

9-1-1999

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Recommended Citation

Nicole A. King, *Role of Culture in Psychology: A Look at Mental Illness and the Cultural Defense, The*, 7 Tulsa J. Comp. & Int'l L. 199 (1999).

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THE ROLE OF CULTURE IN PSYCHOLOGY: A LOOK AT MENTAL ILLNESS AND THE “CULTURAL DEFENSE”

Nicole A. King[†]

“The survival of mankind will depend to a large extent on the ability of people who think differently to act together.”¹

I. INTRODUCTION

The world we live in is no longer governed solely within our own borders. Internal decisions and measures are of course implemented, but not without first considering their international ramifications. As the world becomes a more global place, the role that culture plays in our society can no longer be ignored. Matters that transcend across borders affect all areas of life. International treaties and customs of international law are respected and followed by numerous governments, companies conduct business overseas and expand into foreign markets, and travel and migration expose individuals daily to new cultures and values.

Understanding and respecting culture is crucial. It is no surprise that characteristics of human behavior are to an extent dictated by their social and cultural background.² “[B]eliefs, attitudes, values, and lifestyles differ in striking ways across social classes, ethnic groups, religions, and nations.”³ Governments and businesses have recognized this imperative factor in establishing foreign relations and venturing abroad, however, has this understanding extended to the area of mental health? And if so, what legal ramifications come into play when cultural factors are in fact

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1. GEERT HOFSTEDÉ, CULTURE’S CONSEQUENCES: INTERNATIONAL DIFFERENCES IN WORK-RELATED VALUES, [5 Cross-Cultural Research and Methodology Series] 8 (1984).

2. MARSHALL H. SEGALL ET AL., HUMAN BEHAVIOR IN GLOBAL PERSPECTIVE: AN INTRODUCTION TO CROSS-CULTURAL PSYCHOLOGY 67 (1990).

3. *Id.*

recognized?

It has been projected that people of color—African Americans, Hispanic or Latino Americans, Asian Americans, and Native Americans—who constitute 18% of the U.S. population,⁴ will increase to 47% by the year 2050.⁵ “As cultural diversity steadily increases in the United States, our scientific understanding of social and psychological functioning and mental health must be based on knowledge of these varied populations and their relations with each other.”⁶ The rise of multiculturalism exemplifies “both a challenge and an opportunity for behavioral science to expand its knowledge foundation.”⁷

This article addresses the role of culture in an area that has only recently begun to recognize its importance. Part Two serves as an introduction to cross-cultural psychology, the newest field of psychology, and is designed to introduce the reader to this emerging field of study that goes hand in hand with extending cultural awareness across borders. An analysis of culture and its implications on mental illness are addressed in Part Three, including cultural beliefs concerning the nature of mental illness and the diagnoses and expression of symptoms across cultures and sub-cultures. In Part Four, how the Fourth Edition of the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) examines culture is addressed. Finally, Part Five looks at the future importance of observing culture with respect to mental issues in the legal setting. Additionally legal ramifications of the “cultural defense” are addressed. This article is by no means an attempt to educate the reader on the complex field of psychology, rather it is written to stress the importance of culture in an area that is slowly beginning to recognize that in which numerous areas have known for years.

II. CROSS-CULTURAL PSYCHOLOGY

“To study the values of others is to search for universal values, motives that transcend cultural differences in behavior settings.”⁸

4. Numbers reflect projections conducted in 1996.

5. Basic Behavioral Science Task Force of the National Advisory Mental Health Council, *Basic Behavioral Science Research for Mental Health: Sociocultural and Environmental Processes*, AM. PSYCHOLOGIST, July 1996, at 725. Racial and ethnic diversity is increased yearly in the United States by immigrants and refugees from many parts of the world.

6. *Id.*

7. *Id.* at 722.

8. SEGALL ET AL., *supra* note 2, at 215.

A. *Evolution of Cross-Cultural Psychology*

Cross-cultural psychology is one of the latter developed fields of psychology, and is referred to as "the scientific study of the ways in which social and cultural forces shape human behavior."⁹ This field of psychology "seeks to broaden our vision and deepen our insights."¹⁰ The underlying theme of cross-cultural psychology is to "understand how factors in the natural and man-made environments influence our behavior."¹¹

As a discipline, cross-cultural psychology was not born until the 1960's.¹² Only recently has psychology included concern for culture; however, the need for a global perspective has been recognized.¹³ "Psychologists in various cultures are now aware of the discipline's culture-boundedness and the inappropriateness of many psychological theories and findings when applied to particular societies."¹⁴ "Cross-cultural psychologists try to determine how sociocultural variables influence human behavior."¹⁵ The ultimate goal for these psychologists is "always to discover how culture and individual behavior relate."¹⁶

Workers in the field of transcultural psychiatry have suggested that some symptoms cannot be universally accepted as signs of abnormality due to the differences in degree of their acceptability from one culture to the next.¹⁷ For example, an African American male "committed to a mental hospital and thought to be suffering from private delusions was discovered by a psychiatrist to belong to a local religious cult of which his ideology was characteristic."¹⁸ In a second illustration,

an elderly Neapolitan cobbler comes to a hospital clinic with a rambling story told in broken English. His account wanders from headaches and listlessness to an old woman who has made him sick. He is referred to the neuro-psychiatric department with the comment: *Ques-*

9. *Id.* at 3, 349.

10. *Id.* at xii.

11. *Id.* at 262.

12. *See id.* at 39.

13. The composition of the six-volume work entitled *Handbook of Cross-Cultural Psychology* (Triandis et al. ed.) (1980) and *The Handbook of Cross-Cultural Human Development* (Munroe, Munroe & Whiting eds.) (1981) made a remarkable impact on culture and have made it apparent that it is no longer necessary to preach the need for a global perspective in psychology.

14. SEGALL ET AL., *supra* note 2, at 46.

15. *Id.* at 48.

16. *Id.*

17. *See* IHSAN AL-ISSA & WAYNE DENNIS, *CROSS-CULTURAL STUDIES OF BEHAVIOR* 500 (1970).

18. *Id.* at 474.

tion of psychosis. Examination brings out little more than irrelevant detail about the enemy and how long she has wished him ill, and why, and how she makes his head hurt. There is all the first indication of persecutory delusion. The man is told to come back with an interpreter. He returns with a fluent Italian-American who explains apologetically that the old man is illiterate and believes the woman is a witch and has cast the evil eye on him. The apparent delusion dissolves into a bit of superstition typical generally of the lower orders of Neapolitan society. What is a normal belief there is a psychotic symptom in one of our hospitals. If the writer or reader of these lines were to harbor the same conviction as this Neapolitan, it would be *prima facie* evidence of mental derangement. . . .¹⁹

1. Psychopathology²⁰

Psychopathology is the concern of "the manifestations of psychologically disturbed abnormal behavior on a worldwide basis."²¹ The study of psychopathology began in the early twentieth century as the study of psychological disturbance in alien cultures, which provided nothing more than a "quaint catalogue of symptoms and syndromes never or rarely seen at the primary sites of Western psychiatrists' professional activity."²² This peripheral role contrasted greatly from the West, where "description, investigation, and treatment of psychological disorder within Western cultures quickly evolved into a significant, if contested, source of information for the understanding of complex human behavior, of difficult personal decisions and choices, and of their consequences."²³

In relation to culture, this "worldwide behavior" arose "rather casually and inconspicuously."²⁴ Developments such as distribution and modes of expression of disorders observed in different cultures and reports of culture-specific patterns of psychological disturbance encountered outside European and Western settings, "marked a direction in transcultural psychiatric effort that has not been fully overcome to this day: the equating of the transcultural with the exotic and the study of cultural effects upon psychopathology in the form of their most dramatic and conspicuous manifestations."²⁵

19. *Id.* at 474-475.

