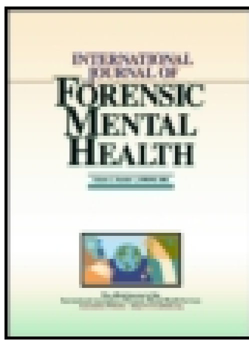

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Addressing Linguistic and Cultural Differences in the Forensic Interview

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ABSTRACT
Given the increased cultural, linguistic and socioeconomic diversity of individuals undergoing legal proceedings, forensic mental health professionals around the world are often tasked with evaluating defendants who are drastically different from themselves. There appears to be a clear consensus that cultural competency should be a key component of both the training and practice of forensic mental health. However, despite the growing literature on multicultural assessment in clinical settings, there is little guidance on how to apply cultural competency principles to the area of forensic mental health assessment. This article reviews some of the challenges that arise during the forensic mental health interview with culturally diverse individuals. In addition, practice recommendations to mitigate some of these challenges are provided. Identified challenges and recommendations are organized around three stages: preparation for the interview (e.g., what type of knowledge about the defendant's culture is needed beforehand, how to attain that knowledge, or whether and how to use translators), the initiation of the forensic interview (e.g., the effect of culture in the informed consent process), and the interviewing process itself (e.g., cultural challenges to developing rapport, and identification of mental status assessment domains that may be vulnerable to cultural influences).

KEYWORDS
Diversity; cross-cultural; guidelines; interview

With the increasing diversification of society, the need to understand and address linguistic and cultural differences has become a standard component of effective clinical practice. Indeed, training programs in virtually all domains of health care have articulated the need to develop "cultural competence" in order to provide adequate services (American Psychological Association, 2003; Ridley, Li, & Hill, 1998; Ring, Nyquist, & Mitchell, 2016; Truong, Paradies, & Priest, 2014). For example, cultural competence is critical to accurately differentiating pathological versus normative behaviors and beliefs, and identifying culturally unique considerations in the evaluation process. Yet translating the goal of cultural competence into practice remains an elusive task, particularly for those working in forensic mental health settings, where an incorrect assessment can have profound ramifications on both the individual being evaluated and society at large.

Not only are Western societies becoming increasingly diverse, but ethnic and cultural diversity is even more dramatic in criminal justice settings, where foreign born prisoners represent roughly 20% of U.S. prisons, 12% of UK prisons, and roughly comparably (if not far higher) percentages in Australian and European prisons (Australian Bureau of Statistics, 2016; Berman & Dar, 2013; Federal Bureau of Prisons Statistics, 2017; World Prison Brief, 2017). Thus, forensic mental health professionals are increasingly tasked with evaluating individuals that speak a different language and have different customs and expectations. It should be noted that the purpose of a forensic evaluation may be quite broad (an evaluation of mental state, violence risk, and treatment needs to guide criminal sentencing) or relatively narrow (i.e., competency to stand trial). Therefore, the depth, or even necessity, of the forensic interview itself—which is the focus of this review—will vary across these different evaluation types. However, the cultural background of the individual being evaluated will require some consideration in virtually all forensic evaluations, and has the potential to greatly impact the forensic interview process itself. This article highlights a range of issues that complicate the assessment of individuals from diverse backgrounds, including the influence of culture on the interview, the use and training of translators, and the interpretation of clinical observations.

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What is cultural competence?

A critical starting point in addressing cultural diversity is understanding what is meant by "cultural competence." Betancourt and colleagues (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003) define cultural competence as acknowledging and incorporating "the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs" (p. 294). Many formulations of cultural competence encourage clinicians to engage in a continuous, ongoing process of learning, not in order to master a range of "cultures", but in order to understand the extent of one's own limitations. Indeed, the belief that one can fully understand a culture is naïve, as even one's own native culture is likely to be diverse and multifaceted (as evidenced by the political and racial climate in the U.S. over the past few years). There is little doubt that every practicing clinician should engage in an ongoing process of learning, not only about other cultures that they encounter but about subcultures different from their own that exist within their own country.

