Recognizing cultural dysthymia: The implications of including discrimination-mediated mental illnesses in the *Diagnostic and Statistical Manual of Mental Disorders*

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Abstract

Cultural dysthymia is a form of persistent depressive disorder (PDD; dysthymia) that is precipitated and exacerbated by racial discrimination.[2,3,21] Symptoms include chronic depressed mood and anger or hostility, especially when in interpersonal conflicts with a member of a privileged group. Racism is a known stressor that precipitates and exacerbates mental illness in those targeted; however, the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) *does not officially recognize disorders arising from discrimination. Cultural dysthymia is mainly applied to African Americans, but can be applied to other racially oppressed groups. This paper will address how stress affects mental and physical health, including factors that lead to development of this condition, categorizing cultural dysthymia in the* DSM *as to yield the most accurate and beneficial results, and some implications of this diagnosis being officially recognized by the* DSM. *Tangible future steps to improve adequacy of care for disadvantaged groups will be presented.*

Introduction

Racism and poverty are two major stressors that are known to negatively impact mental and physical health.[2,9] Currently, there is little mention of these two stressors as precipitators of mental illness in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*). At the end of the *DSM-5* under the "Other Conditions" section, poverty- and discrimination-induced mental stress appear.[1] However, these are not included in the main areas of the *DSM-5* as legitimate causes of mental illness, leaving many people misdiagnosed and under-treated. The "Other Conditions" is meant to give context to possible factors leading to the development of mental illness, however, there is also a section titled "Conditions for Further Study". In this section, there are several proposed conditions complete with accompanying symptoms, etiology, prevalence, and comorbidity. A condition such as cultural dysthymia could be placed here where it can be thoroughly detailed, instead of having a few sentences in the "Other Conditions" section.

Though poverty and discrimination are included as possible stressors and precipitators of mental disorders, the language surrounding these risk factors is problematic; discrimination is described as "perceived" instead of "experienced". This invalidates the lived experiences of people facing discrimination – which does not have to be validated by someone not experiencing that discrimination, nor does it have to be deliberate or overt discrimination in order to be legitimate. By calling discrimination "perceived", it puts the onus on the receiver for supposedly having the "wrong" perception and outlook on life.

All residents of a country do not share the same culture, regardless of a supposed shared national culture and identity. Ethnicity and socioeconomic status are two of many factors that influence the way people live, and mental health professionals are supposed to view symptoms with cultural awareness. Without this awareness, it is ignored that many mental illnesses have factors directly stemming from societal discrimination. Among African Americans, racism has been identified as the number one most prevalent and most potent cause of psychological distress.[3] Since racism and poverty are inextricably linked[16], African Americans experience more than just "pure" race-based discrimination; being Black in America precipitates and exacerbates mental illness. Cultural dysthymia is a form of persistent depressive disorder (PDD; dysthymia) that is precipitated and exacerbated by racial discrimination.[3,4] Symptoms include chronic depressed mood and anger or hostility, especially when in interpersonal conflicts with a member of a privileged group.[4] Although the condition is primarily applied to African Americans, it is applicable to a range of ethnic groups that experience historic and contemporary oppression and discrimination resulting from colonization. As a result of centuries of enslavement, dehumanization, and deliberate social exclusion and inhibition, these stressors have negative and lasting impacts on the mental and physical health of those targeted. Cultural awareness, and respect for underprivileged groups, in therapeutic settings is necessary to provide more adequate and appropriate care. These cannot stem from interpersonal interactions between health providers and patients; systemic incorporation of the ways in which discrimination impact mental health is necessary. Including cultural dysthymia in the *DSM-5* would lead to better treatment outcomes and greater attention to combating the intersectional factors that cause cultural dysthymia. While this paper is focusing specifically on Black American populations, racism has negative effects on the mental health of other ethnic minority groups as well.

Racism as Stress and its Effects on Mental and Physical Health

It is known that stress precipitates and exacerbates many health conditions.[16] Overall health on average decreases (including increases of early mortality and morbidity) as one decreases along the socioeconomic scale.[6] To a certain degree the body is able to adapt to changes caused

by stress; the ability to maintain homeostasis through change is called allostasis.[6] The amygdala and hippocampus are involved in fear learning and conditioning and play an important role in the response to instances of stress (in this case, the stress is racism); they, along with other brain structures, form a "network". With trauma, it is believed that amygdala-based fear completely circumvents the hippocampus (which is important for memory and learning), leading to somatic and physiological effects when presented with the same or similar stimuli; this recreates the negative experience of being introduced to the stimuli for the first time. Each time the body has to remedy an unbalance it is referred to as an allostatic cycle.[5,6,27] Allostatic load describes the "wear and tear the body experiences due to repeated cycles of allostasis" and stress from having to repeatedly start and stop these cycles.[6] Stress disrupts physiological homeostasis, and the body must have sufficient ability to remedy this (allostasis); although the body may return to homeostasis, there exists a gradual deterioration of overall health due to the build-up of stressful incidents (allostatic load).

