communities. It may be rooted in a common history, ancestry, geography, language, religion, or other shared characteristics of a group, which distinguish that group from others. Ethnicity may be self-assigned or attributed by outsiders. Increasing mobility, intermarriage, and intermixing of cultural groups have defined new mixed, multiple, or hybrid ethnic identities. These processes may also lead to the dilution of ethnic identification. Culture, race, and ethnicity may be related to political, economic, and social structural inequities associated with racism and discrimination resulting in health disparities. Cultural, ethnic, and racialized identities can be sources of strength and group support that enhance resilience. They may also lead to psychological, interpersonal, and intergenerational conflict or difficulties in adaptation that require socially and culturally informed diagnosis and clinical assessment. Additional key terms related to racialization and racism are defined in the DSM-5TR Section I Introduction, under “Cultural and Social Structural Issues,” in the subsection “Impact of Racism and Discrimination on Psychiatric Diagnosis.” Cultural Formulation Outline for Cultural Formulation The Outline for Cultural Formulation introduced in DSM-IV provided a framework for assessing information about cultural features of an individual’s mental health problem and how it relates to a social and cultural context and history. This assessment provides useful information on social context and illness experience relevant to the assessment of every individual, not only those whose cultural background may be unfamiliar to the clinician.

861 Updated from DSM-5, DSM-5-TR includes an expanded version of the Outline and an approach to assessment using the Cultural Formulation Interview (CFI), which has been field-tested among

clinicians, patients, and accompanying relatives and found to be a feasible, acceptable, and useful cultural assessment tool. The Outline for Cultural Formulation calls for systematic assessment of the following categories: Cultural identity of the individual: Describe the individual's demographic (e.g., age, gender, ethnoracial background) or other socially and culturally defined characteristics that may influence interpersonal relationships, access to resources, and developmental and current challenges, conflicts, or predicaments. Other clinically relevant aspects of identity may include religious affiliation and spirituality, socioeconomic class, caste, personal and family places of birth and growing up, migrant status, occupation, and sexual orientation, among others. Note which aspects of identity are prioritized by the individual and how they interact (intersectionality), which may reflect the influence of clinical setting and health concerns. For migrants, the degree and kinds of involvement with both the cultural contexts of origin and the new cultural contexts should be noted. Similarly, for individuals who identify with racialized and ethnic groups, the degree of interaction and identification with their own group and other segments of society should be noted. Language abilities, preferences, and patterns of use are relevant for identifying difficulties with access to care, social integration, and clinical communication or the need for an interpreter. Cultural concepts of distress: Describe the cultural constructs that influence how the individual experiences, understands, and communicates his or her symptoms or problems to others. These constructs include cultural idioms of distress, cultural explanations or perceived causes, and cultural syndromes. The level of severity and meaning of the distressing experiences should be assessed in relation to the norms of the individual's cultural background. Priority symptoms, perceived seriousness of the illness, the level of associated stigma, and anticipated outcomes are all relevant. Elicit the individual's and family's or friends' help-seeking expectations and plans, as well as patterns of self-coping and their connection to the individual's cultural concepts of distress, including past help-seeking experiences. Assessment of coping and help-seeking patterns should consider the use of professional as well as traditional, alternative, or complementary sources of care. Psychosocial stressors and cultural features of vulnerability and resilience: Identify key stressors, challenges, and supports in the individual's social environment (which may include both local and distant events). These include social determinants of the individual's mental health such as access to resources (e.g., housing, transportation) and opportunities (e.g., education, employment); exposure to racism, discrimination, and systemic institutional stigmatization; and social marginalization or exclusion (structural violence). Also assess the role of religion, family, and other interpersonal relationships and social networks (e.g., friends, neighbors, coworkers, online forums or groups) in causing stress or providing emotional, instrumental, and informational support. Social stressors and social supports vary with social context, family structure, developmental tasks, and the cultural meaning of events. Levels of functioning, disability, and resilience should be assessed in light of the individual's cultural background. Cultural features of the relationship between the individual and the clinician, treatment team, and institution: Identify differences in cultural background, language, education, and social status among other aspects of identity between an individual and clinician (or the treatment team and institution) that may cause difficulties in communication and may influence diagnosis and treatment. Considering the ways that individuals and clinicians are positioned socially and perceive each other in terms of social categories may influence the assessment

process. Experiences of racism and discrimination in the larger society may impede establishing trust and safety in the clinical diagnostic encounter. Effects may include problems eliciting symptoms, misunderstanding of the cultural and clinical significance of symptoms and behaviors,

and difficulty establishing or maintaining the rapport needed for accurate assessment and an effective clinical alliance. Overall cultural assessment: Summarize the implications of the components of the cultural formulation identified in earlier sections of the Outline for the differential diagnosis of mental disorders and other clinically relevant issues or problems, as well as appropriate management and treatment intervention. Cultural Formulation Interview (CFI) The Cultural Formulation Interview (CFI) is a set of protocols that clinicians may use to obtain information during a mental health assessment about the impact of culture on key aspects of an individual's clinical presentation and care. The CFI consists of three components: the core CFI, a set of 16 questions that can be used to obtain an initial assessment from any individual; an Informant version of the core CFI to obtain collateral information; and a set of Supplementary modules to expand the evaluation as needed. In the CFI, the term culture includes: The processes through which individuals assign meaning to experience, drawing from the values, orientations, knowledge, and practices of the diverse social groups (e.g., ethnic groups, faith groups, occupational groups, veterans' groups) and communities in which they participate. Aspects of individuals' background, developmental experiences, and current social contexts and position that affect their perspective, such as age, gender, social class, geographic origin, migration, language, religion, sexual orientation, disability, or ethnic or racialized background. The influence of family, friends, and other community members (particularly, the individual's social network) on the individual's illness experience. The cultural background of the health care providers and the values and assumptions embedded in the organization and practices of health care systems and institutions that may affect the clinical interaction. Cultural processes involve interactions of the individual with local and larger social contexts. A cultural assessment thus evaluates processes both within the individual and in the social world, assessing the context as much as the person. The CFI is a brief semistructured interview for systematically assessing cultural factors relevant to the care of any individual. The CFI focuses on the individual's experience and the social contexts of the clinical problem, symptoms, or concerns. The CFI follows a personcentered approach to cultural assessment by eliciting information from the individual about his or her own views and those of others in his or her social network. This approach is designed to avoid stereotyping, in that each individual's cultural knowledge affects how he or she interprets illness experience and guides how he or she seeks help. Because the CFI concerns the individual's personal views, there are no right or wrong answers to these questions. The core CFI (and informant version) is included later in this chapter and is available online at [www.psychiatry.org/dsm5](http://www.psychiatry.org/dsm5); the Supplementary modules are also available online. The core CFI (and informant version) is formatted as two text columns. The left-hand