The American Psychological Association's (APA) Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (2003), define culture as "the belief system and value orientations that influence customs, norms, practices and social institutions … " and "the embodiment of a worldview through learned and transmitted beliefs, values and practices, including religious and spiritual traditions" (p. 380). These guideless encourage psychologists to use a "culture lens" approach, that emphasizes considering the role culture plays in shaping an individual's behavior. Similarly, the APA's Specialty Guidelines for Forensic Psychology (2013) emphasize the need for evaluators to consider "linguistic, and cultural differences that might affect their judgments or reduce the accuracy of their interpretations" (p. 15). This principle is grounded in the APA's Ethics Code, which cites the importance of understanding possible sources of bias, including an individual's race, culture and ethnicity (APA, 2002). In short, there appears to be a clear consensus that an understanding of the evaluatee's culture, along with possible sources of bias on the part of the evaluator is required for conducting culturally sensitive evaluations (APA, 2002, 2003, 2013).

Understanding the differences between one's own experience and those of the individuals we seek to understand is particularly important for forensic psychologists, because cultural differences are not simply a product of immigration and language. Mental health professionals often have little in common with those they evaluate, even when they are born and raised in close proximity to one another (APA, 2015; Ponterotto, 1988; Sue & Sue, 2003). Educational, socioeconomic, and religious differences are among the many factors that can impede the evaluation process, hindering the development of rapport, creating misunderstandings and perhaps even leading to incorrect conclusions about important psycho-legal questions. These issues are particularly impactful during the forensic interview process, as the development of rapport is critical to a successful interview and an accurate interpretation of both verbal responses (the evaluator's questions and the respondent's answers) and non-verbal behaviors. The myriad ways that cultural differences impede effective forensic interviewing can be divided into those that are evident (and addressed) before the interview begins, the use (and training) of translators, and conducting the interview process itself. These challenges will be addressed in the paragraphs below, along with steps that can be taken to minimize the impact of these challenges.

Before the interview begins

Background research on culture

It is by now axiomatic that culturally responsive assessment practices (which are a necessary component of cultural competence) require familiarity with the culture of the evaluatee. Many clinicians would agree that greater depth of knowledge about an evaluatee's cultural background will increase the accuracy of the evaluation. However, there is little published guidance about how to gather information about someone's cultural history, or to assist in determining how much depth is necessary in order to conduct an adequate forensic interview of an individual from a unique cultural background. As a starting point, the evaluator should be knowledgeable about not only the primary language spoken by the individual, but whether there are regional dialects that might impact selection of a translator (discussed in more detail below). Additional topics that may be relevant include obtaining information about the educational system and economic and political climate in the individual's country of origin. Religious and spiritual traditions, as well as the existence of traditional medical explanations for, or treatments to address health problems can be crucial to recognizing symptoms that may be

masked by cultural norms or conversely, culturally normative behaviors and beliefs that may be mistakenly interpreted as evidence of a mental disorder. Determining whether there are culturally unique symptoms, such as "sinking heart" described by Punjabi Sikh's (Krause, 1989) or the phenomenon of "wind" among Cambodian trauma survivors (Hinton & Otto, 2006), is another critical aspect of preparation, as these symptoms may be ignored or interpreted incorrectly by clinicians who are unfamiliar with culturally-specific symptom manifestations.

Cultural norms regarding the role of family or community in decision making, as well as patterns of emotional expression and self-disclosure can also be critical to the interview process (Sue & Sue, 2003). For example, Shepherd and Lewis-Fernandez (2016) note that Australian Aboriginal individuals often respond to questions by "a trading of narratives," a response style that may be perceived as evasive or tangential by the naïve clinician (p. 431). Furthermore, some topics may be seen as "taboo" in particular cultures (e.g., use of alcohol, thoughts of suicide), and inquiring about these topics can dramatically impact the evaluation process. While we do not recommend avoiding such topics, as they may have tremendous importance when present, the interviewer's ability to frame questions in a culturally sensitive manner, that optimizes accurate responses, is dependent on an awareness of the cultural implications of this information.

Gender roles and social class can also have particular importance for the forensic interview, necessitating an understanding of these issues for both the region as well as the evaluatee. For example, some cultures strictly limit interactions between men and women that are not married to one another (which is always the case in the forensic interview). These restrictions may impede, or even prevent the interview itself, or necessitate the addition of another person in the interview room. Similarly, the type of clothing worn by the evaluator may prove problematic if it violates cultural norms. For example, the forensic evaluator interviewing someone in a warm Middle-Eastern country may be more comfortable wearing cool, loose fitting clothing but a devout Muslim interviewee is unlikely to be equally comfortable, and may refuse the interview altogether until the evaluator returns wearing more culturally appropriate clothing. Of course, gender norms may vary across individuals, even within a culture in which cross-gender relationships are normally proscribed. Whereas some individuals may be unwilling to be interviewed by a member of the opposite sex, others may feel uncomfortable disclosing sensitive information to someone of the same gender (e.g., men disclosing sexual abuse). It is often difficult to know in advance how these gender issues will impact the evaluation, but inquiring in advance and attention to discomfort during the interview, even if not acknowledged explicitly, may help guide decision making.

