

PUBLIC ANNEX F

Culture, Communication, and DSM-5 Diagnostic Reliability

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Those of us committed to improving mental health services and treatment for underserved racial and ethnic minorities can use theories from the field of cultural psychiatry to analyze the field trials for the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). Cultural psychiatrists have traditionally studied (1) whether psychiatric symptoms are universal across racial and ethnic groups, (2) how to provide services for diverse populations, and (3) how psychiatric knowledge is itself a cultural product.¹ One type of knowledge is psychiatric classification that distinguishes socially defined normal from abnormal thoughts, behaviors, and emotions.² Psychiatric classification also reflects the social values and professional ideologies of a given historical moment.³ As a psychiatric classification system, the importance of the DSMs cannot be overstated: they aggregate all mental disorders recognized by the American healthcare system, standardize communication among health professionals, and provide codes for insurance reimbursement.⁴

One approach to recognizing the values and professional ideologies of contemporary American psychiatry is to examine the design of the DSM-5 field trials. The field trials have been designed to test the clinical utility, reliability, and validity of revised DSM-5 diagnoses and new dimensional measures.⁵ These measures consist of checklists for symptoms such as depression, anxiety, insomnia, and suicidal ideation that cut across disorders.⁶ The dimensional measures bring psychiatry in line with general medicine in which conditions such as hypertension and hypercholesterolemia are measured on a numerical continuum, not a binary that notes either a presence or absence.⁷ The field trials have adopted a test (visit 1)-retest (visit 2) design to assess diagnostic reliability: patients with DSM-IV or probable DSM-5 criteria completed dimensional measures and two diagnostic interviews with two clinicians who were blinded to each other and trained in the diagnoses under examination.⁸ The second interview occurred anywhere between four hours to fourteen days after the first to maximize the interviewer's independence and minimize the occurrence of new disorders or

spontaneous recoveries.⁸ As with DSM-III and DSM-IV, the DSM-5 Task Force has contended that establishing diagnostic reliability is necessary prior to establishing diagnostic validity whereby mental disorders are assumed to have separate causes, courses of illness, treatments, and laboratory findings.^{9,10} This prioritization assumes that without reproducible laboratory findings, diagnostic reliability can be achieved by integrating multiple types of investigation to delineate diagnostic validity for a mental disorder.¹¹ This method motivated the first attempt to classify mental disorders based on reviews of the extant scientific evidence¹² and has served as a template for classification since DSM-III.¹³ Thus, one social value has been to align psychiatry with medicine based on assumptions of what constitutes objective evidence and one professional ideology has been to affirm diagnostic reliability over validity.

Another approach to examining the values and professional ideologies is to scrutinize the field trial data for what is reported and unreported. The DSM-5 Task Force declared that the field trial would aim for a *kappa* coefficient (the probability that two clinicians would make the same diagnosis not due to chance) of 0.6–0.8 and accept a range between 0.4 and 0.6.¹⁴ In January 2013, the DSM-5 Task Force reported findings of diagnostic reliability from eleven adult and pediatric sites in North America that collectively enrolled 2246 patients and 279 clinicians.⁹ Excluding the new diagnoses proposed for DSM-5, the Task Force revealed *kappa* coefficients for the following disorders: posttraumatic stress disorder (PTSD) 0.67, attention deficit-hyperactivity disorder (ADHD) 0.61, bipolar I disorder 0.56 in adults and 0.52 in children, borderline personality disorder 0.54, schizoaffective disorder 0.50, schizophrenia 0.46, conduct disorder (CD) 0.46, bipolar II disorder 0.40, oppositional defiant disorder (ODD) 0.40.⁹ The results were not analyzed by race or

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ethnicity either for patients or clinicians, even though differences in diagnoses have been reported based on certain combinations of race and ethnicity for patients and clinicians. Blacks are less likely than Whites to be diagnosed with PTSD¹⁵ and more likely to be diagnosed with ADHD,¹⁶ schizophrenia, and substance use.¹⁷ Even with similar clinical presentations, Blacks are more likely than Whites to receive diagnoses of CD than ADHD and less likely to utilize mental health services after receiving such a diagnosis.¹⁸ Here, the social value is to assume that patient–clinician racial and ethnic differences do not need to be reported when the stated professional ideology is to promote an acceptable diagnostic reliability.