20. Also variously designated as ethnopsychiatry, transcultural psychiatry, comparative psychiatry, or psychopathology across cultures.

21. 6 HARRY C. TRIANDIS & JURIS G. GRAGUNS, *HANDBOOK OF CROSS-CULTURAL PSYCHOLOGY: PSYCHOPATHOLOGY* 1 (1980).

22. *Id.*

23. *Id.*

24. *Id.* at 102.

25. *Id.* at 102-103.

Anthropologists have also contributed to the investigation of psychopathology across cultures.²⁶ Their contributions have been characterized as twofold: 1) they enriched the documentation of psychopathology in the natural milieus of its occurrence, and 2) they raised the question concerning the applicability and nature of any etic standards of psychopathology to all human groups.²⁷ More specifically, they asked: "Is psychopathology, as a matter of definition, infrequent in any cultural milieu; or can the modal characteristics of the members of a culture be realistically and meaningfully be described by such terms as 'neurotic,' 'paranoid,' or 'hysterical'?"²⁸ Both psychology and anthropology have focused on "pathological phenomena within their respective contexts; psychiatrists have focused upon clinical settings and anthropologists have focused upon cultural milieus."²⁹

In looking at psychopathology, penetrating questions exist such as: "to what extent—if any—is the model of psychiatric classifications and diagnosis historically evolved in Paris, Leipzig, and New York appropriate for the description and comparison of psychopathologists across the world?"³⁰ Though answering such types of questions has presented a clash of opinions,³¹ differing views have come together to acknowledge that "psychopathology can be neither fully described nor explained unless the social transactions in which the disturbed person participates with other members of his community are taken into account."³²

III. CULTURE

A. Defining Culture

Culture has been defined a number of ways.³³ A consensus of an-

26. 6 TRIANDIS & GRAGUNS, *supra* note 21, at 103.

27. *See id.*

28. *Id.*

29. *Id.* at 104.

30. *Id.* at 2.

31. 6 TRIANDIS & GRAGUNS, *supra* note 21, at 2-3.

32. *Id.* at 3.

33. Numerous definitions include:

- 1) encompassing "the learned behaviors, beliefs and attitudes that are characteristic of a particular society or population";
- 2) "the shared customs of a society";
- 3) "continuous, cumulative, and progressive";
- 4) "first of all an abstraction, in the sense that it is merely a convenient label for a very large category of phenomena. It designates knowledge, skills, and information that are learned. Further, it is social knowledge, in the sense that it is taught to and learned by many individuals and is thus shared. Since it tends to persist over generations, it is more or less adaptive. Finally, it tends to be integrated; that is to say, its contents tend to be mutually reinforcing";

thropological definitions states that "culture consists in patterned ways of thinking, feeling and reacting, acquired and transmitted mainly by symbols, constituting the distinctive achievements of human groups, including their embodiments in artifacts; the essential core of culture consists of traditional (i.e. historically derived and selected) ideas and especially their attached values."³⁴ While defined variously and ambiguously, culture is used as if its meaning were clear. Regardless of the definition, however, it has been apparent that culture

[i]ncludes the products of the behavior of others, especially others who preceded us. It connotes a set of social stimuli that to a very great extent have existence prior to us. Put very simply, culture is already there for all of us as we begin life. It contains values that will be expressed and a language in which to express them. It contains a way of life that will be followed by most of us, who through most of our lifetimes will unquestioningly assume that there is no better. . . . Culture also includes language, music, and art forms. It includes preferences, appetites, and aversions. It includes rules, norms, and standards. It includes hopes and fears, beliefs and attitudes, convictions and doubts, at least to the extent that such are shared, inculcated, and transmitted from people to people. To be considered part of culture, anything, material or symbolic, need only be of human origin.³⁵

Despite the fact that culture is discernable as a concept of abstraction, culture plays a substantial role in influencing human behavior.³⁶ Utilizing this concept allows us to categorize and explain many important differences that exist in human behavior that years ago were "erroneously attributed to ill-defined biological differences."³⁷

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- 5) "the totality of whatever all persons learn from all other persons. Anything one person learns from another, then, is an element of culture, and it is recognized as such to the extent that it is adaptive and persistent over generations";
 - 6) "[c]ultures have no existence except as they are manifest in the behavior of the people who constitute them. A culture is only an abstraction based on the communalities displayed in the behavior of a given community of people." SEGALL ET AL., *supra* note 2, at 26.

34. HOFSTEDE, *supra* note 1, at 21.

35. SEGALL ET AL., *supra* note 2, at 26-27.

36. *See id.* at 27.

37. *Id.*

Social, cultural, and environmental forces all profoundly affect our mental health.³⁸ These forces shape who we are and how we function from day to day. “The culture we belong to, the neighborhood we live in, the demographic composition of our community, and the opportunities and frustrations of our work environment”, encompassed with powerful factors such as “whether we are rich or poor, native-born Americans or immigrants or refugees, and residents of a city or a rural area”, all interact “with our individual biological and psychological characteristics [to] color our experience, limit or enhance our options, and even affect our conceptions of mental illness and mental health.”³⁹

B. The Influence of Culture on the Course of Mental Illness

“The norm of one culture is a sign of nervous pathology in the other.”⁴⁰ As we remember the Neapolitan cobbler, we are able to better understand the importance of culture and the role it plays in the area of mental illness. The illiterate cobbler was lucky—he was able to return with a translator that could explain the superstitious norm of the “evil eye.” But what about the individuals who have no translator, no friend that is knowledgeable in their culture? Will their case turn out like the man who was actually committed to a mental hospital for displaying norms consistent with his ideology?⁴¹ These examples are only two cases of many that are consistently seen in clinical practice.⁴² Fortunately, studies are now highlighting the importance of multivariate international research.⁴³

The American Psychiatric Glossary defines mental illness⁴⁴ as:

[a] behavioral or psychological *syndrome* that causes significant distress (a painful symptom) or disability (impairment in one or more important areas of functioning), or a significantly increased risk of suffering death, pain, or an important loss of freedom. The syndrome is considered to be a manifestation of some behavioral, psychological, or biological dysfunction in the person (and in some cases it is clearly secondary to or due to a *general medical condition*). The term is not

38. See Basic Behavioral Science Task Force of the National Advisory Mental Health Council, *supra* note 5, at 722.

39. *Id.* at 722.

40. AL-ISSA & DENNIS, *supra* note 17, at 475.

41. See discussion *supra* pp. 3-4. I am not suggesting the requirement of all medical staff to be trained in cultures other than their own. I am merely pointing out the importance of culture and the ramifications on the patient if those assessing the individual do not take this factor into account.

