

DIAGNOSTIC CRITERIA IN CLINICAL SETTINGS: DSM-IV AND CULTURAL COMPETENCE

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Abstract: Historically, the Diagnostic and Statistical Manual of Mental Disorder (DSM) gave little attention to cultural variations in mental disorder. DSM-IV includes a cultural case formulation outline. The current paper presents a case formulation of an American Indian client who presented with depressive symptoms and a history of substance dependence.

The Diagnostic and Statistical Manual of Mental Disorders (DSM) distinguishes sixteen broad classes of mental disorders (e.g., mood disorders, anxiety disorders) and over 100 specific types of mental disorder (e.g., depression, dysthymia, generalized anxiety disorder), each defined by a set of symptom criteria. The types of mental disorders included in DSM and the symptoms characterizing those disorders have often been considered universal experiences that manifest similarly for all people regardless of cultural background. However, the publication of the DSM-IV, with its attention to culture acknowledges, as Manson (1995) states, “the need to better understand, articulate, and incorporate relevant cultural insights from clinical care into the taxonomic codification of major mental illness” (p. 487-488). This paper will present a brief background regarding the inclusion of culture in DSM, followed by a DSM-IV cultural case formulation of an American Indian client.

DSM and the Inclusion of Culture

The process of psychiatric diagnosis has been described as an interpretation of an interpretation (Kleinman, 1996). The first level of interpretation is the process by which an individual translates his/her experience into culturally based categories, words, images, and feelings. The second level of interpretation is the process by which a clinician then

translates a client's translation of his/her internal experience into the language of psychiatry. The *Diagnostic and Statistical Manual of Mental Disorders IV* (DSM-IV); (American Psychiatric Association, 1994) provides a professional standard of psychiatric nomenclature to capture that experience in terms of psychiatric diagnosis.

The DSM has been in existence since 1952 and over the course of almost fifty years, has undergone five revisions (i.e., DSM-I, DSM-II, DSM-III, DSM-III-R, and DSM-IV). Each of these revisions reflected advances in the ways in which mental disorders are understood. The system of classifying mental disorders most familiar to mental health providers today was introduced with DSM-III. DSM-III provided a greater level of specificity, with regard to diagnostic criteria, implemented a multi-axial system for organizing an array of clinically relevant information, and provided a descriptive approach to mental disorders that was assumed to be neutral with regard to etiology. Though DSM-III signified an advance in defining and classifying mental disorders, it paid little attention to the role of culture in psychiatric diagnosis. It was not until DSM-IV that the impact of culture on psychiatric diagnosis was more fully acknowledged. Through the efforts of a task force of 50 experts from psychiatry, psychology, medical anthropology, and sociology, DSM-IV now recognizes the role of culture in the expression, course, treatment, and existence of psychiatric disorders, in three significant ways (for a complete discussion of the efforts of this group, see Mezzich et al., 1995).

First, DSM-IV provides a discussion of the cultural variations in 76 currently recognized DSM disorders. For these 76 disorders, a discussion of the cultural variations in describing distress, patterning of symptoms, course of the disorder, and socio-demographic correlates of the disorder is provided (Mezzich et al., 1995). For example, the DSM notes that major depression may be predominantly characterized by somatic complaints in some cultural groups, rather than by feelings of sadness or guilt. It is noted that for the Hopi in particular, such symptoms of distress may include a sense of being "heartbroken" (American Psychiatric Association, 1994).

Second, DSM-IV includes an appendix (Appendix I) of culture-bound syndromes. These syndromes are "recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category" (p. 844). For example, "ghost sickness," an experience observed among certain American Indian groups, is described as a preoccupation with death and/or the deceased person that can lead to symptoms such as bad dreams, loss of appetite, fear, and anxiety.

Third, Appendix I of the DSM-IV includes an outline for a culturally relevant case formulation of the individual's presenting concerns. Of the three additions to DSM-IV, the cultural case formulation has provided an especially important tool for understanding mental disorders in a cultural context (Manson, 1997). The cultural case formulation outline consists of

five dimensions along which to elaborate the clinical picture in a cultural context. These five dimensions include the following: cultural identity of the individual, cultural explanation of the individual's illness, cultural factors related to psychosocial environment and levels of functioning, cultural elements of the relationship between the individual and clinician, and overall cultural assessment for diagnosis and care. This cultural case formulation outline offers clinicians a way to supplement the standard diagnostic formulation with a statement unique to the individual, emphasizing his/her personal and cultural experiences (Mezzich et al., 1995).

