Appendix I

Outline for Cultural Formulation and Glossary of Culture-Bound Syndromes

This appendix is divided into two sections. The first section provides an outline for cultural formulation designed to assist the clinician in systematically evaluating and reporting the impact of the individual's cultural context. The second is a glossary of culture-bound syndromes.

Outline for Cultural Formulation

The following outline for cultural formulation is meant to supplement the multiaxial diagnostic assessment and to address difficulties that may be encountered in applying DSM-IV criteria in a multicultural environment. The cultural formulation provides a systematic review of the individual's cultural background, the role of the cultural context in the expression and evaluation of symptoms and dysfunction, and the effect that cultural differences may have on the relationship between the individual and the clinician.

As indicated in the introduction to the manual (see p. xxiv), it is important that the clinician take into account the individual's ethnic and cultural context in the evaluation of each of the DSM-IV axes. In addition, the cultural formulation suggested below provides an opportunity to describe systematically the individual's cultural and social reference group and ways in which the cultural context is relevant to clinical care. The clinician may provide a narrative summary for each of the following categories:

Cultural identity of the individual. Note the individual's ethnic or cultural reference groups. For immigrants and ethnic minorities, note separately the degree of involvement with both the culture of origin and the host culture (where applicable). Also note language abilities, use, and preference (including multilingualism).

Cultural explanations of the individual's illness. The following may be identified: the predominant idioms of distress through which symptoms or the need for social support are communicated (e.g., "nerves," possessing spirits, somatic complaints,

inexplicable misfortune), the meaning and perceived severity of the individual's symptoms in relation to norms of the cultural reference group, any local illness category used by the individual's family and community to identify the condition (see "Glossary of Culture-Bound Syndromes" below), the perceived causes or explanatory models that the individual and the reference group use to explain the illness, and current preferences for and past experiences with professional and popular sources of care.

Cultural factors related to psychosocial environment and levels of functioning. Note culturally relevant interpretations of social stressors, available social supports, and levels of functioning and disability. This would include stresses in the local social environment and the role of religion and kin networks in providing emotional, instrumental, and informational support.

Cultural elements of the relationship between the individual and the clinician. Indicate differences in culture and social status between the individual and the clinician and problems that these differences may cause in diagnosis and treatment (e.g., difficulty in communicating in the individual's first language, in eliciting symptoms or understanding their cultural significance, in negotiating an appropriate relationship or level of intimacy, in determining whether a behavior is normative or pathological).

Overall cultural assessment for diagnosis and care. The formulation concludes with a discussion of how cultural considerations specifically influence comprehensive diagnosis and care.

Glossary of Culture-Bound Syndromes

The term *culture-bound syndrome* denotes recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category. Many of these patterns are indigenously considered to be "illnesses," or at least afflictions, and most have local names. Although presentations conforming to the major DSM-IV categories can be found throughout the world, the particular symptoms, course, and social response are very often influenced by local cultural factors. In contrast, culture-bound syndromes are generally limited to specific societies or culture areas and are localized, folk, diagnostic categories that frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations.

There is seldom a one-to-one equivalence of any culture-bound syndrome with

distress that may be encountered in clinical practice in North America and includes relevant DSM-IV categories when data suggest that they should be considered in a diagnostic formulation.

amok A dissociative episode characterized by a period of brooding followed by an outburst of violent, aggressive, or homicidal behavior directed at people and objects. The episode tends to be precipitated by a perceived slight or insult and seems to be prevalent only among males. The episode is often accompanied by persecutory ideas, automatism, amnesia, exhaustion, and a return to premorbid state following the episode. Some instances of amok may occur during a brief psychotic episode or constitute the onset or an exacerbation of a chronic psychotic process. The original reports that used this term were from Malaysia. A similar behavior pattern is found in Laos, Philippines, Polynesia (*cafard* or *cathard*), Papua New Guinea, and Puerto Rico (*mal de pelea*), and among the Navajo (*iich'aa*).

ataque de nervios An idiom of distress principally reported among Latinos from the Caribbean, but recognized among many Latin American and Latin Mediterranean groups. Commonly reported symptoms include uncontrollable shouting, attacks of crying, trembling, heat in the chest rising into the head, and verbal or physical aggression. Dissociative experiences, seizurelike or fainting episodes, and suicidal gestures are prominent in some attacks but absent in others. A general feature of an ataque de nervios is a sense of being out of control. Ataques de nervios frequently occur as a direct result of a stressful event relating to the family (e.g., news of the death of a close relative, separation or divorce from a spouse, conflicts with a spouse or children, or witnessing an accident involving a family member). People may experience amnesia for what occurred during the ataque de nervios, but they otherwise return rapidly to their usual level of functioning. Although descriptions of some ataques de nervios most closely fit with the DSM-IV description of Panic Attacks, the association of most ataques with precipitating event and the frequent absence of the hallmark symptoms of acute fear or apprehension distinguish them from Panic Disorder. Ataques span the range from normal expressions of distress not associated with having a mental disorder to symptom presentations associated with the diagnoses of Anxiety, Mood, Dissociative, or Somatoform Disorders.

bilis and **colera** (also referred to as *muina*) The underlying cause of these syndromes is thought to be strongly experienced anger or rage. Anger is viewed among many Latino groups as a particularly powerful emotion that can have direct effects on the body and exacerbate existing symptoms. The major effect of anger is to disturb core be

Clasificaciones Diagnósticas: DSM-IV-TR, DSM-5 y CIE-10

OMS (CIE, 1992)	DSM-IV-TR (APA, 2002)	DSM-5 (APA, 2013)
– Amok – Dhta, Dhatu, Jiryan, Shen-Kuei – Koro – Latah – Nervios, nerves – Pa-Leng, frigofobia – Pibloktoq, histeria del Ártico – Susto, espanto – Taijin Kyofusho, Shinkeishitsu, antropofobia – Ufufuyane, Saka – Ugamarinireq – Windigo	– Agotamiento cerebral – Amok – Ataque de nervios – Atracción – Bilis y cólera – Boufée delirante – Dhat – Enfermedad de los espíritus – Fallo o desconexión temporal – Hwa-Byung (wool-hwa-byung) – Koro – Latah – Locura – Mal de ojo – Nervios – Pibloktok – Reacción psicótica de Qi-Jong – Rituales mágicos (Rootwork) – Sangue dormido – Shenjing shuairuo – Shen-k'uei (shenkui) – Shin-Byung – Susto – Taijin kyofusho – Zar	– Síndrome de dhat – Khyâl cap – Kufungisisa – Maladi moun – Nervios – Susto – Taijin kyofusho – Ataque de nervios – Shenjing shuairuo

Cambios en el DSM-5

El DSM-5 reduce el número de trastornos recogidos en esta categoría de 25 a 9

El DSM-5 sólo mantiene 6 síndromes culturales de los 25 propuestos en el DSM-IV-TR; concretamente, el Síndrome de dhat, los Nervios, el Susto, el Taijin kyofusho, el Ataque de nervios y el Shenjing shuairuo.

El Khyâl cap, el Kufungisisa y el Maladi moun del DSM-5 constituyen nuevas patologías culturales