column contains the instructions for administering the CFI and describes the goals for each interview domain. The questions in the right-hand column illustrate how to explore these domains, but they are not meant to be exhaustive. Follow-up questions may be needed to clarify individuals' answers. Questions may be rephrased as needed. The CFI is intended as a guide to cultural assessment and should be used flexibly to maintain a natural flow of the interview and rapport with the individual. The CFI is best used in conjunction with demographic information obtained before the interview in order to tailor the CFI questions to address the individual's background and current situation. Specific demographic domains to be explored with the CFI will vary across individuals and settings. A comprehensive assessment may include place of birth, age, gender, ethnic or racialized background, marital status, family composition, education, language fluencies, sexual orientation, religious or spiritual affiliation, occupation, employment, income, and migration history. The CFI can be used in the initial assessment of individuals at any age, in any clinical setting, regardless of

the cultural background of the individual or of the clinician. Individuals and clinicians who appear to share the same cultural background may nevertheless differ in ways that are relevant to care. The CFI may be used in its entirety, or components may be incorporated into a clinical evaluation as needed. The CFI may be especially helpful in clinical practice when any of the following occur: Difficulty in diagnostic assessment owing to significant differences in the cultural, religious, or socioeconomic backgrounds of clinician and the individual. Uncertainty about the fit between culturally distinctive symptoms and diagnostic criteria. Difficulty in judging illness severity or impairment. Divergent views of symptoms or expectations of care based on previous experience with other cultural systems of healing and health care. Disagreement between the individual and clinician on the course of care. Potential mistrust of mainstream services and institutions by individuals with collective histories of trauma and oppression. Limited engagement in and adherence to treatment by the individual. The core CFI emphasizes four domains of assessment: Cultural Definition of the Problem (questions 1-3); Cultural Perceptions of Cause, Context, and Support (questions 4-10); Cultural Factors Affecting Self-Coping and Past Help Seeking (questions 11-13); and Cultural Factors Affecting Current Help Seeking (questions 14-16). Both the person-centered process of conducting the CFI and the information it elicits are intended to enhance the cultural validity of diagnostic assessment, facilitate treatment planning, and promote the individual's engagement and satisfaction. To achieve these goals, the clinician should integrate the information obtained from the CFI with all other available clinical material into a comprehensive clinical and contextual evaluation. An Informant version of the CFI can be used to collect collateral information on the CFI domains from family members or caregivers. Supplementary modules have been developed that expand on each domain of the core CFI and guide clinicians who wish to explore these domains in greater depth. Supplementary modules have also been developed for specific populations, such as children and adolescents, elderly individuals, caregivers, and immigrants and refugees. These supplementary modules are

referenced in the core CFI under the pertinent subheadings and are available online at [www.psychiatry.org/dsm5](http://www.psychiatry.org/dsm5). Core Cultural Formulation Interview (CFI) Supplementary modules used to expand each CFI subtopic are noted in parentheses. **GUIDE TO INTERVIEWER INSTRUCTIONS TO THE INTERVIEWER ARE ITALICIZED.** The following questions aim to clarify key aspects of the presenting clinical problem from the point of view of the individual and other members of the individual's social network (i.e., family, friends, or others involved in current problem). This includes the problem's meaning, potential sources of help, and expectations for services. **INTRODUCTION FOR THE INDIVIDUAL:** I would like to understand the problems that bring you here so that I can help you more effectively. I want to know about your experience and ideas. I will ask some questions about what is going on and how you are dealing with it. Please remember there are no right or wrong answers. **CULTURAL DEFINITION OF THE PROBLEM CULTURAL DEFINITION OF THE PROBLEM (Explanatory Model, Level of Functioning)** Elicit the individual's view of core problems and key concerns. Focus on the individual's own way of understanding the problem. Use the term, expression, or brief description elicited in question 1 to identify the problem in subsequent questions (e.g., "your conflict with your son").

1. What brings you here today? **IF INDIVIDUAL GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE:** People often understand their problems in their own way, which may be similar to or different from how doctors describe the problem. How would you describe your problem? Ask how individual frames the problem

for members of the social network.

2. Sometimes people have different ways of describing their problem to their family, friends, or others in their community. How would you describe your problem to them? Focus on the aspects of the problem that matter most to the individual.
3. What troubles you most about your problem? CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT CAUSES (Explanatory Model, Social Network, Older Adults) This question indicates the meaning of the condition for the individual, which may be relevant for clinical care. Note that individuals may identify multiple causes, depending on the facet of the problem they are considering.
4. Why do you think this is happening to you? What do you think are the causes of your [PROBLEM]? PROMPT FURTHER IF REQUIRED: Some people may explain their problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes. Focus on the views of members of the individual's social network. These may be diverse and vary from the individual's.
5. What do others in your family, your friends, or others in your community think is causing your [PROBLEM]? STRESSORS AND SUPPORTS (Social Network, Caregivers, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Cultural Identity, Older Adults, Coping and Help Seeking) Elicit information on the individual's life context, focusing on resources, social supports, and resilience. May also probe 6. Are there any kinds of support that make your [PROBLEM] better, such as support from family, friends, or others?

