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Culture and expert psychiatric evidence

by

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[53.100] Introduction

In determining the boundaries of what constitutes criminal conduct, each society or nation must look to the fabric of its own moral or cultural heritage to demarcate these limits. Every culture has its own notions of what constitutes right and wrong, of what is good and evil. Each society therefore must, and does, predicate its criminal laws and sanctions upon characteristics inherent to its own cultural norms. However, what is considered to be normal, acceptable conduct for one society is not necessarily acceptable for another. Social values foster norms, or standards of conduct, which are reflected within the criminal codes of these diverse nations. Conflicts between the criminal laws of different countries are to be expected in a world as culturally diverse as this. But what happens when such a conflict of cultural traditions is manifested within the legal system of one single nation? May conduct which is normal and acceptable in one culture be justified or excused when it violates the criminal code of the nation in which it is performed? The laws of a nation are not intended to be instructive of moral truth for mankind as a whole, but they must serve that function for the society they govern. (Lyman 1986)

The remarkable cultural and linguistic diversity of the Australian population, a product of the massive waves of migration that have characterised the 20th and the early 21st Centuries (Blugra and Minas, 2007), presents many challenges – in clinical practice (Steel, McDonald et al 2006; Colucci, Chopra et al, 2013), in the organisation and delivery of mental health services (Minas, 2001; Kiropoulos, Blashki et al, 2005; Minas, 2007), in what we know and do not know about the mental health of immigrant and refugee populations (Minas, Kakuma et al, 2013) and in the field of forensic psychiatry (Carter and Forsythe, 2009). This diversity is a feature of many countries, particularly those that have had active immigration programs, such as the USA, Canada and the United Kingdom.

When a psychiatrist assesses a person who comes from a different cultural background, especially when they do not share a common language, a number of theoretical and practical difficulties arise. A matter that ought to be of considerable interest to the court, the lawyers and the parties is whether the psychiatrist (or any other clinician involved) has sufficient expertise in cross-cultural assessment to be able to arrive at a useful and truly expert opinion.

[53.110] Culture

The term “culture” is used in three broad and related ways (Kirmayer, 2011). The original meaning is derived from cultivation or agriculture. This meaning was expanded to include the
idea of cultivation as a process of civilisation (as opposed to the uncultured and barbaric), the elaboration of codes of conduct and civility, acquisition of knowledge and skills, refinement and sophistication, and appreciation of the high culture of literature and arts. The second meaning of culture is concerned with the identification of groups, and the demarcation of one group from another, on the basis of descent, “ethnicity”, shared history and territory, patterns of kinship or citizenship, and common language, religion, values and practices. This may be a community, region or nation in its original location, or a community or people in a foreign territory, such as immigrants and refugees. The third meaning, which overlaps considerably with the second, is the idea of culture as a way of life, or as the rules, customs and traditions that govern relationships between people and between people and institutions and the state.

A society’s culture consists of whatever it is one has to know in order to operate in a manner acceptable to its members. Culture is not a material phenomenon; it does not consist of things, behaviour or emotion. It is rather an organisation of those things. It is the form of things that people have in mind, their models for perceiving, relating, and otherwise interpreting them. Culture consists of standards for deciding what is … for deciding what one feels about it … for deciding what to do about it, and … for deciding how to go about doing it (Goodenough, 1970).

Culture, in the sense most useful to psychiatry and law, consists of shared ideas, rules and meanings: an implicit code which enables individuals within a distinctive community to communicate, live, work, anticipate and interpret behaviour. The culture of a particular ethnic or any other group (for example medical professional or legal culture) can be seen as that group’s dominant epistemology. The culture informs, influences and shapes fundamental beliefs and values, and thereby shapes attitudes and behaviours, including beliefs about what is right and wrong and about what is and is not acceptable behaviour.

The term subculture is often used to describe identifiable groups within the dominant culture who differentiate themselves from the majority: for instance emo or goth subcultures, LGBTI or queer culture.