Cultural Case Formulation of an American Indian Client

The following is the hypothetical case of an American Indian woman who presents with a history of alcohol dependence and major depression. For reasons of confidentiality, the following case does not represent any particular individual. It is, however, based on a composite of observations made in the course of clinical and research work with American Indian people.

Clinical History

Patient Identification: Kim was a 37-year-old American Indian woman residing on a Northern Plains reservation. She had been with her common-law husband for 15 years. She lived with him and six of her seven children (who ranged in age from two to 15 years). At the time of intake, Kim was unemployed, having lost her housekeeping job with the tribal casino about six months prior, due to a car accident, which left her without a means of getting to work. Kim helped her uncle with his recycling business periodically to supplement her monthly general assistance check. She presented with marital and relationship difficulties, feelings of anger and boredom, frequent crying spells, and loss of appetite. Though she had not pursued counseling previously, she was considering it because her 15 year-old daughter was being seen by a counselor through the tribal mental health program for her own problems with alcohol and depression, and had been urging Kim to do the same. Kim was concerned that if she did not do something about her problems, she would return to using alcohol to cope. She had actively been contemplating drinking again for the previous six months, and on several isolated occasions drank beer and wine to the point of intoxication. Given her history of alcohol dependence, it was a serious concern that her presenting problems could precipitate a relapse of alcohol abuse and dependence. However, Kim had reservations about pursuing counseling. She worried whether or not counselors at the tribal mental health program would respect her confidentiality. Her worry was in part due to the fact that she was related to, or otherwise knew, many of the counselors who worked at the tribal mental health center. There was a new counselor at the center

who was not from Kim's community. Thus, Kim was willing to speak with this person.

History of Present Illness: Kim reported that the marital problems between her and her husband had always existed, with periods of abatement and escalation. In the last 6 months, their marital problems escalated, as her husband's drinking and drug use worsened. Kim reported that her husband was often not home to help with their children and household duties, was out drinking and drugging with his friends four to five nights a week, and routinely spent the majority of his monthly general assistance check on alcohol and drugs. In addition, Kim suspected her husband of having an extramarital affair. When Kim confronted her husband about his behavior, these discussions often turned to violence in which Kim and her husband threw things and hit one another. Kim called the tribal police on numerous occasions, but never pressed charges for fear that she too would be subject to jail time for her own behavior. Kim reported such confrontations with her husband on a weekly basis. After these confrontations Kim reported feelings of rage and anger, uncontrollable crying, and loss of appetite. In addition, Kim took her anger out on her children by yelling at them and being impatient with them. She denied being physically abusive to her children and also reported that her husband was not physically abusive to them. Feeling hopeless that her situation would improve, Kim frequently contemplated drinking. On three occasions in the previous six months Kim bought a bottle of wine and a six-pack of beer, drinking at home alone to the point of intoxication and passing out.

Psychiatric History and Previous Treatment: Kim reported a history of depression, suicide attempts, and substance abuse, starting when she was 15 years old. Kim described her life between ages 15 and 19 by saying that she "really had a hard time" and that those were the "roughest times" of her life. During her late teenage years, Kim was dealing with the loss of her mother and her father. Her mother had been murdered, and her father convicted of that murder and incarcerated. Kim maintained that her father was innocent, and indeed his conviction was overturned and he was released from prison when new evidence came to light about the case several years ago. Kim described herself as having felt "totally lost" without her mother and father. With both of them gone, Kim decided to quit school and set out on her own. Kim moved in with a boyfriend she met at boarding school who lived on a nearby reservation. Soon after she moved in with him the two began using alcohol heavily. Kim said that using alcohol was one way of forgetting about her life and the tragic turn it had taken. Despite her attempts to "forget" the trouble in her life, Kim became quite depressed and made two suicide attempts. On her first attempt Kim swallowed a bottle of her boyfriend's grandmother's heart medication. She was hospitalized at the local Indian Health Service hospital for several days and encouraged to pursue counseling with a local mental health counselor after discharge (which she chose not to do). After her second suicide attempt, in which she