Finally, depending on the specific question at hand, information about class-bound values may also be important, as individuals from lower socioeconomic classes may have experienced oppression and discrimination which can affect their willingness to share potentially relevant information. Whaley (1997) described a phenomenon he termed "cultural mistrust" to refer to a suspiciousness that helps individuals cope with experiences of racial injustice and discrimination, which may adversely impact the development of rapport in the clinical interview (see also Kapoor, Dike, Burns, Carvalho, & Griffith, 2013). Of course, some suspiciousness is common, and understandable, when interviewing individuals that have been victimized or discriminated against by the evaluator's own country or culture. Likewise, comfort with a translator may hinge on the extent to which the evaluatee perceives the translator as a representative of the government or dominant social class. Without recognizing this possible barrier and addressing it directly, the potential for guardedness and incomplete disclosure is heightened.

Although substantial information may be gleaned from readily available sources (e.g., Wikipedia), detailed information may be obtained from official government websites (depending on the nature of the information sought) or independent agencies (e.g., Amnesty International). For more in depth or nuanced information, consultation with someone very familiar with the evaluatee's particular region or subculture may be useful. Sources of such consultation might include community service agencies that serve the particular culture, which are often present in regions where a large community of immigrants from that region have settled. For example, in one evaluation of a Pakistani immigrant charged with terrorism offenses, contact with a Pakistani physician who was familiar with the defendant's specific background provided invaluable information regarding the defendant's behavior and the context of the alleged offense.

The cultural consultant may also be another clinician who does not know the evaluatee but has expertise working with individuals of the same culture. For example, Washington State certifies mental health professionals as an Ethnic Minority Mental Health

Specialist when that individual has established competence in working with ethnic minority individuals, and has demonstrated either support from the specific community or has accumulated a minimum of 100 specialized hours in training specifically focused on ethnic minority issues (Washington Administrative Code, 2012). Although these specialists are typically used to consult on treatment issues, they (or a similarly knowledgeable expert) can also be consulted in the context of forensic evaluations. However, the use of a cultural consultant does not negate the need for more case-specific collateral informants, as the cultural consultant cannot provide specific details about individual being evaluated (Hays, 2016).

It should be noted, however, that the term "culture" can often be mistakenly perceived as a static characteristic that applies to all individuals from a particular region, country or ethnic group. This oversimplification ignores the variability in acculturation (for individuals that have emigrated to another country), as most people become increasingly "acculturated" to the dominant culture over time (e.g., gradually learning the customs and/or language). In some cases, acculturation may be a more important consideration for mental health examiners than culture (Weiss & Rosenfeld, 2012). Moreover, there are often important regional and social class differences that may exist even within groups of individuals that are considered homogeneous by those from another culture or country. Appreciating the variability within cultural, racial, and ethnic groups is as important as understanding the differences between an ethnic/cultural/racial minority individual and someone from the dominant culture.

Use and training of translators

Another key decision point that typically arises before the interview has begun is whether a translator is needed. Depending on the length of time the individual has been in the host country, some degree of language fluency may exist. In the U.S., for example, even recent immigrants often have some familiarity with English and those that have lived in the U.S. for much of their lives may speak English with nearly equal fluency to their native language. Deciding whether to conduct the interview in the person's native language versus the language of the host country depends in part on an analysis of whether subtleties are more likely to be lost in translation versus through misunderstanding. Attorneys may report having had little trouble communicating without a translator, but the nature of attorney-client communications are often relatively simple, with little demand for the level of precision typical of a forensic clinical interview. Thus, it is often unclear what level of fluency exists prior to beginning the evaluation. Although assessing language fluency (or dominance) is a useful skill for clinicians who frequently evaluate linguistically diverse individuals, this topic is beyond the scope of this article (but see Ridley et al., 1998, for additional guidance). However, when fluency is questionable, it is advisable to have a translator available if needed, even if this precaution turns out to be unnecessary since the difficulty rescheduling an evaluation often outweighs the translator's fee. Even when the evaluatee's fluency makes a translator largely unnecessary, there may still be aspects of the interview that require assistance in order to minimize misunderstandings (e.g., when inquiring about hallucinations or flashbacks, or determining whether beliefs are delusional). Thus, having a translator available can be critical to conducting a thorough and accurate clinical interview.