42. See AL-ISSA & DENNIS, *supra* note 17, at 474.

43. See generally, 6 TRIANDIS & GRAGUNS, *supra* note 21.

44. Mental illness and mental disorder are used interchangeably.

applied to behavior or conflicts that arise between the person and society (e.g., political, religious, or sexual preference) unless such conflicts are clearly an outgrowth of a dysfunction within that person. In lay usage, "emotional illness" serves as a term for mental disorder, although it may imply a lesser degree of dysfunction, whereas the term "mental disorder" may be reserved for more severe disturbances.⁴⁵

Compelling evidence exists that shows major psychiatric disorders are panhuman phenomena. "However, the way any illness is experienced is clearly linked to the social context in which the individual lives."⁴⁶ For example, a recent study conducted by the World Health Organization (WHO) found a better outcome among patients with schizophrenia among patients in developing countries.⁴⁷ The study supported the earlier findings of its nine-country study indicating that people diagnosed with schizophrenia "fare far better in developing countries than in North America and Europe."⁴⁸

"It has long been thought that major mental illness is almost inevitably chronic and incurable."⁴⁹ Despite this belief, research has revealed that many severe forms of mental illness such as depression, manic-depressive illness and schizophrenia have remarkably dissimilar advancements, "ranging from complete recovery through patterns of waxing and waning, to nearly complete disability."⁵⁰ Social and cultural factors are now being explored to determine how these factors amplify or attenuate symptoms and disability.⁵¹ The following lines of study provide important clues to answer this inquiry.

1. Cultural Beliefs Concerning the Nature of Mental Illness

"[C]ultural beliefs about the nature of mental illness influence the community's view of its course and treatment,"⁵² thus actual duration of the illness may be affected by these views.⁵³ Western views toward men-

45. AMERICAN PSYCHIATRIC GLOSSARY 81-82 (7th ed. 1994).

46. Harriet P. Lefley, Ph.D., *Foreword*, 34 COMMUNITY MENTAL HEALTH J., 457 (1998).

47. See Basic Behavioral Science Task Force of the National Advisory Mental Health Council, *supra* note 5, at 722.

48. *Id.* This earlier study was published by the WHO in 1979. Among its findings: 58% of the patients in Nigeria and 51% of the patients in India were reported as being in full remission two years after their first treated episode of schizophrenia. In Denmark, in contrast, only 6% were reportedly in full remission at two-year follow-up. See *id.*

49. *Id.*

50. *Id.* at 722-723.

51. See *id.* at 723.

52. Basic Behavioral Science Task Force of the National Advisory Mental Health Council, *supra* note 5, at 723.

53. See *id.*

tal illness often contrast sharply with many countries, as those societies have not yet accepted the West's common view of institutionalism.⁵⁴

a. Attitudes toward Mental Illness

It is in more primitive societies, where cultural and social variables vary little, that we see greater tolerance of the mentally ill than is usually witnessed in the West.⁵⁵ Rather than institutionalize patients, the mentally ill are enabled to function in the community.⁵⁶ Nigeria, among Africans of various social and cultural backgrounds, exercises communal care and support of the mentally ill. "Work responsibilities are simple and non-demanding and members of the extended family are ready to take over when an individual is unable to carry on with his work."⁵⁷ Community attitudes allow the majority of African mental patients, who remain at some sort of functioning level, "to live as tolerated members of the general community."⁵⁸

This same acceptance of mentally ill individuals is seen amongst the Hutterite sect,⁵⁹ although the Hutterites are not primitive in the ethnographic sense.⁶⁰ The Hutterite culture stresses "religion, conformity, and cooperation among its members rather than aggression and competition."⁶¹

Hutterites believe in the communal ownership and control of all property. . . . Hutterites expect the community to assume a great deal of responsibility for each member. It is the community which buys clothing, doles out pocket money to each person, and pays a traffic ticket. No wages are paid. . . . If he is sick, the colony pays for all necessary care.⁶²

54. *See id.*

55. *See AL-ISSA & DENNIS, supra* note 17, at 455. A Western movement in the 1970s began to encourage patients to remain part of the community through practices of liberal hospital policy and the use of outpatient treatment and day hospitals. *See id.* at 549.

56. *See id.* at 549.

57. *Id.*

58. *Id.*

59. The Hutterite sect originated in Germany in 1528. Between 1874 and 1877, its members migrated to the United States from southern Russia. Settling in eastern South Dakota, these immigrants are currently found throughout the Dakotas, Montana, and the Prairie Provinces of Canada. *See id.* at 445.

60. *See AL-ISSA & DENNIS, supra* note 17, at 447. In contrast to American Indian tribes or other folk societies studied by anthropologists in cross-cultural studies, the Hutterite sect is more similar to the larger American scene.

61. *Id.* at 445.

62. *Id.* at 447.

Recognizing the Hutterite culture, we are able to see how these values and beliefs affect mental health. While not immune from mental illnesses known in the West, "cultural and social factors [are] shown to be associated with the relative frequency of various disorders."⁶³ Similar to the African community, the Hutterites "provide an atmosphere where emotionally disturbed members are accepted and encouraged to function within the limits of their handicaps."⁶⁴ Hutterite practices ameliorate "the traumatic social consequences of mental disorders for the individual patient, his family, and his community."⁶⁵ For example, studies showed:

[t]he onset of a symptom of disorder served as a signal for the entire community to demonstrate support and love for the patient. He was generally approached with considerable sympathy and understanding. Mentally ill persons were treated as "ill" rather than "crazy." . . . Patients were encouraged to participate in the normal activities of their family and community. . . . Rarely were their afflictions regarded as a social disgrace.⁶⁶

The Hutterite way of life provides an atmosphere where mentally ill individuals are encouraged to get well or to function in a socially accepted manner.⁶⁷ The studies also found that

[t]here seemed to be little need for the severely restrictive care which is so characteristic of many mental hospitals. This fact supports the theory that many of the severe disturbances of some psychoses and personality disorders are not an inherent attribute of these conditions. At least in part they seem to be a consequence of the methods of handling patients used by hospitals, families, and communities.⁶⁸

Examining the Hutterite culture serves as "a good example of the implications of values and beliefs of a society for mental health."⁶⁹

In contrast, apprehension toward individuals with mental illness is existent in Beijing and Hong Kong.⁷⁰ Chinese people reported that they

63. *Id.* at 446. Hutterites were found to have a high rate of depression and a low rate of schizophrenia, reversing the pattern usually seen in the West. *See id.*

64. *Id.*

65. AL-ISSA & DENNIS, *supra* note 17, at 453.

66. *Id.*

67. *See id.*

68. *Id.* at 453.

69. *Id.* at 446.