cut her wrists, Kim was sent to an inpatient psychiatric hospital off-reservation where she stayed for 30 days. Kim spoke positively of this experience and stated that it was here that she felt safe, understood, and cared for, for the first time in her life. Her inpatient therapy focused on becoming sober and participating in individual and group therapy to address Kim's history of loss, her feelings related to same, and her coping strategies. Kim's psychiatrist stabilized her on a program of antidepressant medication during her stay at the hospital. Following discharge, Kim was encouraged to adhere to a regimen of outpatient therapy, AA, and antidepressant medication. When Kim returned to her home reservation she did not pursue these recommendations, citing distrust of the local mental health workers and perhaps more importantly, a return to using alcohol after being pressured by her friends to do so. It was when Kim became pregnant at age 19 that she made a commitment to sobriety. Her sobriety at age 19 was achieved without therapy or AA.

In the years following this difficult period Kim struggled with sobriety, with intermittent bouts of use of and dependence on alcohol. One significant relapse into alcohol dependence occurred after the death of Kim's first child, in an automobile accident, when Kim was 21 years old. This relapse lasted over a year, until she became pregnant with her second (and now oldest) child. During this period of relapse Kim had two DUIs, often got into fights with both men and women, and was arrested several times for disorderly conduct.

Kim said that nowadays she tries to remain committed to her sobriety by thinking of her children and her pledge to provide a better life for them than the one she had. Despite continued struggles with depression, extreme feelings of anger, and a general sense of boredom with her life over the years, Kim did not seek further therapy or counseling. She reported attending sweat-lodge ceremonies from time to time, though in general she felt her access to these traditional ceremonies was limited for reasons outlined below.

Social and Developmental History: Kim was born and raised until age five on the Northern Plains reservation on which she currently resides. Until age five Kim lived with her mother and father and was sent to live with other relatives, like her grandparents and various aunts, when her parents drinking and partying "got out of hand," in the eyes of her other relatives. She attended boarding school from first through ninth grade. Because the boarding school was located over 100 miles away from her home reservation, Kim's parents and relatives could not afford to visit her nor could they afford for her to return home during the school year to visit them. Kim expressed much regret over having grown up essentially without her parents and relatives. She expressed much lingering resentment toward her parents for "abandoning" her. She felt it was due to her parents' excessive "drinking and partying" that they were unable to care for her and thus sent her away to be raised by strangers. Kim dropped out of school in

10th grade because of trouble at home (i.e., the death of her mother and incarceration of her father). She never completed high school, nor did she receive a general equivalency degree (GED). Though not uncommon for people in Kim's community and generation to leave high school, many ultimately receive their GED. Kim expressed embarrassment about her lack of education and made several unsuccessful attempts to complete her GED at the tribal college, but each time problems at home have prevented her from finishing the coursework. After dropping out of school, Kim returned home to help care for her younger siblings, who were without parents. However, she left the reservation shortly after returning home because, as she described, it had become "just too lonely" without her parents around. She described herself as feeling completely "lost" at the time and so sought to find a new home in a place that would not be filled with so many painful memories. Kim moved to a neighboring reservation to live with a boyfriend she met at boarding school. Kim quickly turned to partying and drinking heavily with her boyfriend. After two suicide attempts, she stayed at an inpatient psychiatric hospital for 30 days. Upon discharge Kim again returned to her home reservation. She lived with her aunt and helped take care of her aunt's young children. Still devastated by the loss of her parents, Kim said she quickly gave in to pressure by her friends to party; thus, her abusive use of alcohol resumed. At age 19, Kim became pregnant with her first child. This served as a rallying point for Kim to stop drinking. Shortly after the child's birth, however, Kim and her baby were in a car accident, in which the child was killed. This triggered another period of drinking and depression for Kim, which again she emerged from when she became pregnant with her now 15-year-old daughter. Kim remained with the father of this child, and subsequently they had 5 more children.

Family History: Kim reported a history of alcohol abuse and dependence among her mother and father, as well as several of her siblings. She had one brother who committed suicide 10 years prior, by hanging himself in the tribal jail, after being arrested for drunk driving. Her father maintained his sobriety following his release from prison and frequently reminded Kim of the importance of sobriety for Native people.