Many evaluators mistakenly conflate language fluency with cultural assimilation. This, of course, ignores the obvious impact of culture that can be independent of language. For example, a US-based evaluator might be asked to evaluate a defendant from Liberia, where the official language is English but the culture is markedly different. Because culture and language are distinct issues, it is best to identify translators that are from the same country, and ideally even the same region as the person being evaluated. Evaluators often assume that countries are far more homogenous than is accurate, as important differences often exist (e.g., while English is commonly spoken by Liberians from the capital, several regional dialects are used by those living in less developed regions of the country). For example, a recent evaluation of a Kurdish Iraqi defendant revealed substantial regional differences from his Southern Iraq countrymen. These differences not only included subtleties of language (according to the translator), but also culture, religion (Sunni Kurd vs. Shia Arab) and experience (having been the subject of discrimination by the ruling majority, particularly under the Hussein regime). Thus, while a Southern Iraqi translator was able to adequately manage the translation, he was unfamiliar with important aspects of Kurdish culture and typical behaviors or customs, let alone the nature and extent of discrimination experienced by many Northern Iraqis. These issues highlight the benefits of using translators that not only speak the same language as

the person being evaluated, but ideally are from the same country and possibly even the same cultural background.

Of course, the careful selection of an ideal translator is not always possible, even in settings where financial limitations and time constraints are absent. In many settings, a translator has already been identified (e.g., by the attorneys), or in less populated regions (or for less common languages), there may only be one or two people available. Regardless of the level of skill—or cultural familiarity—a translator might possess, few are familiar with the nuances of a forensic mental health interview. It is often useful to have a discussion with the translator before beginning the interview, to review some of the concepts that might arise. A skilled translator will often take notes, perhaps clarifying or looking up complex words or concepts in advance of the interview. Concepts like auditory hallucinations, flashbacks, nightmares, and thoughts of suicide are often unfamiliar to translators and may benefit from a more detailed explanation in advance of the evaluation, to facilitate accurate translation during the interview.

Another critical aspect of preparing a translator is to emphasize the importance of a word-for-word translation (hence, our use of the term "translator" rather than "interpreter"). There are, of course, contexts in which translation should focus on the meaning, rather than the specific words used (e.g., when translating items from a test or structured interview, or transcribing medical records), but in the clinical interview, the precise nature of an individual's speech can reveal important symptoms (e.g., disordered thought processes, confusion, paranoia). Interpretation, on the other hand, is influenced by the translator's expectations, beliefs and experiences, rather than simply reflecting the evaluatee's mental state. Hence, we recommend clearly instructing the translator to refrain from ANY back-and-forth with the evaluatee that does not involve the evaluator. Translators will often ask the evaluatee for clarification without explaining to the evaluator what has been said or why the response needs clarification, effectively providing their own interpretation of what the individual "means" rather than simply conveying what was said. In our experience, even seasoned translators are much more comfortable "interpreting" than translating, as most translation needs require a coherent response, not a word-for-word translation. Asking the translator to explain any confusing responses, so the evaluator can clarify the question or perhaps ask a different question, allows the evaluator to determine the importance of the communication problem rather than relying on the translator to decide what information is worth communicating to the evaluator.

A final consideration, that should go without saying (but sometimes apparently does not), is who should serve as a translator. There are obvious taboos that are nevertheless violated too often by evaluators who fail to think through these issues. For example, using an attorney as an interpreter, while convenient, is clearly inappropriate, as the attorney's need to serve his or her client's best interest might preclude an accurate translation of information. Likewise, family or friends of the person being evaluated may offer to serve as interpreters, but often impede an honest disclosure of information (since the person being evaluated may not feel comfortable revealing sensitive information) and these individuals may also have a vested interested in the outcome of the evaluation. Thus, a general rule of thumb is to use only a translator that has no connection to the person being evaluated, to prevent any real or perceived conflict of interest, and ideally has been certified (e.g., by a court or other certifying body). It may also be helpful to inquire as to the evaluatee's comfort with the translator selected, since concerns about information getting back to their community, whether justified or not, may inhibit rapport or honest responding. Because establishing rapport can be hindered even by the need for a translator, it is also advisable to utilize the same person for subsequent interviews whenever possible (provided they have performed adequately), rather than using a "new" translator each time an interview needs to be conducted (unless problems arose that warrant using a new translator for a follow-up interview).