70. *See* Cynthia Fan, Ph.D., *A Comparison of Attitudes Towards Mental Health Illness and Knowledge of Mental Health Services Between Australian and Asian Students*, 35 COMMUNITY MENTAL HEALTH J., 48 (1999). Chinese people were surveyed in Beijing and

were scared of individuals with mental illness “and avoided contact with them, regarding them as a risk to the community, maintaining that they should remain in [a] hospital for a long time.”⁷¹ While argued that Chinese people are unclear about their understanding of mental illness,⁷² the Chinese mentality reflects a part of their culture that must be recognized. “People with mental illness were regarded with superstition and prejudice, and the causes of mental illness were attributed to ghosts, punishment for bad behaviour [sic] of ancestors or bad thoughts.”⁷³

Cross-cultural literature concerning public attitudes toward mental illness has found that “within developing countries, such as Costa Rica, tolerance and acceptance of the mentally ill is positively correlated with higher levels of modernization . . . and this finding is paralleled by reports of greater acceptance of the mentally ill by people higher in educational attainment in developed countries.”⁷⁴

Another global explanation for the differences in attitudes may be reflected by “the dominant conceptions concerning the nature of such disturbance within the mental health professions of the respective countries.”⁷⁵ A series of comparisons between Germany and the U.S. illustrate the importance of this source of differences.⁷⁶ “Germany tended to regard mental illness as a long-term state—to be cured, if at all, by expert intervention. By contrast, Americans emphasized environmental stress, malleability of behavior, and the importance of the patient’s own efforts in overcoming the disorder.”⁷⁷

Though future work is necessary, such findings might be heuristically useful both intraculturally and cross-culturally “in relating attitudes toward psychological disorder to sets of broadly comparable dimensions.”⁷⁸

b. Attitudes toward Treatment

Hong Kong. It should be noted that although the studies suggest that many Chinese people hold stigmatized attitudes toward mental illness, “these studies did not compare the attitudes of Chinese with other ethnic groups and so it is unclear whether Chinese attitudes toward mental illness are different from other ethnic groups.” *Id.* It is in this paper that attitudes of other ethnic groups will be reflected.

71. *Id.*

72. *See id.*

73. *Id.*

74. 6 TRIANDIS & GRAGUNS, *supra* note 21, at 142. This research, however, presents a paradox because the results available do not support the motion that developed countries are the most tolerant toward the mentally ill.

75. *Id.* at 143.

76. Participants included mental hospital personnel, segments of the general public, and patients.

77. 6 TRIANDIS & GRAGUNS, *supra* note 21, at 143.

78. *Id.* at 144.

"Cultural factors (including primary language, national and regional origin, religion, ethnicity, and socio-economic status) often affect whether a patient seeks medical care, the type of problems which are presented, compliance, and the care which is obtained."⁷⁹ Cultural knowledge is essential in epidemiological studies within a community.⁸⁰ However, it is the culture which not only "determines the acceptability, the success or failure of a particular treatment orientation,"⁸¹ but also "either permits or hinders the readiness of the relatives to adjust to the sick person and his emotional needs."⁸² As Dr. T.A. Lambo, a psychiatrist who started a therapeutic village in Nigeria,⁸³ stressed:

one of the most important cultural factors which influences or determines the nature of treatment is community attitudes. Community attitudes towards emotional disorder, especially in cultures outside the West, have been found to be complex. . . . Such attitudes may considerably influence what action the patient takes about his disability, and even the content and evolution of his neurotic symptoms. They may impede free communication of his emotional (inner) experiences without the knowledge of which proper diagnosis of his condition is impossible.⁸⁴

Dr. Lambo's experience in parts of Africa revealed the greater the confidence of the community with respect to both the treatment they could obtain and in the people who would treat them, "the more readily [they would] come forward for treatment or encourage their ill relatives to do so."⁸⁵

79. Wendy L. Thompson, M.D., et al., *Taking Care of Culturally Different and Non-English Speaking Patients*, 20(3) INT'L. J. PSYCHIATRY IN MED. 235, 236 (1990).

80. See AL-ISSA & DENNIS, *supra* note 17, at 549.

81. *Id.*

82. *Id.*

83. Dr. Lambo has successfully integrated local therapy with modern psychiatric treatment, providing him with the opportunity to both evaluate local treatment and make his medical treatment acceptable to patients. See *id.* at 548. Dr. Lambo "has divided psychiatric care between himself and the local Ju-Ju medicine men who are employed on his hospital staff." *Id.* at 548. Dr. Lambo gives symptomatic treatment, while the Ju-Ju men are responsible for dealing with causes of abnormality, such as magic, possession and evil eye. See *id.* His approach is "an attempt to avoid the negative effects of institutionalization as known in the West." *Id.* at 549.

84. AL-ISSA & DENNIS, *supra* note 17, at 550.

85. *Id.*

Under-utilization of mental health services is common throughout many societies. In many cultures, including Southeast Asia, individuals are "ashamed to admit to psychiatric problems in themselves or in family members."⁸⁶ Despite being from different cultural and ethnic backgrounds, many patients are reluctant to bring up psychiatric issues or illnesses. Reasons include "fear of having their beliefs belittled, feeling that they might be insulting their physician or other health care personnel, potentially compromising their care, or appearing unappreciative of the care they are receiving."⁸⁷

Among Israelis, the type of care obtained depends on the patient's background. "Western" or "modern" Israelis "tend to utilize a widespread network of support, including health care providers."⁸⁸ In contrast, Israelis from an "Oriental" or "traditional" background primarily utilize the support of family.⁸⁹

Other components contributing to the under-utilization of health care treatment include more specific beliefs and norms of each particular culture. For example,

[s]ome cultures ignore preventive measures and do not take medications because they believe that medical procedures, such as immunization, and following a prescribed medical regimen have no effect on recovery from illness. [If the patient's perception] is due to a hex or a curse, they may not comply with usual medical treatment. Some Hispanic patients have more confidence in a curandero or curandera, native healers, and folk remedies than in scientific [W]estern medicine. Asian immigrants may believe that cupping (applying a cup with a vacuum in it to a skin area), coining (rubbing a coin over the skin in specified areas), acupressure or acupuncture are more effective than Western medicine, and many cultures have similar beliefs that affect their confidence in and compliance with a native healer to increase the chances that the patient will receive effective treatment.⁹⁰

Additionally, in more primitive countries and some unsophisticated American subcultures, psychiatric consultation may be frightening because it is believed that mental symptoms are still caused by "sin, demons, fate or some failure by the individual."⁹¹

86. Thompson, M.D., et al., *supra* note 79, at 236.

87. *Id.*

88. *Id.*

89. *See id.* Because some institutional practices tend to prevent or discourage family involvement in patient care, the "traditional" view may present problems.

90. *Id.* at 237.

91. Thompson, M.D., et al., *supra* note 79, at 239.

2. Diagnoses of Mental Illness across Cultures and Subcultures

"Beliefs which may be indicative of psychosis in one culture, may be culturally validated in another."⁹² Again using the illustration of the Neapolitan cobbler, we are able to see how the diagnosis of mental illness differs across cultures and subcultures. It has been suggested that the difficulty in diagnosing mental illness in non-Western cultures may be due to the lack of attention given to cultural factors.⁹³ Rather than taking into account such factors or individual variations within the culture, a "wholesale" application of Western criteria are used in diagnosing mental illness.⁹⁴ It has been suggested by transcultural psychiatrists that "some symptoms cannot be accepted universally as signs of abnormality because of differences in the degree of their acceptability from one culture to the other, e.g., hallucinations involving religion are accepted in some cultures."⁹⁵

The role of culture in the accuracy of psychiatric diagnoses and assessment is evident.⁹⁶ Psychiatric diagnoses may be misinterpreted due to cultural and language differences.⁹⁷ Accurate evaluations of the mental status and neurological examination may be affected by the complexities that arise when physicians are treating patients of different cultural or language backgrounds.⁹⁸ The background of the psychiatrist will also affect the diagnoses. "The diagnoses as well as the rating of specific symptoms is very much determined by the background and outlook of the psychiatrist."⁹⁹ More troublesome is when physicians have a "bias towards or against a particular ethnic group which may affect their evaluation."¹⁰⁰

"Culture does not only define the situations that arouse certain fears and anxieties, but also determines the degree to which responses may be regarded as abnormal."¹⁰¹ Distinguishing between true neurotic reactions and fears on one hand, and anxieties sanctioned by society on the other, is a difficult endeavor for psychiatrists.¹⁰² Illustrations include

[t]he belief that someone can be hexed or cursed and caused to fall ill.