Course and Outcome: With encouragement from her daughter to seek counseling, Kim was willing, at the time of intake, to try outpatient therapy for the first time. Though she had a good experience with counselors and group therapy during her inpatient stay as a teenager, Kim remained reluctant to go to counseling on the reservation for fear that the counselors would not protect her confidentiality. Kim also noted that she considered counseling in the past, but was easily discouraged by the lack of available appointments. Kim was eager at intake, however, to do something. She felt as though she was on the verge of using alcohol again given the escalating trouble with her husband, and her increased despair and anger over that situation. With a new counselor from outside her community now working at the tribal mental health clinic, Kim was ready to seek counseling

in hopes of avoiding a return to alcohol abuse/dependence, a relapse into clinical depression, and ultimately, in hopes of feeling more pleasure in her life.

Diagnostic Formulation:

- Axis I: 296.35 Major Depressive Disorder, Recurrent, In Partial Remission
03.90 Alcohol Dependence, Sustained Partial Remission
- Axis II: Deferred
- Axis III: 493.90 Asthma, unspecified
- Axis IV: Current: Marital difficulties, including domestic violence
Substance abuse (drug and alcohol) in the home
Inadequate health care services (her perception)
Recent car accident
Friends urging her to drink
- Past: Tragic loss of mother
Tragic loss of daughter in automobile accident
Father incarcerated
Grew up without parents, in boarding school
- Axis V: Global Assessment of Functioning: 51

Cultural Formulation

A. *Cultural Identity of the Individual*

1. *Cultural Reference Group(s):* Kim was an enrolled member of a Northern Plains American Indian tribe; both of her parents were enrolled tribal members, as were her husband and his parents. All of Kim's six surviving children were tribal members and resided on the reservation.

2. *Involvement with Culture of Origin:* Kim was born on the reservation but her school-aged years (from five to 16) were spent away from the reservation at boarding school. She participated in traditional ceremonies over the years, but felt alienated because she did not speak her Native language as well as others who participated and also because she and her parents were raised as Christians. She expressed a desire to someday participate more fully in the traditional ways and spiritual practices of her tribe. She did incorporate certain Native practices into her daily life such as "smudging" with sage (Yellow Horse Brave Heart & Spicer, 2000), dancing in powwows, and helping her children put together their powwow dancing regalia.

3. *Involvement with Host Culture*¹: Kim's greatest contact with the "host culture" was during her years at boarding school. Though boarding school was a lonely place for her because of the alienation she felt from her family and culture, she said she was glad she learned "discipline and good housekeeping" there. In boarding school Kim reported there were strict rules for all boarders to follow about making beds, shining shoes, pressing clothes, and so forth. The reservation on which Kim was residing at intake is located about 40 miles from the nearest small rural non-Native community where reservation residents often go for a greater selection of groceries and other supplies, such as clothing, vehicles, and house wares. Reservation residents have described this community as a "racist" town where they felt unwelcome and discriminated against (e.g., being watched carefully in stores, being made to pay for gas upfront when locals seem not to be required to do the same, slower service in restaurants). Kim reported one incident when she and her children were shopping for new school shoes, and the store clerk followed them out of the store and threatened to call the police if Kim did not show her what was inside her handbag, under suspicion that Kim had taken some socks from the store. Indeed, Kim had not taken anything but nonetheless felt humiliated in front of her children. Other than her trips to this small neighboring town, Kim reported little direct contact with non-Native communities and people, outside of what she watched on television.

4. *Language*: Kim spoke English fluently and as her first and primary language. She used isolated words from her Native language but did not have full command of her Native tongue. This was not uncommon for individuals of Kim's generation on her reservation. Having been raised in a boarding school, where children were often forbidden from speaking their Native language (Child, 1998), combined with the fact that Kim had little contact with her family during her years in boarding school, it was even less surprising that she did not speak her Native language. Kim reported that her parents were both fluent speakers of their Native language, but that they only spoke their language with their own parents (Kim's grandparents) and on occasion with one another. Her parents only spoke English with Kim and her siblings. In fact, Kim's parents pushed her and her siblings to speak English and learn "White ways" so that they would be better equipped to succeed in school and get jobs afterwards. People of Kim's generation, and in her reservation community, often rue the loss of their language and seek to relearn it (or learn it for the first time). Likewise, Kim regretted not knowing her language and felt that this was a deep cultural loss that would be hard, if not impossible, to recover.