The forensic interview

Informed consent

The first step in any clinical interview is to outline the legal contours and seek the individual's consent to participate in the evaluation. This requirement is grounded in both case law and ethics codes (e.g., American Academy of Psychiatry and the Law, 2005; APA, 2002, National Association of Social Workers, 2017). Informed consent has been defined as a process in which "the professional communicates sufficient information to the other individual so that she or he may make an informed decision about participation in the professional relationship" (Barnett, Wise, Johnson-Greene, & Bucky, 2007, p. 179). How much

information is included in the informed consent process varies across settings (Otto, Ogloff, & Small, 1991). However, in the forensic context this notification typically involves providing information about the purpose and nature of the examination, possible uses of information, limits of confidentiality, the voluntary or involuntary nature of participation (including potential consequences of participation or non-participation), and the fact that the evaluation is not being conducted for treatment purposes (APA, 2013; Heilbrun, 2009).

Being aware of the cultural factors that can affect the informed consent process is of particular relevance in forensic evaluations because substantial rights are often at risk and the methods and procedures of forensic practitioners may not be known to the evaluatee (APA, 2013). Although there is no research on how culture affects the informed consent specifically in forensic evaluations, it is important to consider that the informed consent process is deeply rooted in the Western concepts of autonomy and self-determination (Snyder & Barnett, 2006; Yousuf, Fauzi, How, Rasool, & Rehana, 2007), whereas in many non-Western cultures, autonomy is not prioritized and instead inter-dependence is preferred. Hence, even the disclosure of the nature and purpose of the evaluation may be confusing to the individual being evaluated. Indeed, medical professionals working with Navajo individuals advise against providing information about the risks associated with a diagnosis or treatment, as Navajo individuals typically believe that this information can be detrimental (Carrese & Rhodes, 1995). In the forensic setting, individuals who are unfamiliar with the informed consent process may not understand that they have a choice whether or not to participate in the interview, that they will not face harsh adverse consequences for not participating (e.g., torture), or that the information they disclose may be used against them in court.

In the context of forensic evaluations, there is variability as to whether informed consent is provided verbally only or also in writing. The use of written documents can help increase the evaluatee's understanding, particularly if written in language that is clear and understandable. The APA Ethics Code's (APA, 2002) states that, "psychologists obtain appropriate informed consent to therapy or related procedures, using language that is reasonably understandable to participants" (p. 1605). However, Gostin (1995) warned that the application of formal consent procedures (e.g., standardized disclosures, written informed consent forms) may be perceived as "alienating and dehumanizing" by individuals unfamiliar with Western standards for informed consent. Instead, he recommends that "It is respect for that human dignity that compels health care professionals to obtain the consent of patients in ways that are comprehensible and consistent with the person's language, custom and culture" (p. 844). In forensic settings, where written informed consent may be desirable, documents should be written at a level appropriate to the individual's reading level, translated into the evaluatee's native language in advance of the evaluation, and back-translation (by a different linguist) should be conducted to insure accuracy (Barnett & Ian, 2008). Whether or not a written translation is used, the evaluator should take steps to insure the individual understands the information provided, as well as the reason for disclosure (and/or documentation), and is making a voluntary choice to participate in the evaluation (as would be the case when cultural differences are not present). Deviating from the standard ways of obtaining informed consent in forensic evaluations can be controversial and must be done with caution. Forensic evaluators have to balance the need to be aware of and respect cultural differences, with the clear mandate and ethical obligation for Western practitioners of obtaining informed consent in a way that respects individuals' autonomy.

The interview process

The forensic interview itself shares many similarities to any other clinical interview, although important differences exist—and are the focus of other articles in this special issue. Unlike many clinical interactions, where the establishment of a diagnosis is the sole or primary focus of the clinical interview, this represents only one (admittedly important) element of the forensic interview. This section highlights challenges that are unique to, or exacerbated by the linguistic and cultural differences that impede the typical forensic interview process.