Culture is not static. It is not “a way of life demarcated by jealously guarded traditions” (Bottomley 1992) but is both historically specific and fluid. Although there has been a strong tendency to identify culture with ethnicity, culture (meanings, values, traditions and practices) can “arise from, express and constitute a range of social relations, including those based on gender, class, region of origin and religion, as well as ethnicity” (Bottomley, 1992). For instance, while Italian-born immigrants in Australia and Italians in Italy are both ethnically Italian, the two cultures have diverged enormously. It is also self-evident that the range of beliefs, values and practices within the Italian-Australian community (as within any other ethnic group) is very broad. As a result, terms such as “Italian culture”, “Vietnamese culture” or “Lebanese culture”, used uncritically, can mislead as much as they might inform.

“Culture is a moving target – continuing to change with new configurations of the social world – and psychiatry is now part of transnational flows of information that are used by professionals, institutions, and individuals to refashion identities in health and illness. This recognition of the constant circulation of cultural knowledge and practices across nations, geographic boundaries, and disciplines, gives renewed significance to the “trans” in transcultural psychiatry. The models we use to understand and help others are also agents of social transformation that change how suffering is experienced and expressed” (Kirmayer, 2013).

It is worth reflecting on the differing beliefs, values, traditions and practices, and institutions of the legal and medical professions, and on the distinct educational and other processes that result in enculturation of students and young professionals into the different professions. A central issue in any consideration of culture is power – how it is generated, acquired, defended and maintained, and denied.
The Mental Health: Culture Race and Ethnicity report (US Department of Health and Human Services, 2001), a supplement to the Mental Health Report of the US Surgeon General, concluded that there are significant differences in the ways in which members of ethnic minority groups experience mental illness, and in the levels of access to mental health services and quality of mental health care received. “Mental illness is considered the product of a complex interaction among biological, psychological, social, and cultural factors.” While the cultures of the patients and their families are important so also are the cultures of clinicians and the service systems that “influence diagnosis, treatment and service delivery.” People in the lowest stratum of income, education, and occupation – in which ethnic and racial minorities are over-represented – are two to three times more likely than those in the highest stratum to have a mental disorder, and ethnic and racial minorities are more likely to experience inequality that includes greater exposure to racism and discrimination, violence, and poverty. “Mistrust of mental health services is… reinforced by evidence, both direct and indirect, of clinician bias and stereotyping.”

The situation in Australia, in terms of equitable access to high quality mental health services, is not dissimilar (Stolk, Minas et al, 2008). There is an absence of adequate population epidemiological data, and a failure to include the necessary cultural variables in national mental health data collections. There is also a lack of quality data on clinical and social outcomes of contact with services. This limits our understanding of mental health and illness in immigrant and refugee communities, and of their observed patterns of under-utilisation of mental health services. Finally, there is a notable under-representation of immigrant and refugee communities in mental health research (Minas, Kakuma et al, 2013).

As in health, the cultural diversity of modern societies has generated a growing awareness of, and debate about, the place of culture in the legal system and in expert evidence (Golding, 2002). Much of what has been concluded in the Surgeon General’s report on culture and mental illness is broadly applicable also to the law and its institutions. Cultural minorities are more likely to face the social and economic disadvantages, such as unemployment and discrimination, that are associated with more frequent and more negative contacts with police and with the justice system. Rates of offending, conviction and detention vary widely among different cultural groups in Australia (Ashkar and Kenny, 2008), the USA (Hicks 2004) and the UK (Ajaz, Owiti et al, 2014). The quality of information on frequency and nature of contact of immigrants and refugees with the justice system, and the outcomes of such contacts, is very poor.

[53.120] Transcultural psychiatry

Transcultural psychiatry is also known as cross-cultural, multicultural or cultural psychiatry (Kirmayer and Minas, 2000). These terms refers to a sub-discipline of research and practice within psychiatry that is concerned with relationships between culture, mental health and mental illness, and mental health services. There is a growing body of knowledge in the field of transcultural psychiatry, and there exist several associations and societies for the advancement of the field, such as the Section of Social and Cultural Psychiatry of the Royal Australian and New Zealand College of Psychiatrists, the Transcultural Psychiatry Section of the World Psychiatric Association, and the World Association for Cultural Psychiatry. Units such as the Victorian Transcultural Mental Health Unit in Melbourne, similar such organisations in other states, and the national program Mental Health in Multicultural Australia are involved in transcultural psychiatric research, teaching and service development.