other supports (e.g., from co-workers, from participation in religion or spirituality). Focus on stressful aspects of the individual's environment. Can also probe, e.g., relationship problems, difficulties at work or school, or discrimination. 7. Are there any kinds of stresses that make your [PROBLEM] worse, such as difficulties with money, or family problems? ROLE OF CULTURAL IDENTITY (Cultural Identity, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Older Adults, Children and Adolescents) Sometimes, aspects of people's background or identity can make their [PROBLEM] better or worse. By background or identity, I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, or your faith or religion. Ask the individual to reflect on the most salient elements of his or her cultural identity. Use this information to tailor questions 9-10 as needed. 8. For you, what are the most important aspects of your background or identity? Elicit aspects of identity that make the problem better or worse. 9. Are there any aspects of your background or identity that make a difference to your [PROBLEM]? Probe as needed (e.g., clinical worsening as a result of discrimination due to migration status, race/ethnicity, or sexual orientation). Probe as needed (e.g., migration-related problems; conflict across generations or due to gender roles). 10. Are there any aspects of your background or identity that are causing other concerns or difficulties for you? CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING SELF-COPING (Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors) Clarify self-coping for the problem. 11. Sometimes people have various ways of dealing with problems like [PROBLEM]. What have you done on your own to cope with your [PROBLEM]? PAST HELP SEEKING (Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship) Elicit various sources of help (e.g., medical care, mental health treatment, support groups, work-based counseling, folk healing,

religious or spiritual counseling, other forms of traditional or alternative healing). 12. Often, people look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing have you sought for your [PROBLEM]? Probe as needed (e.g., “What other sources of help have you used?”). **PROBE IF DOES NOT DESCRIBE USEFULNESS OF HELP RECEIVED:** Clarify the individual’s experience and regard for previous help. What types of help or treatment were most useful? Not useful? **BARRIERS** (Coping and Help Seeking, Religion and Spirituality, Older Adults, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship) Clarify the role of social barriers to help seeking, access to care, and problems engaging in previous treatment. Probe details as needed (e.g., “What got in the way?”). 13. Has anything prevented you from getting the help you need? **PROBE AS NEEDED:** For example, money, work or family commitments, stigma or discrimination, or lack of services that understand your

language or background? **CULTURAL FACTORS AFFECTING CURRENT HELP SEEKING PREFERENCES** (Social Network, Caregivers, Religion and Spirituality, Older Adults, Coping and Help Seeking) Clarify individual’s current perceived needs and expectations of help, broadly defined. Now let’s talk some more about the help you need. Probe if individual lists only one source of help (e.g., “What other kinds of help would be useful to you at this time?”). 14. What kinds of help do you think would be most useful to you at this time for your [PROBLEM]? Focus on the views of the social network regarding help seeking. 15. Are there other kinds of help that your family, friends, or other people have suggested would be helpful for you now? **CLINICIAN-PATIENT RELATIONSHIP** (Clinician-Patient Relationship, Older Adults) Elicit possible concerns about the clinic or the clinician-patient relationship, including perceived racism, language barriers, or cultural differences that may undermine goodwill, communication, or care delivery. Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations. Probe details as needed (e.g., “In what way?”). Address possible barriers to care or concerns about the clinic and the clinician-patient relationship raised previously. 16. Have you been concerned about this and is there anything that we can do to provide you with the care you need? **Cultural Formulation Interview (CFI)—Informant Version** The CFI Informant Version collects collateral information from an informant who is knowledgeable about the clinical problems and life circumstances of the identified individual. This version can be used to supplement information obtained from the core CFI or can be used instead of the core CFI when the individual is unable to provide information (e.g., children or adolescents, individuals with florid psychosis, individuals with cognitive impairment). **Cultural Formulation Interview (CFI)—Informant Version GUIDE TO INTERVIEWER INSTRUCTIONS TO THE INTERVIEWER ARE ITALICIZED.** The following questions aim to clarify key aspects of the presenting clinical problem from the informant’s point of view. This includes the problem’s meaning, potential sources of help, and expectations for services. **INTRODUCTION FOR THE INFORMANT:** I would like to understand the problems that bring your family member/friend here so that I can help you and him/her more effectively. I want to know about your experience and ideas. I will ask some questions about what is going on and how you and your family member/friend are dealing with it. There are no right or wrong answers. **RELATIONSHIP WITH THE PATIENT** Clarify the informant’s relationship with the individual and/or the individual’s family.

1. How would you describe your relationship to [INDIVIDUAL OR TO FAMILY]? **PROBE IF NOT CLEAR:** How often do you see [INDIVIDUAL]?

Elicit the informant's view of core problems and key concerns. Focus on the informant's way of understanding the individual's problem. Use the term, expression, or brief description elicited in question 1 to identify the problem in subsequent questions (e.g., "her conflict with her son"). Ask how informant frames the problem for members of the social network. Focus on the aspects of the problem that matter most to the informant. This question indicates the meaning of the condition for the informant, which may be relevant for clinical care. Note that informants may identify multiple causes depending on the facet of the problem they are considering. Focus on the views of members of the individual's social network. These may be diverse and vary from the informant's. Elicit information on the individual's life context, focusing on resources, social supports, and resilience. May also probe other supports (e.g., from co-workers, from participation in religion or spirituality). Focus on stressful aspects of the individual's environment. Can also probe, e.g., relationship problems, difficulties at work or school, or discrimination. Ask the informant to reflect on the most salient elements of the individual's cultural identity. Use this information to tailor questions 10-11 as needed. Elicit aspects of identity that make the problem better or worse. Probe as needed (e.g., clinical worsening as a result of discrimination due to migration status, race/ethnicity, or sexual orientation). Probe as needed (e.g., migration-related problems; conflict across generations or due to gender roles).

**CULTURAL DEFINITION OF THE PROBLEM**

2. What brings your family member/friend here today? IF INFORMANT GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE: People often understand problems in their own way, which may be similar or different from how doctors describe the problem. How would you describe [INDIVIDUAL'S] problem?

3. Sometimes people have different ways of describing the problem to family, friends, or others in their community. How would you describe [INDIVIDUAL'S] problem to them?

4. What troubles you most about [INDIVIDUAL'S] problem?

**CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT CAUSES**

5. Why do you think this is happening to [INDIVIDUAL]? What do you think are the causes of his/her [PROBLEM]? PROMPT FURTHER IF REQUIRED: Some people may explain the problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes.