92. *Id.*

93. See AL-ISSA & DENNIS, *supra* note 17, at 500.

94. See *id.*

95. *Id.* This will be further addressed in Part III.3.

96. See Basic Behavioral Science Task Force of the National Advisory Mental Health Council, *supra* note 5, at 723.

97. See Thompson, M.D., et al., *supra* note 79, at 238.

98. See *id.*

99. AL-ISSA & DENNIS, *supra* note 17, at 500.

100. Thompson, M.D., et al., *supra* note 79, at 239.

101. AL-ISSA & DENNIS, *supra* note 17, at 467.

102. See *id.*

Also, Puerto Rican patients, whose culture encourages hypervocal, hyperactive behavior and easy expression of emotions, sometimes have been erroneously considered to have mania or an acute schizophrenic episode. Black patients who have questioned or expressed doubts about the care they have received from predominately white health care professionals have been inaccurately labeled as paranoid. A hospitalized Third World patient who had never been in a hospital previously complained about hearing voices calling out names all night and day. He was initially thought to be psychotic until a careful interview determined that the "voices" were coming from the overhead paging system.¹⁰³

Optimal diagnosis and treatment of mentally ill patients will be compromised if careful consideration is not given to cultural factors.¹⁰⁴ The role the psychiatrist plays in dealing with mentally ill patients from culturally different backgrounds is extremely important, as psychiatrists and psychologists are "guardians of the permissible and tolerable limits of social eccentricity."¹⁰⁵ As previously mentioned, biases may be present within the examining or treating physician. However, often the physician may be "unaware of or not attentive to their own cultural biases and medical care delivery system values."¹⁰⁶ By emphasizing the need for alertness and sensitivity to cultural issues and becoming educated about traditional beliefs of commonly treated patient groups, psychiatrists can "further medical compliance and also help patients achieve their maximum health care potential within [their] culture."¹⁰⁷

3. Symptoms of Mental Illness across Cultures and Subcultures

How individuals in different cultures experience and express symptoms of mental illness are not universal.¹⁰⁸ Most psychiatric diagnoses are based on symptoms.¹⁰⁹ When faced with symptoms that are unique to certain cultures or subcultures such as "believing in devils, hearing voices of the dead, or describing physical sensations in vivid metaphors not used in English,"¹¹⁰ misunderstanding and misdiagnoses are likely to follow.

103. Thompson, M.D., et al., *supra* note 79, at 239.

104. *See id.* at 235.

105. 6 TRIANDIS & GRAGUNS, *supra* note 21, at 145.

106. *Id.* at 241.

107. *Id.*

108. *See* Basic Behavioral Science Task Force of the National Advisory Mental Health Council, *supra* note 5, at 723.

109. *See id.*

110. *Id.*

Additionally, higher frequencies of medical and psychiatric problems among certain populations exist due to "culturally encouraged practices, recent immigration or migration, or other factors."¹¹¹ It is important for treating physicians to be aware of such common characteristics. For example,

Canadian natives who have migrated to cities have higher rates of infant death, injuries and mental health problems, as well as some medical illnesses, than those who remain in rural areas. Gypsies have a culture which fosters a fatty diet, use of tobacco, obesity and inbreeding with subsequent genetic defects. In one study Hispanics had an increased incidence of intoxication, as well as increased toleration of this behavior among others. Laotian immigrants who had difficult experiences during immigration and who were not proficient in English had more depressive symptoms than those who spoke English well.¹¹²

As early as the 1900's, therapy pioneer Emil Kraepelin observed that "symptoms and incidence rates for mental disturbance varied across industrialized versus developing countries."¹¹³ In fact, some disorders are unique to a particular culture. In the Iberian Peninsula, "people fear 'evil eye' spells cast by the disturbed. Mexican patients dread the 'fright illness' or 'nerves.' 'German melancholia' has as its symptoms conscientious orderliness, achievement motivation, conventional thinking, work efficiency, and conflict-free personal relationships. . . . Delusions about poisoning or sexual infidelity are common in Spain."¹¹⁴

National differences among psychiatrists also contribute to varying symptoms. Differences have been reported in "ratings of symptom severity, use of symptom data in arriving at identical diagnoses, numbers of symptoms reported, and reliabilities of symptoms observed."¹¹⁵ Yet these differences are not surprising considering almost every country develops its own brand of psychiatry.¹¹⁶ The following description serves as a good explanation of the impossibility of having worldwide psychiatrists agree on a universal classification of mental disorders:

[t]here is an international surgery, but only a national psychiatry. . . . In all departments of medicine, the physician intercedes between man and

111. Thompson, M.D., et al., *supra* note 79, at 236.

112. *Id.*

113. Stephen Buggie, Book Review, 30 J. OF CROSS-CULTURAL PSYCHOL. 129 (1999) (reviewing HISAN AL-ISSA, HANDBOOK OF CULTURE AND MENTAL ILLNESS: AN INTERNATIONAL PERSPECTIVE (1995)).

114. *Id.*

115. 6 TRIANDIS & GRAGUNS, *supra* note 21, at 145.

116. *See id.* at 197.

nature, and, of course, nature is the same the world over. In psychiatry, however, the physician intercedes between not only man and nature, but often and mainly between man and society, and society, that is the social organism, its structure, operations, exaction, etc., quite unlike nature's, is not the same the world over. Society frequently changes in the most astonishing ways "at the national border."¹¹⁷

Though classification of mental illness is not universal, through the development of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and the *International Classification of Diseases* (ICD), an official nomenclature for the classification of mental disorders is available for application in a wide variety of contexts.¹¹⁸ Now in their fourth and tenth volumes the DSM and ICD, respectively, have received validation among numerous sectors.¹¹⁹ In fact, mental illness¹²⁰ has been defined within the limits of DSM and ICD. The *Comprehensive Glossary of Psychiatry and Psychology* defines mental illness as "any serious impairment of adjustment; any psychiatric disorder listed in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* or in the World Health Organization's *International Classification of Diseases*."¹²¹

IV. DSM-IV

Due to the acceptance and recognition of the impact culture has had on mental illness, the DSM-IV has "incorporated an awareness that the manual is used in culturally diverse populations in the United States and internationally."¹²² DSM-IV identifies with how challenging diagnostic assessment is for clinicians from one ethnic or cultural background to use the DSM-IV Classification "to evaluate an individual from a different ethnic or cultural group."¹²³ Throughout this article there have been ex-

117. *Id.*

118. See generally AMERICAN PSYCHIATRIC ASSOCIATION, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS*, intro. (4th ed. rev. 1994) [hereinafter AMERICAN PSYCHIATRIC ASSOCIATION].