One key issue alluded to previously is the process of rapport building. Developing rapport is inherently challenging in forensic settings, where the evaluation may be unwanted (e.g., in the case of a court-ordered evaluation or one requested by an opposing attorney) and has potentially severe consequences for the individual being evaluated. Thus, many individuals perceive the forensic interview as being inherently coercive (and this perception is often accurate), and the interviewer as someone whose job is to provide an opinion that will be detrimental (which may also be

an accurate belief). Although little can be done to offset these assumptions, we have found that the best method for overcoming perceptions of bias and coercion is through a relaxed pace and conversational interview process. Rushed evaluations where the interviewer is perceived as having little time or concern for the defendant risk being perceived as an interrogation, and hence impede rapport regardless of culture. These issues are compounded when the individual does not share the Western conceptualization of time, scheduling or priorities. When possible, providing a cup of coffee or bottle of water to the individual being evaluated will demonstrate the evaluator's concern and respect for the individual. Conversely, rigid scheduling or an overly terse or casual demeanor (e.g., joking) may lead the individual to perceive that they are not being taken seriously. There may also be culture-specific considerations to take into account, such as permitting breaks at prayer times, or scheduling to avoid holidays or fasting days, if these are likely to result in diminished concentration or energy.

The requirement of a translator injects another challenging element into the process of rapport building. Many evaluatees will sit facing the translator rather than the evaluator, which may shift the burden of rapport building to the translator, who is usually not trained to conduct a clinical interview. Setting up the interview room to have the evaluator and evaluatee face to face, with the translator to the side, will help minimize this risk, and will allow the translator to remain a neutral element rather than the lynchpin for rapport. Of course, use of a good translator (who is accurate and unobtrusive) can greatly facilitate the clinical interview, primarily by being less visible or prominent in the interview process.

The choice of language is also critical in the forensic interview, particularly with an individual who is not completely fluent in the evaluator's native language. Of course, even when the evaluator and evaluatee speak the same language, nuances may still be lost or misinterpreted due to cultural differences. Because of the potential for misunderstandings, the clinician must be particularly vigilant in phrasing questions as simply and clearly as possible. Many interviewers couch their questions in lengthy introductions, or use terminology that is unknown to those unfamiliar with the language of a clinical interview. Even in the absence of language or cultural barriers, differences in education and familiarity with mental health can increase the likelihood of confusion, but this problem is magnified by a lack of shared culture and/or language. Of course, communication problems are even more pronounced when conducting the evaluation through a translator, as any nuance in the questions asked will likely be stripped away by the translator. A frequent observation when working through an interpreter is to phrase a lengthy question that is translated into just a few words. Rather than allowing the translator to choose the most relevant portions of the question, the evaluator should phrase the question in language that can be easily translated and understood, and when "interpretation" occurs, the evaluator should interrupt the process and rephrase the question.

Another aspect of the forensic interview that requires consideration is eliciting relevant history. One source of challenge is the emphasis placed on shame or "loss of face" by individuals from many non-Western cultures, and those from Asia and Latin America in particular. This may lead an evaluatee to withhold potentially important information out of a concern about how that information may be perceived by others, or may reflect upon their family or community members (Hall, Yip, & Zarate, 2016). This is a particularly challenging when asking about behaviors or actions that might be considered taboo in the individual's culture. For example, alcohol use is prohibited in many Muslim countries and some individuals will be offended by the very question of whether they have violated this taboo. However, the avoidance of questions about alcohol use (or suicidal ideation, which is also considered taboo in many cultures) risks ignoring potentially important information that when present, is even more salient given the violation of social norms. An acknowledgment of the social norms that surround sensitive topics can minimize the risk of offense, and can reassure the individual that the evaluator understands the significance of the question.

Finally, a thorough forensic evaluation should include an inquiry into any symptoms or disorders that may be unique to, or have differential relevance for the individual's particular culture. This may begin with specific questions based on the background research conducted prior to the evaluation (as previously described), but should also include more open-ended questions related to changes the evaluatee has observed and interventions that have been sought or encouraged by family or friends. Inquiring about whether the individual has sought treatment from traditional healers or faith-based interventions can help the clinician identify problems or symptoms that may be unique to the individual's cultural background. The Cultural Formulation Interview detailed in the most recent edition of the Diagnostic and

Statistical Manual for Mental Disorders (DSM-5; American Psychiatric Association Press, 2013) outlines a number of questions that can help elicit culturally unique symptom presentations, along with the individual's understanding of those symptoms. Although not specific to any particular culture, this approach serves as a useful framework for thinking about cultural influences, particularly as they pertain to the diagnostic interview.