6. What do others in [INDIVIDUAL'S] family, his/her friends, or others in the community think is causing [INDIVIDUAL'S] [PROBLEM]?

**STRESSORS AND SUPPORTS**

7. Are there any kinds of supports that make his/her [PROBLEM] better, such as from family, friends, or others?

8. Are there any kinds of stresses that make his/her [PROBLEM] worse, such as difficulties with money, or family problems?

**ROLE OF CULTURAL IDENTITY**

Sometimes, aspects of people's background or identity can make the [PROBLEM] better or worse. By background or identity, I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, and your faith or religion.

9. For you, what are the most important aspects of [INDIVIDUAL'S] background or identity?

10. Are there any aspects of [INDIVIDUAL'S] background or identity that make a difference to his/her [PROBLEM]?

11. Are there any aspects of [INDIVIDUAL'S] background or identity that are causing other concerns or difficulties for

him/her?

**CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING**

**SELF-COPING**

Clarify individual's self-coping for the problem.

12. Sometimes people have various ways of dealing with problems like [PROBLEM]. What has [INDIVIDUAL] done on his/her own to cope with his/her [PROBLEM]?

**PAST HELP SEEKING**

Elicit various sources of help (e.g., medical care, mental health treatment, support groups, work-based counseling, folk healing, religious or spiritual counseling, other alternative healing). Probe as needed (e.g., "What other sources of help has he/she used?").

Clarify the individual's experience and regard for previous help. 13. Often, people also look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing has [INDIVIDUAL] sought for his/her [PROBLEM]? PROBE IF DOES NOT DESCRIBE USEFULNESS OF HELP RECEIVED: What types of help or treatment were most useful? Not useful? BARRIERS Clarify the role of social barriers to help seeking, access to care, and problems engaging in previous treatment. 14. Has anything prevented [INDIVIDUAL] from getting the help he/she needs? Probe details as needed (e.g., "What got in the way?"). PROBE AS NEEDED: For example, money, work or family commitments, stigma or discrimination, or lack of services that understand his/her language or background? CULTURAL FACTORS AFFECTING CURRENT HELP SEEKING PREFERENCES Clarify individual's current perceived needs and expectations of help, broadly defined, from the point of view of the informant. Now let's talk about the help [INDIVIDUAL] needs. Probe if informant lists only one source of help (e.g., "What other kinds of help would be useful to [INDIVIDUAL] at this time?"). 15. What kinds of help would be most useful to him/her at this time for his/her [PROBLEM]? Focus on the views of the social network regarding help seeking. 16. Are there other kinds of help that [INDIVIDUAL'S] family, friends, or other people have suggested would be helpful for him/her now? CLINICIAN-PATIENT RELATIONSHIP Elicit possible concerns about the clinic or the clinician-patient relationship, including perceived racism, language barriers, or cultural differences that may undermine goodwill, communication, or care delivery. Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations. Probe details as needed (e.g., "In what way?"). Address possible barriers to care or concerns about the clinic and the clinician-patient relationship raised previously. 17. Have you been concerned about this, and is there anything that we can do to provide [INDIVIDUAL] with the care he/she needs?

Cultural Concepts of Distress Relevance for Diagnostic Assessment The term cultural concepts of distress refers to ways that individuals experience, understand, and communicate suffering, behavioral problems, or troubling thoughts and emotions. Three main types of cultural concepts of distress may be distinguished. Cultural idioms of distress are ways of expressing distress that may not involve specific symptoms or syndromes, but that provide collective, shared ways of experiencing and talking about personal or social concerns. For example, everyday talk about "nerves" or "depression" may refer to widely varying forms of suffering without mapping onto a discrete set of symptoms, syndrome, or disorder. Cultural explanations or perceived causes are labels, attributions, or features of an explanatory model that indicate culturally recognized meaning or etiology for symptoms, illness, or distress. Cultural syndromes are clusters of symptoms and attributions that tend to co-occur among individuals in specific cultural groups, communities, or contexts and that are recognized locally as coherent patterns of experience. These three cultural concepts of distress—cultural idioms of distress, cultural explanations, and cultural syndromes—are more relevant to clinical practice than the older formulation culture-bound syndrome. Specifically, the term culture-bound syndrome ignores the fact that clinically important cultural differences often involve explanations or experience of distress rather than culturally distinctive configurations of symptoms. Furthermore, the term culture bound overemphasizes the extent to which cultural concepts of distress are characterized by highly idiosyncratic experiences that are restricted to specific geographic regions. The current formulation acknowledges that all forms of distress are locally shaped, including the DSM disorders. From this perspective, many DSM diagnoses can be understood as operationalized prototypes that started out as cultural syndromes and became widely accepted as a result of their clinical and research utility. Across groups there

remain culturally patterned differences in symptoms, ways of talking about distress, and locally perceived causes, which in turn are associated with coping strategies and patterns of help seeking. Cultural concepts of distress arise from local “folk” or professional diagnostic systems for mental and emotional distress, and they may also reflect the influence of biomedical concepts. Cultural concepts of distress have four key features in relation to the DSM-5 nosology: There is seldom a one-to-one correspondence of any cultural concept of distress with a DSM diagnostic entity; the correspondence is more likely to be one-to-many in either direction. Symptoms or behaviors that might be sorted by DSM-5 into several disorders may be included in a single cultural concept of distress, and diverse presentations that might be classified by DSM-5 as variants of a single disorder may be sorted into several distinct concepts by an indigenous diagnostic system. Cultural concepts of distress may apply to a wide range of symptom and functional severity, including presentations that do not meet DSM criteria for any mental disorder. For example, an individual with acute grief or a social predicament may use