119. "DSM-IV is used by clinicians and researchers of many different orientations (e.g., biological, psychodynamic, cognitive, behavioral, interpersonal, family/systems). It is used by psychiatrists, other physicians, psychologists, social workers, nurses, occupational and rehabilitation therapists, counselors, and other health and mental health professionals." *Id.* at xv.

120. Mental illness and mental disorder are used interchangeably.

121. HAROLD I. KAPLAN, M.D., & BENJAMIN J. SADOCK, M.D., *COMPREHENSIVE GLOSSARY OF PSYCHIATRY AND PSYCHOLOGY* 117 (1991).

122. AMERICAN PSYCHIATRIC ASSOCIATION, *supra* note 118, at xxiv.

123. *Id.*

amples illustrating the misdiagnoses of mental illnesses when cultural factors have not been acknowledged. The DSM-IV supports such illustrations, and has included a section entitled Ethnic and Cultural Considerations, where their own illustration is presented:

[a] clinician who is unfamiliar with the nuances of an individual's cultural frame of reference may incorrectly judge as psychopathology those normal variations in behavior, belief, or experience that are particular to the individual's culture. For example, certain religious practices or beliefs (e.g. hearing or seeing a deceased relative during bereavement) may be misdiagnosed as manifestations of a Psychotic Disorder.¹²⁴

Though the use of DSM is widely accepted internationally, the symptoms and course of a number of DSM-IV disorders are influenced by cultural and ethnic factors.¹²⁵ To facilitate this area, the DSM-IV has included a new section to cover culture-related features.¹²⁶ The section addresses how different cultural backgrounds may "affect the content and form of the symptom presentation (e.g., depressive disorders characterized by a preponderance of somatic symptoms rather than sadness in certain cultures), preferred idioms for describing distress, and information on prevalence when it is available."¹²⁷

The DSM-IV also includes "culture-bound syndromes" whereby the illness has been described in just one, or a few, of the world's societies.¹²⁸ "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."¹²⁹

The DSM-IV includes a glossary of culture-bound syndromes which lists "some of the best-studied cultural-bound syndromes and idioms of distress that may be encountered in clinical practice in North America."¹³⁰

124. *Id.*

125. *See id.*

126. *See id.*

127. AMERICAN PSYCHIATRIC ASSOCIATION, *supra* note 118, at xxiv.

128. *Id.*

129. *Id.* at 844.

130. *Id.* at 844-845. For illustration, the glossary includes:

- 1) [a]mok: 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

In addition to the glossary, an outline for cultural formulation is also included "to assist the clinician in systematically evaluating and reporting the impact of the individual's cultural context."¹³¹ Issues addressed include: 1) cultural identity of the individual; 2) cultural explanations of the individual's illness; 3) cultural factors related to psychological environment and levels of functioning; 4) cultural elements of the relationship between the individual and the clinician; and 5) overall cultural assessment for diagnosis and care.¹³²

The purpose of including a culture-specific section in the DSM-IV is "designed to enhance the cross-cultural applicability of DSM and hoped that the new features will increase sensitivity to variations in hopes that disorders may be expressed in different cultures and will reduce the possible unintended bias stemming from the clinician's own cultural background."¹³³

V. LEGAL IMPLICATIONS

Parts II, III and IV addressed mental illness within the psychological context. This article now shifts to the cultural implications of mental illness as examined under the legal setting.

A. Background

When the label of mental illness is "invoked to justify the deprivation of a fundamental liberty or to excuse an individual from what otherwise would constitute a crime, the definition must be legal, not clinical."¹³⁴ It has long been recognized "that an individual whose mental

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*).

- 2) [z]ar: A general term applied in Ethiopia, Somalia, Egypt, Sudan, Iran, and other North African and Middle Eastern societies to the experience of spirits possessing an individual. Persons possessed by a spirit may experience dissociative episodes that may include shouting, laughing, hitting the head against a wall, singing, or weeping. Individuals may show apathy and withdrawal, refusing to eat or carry out daily tasks, or may develop a long-term relationship with the possessing spirit. Such behavior is not considered pathological locally.

See generally Jisheng Li, Comment, *The Nature of the Offense: An Ignored Factor in Determining the Application of the Cultural Defense*, 18 U. HAW. L. REV. 765, 789-794 (1996) (discussing the "amok defense").

131. *Id.* at 843.

132. See *id.* at 843-844.

133. AMERICAN PSYCHIATRIC ASSOCIATION, *supra* note 118, at xxv.

134. Bruce J. Winick, *Ambiguities in the Legal Meaning and Significance of Mental Illness*, 1

illness is responsible for crime cannot be considered a criminal."¹³⁵

Though the law uses the term mental illness as a prerequisite for legal intervention,¹³⁶ at what point will cultural factors be admitted to play a role in such intervention? As discussed thus far, culture can and should not be ignored within the psychological context; however, should its importance also extend into the legal realm? As the guardians of permissible and tolerable limits of social eccentricity,¹³⁷ should psychiatrists and psychologists, as expert witnesses, be able to influence what is tolerable under a legal setting?¹³⁸

Courts have historically followed the century-old Supreme Court decision of *Carlisle v. United States*¹³⁹ which announced that an alien who comes to the United States immediately adopts all the laws of the nation. The Court, in announcing their opinion, referred to the words of former Secretary of State Daniel Webster:

[e]very foreigner born residing in a country owes to that country allegiance and obedience to its laws so long as he remains in it, as a duty upon him by the mere fact of his residence, and that temporary protection which he enjoys, and is as much bound to obey its laws as native subjects or citizens. This is the universal understanding in all civilized states, and nowhere a more established doctrine than in this country.¹⁴⁰

Despite this well recognized principle, an increasing number of courts today have begun to allow immigrant defendants to excuse their criminal acts.¹⁴¹ Over the past decade, there have been an increasing number of cases that have considered the use of a continuously debated defense referred to as the "cultural defense." This controversial defense arises when defendants seek to admit evidence of their cultural background to excuse in some way their unlawful act.¹⁴² To illustrate:

PSYCHOL. PUB. POL'Y & L. 534, 538 (1995).

135. *Id.* at 536.

136. *See id.* at 534.

137. *See* discussion *supra* Part III.B.1.b.

138. Experts testify about the "normal" behaviors of the immigrant defendant's culture at issue. It is argued; however, that because the cultural defense is not a psychiatric diagnosis, such testimony is often "inaccurate and subjective in nature." Terry F. Goldstein, Comment, *Cultural Conflicts in Court: Should the American Criminal Justice System Formally Recognize a "Cultural Defense"?*, 99 DICK. L. REV. 141, 165 (1994) (discussing the problems with relying on social science testimony).

139. 83 U.S. (1 Wall.) 147 (1872).

140. *Id.* at 155.

141. *See* Michael Fischer, Note, *The Human Rights Implications of a "Cultural Defense"*, 6 S. CAL. INTERDISCIPLINARY L.J. 663, 665 (1998).