[53.130] Communication

Communication is complex. It involves achieving consensus in meaning between communicators who may approach their encounter from different perspectives, with different
communicative styles and behaviour, and differences in representing meaning in words and actions. There are cultural and situational influences, variations in intimacy, trust and power in relationships, as well as many other factors that can influence the quality of communication (Klimidis and Minas 2010).

Adequate communication is obviously essential to any psychiatric assessment and treatment. Language is critical, but non-verbal communication is also very important. Doctor-patient communication may be difficult even when the doctor and patient speak the same language. One of the problems is that they do not always, in fact, speak the “same language”. The same words used by patient and doctor frequently have different meanings for them. If their respective meanings are not examined and clarified, there is room for major interpretive error and miscommunication. In a clinical encounter where clinician and patient do not have a common language, adequate communication is especially difficult, even when an interpreter is present.

Doctors, in clinical and forensic evaluations, ask questions of patients, receive responses, and interpret those responses to indicate the presence or absence of illness and to make judgments about diagnosis, disability (including capacity) and prognosis (including risk of self-harm or violence). It is not standard practice for clinicians to explore whether the meanings of questions asked and answers given are the same for doctor and patient. The neglect of this issue of meaning frequently leads to errors of interpretation. A medical or legal interpreter who is not fluently bilingual would be regarded as incompetent. A clinician who is carrying out a cross-cultural clinical assessment and is not “fluently bicultural” faces great difficulties. Although such difficulties can, to some extent, be overcome, this requires special attention by the doctor to the difficulties of interpretation of the patient’s experience.

Regarding non-verbal communication in the cross-cultural context, the same general issues apply. Doctors and the courts frequently attach considerable weight to their observations of a person’s non-verbal behaviour. On the basis of such observations conclusions are drawn about such matters as the person’s veracity, exaggeration of symptoms and disability. For instance, in many cultures direct eye contact is taken as impolite or aggressive; however in Anglo-Celtic cultures avoidance of eye contact is frequently interpreted as evidence of evasiveness or anxiety. When such conclusions are given in evidence by an expert witness, the expert may be questioned about their knowledge of non-verbal behaviours in the person’s cultural group and the proper interpretation of such behaviours.

**[53.140] The interpreted interview**

A skilful interpreter can provide the necessary bridge between clinician and non-English speaking patient. However, it is still a too common practice in many clinical settings to use untrained interpreters, such as family members, often children or adolescents. This practice, which demonstrates a gross underestimation of the difficulty of the interpreting task, results in serious problems in assessment and it disadvantages the patient.

Choolun (Choolun, 2009) provides an excellent account of court interpreting as an important issue in the proper functioning of Australia’s legal system. Although Australian common law does not include a right to an interpreter for parties in dispute, witnesses or defendants, in several states there is a statutory right to an interpreter. Often courts have limited the involvement of interpreters to circumstances where the English proficiency of relevant participants in the legal process is demonstrably inadequate, a practice that warrants, and that has received, criticism. There is variation across states and territories in the circumstances in which such a right may be exercised. Beyond such statutory provisions whether an interpreter may be called is at the discretion of the judicial officer.

In criminal cases there is a general understanding that the legitimacy of the justice system depends on the ability of all who are subject to it to comprehend and communicate at an
adequate level. The judgment of what is adequate, however, depends on the judicial officer and the advocates. In civil proceedings there is much more variation in practice. The participation of an interpreter in proceedings no doubt complicates many elements of those proceedings, as it does in medical settings.