the same idiom of distress or display the same cultural syndrome as another individual with more severe psychopathology. In common usage, the same cultural term frequently denotes more than one type of cultural concept of distress. A familiar example may be the concept of “depression,” which may be used to describe a syndrome (e.g., major depressive disorder), an idiom of distress (e.g., as in the common expression “I feel depressed”), or an explanation or perceived cause (e.g., “the baby was born with emotional problems because his mother suffered from depression during her pregnancy”). Like culture and DSM itself, cultural concepts of distress may change over time in response to both local and global influences. Cultural concepts of distress are important to psychiatric diagnosis for several reasons: To enhance identification of individuals’ concerns and detection of psychopathology: Referring to cultural concepts of distress in screening instruments or in reviews of systems may facilitate identification of individuals’ concerns and enhance detection of psychopathology, as individuals may be more familiar with these cultural concepts of distress than with professional terminology. To avoid misdiagnosis: Cultural variation in symptoms and in explanatory models associated with these cultural concepts of distress may lead clinicians to misjudge the severity of a problem or assign the wrong diagnosis (e.g., socially warranted suspicion may be misunderstood as paranoia; unfamiliar symptom presentations may be misdiagnosed as psychosis). To obtain useful clinical information: Cultural variations in symptoms and attributions may be associated with particular features of risk, resilience, and outcome. Clinical exploration of cultural concepts of distress can elicit information on the role that specific contexts play in symptom development and course and in their response to coping strategies. To improve clinical rapport and engagement: “Speaking the language of the patient,” both linguistically and in terms of his or her dominant cultural concepts of distress and metaphors, can result in greater communication and satisfaction, facilitate treatment negotiation, and lead to higher retention and adherence. To improve therapeutic efficacy: Culture influences the psychological mechanisms of a disorder, which need to be understood and addressed to improve clinical efficacy. For example, culturally specific catastrophic cognitions can contribute to symptom escalation into panic attacks. To guide clinical research: Locally perceived connections between cultural concepts of distress may help identify patterns of comorbidity and underlying biological substrates. Cultural concepts of distress, particularly cultural syndromes, may also point to previously unrecognized disorders or variants that could be included in future nosological revisions (e.g., in a change from DSM-IV, the concept of possession was added to the DSM-5 criteria for dissociative identity disorder). To clarify cultural epidemiology: Cultural concepts of distress are not endorsed uniformly by everyone in a

given cultural context. Distinguishing cultural idioms of distress, cultural explanations, and cultural syndromes provides an approach for studying the distribution of cultural features of illness across settings and regions, and over time. It also suggests questions about cultural determinants of risk, course, and outcome in clinical and community settings to enhance the evidence base of cultural research. DSM-5 includes information on cultural concepts of distress in order to improve the accuracy of diagnosis and the comprehensiveness of clinical assessment. Clinical assessment of individuals presenting with these cultural concepts of distress should determine whether their presentation meets DSM-5 criteria for a specified disorder or instead is best classified as an other specified diagnosis. Once the disorder is diagnosed, the cultural terms and explanations should be included in case formulations; they may help clarify symptoms and etiological attributions that could otherwise be confusing. Individuals whose symptoms do not meet DSM criteria for a specific mental disorder may still expect and require treatment; this should be assessed on a case-by-case basis. In addition to the CFI and its informant and supplementary modules, DSM-5-TR contains the following information and tools that may be useful when integrating cultural information in clinical practice: Data in updated DSM-5-TR text for specific disorders: The text includes information on cultural variations in symptom expression; attributions for disorder causes or precipitants; factors associated with differential prevalence across demographic groups; cultural norms that may affect the threshold for pathology and the perceived severity of the condition; risk for misdiagnosis when evaluating individuals from socially oppressed ethnoracial or marginalized groups; associated cultural concepts of distress; and other material relevant to culturally informed diagnosis. It is important to emphasize that there is no one-to-one correspondence at the categorical level between DSM disorders and cultural concepts of distress. Differential diagnosis for individuals must therefore incorporate information on cultural variation with information elicited by the CFI. Other Conditions That May Be a Focus of Clinical Attention: Some of the clinical concerns identified by the CFI may correspond to one of the conditions or problems listed in the Section II chapter "Other Conditions That May Be a Focus of Clinical Attention" (e.g., acculturation problems, parent-child relational problems, religious or spiritual problems), along with the associated ICD-10-CM code. Examples of Cultural Concepts of Distress Clinicians need to familiarize themselves with individuals' cultural concepts of distress to understand individuals' concerns and facilitate accurate diagnostic assessment; use of the Cultural Formulation Interview may help in this regard. The following ten examples were selected to illustrate some of the ways in which cultural concepts of distress may affect the process of diagnosis. The principles illustrated with these examples can be applied to the myriad other cultural concepts of distress found in specific cultural contexts. The same term may be used for multiple types of cultural concepts of distress and clinical presentations, depending on context. Potentially, cultural concepts of distress can occur on their own or coexist with any psychiatric disorder and influence clinical presentation, course, and outcome. For example, in U.S. Latinx communities, *ataque de nervios* can be comorbid with nearly all psychiatric disorders. Each of the following examples of cultural concepts of distress includes a description of "Related conditions in DSM-5-TR" to highlight 1) the DSM-5 disorders that overlap phenomenologically with the cultural concept of distress (e.g., panic disorder and *ataque de nervios*, due to their paroxysmic nature and symptom similarity) and 2) the DSM-5 disorders that are frequently attributed to the causal explanation or idiom (e.g., PTSD and *kufungisisa*). *Ataque de nervios* *Ataque de nervios* ("attack of nerves") is a syndrome found in Latinx cultural contexts,