5. *Cultural Factors in Development:* Both Kim's maternal and paternal grandparents participated fully in the Native rituals and ceremonies practiced among their tribe, and were fluent speakers of their Native language. While recognizing that their children would begin to lose their language and cultural practices, they made the difficult decision to send Kim's parents to a missionary-run boarding school, because the boarding school could better provide for their basic needs. Kim's grandparents were quite poor and the boarding school provided regular meals and amenities, such as indoor plumbing and heating, in addition to an education that would prepare their children for the changing world they lived in. Kim's parents represented the first generation in her family to speak English and be converted to Christianity. For many of the same reasons their parents did, Kim's parents sent her and her siblings to boarding school. Kim resented this since the boarding school she attended was so far away from home that she was unable to see her parents during the school year. In addition, Kim often spent summers at the boarding school because her family also did not have the means to support her and her siblings during the summer. Kim felt added resentment over being "sent away to strangers" since she believes her parents could have supported her and her siblings if, as she says, "they hadn't spent all their money on partying." As a result of her boarding school years, Kim felt she essentially grew up without parents. This only compounded the devastation she felt when she lost her parents completely through her mother's death and her father's incarceration. Kim felt deprived not only of the emotional experiences of having parents and family close by during childhood, but also of the cultural experiences she would have experienced growing up near her extended family. Kim blamed the fact that she grew up without her parents for some of her difficulties as an adult - e.g., in raising her own children and in feeling so desperate for love that she stayed in a troubled relationship. She also felt alienated from the medicine people in her tribe and unable to access the traditional healing practices they utilized because she was raised as a Christian and knew little of her Native language and practices.

B. *Cultural Explanations of the Individual's Illness*

1. *Predominant Idioms of Distress and Local Illness Categories:* Kim stated that she was "cranky" and angry much of the time. She spoke little of feeling depressed per se, but clearly was unhappy with her life and situation.

She also described herself as frequently “bored,” and reported it was difficult to find meaning or pleasure from her life, which largely consisted of taking care of her children, arguing with her husband, and helping her uncle with his recycling business. Kim also reported somatic complaints, such as trouble sleeping and eating. Kim attributed her crying spells more to a sense of frustration and anger, than to sadness per se.

2. *Meaning and Severity of Symptoms in Relations to Cultural Norms:* The experience of boredom is not unusual in Kim’s community. The reservation on which Kim resides offers few opportunities for entertainment outside of community events (e.g., powwows and summer fairs) that occur from time to time. There are only a couple of restaurants on the reservation, few shops, no movie theaters, no coffee shops, and little else for reservation residents to enjoy. The small town, about 40 miles away, has a movie theater and other entertainment venues, but this is often difficult to access given Kim’s lack of reliable transportation. Kim’s feelings of anger are also not uncommon for women in her community who experience troubled marital relationships, feel overwhelmed and unsupported in caring for their children and household, and who have little time for themselves. In all, Kim’s presentation was not unlike that of others in her community reporting a general sense of malaise but not meeting all the DSM-IV criteria for depression or any other specific psychiatric disorder. Kim’s boredom and anger may indeed be a form of depression as they resemble a sense of hopelessness and despair in Kim’s case.

3. *Perceived Causes and Explanatory Models:* Kim explained her boredom, anger, desire to drink, and somatic complaints as largely related to the current relationship problems she was experiencing with her husband, as well as related to the loss of important relationships in the past (i.e., her parents symbolic and actual loss, her daughter’s death). Kim felt that a return to abusive drinking was always a strong temptation given the fact that her friends and family drank heavily, and frequently encouraged her to join them. In her attempt to remain sober Kim was thus faced with decreasing her contact with friends and family because of their drinking. This has left her feeling isolated and more angry and bored.