142. *See* Valerie L. Sacks, *An Indefensible Defense: On the Misuse of Culture in Criminal*

[t]he defendant's actions, had they been committed in the defendant's home country and culture, either would not have been a crime under the laws of the defendant's native jurisdiction, or would not have been punished as severely. The defendant adverts to cultural influences and argues that her native culture would have excused her conduct, that cultural factors or patterns of behavior are relevant to a determination of her state of mind at the time of the criminal act, or that cultural factors warrant reduced charges or punishment.¹⁴³

The critical importance of culture in recognizing symptoms and diagnosing mental illness is also apparent in the legal arena. "Evidence pertaining to a defendant's cultural background may be pertinent regarding the state of mind of the defendant at the time of the act in question or the context in which the act was committed, context which might make the wrongful act seem to warrant less severe punishment."¹⁴⁴ Variations between a defendant's culture and his/her society's majority culture to constitute an independent, substantive defense in criminal trials have rarely been allowed in both American and British courts.¹⁴⁵ Though only a few cases have been successful in using some version of the cultural defense,¹⁴⁶ "attorneys have increasingly sought to introduce cultural evidence for mitigating or exculpatory purposes."¹⁴⁷ Cultural factors may also be relevant to the extent that they establish a case for one or more traditional criminal law defenses.¹⁴⁸

Despite the acceptance of cultural factors in criminal cases and even the application, though minimal, of a cultural defense, neither provides the functional equivalent of a formal cultural defense.¹⁴⁹ Where the cultural defense could be raised, there is generally no question of the defendant's intent. For example, In *State v. Butler*,¹⁵⁰ an intruder was deliberately killed by members of an American Indian tribe for desecrating the tribe's sacred burial grounds.

Law, 13 ARIZ. J. INT'L & COMP. L. 523 (1996).

143. Daina C. Chiu, *The Cultural Defense: Beyond Exclusion, Assimilation, and Guilty Liberalism*, 82 CAL. L. REV. 1053 (1994).

144. Sacks, *supra* note 142.

145. See *The Cultural Defense in the Criminal Law*, 99 HARV. L. REV. 1293 (1986).

146. Court's approaches have been ad hoc and inconsistent with respect to the use of cultural information. Those courts that have admitted cultural evidence have done so primarily for mitigating, rather than exculpatory purposes. See discussion *supra* Part III.B.1.b.

147. Sacks, *supra* note 142.

148. See *The Cultural Defense in the Criminal Law*, *supra* note 145.

149. See *id.* at 1295.

150. No. 44496 (Lincoln Cty. Cir. Ct. filed Mar. 11, 1981), cited in Sherman, *Legal Clash of Cultures*, Nat'l L.J., Aug. 5, 1985, at 27.

Even if it could be shown that the defendants' cultural values differed significantly from those of the majority, it would be difficult to argue that the defendants did not intend to kill a human being. Even if the trial court were [sic] willing to recognize an independent cultural defense, and if the defendants could demonstrate that under their tribal law the killing was considered condign punishment for an act of desecration [sic] and that they were entitled to inflict that punishment, then the defendants would have a defense to a crime that would otherwise qualify as murder.¹⁵¹

B. Modern Practice

As seen thus far, defense attorneys have commonly relied upon traditional criminal theories of diminished capacity and mistake of fact. The attorneys incorporate the defendant's cultural background into these traditional defenses as defense strategies for recent immigrants.¹⁵²

The cultural defense applied to rape, through mistake of fact, was used in *People v. Moua*.¹⁵³ The California Superior Court reduced rape charges against Moua upon considering his cultural background in light of other evidence. The court concluded that Moua's Hmong culture "mistakenly led him to believe that his victim was consenting to his sexual advances."¹⁵⁴ As a Hmong tribesman from Laos, the tribesman practices a form of marriage known as "zij poj niam", or marriage by capture.¹⁵⁵ This tradition calls for the woman to protest the man's sexual advances. "The man is supposed to continue his sexual advances despite the woman's protests in order to demonstrate that he is worthy of being her husband."¹⁵⁶ Charges were reduced from kidnapping and rape to false imprisonment. By combining the mistake of fact theory with the defendant's cultural background, the defendant successfully demonstrated he lacked the requisite intent to be charged with rape.¹⁵⁷

151. *The Cultural Defense in the Criminal Law*, *supra* note 145, at 1297.

152. See Alice J. Gallin, *The Cultural Defense: Undermining the Policies Against Domestic Violence*, 35 B.C. L. REV. 723, 727 (1993).

153. No. 315972 (Fresno Super. Ct. 1985), *cited in* Carolyn Choi, Note, *Application of a Cultural Defense in Criminal Proceedings*, 8 PAC. BASIN L.J. 80, 83 n.37 (1990).

154. Gallin, *supra* note 152, at 727.

155. See *id.*

156. *Id.*

157. See *id.* at 729.

*People v. Chen*¹⁵⁸ illustrates the cultural defense applied to a wife murder through the defense of diminished capacity. Upon learning his wife was sexually involved with someone else, Chen became so enraged that he took a claw hammer and smashed her skull eight times until she died.¹⁵⁹ An expert testified that in traditional Chinese culture, due to societal beliefs concerning infidelity, a Chinese man might threaten to kill his wife if she commits adultery.¹⁶⁰ However, the Chinese community usually stops him from following through with his threats.¹⁶¹ "Mr. Chen argued that in the United States he did not have a tight-knit Chinese community to stop him from murdering his wife."¹⁶² The Brooklyn Supreme Court reduced his charge to the lightest possible sentence of second-degree manslaughter.¹⁶³ In explaining his sentence, Justice Pincus stated: "Chen was the product of his culture. . . . The culture was never an excuse, but it is something that made him crack more easily. That was the factor, the cracking factor."¹⁶⁴ Essentially, because Chinese culture "produced" Dong Lu Chen, his criminal liability for his wife's homicide was reduced to manslaughter.¹⁶⁵

A third example of how cultural defenses are incorporated into traditional criminal defenses is seen in *People v. Wu*,¹⁶⁶ where the cultural defense was applied to an attempted parent/child suicide through the diminished capacity defense. In *Wu*, the jury was entitled to consider the defendant's cultural background in determining whether she had the requisite intent to be guilty of murder. Wu's son informed her that her husband treated him badly and was romantically involved with another woman. The distressed defendant strangled her son and then attempted to kill herself. The trial court refused to issue a jury instruction based on the judge's decision "not to endorse the defendant's actions merely because they would have been acceptable in China."¹⁶⁷ Reversing, the California Court of Appeals indicated that the defendant's cultural background was relevant in addressing the mental states essential to the crimes in which she was charged.¹⁶⁸ The cultural information was relevant because her

158. No. 87-7774 (N.Y. Sup. Ct. Mar. 21, 1989), cited in Melissa Spatz, Note, A "Lesser" Crime: A Comparative Study of Legal Defenses for Men Who Kill Their Wives, 24 COLUM. J.L. & SOC. PROBS. 597, 621 & n.169 (1991).

159. See Gallin, *supra* note 152, at 730.

160. See *id.*

161. See *id.*

162. *Id.*

163. See *id.*

164. Chiu, *supra* note 143.

165. See *id.*

166. 286 Cal. Rptr. 868, 872-73 (Cal. Ct. App. 1991).