The mental status exam and behavioral observations

A critical component of the forensic interview is the mental status examination, which can involve standardized questions or an informal evaluation of the individual's current functioning (Golden & Hutchings, 1998). The mental status exam can be tailored to the forensic referral question and purpose of the evaluation, or it can be limited to a description of observed behaviors during the forensic interview. Regardless of the method used to conduct the mental status examination, the core objective is to accurately describe the individual's behavior (both verbal and non-verbal), emotions and thoughts, particularly as they pertain to either the presence or absence of a mental disorder and/or the specific psycho-legal question (Golden & Hutchings, 1998). However, in the absence of cultural context, those observations can be easily misinterpreted, resulting in faulty conclusions (Mezzich, Caracci, Fabrega, & Kirmayer, 2009; Shepherd & Lewis-Fernandez, 2016).

Several domains of the mental status exam are particularly vulnerable to cultural influences, including the assessment of the evaluatee's attitude, emotions and level of insight. Attitude refers to the individual's level of cooperation and engagement with the evaluator and the interview process more generally. However, there are a number of cultural aspects that can affect how an individual's attitude is perceived. Forensic evaluations typically involve eliciting information about the individual's psychosocial history, which often may require high levels of self-disclosure. In addition to the "typical" reasons why an evaluatee may be reluctant to self-disclose (e.g., concern about how the information will affect the outcome of the case, or an attempt to minimize or exaggerate symptoms), there are also cultural reasons why individuals may decide not to self-disclose. For example, in collectivistic societies, such as many Asian and Hispanic cultures, the individual may decide not to answer questions because any negative aspect of their life could reflect negatively on the entire family (Sue & Sue, 2003). Class-bound values may also play a role, such as when an individual who has experienced oppression and discrimination does not trust the evaluator and may believe that any information disclosed will be used against them (Whaley, 1997). Individuals who are from a culture that has strictly defined roles of dominance and deference, and who are uncomfortable in a situation where the roles are more ambiguous, may also be less likely to self-disclose in the clinical interview (Sue & Sue, 2003).

Evaluating an individual's emotional expression, is another important element of the mental status exam, and can provide important information about how the individual feels about their situation or actions. For example, assessing guilt and remorse are critical to the assessment of psychopathy, and have important implications for assessment of risk for future violent behavior or sexual offending. Accurate assessment of affect is also relevant to the diagnosis of many other disorders, including depression, posttraumatic stress disorder, and schizophrenia. However, many cultural groups do not value emotional expressiveness and instead emphasize the restraint of strong feelings (Shepherd & Lewis-Fernandez, 2016; Sue & Sue, 2003), which can be misinterpreted as coldness or callousness when culture is not taken into consideration. Likewise, individuals from collectivistic cultures more often feel shame for wrongful behaviors (as it reflects on the group) as opposed to guilt (Sue & Sue, 2003), which may influence the evaluator's perception of the evalautee's mental state.

Another consideration in the mental status examination is the assessment of insight into one's behaviors or mental disorder. For instance, insight (or self-awareness) can be relevant to the assessment of violence risk, as well as amenability to treatment, competency to stand trial or to make treatment decisions, and likelihood of complying with the requirements of supervised release. However, insight can be impacted by an individual's understanding of the causes and nature of his or her symptoms, as many cultures conceptualize problems as having their origin in physical or spiritual/religious causes, and may consider the appropriate treatment to be based on these same beliefs. Insight may also be impacted by cultural norms, as some Asian cultures emphasize the avoidance of feelings such as frustration or anger, as they are perceived as detrimental emotions (Sue & Sue, 2003). Thus, a lack of insight into the existence of these feelings may reflect culturally normative behavior, rather than a symptom of a mental disorder. In

summary, an understanding of how a culture conceptualizes and manifests symptoms is necessary to accurately evaluate the nature and extent of the individual's insight.