4. *Preferences for and Experiences with Professional and Popular Sources of Care:* Kim only received professional counseling once. That was during her inpatient stay at a psychiatric hospital when she was in her late teens. She planned to speak with the new mental health counselor at the tribal mental health center. She was willing to work with him since he was not from her community. Kim also wanted the help of a Native healer or medicine person, but was unsure of how to make this contact. She heard, through her daughter, that the local mental health clinic recently hired a medicine man as part of its staff and planned to make an appointment to see him as well. Kim's uncle had been encouraging her to pursue more traditional methods of healing.

C. *Cultural Factors Related to Psychosocial Environment and Levels of Functioning*

1. *Social Stressors:* Kim was unemployed at intake, and as a result did not have a steady income apart from the small general assistance check she received every month. She had no high school education, nor a GED, thus it was even more difficult for her to compete for the small number of jobs in her community. Because she lacked a car, it was impossible for Kim to seek employment off the reservation. Other social stressors included Kim's husband's behavior and the trouble it caused in their relationship. Kim felt alienated from her friends and family because she wanted to stay sober but felt pressured to drink when around them.

2. *Social Supports:* Kim had virtually no source of social support in her life, outside of the relationship with her father and one of her uncles, the only two people close to her who were committed to sobriety. In her moments of greatest despair, Kim felt that the only way to stay sober and create a better life for her and her children was to leave the reservation entirely. This reflected the fact that Kim felt surrounded by people she deemed dysfunctional, hopeless, and damaging. The belief that she must "leave the rez" contradicted her more hopeful view that regaining her cultural practices, and by necessity, reconnecting with others in her tribe would be healing. Though Kim did not speak of it as such, she did benefit from some tribal support systems. In particular, Kim relied upon the tribe for healthcare, food commodities, and housing.

3. *Levels of Functioning and Disability:* The losses, both interpersonal (e.g., mother, daughter, and father) and cultural (e.g., language and cultural practices), Kim sustained over the years are not uncommon in her reservation community. Nor is the fact that she was unemployed and found it difficult to make ends meet for her family. There are differences, however, between the ways in which others deal with these losses and stresses, and how Kim dealt with them. For example, whereas Kim seemed to have reached a certain level of hopelessness, others in her community have taken it upon themselves to enroll in language classes or seek relationships with elders or spiritual leaders who can provide guidance in terms of cultural practices.

D. *Cultural Elements between the Individual and Clinician:* Kim indicated that she preferred a clinician or counselor who, whether or not s/he was Native, was not from her community. To her, this provided an added assurance that what she shared with this person would remain confidential and not gossiped about around town. Whether or not her fears were founded or based on her knowledge of true breaches of confidentiality by mental health clinic staff, it was important that Kim see someone who was from outside her community. In this way Kim would at least begin the process of counseling, which she seemed in desperate need of at the time of intake. It was recommended that her counselor be patient with Kim and not press her to divulge more than she was ready to. Her counselor was aware that there would likely be a period in which Kim needed to “test the waters” with him/her in order to feel certain that her story would be kept confidential. Once a trusting relationship was developed, Kim would have benefitted from having a reliable source of support in her life, which she was without. It was also recommended that Kim’s counselor should support her efforts to connect with the medicine man at the mental health center and not see that work as contradictory to the work that Kim did in her therapy sessions. In addition to individual therapy, Kim was encouraged to join a local women’s support group.

E. *Overall Cultural Assessment for Diagnosis and Care:* Kim was a 37-year-old American Indian woman living on a Northern Plains reservation with her common-law husband of 15 years and their six children. At the time of intake, Kim sought counseling because of escalating marital problems, feelings of anger and boredom, crying spells, and loss of appetite. Kim had a history of alcohol dependence, depression, and suicide attempts. She felt that if she did not seek help soon, she would relapse into alcohol dependence and depression. Kim was born on the reservation and raised there until age five by her parents. Before age five, she lived with aunts and grandparents at various times, because of her parents’ alcohol abuse. At age five, Kim was sent to a missionary-run boarding school, where she felt

both abandoned by her parents and deprived of her cultural heritage. Kim dropped out of school when her mother was killed and her father sent to prison. This was the start of a period of heavy drinking and deep depression, during which Kim made several suicide attempts and was hospitalized at a psychiatric facility. She struggled since this time with periods of depression and alcoholism but always maintained sobriety during her pregnancies and was inspired to remain sober because of a commitment to raising her children in a healthy way. In addition to the marital difficulties that initiated her desire to seek counseling, Kim blamed many of her past struggles with alcoholism and depression on the significant losses she sustained over the course of her life - that of her mother, daughter, and brother (all of whom died tragically and unexpectedly).