However, researchers in cultural psychiatry and psychiatric anthropology have long shown that diagnosis rests upon patient–clinician communication, which is highly dependent on context. Unlike most other fields of medicine, psychiatry lacks laboratory and radiological biomarkers that can be used reliably to make diagnoses, so the clinical interview remains an act of double interpretation: patients must interpret their experiences to construct narratives of their symptoms and clinicians must interpret such narratives through professional diagnostic categories.¹⁹ Patient narratives of symptoms can change based on point of time within the course of illness and by audience,²⁰ just as the diagnostic interpretations of clinicians can vary based on personal biases, professional training, and institutional demands.²¹ Information from the diagnostic evaluation regarding the patient's educational, familial, housing, and insurance status — the context of a patient's life — can also influence the clinician's diagnosis.²² This has significant implications for diagnostic reliability. For example, clinicians viewing videotapes of patients who report the same symptoms for the same diagnosis are more likely to accurately diagnose those who belong to their own race.²³ Racially²⁴ and ethnically²⁵ concordant patient–clinician dyads show higher rates of patient participation in medical interviews and patients in these dyads rate clinicians higher in interpersonal satisfaction, compared to discordant dyads in which clinicians tend to dominate interviews, eliciting less positive effect and information from patients.²⁶ For these reasons, studies from the DSM-5 field trials should report *kappa* coefficients according to whether patient–clinician dyads were racially/ethnically concordant or discordant. Medical communication can vary based on racial concordance within the patient–clinician dyad which affects diagnostic reliability, meriting a process of data analysis that is transparent to mental health researchers and practitioners given the influence of DSM-5.

Fortunately, remedies exist. The DSM-5 Task Force has publicized an unprecedented commitment to cultural

issues throughout the revision process²⁷ by adding cultural experts to disorder work groups²⁸ and convening a study group to assess the differential expression of symptoms based on culture.²⁹ Disparities researchers involved in the DSM-5 development process have proposed a broad-reaching agenda that specifically called for studies on systematic biases in the diagnostic process and the unequal distribution of treatment resources.³⁰ The DSM-5 Task Force could complete its commitment to cross-cultural issues by pledging to analyze inter-clinician diagnostic reliability according to patient–clinician racial and ethnic dyadic concordance or discordance in all future publications from the field trials. This would revitalize the study of psychiatric knowledge by outlining possible differences in diagnoses made by clinicians based on certain combinations of race and ethnicity in the patient–clinician dyad. Field trial results that have been published thus far for the diagnosis of hypersexual disorder,³¹ the cluster of parent–child relational problems,³² and a standardized personality inventory³³ do not report *kappa* coefficients stratified by race and ethnicity. By not reporting the relationships of race and ethnicity to inter-clinician diagnostic reliability, the DSM-5 loses an opportunity to advance the science of why differences in diagnosis persist. Do diagnostic differences result from patient presentations? Clinician interpretations? DSM-5 diagnostic criteria that miss the cultural patterning of symptoms? Patient narratives, clinician interpretations, and the process of communication between patients and clinicians can all affect diagnostic reliability and, ultimately, diagnostic validity. Therefore, communication disparities researchers have suggested that scientific results be reported according to whether patients and clinicians in a dyad belong to the same or different race and ethnicity.³⁴ This suggestion assumes great importance in mental health where diagnosis rests entirely upon communication between patients and clinicians. Otherwise, the DSM-5 risks exhibiting a trend of “recruitmentology,” claiming that cultural differences are important in inviting racial and ethnic minorities to enroll in clinical research studies, but ultimately not connecting the results of studies to eliminating differences in the actual experiences of care.³⁵

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