The capacity to work effectively with interpreters is a skill which is not adequately taught to clinicians, although guidelines and the necessary training are available (Miletic, Piu et al, 2006). The presence of the interpreter inevitably changes the nature of the interaction between patient and clinician (Klimidis and Minas, 2010). A number of deviations from the ideal pattern of triangular interaction have been identified (Baker and Briggs, 1975). These include:

- ethnic over-identification between patient and interpreter;
- over-identification between interpreter (who may wish to distance himself or herself from the culture of origin or from an “unsophisticated” compatriot) and clinician;
- interpreter dominance;
- rejection of interpreter by patient, eg when interpreter and patient come from different “factions” within an ethnic community;
- distorted understanding of actions, thoughts and feelings by all three participants;
- emotional or cultural relatedness combined with restricted or blocked verbal comprehension; and
- verbal understanding combined with restricted or blocked emotional or cultural relatedness.

A properly conducted interpreted interview will generally take twice as long to carry out as an interview in which patient and clinician speak the same language. The fact that there is no provision made for this in schedules of payment for forensic evaluation is a significant problem which disadvantages the non-English speaking patient. A clinician who has performed an assessment with the assistance of an interpreter ought to be asked about the duration of the assessment interview, the quality of the interpreting and about her/his level of experience and skill in working with an interpreter.

Major impediments to the participation of skilled interpreters in legal proceedings include the manifestly inadequate numbers of interpreters across a very wide array of languages and the fact that it is not the responsibility of the court to provide an interpreter.

[53.150] Do people from different cultures experience and express illness in different ways?

Clinical experience and an expanding body of research demonstrate that people from different cultures experience and express psychological distress and psychiatric illness in different ways. The early work of Zborowski (Zborowski, 1952) and others on pain in various ethnic groups, the World Health Organisation (WHO) multicentre studies of schizophrenia (Leff, Sartorius et al. 1992) and the work of Kleinman (Kleinman, 1988) Marsella (Marsella and White, 1982) and others on cross-cultural aspects of depression are examples of this.

An illness episode begins with the perception that something is wrong, with perceived physical or psychological dysfunction, pain or discomfort, or disturbed relationships or behaviour. The perception of such troubles, their naming and the evaluation of their meaning for the person are cognitive processes which are deeply embedded in a complex family, social and cultural context. Illness is constructed from popular medical culture, as the sufferer draws on available theories, beliefs and networks of meaning to interpret and communicate his or her distress.
Each culture provides distinctive interpretations of human suffering and of healing. Each provides explanatory models of illness, models of human physiology, and personality, and forms of dealing with illness, grounded in a particular cosmology, epistemology and set of beliefs and values. It is not that the illness experience is unrelated to or independent of underlying physical and psychological disturbance. Rather, it is that the reality of illness for an individual is not a simple and direct product of disease processes and is not reducible to disease processes. Such personal construction of the illness experience occurs in every social group.

A patient’s degree of distress, illness behaviour, pattern of help-seeking, and compliance or non-compliance with recommended treatments are all related to his or her explanatory model (Kleinman, 1988). A person’s level of motivation, the extent of engagement in treatment and the extent of disability will also be influenced by his or her beliefs about and understanding of the illness (Minas, Klimidis et al., 2007).

Patients’ models, and popular explanations for illness generally, deal with several or all of the following questions:

- What is the cause of the illness?
- Why has it come on now?
- How has the cause produced the illness?
- What is the likely course and outcome?
- What needs to be done to solve the problem?
- Who needs to do it and who should be involved?

The way in which these questions are answered constitute the patient’s explanatory model of her/his illness, although the model may not be fully articulated and may be inconsistent or even self-contradictory. Such models may reflect social class, cultural beliefs, education, occupation, religious background, and past experience of illness and health care. An important difference between patients’ and clinicians’ explanatory models is that patients’ models focus on the total illness experience and its consequences, whereas clinicians’ models are more likely to focus on the construct of underlying disease.