Kim expressed her distress predominantly through feelings of anger and boredom, which in Kim's case may have represented a form or symptom cluster of depression not currently specified in the DSM-IV. In particular, the "boredom" she experienced could have been a marker for the DSM-IV criterion of "loss of pleasure or interest." In this regard, it would have been important to ascertain whether Kim's boredom coincided with or increased at the onset of her other symptoms of depression (e.g., loss of appetite, feeling sad) or whether she experienced boredom more generally. If the former were true, it would seem plausible that Kim's boredom was related to the DSM-IV criterion of "loss of pleasure or interest." Kim's feelings of anger, on the other hand, seemed tied to the interpersonal struggles (e.g., marital, familial) in her life. In her moments of greatest frustration, Kim felt that "leaving the rez" was the only option for improving her life, as she felt surrounded by a host of people whom she deemed dysfunctional and destructive. Yet Kim clearly was not universally angry and disappointed by the people around her, as evidenced by the ways in which Kim was embedded in the social network of her family and her tribe. On a familial level, Kim had a close relationship with her six children and had a close relationship with her father and uncle, who lived nearby. On a tribal level, Kim lived in tribal housing, sent her children to tribally-run schools, received tribal food commodities, and depended on tribal health services for herself and her children. In addition, Kim's thoughts of "leaving the rez" were in opposition to her desire to reconnect with the traditional practices of her tribe.

Regarding psychiatric care, Kim sought help from both a professional outside of her community and a traditional healer deeply embedded in her community. Kim sought a counselor from outside of her reservation community due to her perception that such a counselor would fully respect her confidentiality, whereas someone from her community would not. Though Kim felt alienated from the traditional healers and healing practices in her tribe at the time of intake, she was interested in receiving help from a medicine man who worked at the tribal mental health clinic. In planning for Kim's care, Kim would likely have benefited from a program of

counseling that incorporated both Western therapeutic practices and traditional Native healing practices. Kim's ambivalence about her tribal community (i.e., that it was simultaneously a place to leave/avoid and a place in which to become more deeply embedded) might have been addressed through an historical trauma recovery group (e.g., as outlined by Yellow Horse Brave Heart & DeBruyn, 1998). Such a group could have helped Kim to understand the larger historical forces that have negatively impacted her tribal community and its members—and as a result, perhaps alleviate the anger she felt toward those individuals who somehow failed her (e.g., by abandoning her). In particular, an historical trauma recovery group may have helped Kim understand the impact of one generation's trauma (e.g., her parents own experiences of growing up without parents and being raised in a boarding school) upon the next (e.g., Kim's own sense of abandonment). Ideally, such a group might have helped Kim forgive those who transgressed against her and indicate a traditional path of healing along which to move forward.

More generally, Kim could have benefited from a treatment plan that facilitated her use of tribal services to improve her quality of life, such as a GED program, job training, and connection with a supportive group of other tribal members (e.g., domestic violence support group or recovery support group).

Conclusion

As it relates to the experience of illness, culture can be understood as a set of shared value orientations about the self, illness, and treatment (Kleinman, 1996). If psychiatric assessment is the process by which a clinician translates another's story of illness into the terms of psychiatric diagnosis, careful attention to the cultural context in which these stories unfold allows for a more meaningful telling of that story. Ideally, this practice will result in a system of psychiatric diagnosis and care that better serves the needs of the client. DSM-IV now includes a structured outline for gathering such culturally relevant information that encourages clinicians to gather this information more routinely, and provides a systematized means of doing so.

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Footnote

¹It is interesting to note, that for Native people, the “host culture” is in essence their own culture as their inhabitation of this land preceded that of what is now known as the “dominant” culture. Nonetheless, this speaks to the experience of American Indians in today’s world as guests, so to speak, in their own home. For the purposes of this article, “dominant culture” will be used instead of “host culture” to reflect this experience.