Stress is a broad term that can be applied to a multitude of entities. In terms of social stress, it is very subjective: what is a stressor to one person may not be a stressor to another. Sometimes, as is the case with racism and sexism, only segments of a population experience a specific stressor. Discriminatory stressors, such as race– or sexual orientation–based, have compounding effects, often because a person can identify with one or more marginalized identity. For instance, a woman would experience systemic gender discrimination, but an ethnic minority woman would also face systemic racial discrimination whereas a woman of the dominant racial group would not. Dr. Kimberlé Crenshaw defined this phenomenon as intersectionality, the inextricably linked manner in which systems of oppression and discrimination operate.[8] Discrimination is a prominent social stressor that is detrimental to psychological and physical health. From a biopsychosocial viewpoint, cultural dysthymia has a complex etiology involving multiple interconnected factors.

Psychological stress

Discrimination is a stressor that is significant in the lives of those who experience it. For African Americans, the most prevalent and potent stressor is racism.[2,7] On average, racism causes Black Americans to experience greater overall psychological distress and decreased mastery (skills performance).[9] Interpersonal racism has been shown to have many negative health effects.[3,10,11] Institutional racism, which affects economic status and education for example, also has negative effects on physical and mental health. Among Black inner-city residents, there are higher rates of suicide (including attempts), post-traumatic stress disorder (PTSD), emotional instability, depression, and substance dependence.[12,13,14] It has been found that PTSD rates within impoverished communities in inner cities rival that of returning military veterans, even after controlling for other factors.[15] "Racism operates within objective life conditions, popular culture, and religious and educational institutions".[16] Because of the covert pervasiveness of institutional racism, Black Americans often can better point to specific, isolated instances of interpersonal racism. Racism is also sustained by implicit biases, which are stereotypes that, unknown to ourselves, affect our thoughts and actions. These racist incidents, both institutional and interpersonal, increase allostatic load and have detrimental effects on psychological health.

Physical stress

Institutional racism negatively impacts physical health. Disparities in rates of disease between White and Black Americans can be attributed to historical and social inequality.[10,11,17] Because poverty and race are inextricably linked, the negative health effects from living in poverty are compounded with the negative health effects of racism; those in the cycle of poverty tend to only be aware of scarcity of their resources and not about how their gender and/or race play a role in their situation. Even when socioeconomic status is relatively equal between races, African Americans still experience higher rates of disease.[17] African American women (largely slave-descendant) experience higher rates of fibroids than White women, which can in part be attributed to early medical experimentation on female slaves by J. Marion Sims, whose work helped found the field of gynecology.[18] There is a plethora of instances of historic and contemporary medical experimentation on usually poor and under-educated Black Americans, sometimes funded by the United States government.[19,20,21] This grim reality also negatively impacts psychological health; being faced with the prospects of a higher likelihood of poor health outcomes is a source of stress.

Categorizing Cultural Dysthymia in the DSM-5

If cultural dysthymia were to be included in the *DSM* it would most likely be placed under an existing category. Depressive disorders and trauma- and stressor-related disorders are the two diagnostic categories most relevant to cultural dysthymia. The specific classification of cultural dysthymia does matter, and after analyzing both categories for fit, it was determined that cultural dysthymia would be best suited in a new, distinct category.

Depressive disorders

The *DSM-5* defines persistent depressive disorder (PDD; dysthymia) as "a depressed mood that occurs for most of the day, for more days than not, for at least 2 years, or at least 1 year for children and adolescents".[22] Sometimes PDD is characterized as a low-grade, chronic depression. The major distinguishing factors are four symptoms often present in major depressive disorder (MDD) that are absent in PDD: near daily psychomotor agitation or retardation, suicidal thoughts and actions, anhedonia, and feelings of worthlessness or excessive guilt.[22] Other symptoms of PDD include abnormal sleep, feelings of hopelessness, poor concentration, appetite changes or disturbances, low self-esteem, and low energy or fatigue.[22]

The only environmental risk factor for PDD listed in the *DSM* is parental loss or separation during childhood.[23] Genetic and physiological risk factors do not differ from those of major depressive disorder (MDD).[22]

Trauma- and stressor-related disorders.