167. Gallin, *supra* note 152, at 732.

168. See *id.* at 733.

cultural background "could have provided the trier of fact with a reasonable doubt that one of the necessary mental states existed."¹⁶⁹ This decision represents the first appellate consideration of the cultural defense.¹⁷⁰ "[T]he court in Wu approved the defense strategy used in Moua and Chen, of using a defendant's cultural background in conjunction with traditional criminal defense theories."¹⁷¹

Though viewed by most as simply an excuse, the viewpoint of the cultural minority, as illustrated in these cases, can be summarized as follows:

[t]he values of individuals who are raised in minority cultures may at times conflict with the values of the majority culture. To the extent that the values of the majority are embodied in the criminal law, these individuals may face the dilemma of having to violate either their cultural values or the criminal law.¹⁷²

C. Expert Testimony

While introducing a defendant's cultural background has become an increasingly effective tool implored by creative defense attorneys, the need to submit this evidence stems from the fact "that individuals with decisionmaking [sic] roles in the American criminal courts are often culturally different from those accused of crime."¹⁷³

Accompanying cultural differences within the trial process are factors that often weigh against the immigrant defendant. Such factors were identified in a study of courtroom dynamics conducted in 1960s: the value systems of both the legal profession and jurors, jury selection procedures, "the lack of articulation in communication between the culturally different and the professionals and nonprofessionals composing the court, and the negative stereotypes of cultural minorities held by the professionals."¹⁷⁴

Introducing a defendant's cultural background serves as a communication bridge between the individuals comprising the court.¹⁷⁵ "The purpose of [cultural background evidence] is to provided the fact-finder, usually a jury, with information about the social and psychological con-

169. *Id.*

170. *Id.* at 734.

171. *Id.* at 734-735.

172. *The Cultural Defense in the Criminal Law*, *supra* note 145.

173. Holly Maguigan, *Cultural Evidence and Male Violence: Are Feminists and Multiculturalist Reformers on a Collision Course in Criminal Courts?*, 70 N.Y.U. L. REV. 36, 58 (1995).

174. *Id.* (citing Daniel H. Swett, *Cultural Bias in the American Legal System*, 4 LAW & SOC'Y REV. 79, 101 (1969)).

175. *See* Maguigan, *supra* note 169.

text in which contested adjudicative facts occurred.”¹⁷⁶ This information is believed to aid the fact-finder in rendering a decision.¹⁷⁷ An illustration of this bridge was prevalent in *Wu*, where the expert testimony of Dr. Pasternak, professor of anthropology, contributed to “creating a ‘cultural defense’”.¹⁷⁸ Amongst Dr. Pasternak’s lengthy testimony to introduce Chen’s cultural background, Dr. Pasternak asserted “that a man considered ‘normal’ in the category ‘Chinese’ would react differently from someone in the category of ‘American’ to the belief that his wife was having an affair.”¹⁷⁹ The significant weight of this expert’s testimony was evident by the holding of Justice Pincus:

[w]ere this crime committed by the defendant as someone who was born and raised in America, or born elsewhere but primarily raised in America, even in the Chinese American community, the Court [sic] would have been constrained to find the defendant guilty of manslaughter in the first degree. But, this Court [sic] cannot ignore . . . the very cogent forceful testimony of Doctor Pasternak, who is, perhaps, the greatest expert in America on China and interfamilial relationships.¹⁸⁰

D. The Future of the Cultural Defense

Whether individuals raised in a foreign culture will be held fully accountable for conduct that violates United States law, yet is acceptable in his or her native culture, remains to be seen. Though still in a relatively early stage, as international tourism and immigration increases,¹⁸¹ the cultural defense will exceedingly expand.¹⁸² With this expansion will come great controversy: proponents of the defense arguing that cultural backgrounds should be considered because our society should respect cultural diversity, thus the American legal system should not punish individuals from a culture that emphasizes different values; opponents of the defense arguing that many immigrants are receiving the message that the

176. *Id.*

177. See generally Letti Volpp, *(Mis)Identifying Culture: Asian Women and the “Cultural Defense”*, 17 HARV. WOMEN’S L.J. 57 (1994) (discussing expert testimony given in *People v. Chen* and *People v. Wu*).

178. *Id.* at 67.

179. *Id.*

180. *Id.* at 70 (quoting *People v. Wu*, 286 Cal. Rptr. 868 (Cal. Ct. App. 1991), Record at 301-02).

181. The large influx of immigration, especially Asians, into the United States in the last 15 years has resulted in the increased introduction of evidence of foreign customs in US courtrooms.

182. I refer to the formal recognition of a cultural defense as new. However, adjudication of cases involving conflicts between the laws of the nation and the laws of custom have been seen as early as the 1800s throughout the world.

American judicial system will allow them to get away with violence "that may be illegal in the United States, but that ultimately can be attributable to their background."¹⁸³ Perhaps, the prevailing view is best expressed by Alison Dundes Renteln, assistant professor of political science at the University of Southern California, "I believe a cultural defense should be denied to a person who chooses to come to somebody else's culture. For the most part, I subscribe to the 'When in Rome' philosophy."¹⁸⁴

Regardless of the ongoing debates, resolution of when, how, and if the cultural defense should be allowed will involve reconciling two competing legal principles: "the fundamental tenet of Anglo-American law that the law shall be administered equally to those similarly situated versus the principle that people should not be held responsible for criminal actions committed without the requisite level of intent."¹⁸⁵

VI. CONCLUSION

*"A better understanding of invisible cultural differences is one of the main contributions the social sciences can make to practical policy makers in governments, organizations and institutions—and to ordinary citizens."*¹⁸⁶

As borders "collapse," per se, we can no longer look within our own borders and cultures to deal with everyday components of life. Our views of the world, our values, and our lifestyles are largely conditioned by our particular cultures. As we are exposed to new variables, we cannot ignore their impact and stand opposed to change. Culture is a dynamic concept, which is receiving greater attention as the international arena converges. The reception, however, has been slow. Only until the impact of culture is universally recognized in all fields will we be able to broaden our visions and deepen our insights. Though this article focused on culture within the psychological and legal settings, the first step is recognizing culture itself:

[w]herever [an] individual lives—in your country; close to the equator or one of the poles; in the first, second, third, or umpteenth world—he will sneeze when the nerve endings in his nose are irritated. But, in fact, will he sneeze? Will he try to inhibit this reflex action? What will he say, what will bystanders say, when he does sneeze? What will they think of him if he fails to turn away and sneezes in their faces? Do they

183. Gallin, *supra* note 152, at 723.

184. *U.S. Justice System Called Ambivalent on Use of "Cultural Defense" by Immigrants*, L.A. TIMES, Dec. 13, 1987, at 6.

185. Sacks, *supra* note 142, at 524.

186. HOFSTEDE, *supra* note 1, at 8.

and he consider sneezing an omen and, if so, is it a good or bad omen?¹⁸⁷

This analogy serves to alert us to cross-cultural elements that exist even in an elementary action.¹⁸⁸ “Whoever and wherever we are, we are human, and we possess similar strivings from birth to death. On occasion all of us sneeze, and more compelling, we also struggle with, are perplexed by, and overflow with the conviction that we share common attributes diversely.”¹⁸⁹

187. SEGALL ET AL., *supra* note 2, at xii.

188. *See id.*

189. *Id.* at xiii.