Related conditions in other cultural contexts. Related conditions in DSM-5-TR. characterized by symptoms of intense emotional upset, including acute anxiety, anger, or grief; screaming and shouting uncontrollably; attacks of crying; trembling; heat in the chest rising into the head; and becoming verbally and physically aggressive. Dissociative experiences (e.g., depersonalization, derealization, amnesia), seizure-like or fainting episodes, and suicidal behavior are prominent in some ataques but absent in others. A general feature of an ataque de nervios is a sense of being out of control. Attacks frequently occur as a direct result of a stressful event relating to the family, such as news of the death of a close relative, conflicts with a spouse or children, or witnessing an accident involving a family member. For a minority of individuals, no particular social or interpersonal event triggers their ataques; instead, their vulnerability to losing control comes from the accumulated experience of suffering. No one-to-one relationship has been found between ataque and any specific psychiatric disorder, although several disorders, including panic disorder, other specified or unspecified dissociative disorder, and functional neurological symptom disorder (conversion disorder), have symptomatic overlap with ataque. In community samples, ataque is reported among U.S. Latinx by 7%–15% of adults and 4%– 9% of youth, depending on region and Latinx subgroup. It is associated with suicidal thoughts, disability, and outpatient psychiatric utilization, after adjustment for psychiatric diagnoses, traumatic exposure, and other covariates. However, some ataques represent normative expressions of acute distress (e.g., at a funeral) without clinical sequelae. The term ataque de nervios may also refer to an idiom of distress that includes any “fit”-like paroxysm of emotionality (e.g., hysterical laughing) and may be used to indicate an episode of loss of control in response to an intense stressor. Indisposition in Haiti, blacking out in several West Indies and Caribbean countries, and falling out in the Southern United States. This use of the terms blacking out or falling out should not be confused with alcohol- or other substance-induced blackouts or amnesia. Panic attack, panic disorder, other specified or unspecified dissociative disorder, functional neurological symptom disorder, intermittent explosive disorder, other specified or unspecified anxiety disorder, other specified or unspecified trauma- and stressor-related disorder. Dhat syndrome Dhat syndrome is a term that was coined in South Asia little more than half a century ago to account for common clinical presentations of young men who attributed their various symptoms to semen loss. Despite the name, it is not a discrete syndrome but rather a cultural explanation of distress for individuals who refer to diverse symptoms, such as anxiety, fatigue, weakness, weight loss, erectile dysfunction, other multiple somatic complaints, and depressed mood. The cardinal feature is anxiety and distress about the loss of dhat in the absence of any identifiable physiological dysfunction. Dhat was identified by individuals as a white discharge that was noted on defecation or urination. Ideas about this substance are related to the concept of dhatu (semen) described in the Hindu system of medicine, Ayurveda, as one of seven essential bodily fluids whose balance is necessary to maintain health.

Related conditions in other cultural contexts. Related conditions in DSM-5-TR. Related conditions in other cultural contexts. Related conditions in DSM-5-TR. Although dhat syndrome was formulated as a clinical category to help inform local clinical practice, related ideas about the harmful effects of semen loss have been shown to be widespread in the general population, suggesting a cultural disposition for explaining health problems and symptoms with reference to dhat-related concepts. Research in health care settings has yielded diverse estimates of the prevalence of dhat syndrome (e.g., 64% of men attending psychiatric clinics in India for sexual complaints; 30% of men attending general medical clinics in Pakistan). Although dhat syndrome is most commonly identified with young men from lower socioeconomic backgrounds, middle-age men may also be affected.

Comparable concerns about white vaginal discharge (leukorrhea) have been associated with a variant of the concept for women. The term dhat may also be used as an idiom and causal explanation for sexually transmitted infections (e.g., gonorrhea, chlamydia), in the absence of psychological distress. Koro in Southeast Asia, particularly Singapore, and shen-k'uei ("kidney deficiency") in China. Major depressive disorder, persistent depressive disorder, generalized anxiety disorder, somatic symptom disorder, illness anxiety disorder, erectile disorder, early (premature) ejaculation, other specified or unspecified sexual dysfunction, educational problems. Hikikomori Hikikomori (a Japanese term composed of hiku [to pull back] and moru [to seclude oneself]) is a syndrome of protracted and severe social withdrawal observed in Japan that may result in complete cessation of in-person interactions with others. The typical picture in hikikomori is an adolescent or young adult male who does not leave his room within his parents' home and has no in-person social interactions. This behavior may initially be ego-syntonic but usually leads to distress over time; it is often associated with high intensity of Internet use and virtual social exchanges. Other features include no interest or willingness to attend school or work. The 2010 guideline of the Japan Ministry of Health, Labor, and Welfare requires 6 months of social withdrawal for a diagnosis of hikikomori. The extreme social withdrawal seen in hikikomori may occur in the context of an established DSM-5 disorder ("secondary") or manifest independently ("primary"). Protracted social withdrawal among adolescents and young adults has been reported in many settings, including Australia, Bangladesh, Brazil, China, France, India, Iran, Italy, Oman, South Korea, Spain, Taiwan, Thailand, and the United States. Individuals with hikikomori-type behaviors in Japan, India, South Korea, and the United States tend to display high levels of loneliness, limited social networks, and moderate functional impairment. Social anxiety disorder, major depressive disorder, generalized anxiety disorder, posttraumatic stress disorder, autism spectrum disorder, schizoid personality disorder, avoidant personality disorder, schizophrenia or other psychotic disorder. The condition may also be associated with Internet gaming disorder and, in adolescents, with school refusal. Khyâl cap "Khyâl attacks" (khyâl cap), or "wind attacks," is a syndrome found in Cambodian cultural

Related conditions in other cultural contexts. Related conditions in DSM-5-TR. Related conditions in other cultural contexts. contexts. Common symptoms include those of panic attacks, such as dizziness, palpitations, shortness of breath, and cold extremities, as well as other symptoms of anxiety and autonomic arousal (e.g., tinnitus and neck soreness). Khyâl attacks include catastrophic cognitions centered on the concern that khyâl (a windlike substance) may rise in the body—along with blood—and cause a range of serious effects (e.g., compressing the lungs to cause shortness of breath and asphyxia; entering the cranium to cause tinnitus, dizziness, blurry vision, and a fatal syncope). Khyâl attacks may occur without warning but are frequently brought about by triggers such as worrisome thoughts, standing up (i.e., orthostasis), specific odors with negative associations, and agoraphobic-type cues like going to crowded spaces or riding in a car. Khyâl attacks usually meet panic attack criteria and may shape the experience of other anxiety and trauma- and stressor-related disorders. Khyâl attacks may be associated with considerable disability. Pen lom in Laos, srog rlung gi nad in Tibet, vata in Sri Lanka, and hwa byung in Korea. Panic attack, panic disorder, generalized anxiety disorder, agoraphobia, posttraumatic stress disorder, illness anxiety disorder. Kufungisisa Kufungisisa ("thinking too much" in Shona) is an idiom of distress and a cultural explanation among the Shona of Zimbabwe. As an explanation, it is considered to be causative of anxiety, depression, and somatic problems (e.g., "My heart is painful because I think too much"). As an idiom of psychosocial distress, it is indicative of interpersonal