The *DSM-5* defines trauma- and stressor-related disorders as disorders in which the main criterion for diagnosis is a traumatic or stressful event(s).[24] The disorders included under this umbrella are: reactive attachment disorder, disinhibited social engagement disorder, post-traumatic stress disorder, acute stress disorder, adjustment disorders, and other and unspecified trauma- and stressor-related disorders.[24]

Several environmental, pre-traumatic (before onset) risk factors of PTSD most directly related to cultural dysthymia are: "lower socioeconomic status; lower education; exposure to prior trauma (especially during childhood); childhood adversity (e.g., economic deprivation, family dysfunction, parental separation or death); minority racial/ethnic status; and a family psychiatric history".[24] Although these risk factors are included here in the *DSM-5*, these factors also play large roles in the development of other mental illnesses, such as depression.

Categorizing cultural dysthymia

Given these criteria, it is clear that cultural dysthymia overlaps greatly with both categories. The depressive disorders category

best describes the symptoms of cultural dysthymia whereas the trauma- and stressor-related disorders category encapsulates the triggers. Cultural dysthymia differs from other depressive disorders in that the primary risk factors are racial discrimination-based. While White Americans experience higher rates of depression than African Americans, African Americans experience higher rates of dysthymia.[25] Because of the heavy influence of discrimination-based trauma, cultural dysthymia would be best categorized under trauma- and stressor-related disorders instead of depressive disorders. However, there are other unexplored conditions caused by discriminations such as gender-based and sexuality-based discrimination. Those disorders, like cultural dysthymia, share risk factors that have similar mechanisms of action and could potentially have the same symptoms; because of this, they should be classified under a "Discrimination-mediated" category due to their distinct—but often overlapping—primary causes. For many people, these three areas—race, gender, and sexuality—overlap. There are more interactions between risk factors for these people, and the symptoms are magnified. A separate classification category, complete with uniquely modified treatment options, would best suit people experiencing cultural dysthymia. Although there have been many changes over the years, the *DSM*-5 groups disorders by common characteristics such as symptoms and risk factors. While there is much overlap between cultural dysthymia, depressive disorders, and trauma- and stressor-related disorders, a separate category for discrimination-precipitated disorders would follow *DSM*-5 structure and be most beneficial.

Importance of accurate classification

The categorization of cultural dysthymia is important because of the current general methodology of *DSM* classifications; classification is often an indicator of beneficial treatment options. Per classification group, there are similar stressors and treatments across disorders. A treatment for one disorder can be more beneficial for a patient with a related disorder than the recommended treatment for their specific condition. Thus, it is most beneficial for patients for cultural dysthymia to be classified in the most relevant category.

Implications and Future Steps

Overwhelming evidence of racism's detrimental effects on mental health indicates it is imperative that discrimination-mediated mental disorders be included in the *DSM*. Although dysthymia and MDD have great overlap in symptoms, etiology, and treatment, there are differences that make certain treatments better for the latter condition than the former. For example, a combination of drug therapy and psychotherapy may be more appropriate for MDD, whereas dysthymia may only require psychotherapy. With cultural dysthymia, there are environmental factors that need to be accounted for when assessing patients for diagnosis and conceptualizing treatment. Healthcare professionals must be aware of cultural factors that influence mental health – especially when a patient and professional do not share cultures – the professional must be acutely aware of how gender, race, and class affect mental health. This is important because it affords the provider a more holistic view of the condition and can inform the provider as to the best course of treatment. Treatments geared towards identifying, understanding, and coping with these unique stressors are necessary in order to provide adequate care. For example, schools of social work across the country offer comprehensive courses and programs in diversity and discrimination education so professionals are as equipped as possible to serve diverse groups of disadvantaged populations. The social work profession was founded based on principals of social justice, and this foundation sets these programs apart from other medical professions that later added these components to their training. The issue is not simply a lack of training for future providers, but the disconnect between taking one cultural sensitivity course in school and making that an integral part of an individual's professional praxis. The dilemma is that these environmental factors are vast and pervasive social problems that cannot be escaped; cultural dysthymia would not exist if racial discrimination also did not exist.

If cultural dysthymia were to be recognized in the *DSM*, it would have great implications for society. Although there exists extensive research on racism as a major stressor, societal changes are slow and often stagnant. [8,9,10,11,13] Racial power dynamics in America put African Americans and other non-White people beneath White Americans. Racism exists as an institution in which, fueled by societal power dynamics with historical roots, ethnic groups are stratified by arbitrarily defined and supposedly inherent measures of value, and are disadvantaged accordingly. Those in power, even if they are aware of these effects and are combating them, also hold implicit and explicit racial, class, and gender biases that affect their actions and worldview.