The clinician’s interpretive task is diagnosis and explanation, the identification of a disease entity which provides a causal explanation for the clinical phenomena. Some of the professional models of psychiatric disease in our own culture are: biomedical conceptions; behaviourist models based on learning theories; and, psychodynamic conceptions of illness causation. Professionals from each of these medical subcultures will, when confronted by the same patient, construct a different explanatory model. They are looking at the patient’s illness through different epistemological lenses. The clinician’s explanatory model for illness is as much a cultural construct as are the explanatory models which are meaningful to patients. It is obvious that these professional models of illness change over time, as evidence and knowledge accumulate but also as the broader culture changes (Friedman and Howie, 2013).

Needless to say, the explanatory models of mental illness that are meaningful to the legal system are again different, and also the product of a historical process and a legal cultural tradition. Communication difficulties between doctors and lawyers may be conceptualised as a specific instance of the general problems of cross-cultural communication.

Common ways in which illness may be interpreted by the sufferer include illness as threat, punishment, weakness, relief, loss or challenge (Nurcombe and Gallagher, 1986). The likely interpretations of an illness experience will depend on the values and beliefs held by the patient, which will depend largely on cultural factors.
Illness as threat

When a patient regards illness as threat, the threat may be to everything that the patient values. The threat may be met with denial, minimisation, passivity and acceptance, helplessness, fear, anger and hostility, and over-assertiveness.

Illness as punishment

Illness perceived as punishment may be linked to religious beliefs or to various socially non-sanctioned behaviours (for example the development of a sexually transmitted disease). Such an interpretation may be associated with anger and hostility, a sense of injustice or shame.

Illness as weakness

Illness as weakness may be associated with shame, secretiveness and illness-denying behaviours.

Illness as relief

Illness as relief is associated with a reduction in anxiety in relation to other life problems. The illness, and the sick role accompanying it, may absolve the person from burdensome family, social and work responsibilities. It may also present an opportunity for financial gain.

Illness as irreparable loss or damage

Where illness is interpreted as irreparable loss or damage, the circumstances in which the illness occurred, and the responsibility attributed for its development, will have a profound impact on the response to that illness. For example, illness that has occurred in the workplace may lead to extreme anger, hostility and rage, and possibly to severe depression and to suicidality.

Illness as a challenge or opportunity

Illness as challenge or opportunity may result in a re-evaluation of life priorities and a focus on those aspects of life considered by the sufferer to be truly important. This may cast the illness in a positive rather than a negative light.

Beliefs, illness and response to treatment

There is extensive evidence that we should take into account a patient’s beliefs in evaluating the presence and severity of illness and disability, and in predicting a patient’s response to treatment (Hsiao, Klimidis et al, 2006; Hsiao, Klimidis et al 2006 Klimidis, Hsiao et al 2007; Minas, Klimidis et al 2007).

In the realm of health and illness the person who believes he or she is seriously ill or disabled will, not surprisingly, behave in a manner that is consistent with the belief. However, particularly when such beliefs are held in the context of criminal or civil legal proceedings, there is a great readiness to regard such beliefs as counterfeit or as indicating the presence of “personality disorder” or some other pejorative label, unless there is an “objective” reason or explanation for them, such as an X-ray picture or some other similarly persuasive artefact. Even when it is accepted that the person holds such a belief, there is a reluctance to accept that the belief can contribute substantially to suffering and incapacity.

This situation arises commonly in the courtroom when a person is reporting severe distress and disability after having suffered a relatively trivial physical injury. It is in such a situation that
one hears expressions of incredulity by counsel that such a trifling injury could possibly cause such catastrophic suffering and disability. A belief that there is a necessary connection between the severity of the injury and the extent of suffering and disability is a culturally derived belief in linear causality and in the necessary correlation between the severity of physical pathology and symptoms, and between symptoms and disability. Clinical experience and a body of research evidence concerned with pain teach the unsustainability of such a belief (Bates and Rankin-Hill, 1994; Honeyman and Jacobs, 1996; Lasch, 2000; Kirmayer, 2008).

Moreover, it is worth reflecting on the reduced prospects of rehabilitation available to a person if education, language and skills restrict access to high quality mental health services or to opportunities for alternate employment (Stolk, Minas et al, 2008).