and social difficulties (e.g., marital problems, having no money to take care of children, unemployment). Kufungisisa involves ruminating on upsetting thoughts, particularly worries, including concerns about chronic physical illness, such as HIV-related disorders. Kufungisisa is associated with a range of psychopathology, including anxiety symptoms, excessive worry, panic attacks, depressive symptoms, irritability, and posttraumatic stress disorder. In a study of a random community sample, two-thirds of the cases identified by a general psychopathology measure included this complaint. “Thinking too much” is a common idiom of distress and cultural explanation across many countries and ethnic groups; despite some commonalities across global regions, “thinking too much” shows important heterogeneity across and within cultural contexts. It has been described in Africa, Asia, the Caribbean and Latin America, the Middle East, and among indigenous groups. “Thinking too much” may also be a key component of cultural syndromes such as “brain fag” in Nigeria. In the case of “brain fag,” “thinking too much” is primarily attributed to excessive study, which is considered to damage the brain in particular, with symptoms including feelings of heat or crawling sensations in the head. Cross-culturally, “thinking too much” typically references ruminative, intrusive, and/or anxious thoughts—sometimes focused on a singular concern or past trauma and other times based on numerous current worries. In some contexts, it is thought to lead to more severe disorder-like psychosis, suicidal thoughts, or even death.

Related conditions in DSM-5-TR. Related conditions in other cultural contexts. Related conditions in DSM-5-TR. Major depressive disorder, persistent depressive disorder, generalized anxiety disorder, posttraumatic stress disorder, obsessive-compulsive disorder, prolonged grief disorder. Maladi dyab Maladi dyab or maladi satan (literally “devil/Satan illness,” also referred to as “sent sickness”) is a cultural explanation in Haitian communities for diverse medical and psychiatric disorders, or other negative experiences and problems in functioning. In this explanatory model, interpersonal envy and malice cause people to harm their enemies by having sorcerers send illnesses such as psychosis, depression, social or academic failure, and inability to perform activities of daily living. These sicknesses have various names (e.g., ekspedisyon, mòvè zespri, kout poud) based on how they are “sent”. This etiological explanation assumes that illness may be caused by others’ envy and hatred, provoked by the victim’s economic success as evidenced by a new job or expensive purchase. One person’s gain is assumed to produce another person’s loss, so visible success makes an individual vulnerable to attack. Assigning the label of “sent sickness” depends more on mode of onset, social status, and form of treatment that proves successful than on presenting symptoms. A wide range of psychiatric disorders can be attributed to this cultural explanation. The acute onset of new symptoms or an abrupt behavioral change raises suspicions of a spiritual attack. An individual who is attractive, intelligent, or wealthy is perceived as especially vulnerable, and even young healthy children are at risk. Concerns about illness (typically, physical illness) caused by envy or social conflict are common across cultural contexts and often expressed in the form of “evil eye” (e.g., in Spanish, mal de ojo; in Italian, mal’occhio). Subsyndromal affliction (e.g., problems related to the social environment, educational problems), in addition to a wide range of psychiatric disorders; the cultural explanation of supernatural forces may lead to misdiagnosis of delusional disorder, persecutory type; or schizophrenia. Nervios Nervios (“nerves”) is a common cultural idiom of distress and causal explanation in Latinx cultural contexts in the United States and Latin America. Nervios refers to a general state of vulnerability to stressful life experiences and to difficult life circumstances. The term nervios includes a wide range of symptoms of emotional distress, somatic disturbance, and inability to function. The most common symptoms attributed to nervios include headaches and “brain aches” (occipital neck tension), irritability, gastrointestinal

disturbances, sleep difficulties, nervousness, easy tearfulness, inability to concentrate, trembling, tingling sensations, and mareos (dizziness with occasional vertigo-like exacerbations). Nervios is a broad cultural idiom of distress that spans the range of severity from cases with no mental disorder to presentations resembling adjustment, anxiety, depressive, dissociative, somatic symptom, or psychotic disorders. The term can also refer to a cultural explanation for multiple forms of psychological distress, especially

Related conditions in other cultural contexts. Related conditions in DSM-5-TR. those involving weakness, enervation, and anxiety. Nervios may indicate a range of conditions, which show regional variation, related to the nervous system (literally, the anatomical nerves). In Puerto Rican communities, for example, nervios includes conditions such as “being nervous since childhood,” which appears to be more of a trait and may precede social anxiety disorder, and “being ill with nerves,” which is more related than other forms of nervios to psychiatric problems, especially dissociation and depression. Nevra among Greeks in North America, nierbi among Sicilians in North America, and “nerves” among Whites in Appalachia and Newfoundland. “Tension” is a related idiom and causal explanation among South Asian populations. Major depressive disorder, persistent depressive disorder, generalized anxiety disorder, social anxiety disorder, other specified or unspecified dissociative disorder, somatic symptom disorder, schizophrenia. Shenjing shuairuo Shenjing shuairuo (“weakness of the nervous system” in Mandarin Chinese) is a cultural syndrome that integrates conceptual categories of Traditional Chinese Medicine with the Western construct of neurasthenia. In the second, revised edition of the Chinese Classification of Mental Disorders (CCMD-2-R), shenjing shuairuo was defined as a syndrome composed of three out of five symptom clusters: weakness (e.g., mental fatigue), emotions (e.g., feeling vexed), excitement (e.g., increased recollections), nervous pain (e.g., headache), and sleep (e.g., insomnia). Fan nao (feeling vexed) is a form of irritability mixed with worry and distress over conflicting thoughts and unfulfilled desires. The third edition of the CCMD retained shenjing shuairuo as a somatoform diagnosis of exclusion. However, China adopted the ICD-10 as its official classification system in 2011, displacing the CCMD; although ICD-10 included neurasthenia as a diagnostic category, ICD-11 does not. The use of shenjing shuairuo has decreased substantially in recent years and appears to have been replaced by idioms of depression and anxiety, at least in urban areas; among mental health clinicians, shenjing shuairuo may largely be invoked in interactions with traditional patients to facilitate communication and limit the stigma associated with psychiatric diagnoses. Salient precipitants of shenjing shuairuo include work or family-related stressors, loss of face (mianzi, lianzi), and an acute sense of failure (e.g., in academic performance). Shenjing shuairuo is related to traditional concepts of weakness (xu) and health imbalances related to deficiencies of a vital essence (e.g., the depletion of qi [vital energy] following overstraining or stagnation of qi due to excessive worry). In the traditional interpretation, shenjing shuairuo results when bodily channels (jing) conveying vital forces (shen) become dysregulated as a result of various social and interpersonal stressors, such as the inability to change a chronically frustrating and distressing situation. Various psychiatric disorders are associated with shenjing shuairuo, notably mood, anxiety, and somatic symptom disorders. In medical clinics in China, however, up to 45% of patients with shenjing shuairuo do not have symptoms that meet criteria for any DSM-IV disorder.

