



The expert and the foreigner: Reflections of forensic transcultural psychopathology on a total of 86 reports by experts on criminal liability



Isabella Merzagora *, Alberto Amadasi, Alberto Blandino, Guido Travaini

Sezione di Medicina Legale e delle Assicurazioni, Dipartimento di Scienze Biomediche per la Salute, Università degli Studi di Milano, Via Luigi Mangiagalli, 37, 20133 Milano, Italy

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ABSTRACT

In recent times Italy has been experiencing massive migration flows, therefore the attention on the issue of crimes committed by foreigners is increasing. But within trials, in the evaluation of criminal liability of foreigners, how do experts deal with them? Do the performed evaluations take cultural diversity into account?

The present study took origin from these questions and examined a total of 86 reports by experts on criminal liability of foreign persons (16 females and 70 males). Examinees have been declared indictable in 31 cases (36%), totally mentally ill in 40 cases (45%) and with diminished liability in 15 cases (17%); when liability was excluded, examinees were diagnosed in 11 cases with mood disorders, in 23 cases with personality disorders, in 4 cases with adaptation disorders and post-traumatic stress disorder and in 10 cases with different diagnoses (in some cases more than one diagnosis was present). None of the reports used the section of the DSM concerning “cultural framing”. Tests were used in 48 surveys (56% of cases), with more tests for each examinee, for a total of 39 Rorschach, 14 Raven test, 8 Minnesota Multiphasic Personality Inventory - MMPI - 4 Wechsler Adult Intelligence Scale - WAIS - level test, 8 Thematic Apperception test. When subjects were diagnosed with mental disorder and with diminished liability, 42 (79%) were also socially dangerous.

Results highlight the importance of the relationship between the expert and the foreigner. Many factors ought to be critically considered by experts dealing with foreigners, like cultural awareness, knowledge of verbal communication, critical consideration of meanings and diagnosis, knowledge of the foreigners' personal story, presence of tests with inexact information and cultural fallacy.

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1. Introduction

The “knowledge of the law” in case of foreigners committing crimes may not be a linguistic problem only. The law precepts use clear and easily understandable terms, but their obviousness largely relies on a “learned culture” (Hsiao-Ying, 1995; Papke, 2007) whose fundamental behavioural rules are taught from childhood.

The overrepresentation of immigrants or foreign citizens, in the US and UK, among those who are diagnosed with psychosis, may partly be due to preconceptions or, at least, to methodological approximations. Concerning this issue, Marsella and Kameoka refer to a “conceptual equivalence”, especially in the use of psychometric instruments (Marsella & Kameoka, 1989). As stated by the Authors, the center of cross-cultural assessment is the concept of “equivalence”: the extent to which a behaviour, concept, or measurement procedure shares common meanings and relevance for culturally different groups.

As a consequence, members of minorities would more often be diagnosed as psychotic or dementi. These differences would be due to the fact that doctors are less accurate in the request of information on signs and symptoms of disease in non-white patients (Strakowski et al., 1997), so discrepancies may be reduced if the diagnosis were conducted through structured interviews (Cavalli-Sforza, 2000; Hicks, 2004). Another difference in the therapeutic choice concerns the fact that there are proportionately more black than white people in judicial psychiatric institutions, since they are more often judged as socially dangerous. Researches focused on differences in the prevalence of mental illness according to ethnicity (Flaskerud & Hu, 1992; Linhorst, Hunsucker, & Parker, 1998; Martin, 1993; Warner, 1979), resizing these discrepancies in relation to the socio-economic status: low status means vulnerability to diseases, and members of minorities usually belong to a lower status. According to the ECA (Epidemiological Catchment Area) survey data, once corrections by sex, age and socioeconomic status are inserted, no statistically significant differences are assessed between white and black people among the diagnosis of antisocial personality disorder, affective disorders and drug addiction (Fernando, Ndegwa, & Wilson, 1998). In Europe, a Swedish survey on immigrants and refugees

* Corresponding author.

E-mail address: isabella.merzagora@unimi.it (I. Merzagora).

showed that although non-white people are generally more frequently diagnosed with mental diseases, white people are more frequently declared “insane” and thus avoid imprisonment (Warren, Rosenfeld, & Fitch, 1994; Weisman & Sharma, 1997).

A particular problem in dealing with diagnosis in immigrants concerns the effects of the migration experience itself. There is a sort of “acculturation stress”, a sum of discomforts such as perceived discrimination, intercultural contact stress, cultural deprivation, bicultural tension (Rudmin, 2003); discrimination and racist attitudes may promote this stress with subtle and implicit messages (Carter, 2007; Dovidio, 2001).

Previous literature focused on the possible relationship between migration and mental illness, starting during the Thirties with a research on Norwegian immigrants in the United States: an impressive result of this study was the recorded incidence of schizophrenia in immigrants, twice as in Norwegian citizens (Ödegaard, 1932). Recent surveys found a higher incidence of psychotic disorders in migrants (Coluccia, Ferretti, Fagiolini, & Pozza, 2015; McCallum, MacLean, & Neil Gowensmith, 2015; Vinkers, de Beurs, Barendregt, Rinne, & Hoek, 2010). In a similar Dutch study, criminal liability in native youth was more frequently assessed as ‘diminished’ or ‘strongly diminished’ than within ethnic minorities (Vinkers & Duits, 2011). Immigrant status can be a powerful pathogenic factor, even regardless of previous traumas (Kirmayer, 2001), for the amount of social disadvantage such as underemployment, housing difficulties (Kirmayer, 2006), language barriers, lack of social networks, discrimination, bicultural conflict, nostalgia (Finch & Vega, 2003; Tartakovsky, 2007) that can result from it. Such issues may be crucial also within the forensic field: was the onset of the disease prior or consecutive to the migratory experience? Was migration a trigger? May some psychopathological manifestations be tolerated in the culture of origin? What did the migrant experience and what is he experiencing in the host country?