Many cities and towns across America are racially segregated, even if there exist significant populations of different racial groups.[26] It has been shown that lack of early childhood introduction to racially diverse groups (outgroup members) is strongly correlated with heightened amygdala-based responses later in life when in contact with those outgroup members.[27] The amygdala become active when presented with new stimuli, which is an evolutionary defense mechanism. With repeated exposure, the stimuli are conditioned, or coded, loosely as "safe" or "unsafe"; with conditioning, the amygdala will respond less to "safe" stimuli. How, then, can a health professional raised in a homogenous environment with little to no contact with other racial group members begin to understand and recognize the significant effects racism has on certain groups of people? What are patients supposed to do when they need psychiatric help, but the vast majority of available professionals are members of a privileged class who are complicit in institutional discrimination? This presents a problem for racially oppressed groups, who report discrimination, apathy, and subpar treatment from medical professionals and other authority figures across fields.[28,29,30]

Possible future steps

There are many actions that can be taken to improve the adequacy of mental health care for members of disadvantaged groups. Oppression awareness programs that exist in social work schools can be implemented in other health professional schools on a wider scale. Health professionals at all levels should be required to have this comprehensive level of discrimination education in order to obtain a license to practice. For residents in poorer neighborhoods, there is a shortage of funding that directly impacts the quality of care and resources available to them. Better allocation of monetary resources, especially for public community health centers, would greatly benefit residents of those neighborhoods. Diversity of staff in multiple areas – such as gender, language, race and ethnicity, socioeconomic background, ability, and sexual orientation – would allow for patients to seek treatment from providers who share common background and experiences. This is vital for care, because often times people are deterred from seeking medical care due to a lack of professionals who look – literally and figuratively – like them. The problem is circular because marginalized people are also deterred from entering fields that are dominated by privileged majority groups. These are only a few of a myriad of avenues on the path to improving mental health care.

Impacts on other Discrimination-mediated Mental Illnesses

If cultural dysthymia were to be recognized by the *DSM*, more mental

illnesses catalyzed by discrimination would be recognized as well. Often times in health research, those who are being studied are left out of the process. Epidemiology of diseases is only one component; the experiences and criticisms from patients are important as well. Health professionals and researchers need to be receptive to criticisms of their field, actions, and beliefs in order to benefit disadvantaged populations. It is also critical for members of disadvantaged groups to be health professionals, researchers, and other authority figures in order to be available for disadvantaged group members seeking help; knowledge and awareness have limitations and cannot replace lived experiences. As mentioned previously, groups become underrepresented in fields that are dominated by privileged majority groups due to discrimination and unaccommodating environments; in the sciences especially, there are histories of experimentation on minority groups that make minority group members distrustful of the field and those who are a part of it.[20,21,32,33]

This would have beneficial effects for many groups of people, provided that health care providers are informed and aware of discrimination, as well as their own implicit biases. When aware of biases, providers can take extra steps to assure their patients are being assessed against equitable measures. One issue with this in the medical field is inevitable face-to-face communication, which creates difficulty in assess patients "blindly". However, a double-blind evaluation of patients is possible. Upon arrival for appointments, many health centers already ask patients to fill out a short computer survey before they meet with their provider, rating their emotional wellbeing across numerous measures. A different healthcare provider that does not know the ethnicity of the patient could then evaluate this survey, possibly as part of an oversight committee. The assessment of the patient from their assigned provider and the oversight provider could then be compared, with discrepancies being noted and analyzed. It is important for the survey to be evaluated by someone other than the patient's physician so that the physician does not recognize the patient's verbal answers from their written ones. Financial and time constraints prohibit this kind of intervention from being implemented in high needs areas.

Although extensive research exists on discrimination's effects on mental and physical health, there are substantial improvements to be made.[8,9,10,11,13] Because the healthcare field does not exist independent of society, changes in the field reflect societal attitudes. Female hysteria and homosexuality are two examples of things labeled mental illnesses due to discrimination and ignorance that were later retracted, only after much damage to cisgender women and homosexual people.[30,31,32,33] Including cultural dysthymia and other discrimination-mediated mental illnesses in the *DSM* is a small step toward providing more culturally-sensitive care. Attitudes of health professionals, researchers, and other authority figures also need to change (as well as the demographic makeup of these groups) in order for those seeking care to receive the best care possible.

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