Related conditions in other cultural contexts. Related conditions in DSM-5-TR. Related conditions in other cultural contexts. Related conditions in DSM-5-TR. Neurasthenia-spectrum idioms and syndromes are present in many cultural contexts, including India (ashaktapanna), Mongolia

(yadargaa), and Japan (shinkei-suijaku), among other settings. Other conditions, such as brain fog syndrome, burnout syndrome, and chronic fatigue syndrome, are also closely related. Major depressive disorder, persistent depressive disorder, generalized anxiety disorder, somatic symptom disorder, social anxiety disorder, specific phobia, posttraumatic stress disorder. Susto Susto (“fright”) is a cultural explanation for distress and misfortune prevalent in some Latinx cultural contexts in North, Central, and South America. It is not recognized as an illness category among Latinx from the Caribbean. Susto is an illness attributed to a frightening event that causes the soul to leave the body and results in unhappiness and sickness, as well as difficulties functioning in key social roles. Symptoms may appear any time from days to years after the fright is experienced. In extreme cases, susto may result in death. There are no specific defining symptoms for susto; however, symptoms that are often reported by individuals with susto include appetite disturbances; inadequate or excessive sleep; troubled sleep or dreams; feelings of sadness, low self-worth, or dirtiness; interpersonal sensitivity; and lack of motivation to do anything. Somatic symptoms accompanying susto may include muscle aches and pains, cold in the extremities, pallor, headache, stomachache, and diarrhea. Precipitating events are diverse and include natural phenomena, animals, interpersonal situations, and supernatural agents, among others. Three syndromic types of susto (referred to as *cibih* in the Zapotec language) have been identified, each having different relationships with psychiatric diagnoses. An interpersonal susto characterized by feelings of loss, abandonment, and not being loved by family, with accompanying symptoms of sadness, poor self-image, and suicidal thoughts, seems to be closely related to major depressive disorder. When susto results from a traumatic event that plays a major role in shaping symptoms and in emotional processing of the experience, the diagnosis of posttraumatic stress disorder appears more appropriate. Susto characterized by various recurrent somatic symptoms—for which the individual seeks health care from several practitioners—is thought to resemble a somatic symptom disorder. Similar etiological concepts and symptom configurations are found globally. In the Andean region, susto is referred to as *espanto*. Soul loss conditions in South Asia and Southeast Asia also share features with susto. In soul loss, individuals experiencing a fright are thought to temporarily lose their soul, a piece of their soul, or one of many souls. This makes the individual vulnerable to other physical and psychological forms of distress. Major depressive disorder, posttraumatic stress disorder, other specified or unspecified trauma and stressor-related disorder, somatic symptom disorder. Taijin kyofusho

Related conditions in other cultural contexts. Related conditions in DSM-5-TR. Taijin kyofusho (“interpersonal fear disorder” in Japanese) is a syndrome found in Japanese cultural contexts characterized by anxiety about and avoidance of interpersonal situations due to the thought, feeling, or conviction that the individual’s appearance and actions in social interactions are inadequate or offensive to others. Taijin kyofusho includes two culture-related forms: a “sensitive type,” with extreme social sensitivity and anxiety about interpersonal interactions, and an “offensive type,” in which the major concern is offending others. Variants include major concerns about facial blushing (*sekimen-kyofu*), having an offensive body odor (*jiko-shu-kyofu*), inappropriate gaze (too much or too little eye contact, *jiko-shisen-kyofu*), and stiff or awkward facial expression or bodily movements (e.g., stiffening, trembling) or body deformity (*shubo-kyofu*). Taijin kyofusho is a broader construct than social anxiety disorder in DSM-5. Taijin kyofusho also includes syndromes with features of body dysmorphic disorder, olfactory reference syndrome, and delusional disorder; delusional disorder should be considered when concerns have a delusional quality, responding poorly to simple reassurance or counterexample. The distinctive symptoms of taijin kyofusho occur in specific cultural contexts and, to some extent, with more severe social

anxiety cross-culturally. Similar syndromes are found in Korea (taein kong po) and other societies that place a strong emphasis on the self-conscious maintenance of appropriate social behavior in hierarchical interpersonal relationships. An interdependent self-construal, which emphasizes the relatedness of self to a collective and the identification of self in terms of social roles and relationships, may be a risk factor for taijin kyofusho symptoms across diverse cultures. The concern with offending others through inappropriate social behavior, characteristic of offensive-type taijin kyofusho, has also been described in several societies, including the United States, Australia, Indonesia, and New Zealand. Social anxiety disorder, body dysmorphic disorder, delusional disorder, obsessive-compulsive disorder, olfactory reference syndrome (a type of other specified obsessive-compulsive and related disorder). Olfactory reference syndrome is related specifically to the jikoshu-kyofu variant of taijin kyofusho; this presentation is seen in various cultures outside Japan.

---

Revision #1

Created 2026-01-04 19:28:41 UTC by Omar Ayman

Updated 2026-01-04 19:28:41 UTC by Omar Ayman