In psychiatry, the clinical examination and the doctor-patient relationship is a match played in a particular field: while in classical semiotics inspection, palpation, percussion and auscultation are reliable criteria in the performance of a good clinical examination, in psychiatry a crucial role is played by the conversation between doctor and patient, through the privileged means of words: the interview is therefore the most important aspect of the doctor-patient relationship and communication usually comes from the depth of the dialog (Agarwal & Murinson, 2012; Kleinman, Eisenberg, & Good, 1978). The crucial mediator is verbal language, so the interview in psychiatry is the hinge around which doctor and patient revolve. Firstly, language can be an obstacle: the language problem affects human interaction, and communication may have the most significant impact on the individual's fate.

In Italy, according to the implementation of a European directive (Legislative Decree of March 4, 2014, n. 32) an interpreter is usually provided free of cost for the accused or arrested person who does not speak Italian. In reality, things are not as simple for at least two reasons: a literal translation may not be enough, and language is one of the tools of communication, but not the only one. In the US the problem of the reliability and validity of the interpreter led to the drafting of a document containing 27 recommendations for a more sensible use of translation in the forensic field (Maddux, 2010). Above all, what is needed is a concept and attitude equivalence and not a simple translation. Just to give an example, some cultures consider a “no” as a rude answer, so the patient may prefer to answer “yes” in any case (i.e. the “brief response” in Japanese conversations in which it is very unnatural for someone to talk for a while without getting any response from their listeners so they say words like “yes” or “indeed” but they do not imply any agreement) (Maynard, 1997).

Dutch clinicians complained about the difficulty of carrying out a diagnosis of depressive disorder for Indonesians whose culture requires emotional control and, in particular, always smile (Lewis-Fernández, Agarwal, Hinton, Hinton, & Kirmayer, 2015). Moreover, for certain cultures mental illness may be so “shameful” that only somatic

symptoms are reported (or these are the only felt symptoms). Another important tool is empathy, which consists of gestures, expressions, mimics, meanings: their absence may increase misunderstandings, hence the necessity of the presence of real cultural mediators - and not only interpreters.

Several pages of the DSM-5 focus on “cultural framing”. The “Guide for the cultural framework,” provides several criteria for the evaluation of several issues like cultural identity or conceptualization of suffering, stressful psychosocial events and cultural characteristics of vulnerability and resilience, cultural characteristics of the relationship between the individual and the clinician (American Psychiatric Association, 2013). Moreover, 16 questions are suggested as a guide for the “Cultural Formulation Interview” (CFI).

In Europe (Sweden) an operationalization for cultural assessment was drafted for the “Outline for Cultural Formulation” (the precursor of the CFI) which includes an “ethnographic” section in order to try to understand the examinee along with the role of culture, context, experience of immigration and acculturation, meaning provided to illness. The interview is semi-structured and can be adapted to the patient's needs and situation. The areas covered in the survey are: cultural identity, cultural factors related to psychosocial environment, migration and acculturation, cultural elements in the relationship between doctor and patient. The method is “narrative” (narrative approach).

The topic of criminal liability embraces cultural and even philosophical issues. The expert has to deal with a matter steeped in culture (psychopathology), merge it with legal needs, and take a step further through a critical evaluation of the influence of different cultures on human habits.

2. Materials and methods

The study was performed on a total of 86 reports by experts on criminal liability of foreigners. This survey covered a time range from 1975 to 2016, mainly within the last 16 years, according to the migration flow trends in Italy. 16 immigrants were females and 70 males. Among the 16 cases involving females, 12 concerned murders or attempted murders, and only in one case the victim was an acquaintance; all the remaining were murders within the family: in 7 cases the victim was the son, in 2 cases the husband, in 1 case the lover and in 1 case the brother. Among males, in 6 cases - less than 7% - the murder or attempted murder victims were family members. In 4 cases the age was unknown; among the remaining, there were eight examinees under 18 years old (one of 16 and the remaining 17 years of age); 30 between 19 and 30 years of age and between 31 and 40; 11 in the 41–50 age range; 3 over 50 years of age. None over 55 years of age, consistent with the fact that young people are more frequently involved in crimes (especially aggressive crimes), and that immigrants belong to young population groups. The nationalities are different (Table 1), but reflect the quota of immigrants in Italy (according to ISTAT - Italian National Institute for Statistics - data, Romanians, Albanians and Moroccans are the most frequent). 34 reports concerned serious crimes such as murder (6 of which attempted). Of these, 7 were child murders, all committed by women and 2 of them followed by attempted suicide, 6 cases regarded multiple murders and even 1 mass murder and 1 suspect serial killer. On the other hand, 12 cases concerned petty crimes: minor damages, theft, resisting arrest or arrest (Fig. 1).

Considering all crimes, 52% of the victims were Italian, whereas the other 38% concerned foreigners (in some reports the victim's nationality was not indicated or the perpetrated crime was “victimless” as in the case of violations of the laws on drugs), almost always belonging to the same ethnic group. However, among serious crimes, in 68% of murders and 83% of attempted murders, victims shared the same ethnicity with the perpetrator. On the other hand, almost all the murders within the family were perpetrated within the same ethnic group.

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