Summary

Worldwide, mental health professionals are increasingly conducting evaluations with individuals who are linguistically, culturally and socioeconomically diverse. This is particularly salient in the context of forensic mental health assessment, considering the significant cultural diversity among individuals involved in the criminal justice system, as well as civil legal proceedings such as immigration court. Individuals referred for a forensic evaluation often come from a background that is drastically different from those of the forensic evaluator. The U.S. Supreme Court has commented on this issue, stating that cultural competency should be a requirement for all court-appointed mental health evaluators (State of Washington v. Sisouvanh, 2012), and most professional associations make similar recommendations (AAPL, 2005; APA, 2003). However, despite a growing body of literature on multicultural assessment in clinical settings, there is little guidance available on how to incorporate cultural competency in forensic mental health evaluations in general, and during the forensic interview process in particular. This often leaves forensic evaluators wondering whether to take a referral (if the defendant is from a significantly different culture), whether to use a translator, how much to learn about the individual's culture beforehand, and what the best strategies to develop rapport are.

Given the discrepancy between the demographic composition of forensic mental health professionals and the individuals they evaluate, it is imperative that the field continues to expand on research that examines how cultural diversity affects the outcome of forensic interviews. For example, it unclear how the use of translators impacts the forensic interview process, how much knowledge of the individual's culture is needed to conduct an effective interview, or how culture specifically affects the informed consent process or the interpretation of mental status domains. Given the importance of culture in the assessment process, clinicians working in forensic mental health should seek opportunities for increasing their cultural competence, whether through workshops, consultation, or independent study, such as the DSM-5 Cultural Formulation Interview (see also Lewis-Fernandez, Aggarwal, Hinton, Hinton, & Kirmayer, 2016). Although the benefit of these approaches has not been rigorously tested, such efforts to increase competence are likely useful in improving practice.

The challenges faced by clinicians who evaluate culturally and linguistically diverse individuals are numerous. This article represents an attempt to outline these challenges, and provide guidance that can help improve these evaluations. However, more research and scholarship are needed to establish standards of practice for multicultural forensic interviewing. Until then, forensic evaluators should acknowledge the limitations of the data collected from a forensic interview with culturally diverse individuals.

References

American Academy of Psychiatry and the Law. (2005). *Ethics guidelines for the practice of forensic psychiatry*. Retrieved from http://www.aapl.org/ethics.htm

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*. Washington DC: American Psychiatric Association Press.

American Psychological Association. (2002). Ethical Principles of Psychologists and Code of Conduct. *American Psychologist*, *57*(12), 1060–1073. doi:10.1037/0003-066X.57.12.1060

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for Psychologists. *American Psychologist*, *58*(5), 377–402. doi:10.1037/0003-066X.58.5.377

American Psychological Association. (2013). Specialty guidelines for forensic psychology. *American Psychologist*, *68*(1), 7–19. http://dx.doi.org/10.1037/a0029889

American Psychological Association. (2015). *Demographics of the U.S. psychology workforce: Findings from the American Community Survey*. Retrieved December 15, (2017). from http://www.apa.org/workforce/publications/13-demographics/index.aspx

Australian Bureau of Statistics. (2016). *Prisoners in Australia, 2016*. Retrieved from http://www.abs.gov.au/ausstats/abs@.nsf/mf/4517.0

Barnett, J. E., & Ian, G. (2008). Informed consent with culturally divers clients. *Psychotherapy Bulletin*, *43*, 36–42.

Barnett, J. E., Wise, E. H., Johnson-Greene, D., & Bucky, S. F. (2007). Informed consent: Too much of a good thing or not enough? *Professional Psychology: Research and Practice*, *38*(2), 179–186. doi:10.1037/0735-7028.38.2.179

Berman, G., & Dar, A. (2013). *Prison population statistics*. London: House of Commons Library. Retrieved from http://www.antoniocasella.eu/nume/Berman_2013.pdf

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports*, *118*(4), 293–302.

Carrese, J. A., & Rhodes, L. A. (1995). Western bioethics on the Navajo reservation: Benefit or harm? *Journal of the American Medical Association*, *274*(10), 826–829. doi:10.1001/jama.1995.03530100066036

Federal Bureau of Prisons Statistics. (2017). *Inmate citizenship*. Retrieved from https://www.bop.gov/about/statistics/statistics_inmate_citizenship.jsp

Golden & Hutchings, (1998). The mental status examination. In M. Hersen & V. B. Van Hasselt (Ed.), *Basic interviewing* (pp. 107–128). New York, NY: Psychology Press.

Gostin, L. O. (1995). Informed consent, cultural sensitivity and respect for persons. *JAMA: The Journal of the American Medical Association*, *274*(10), 844–845. doi:10.1001/jama, 1995.03530100084039

Hall, G. C., Yip, T., & Zarate, M. A. (2016). On becoming multicultural in a monocultural research world: A conceptual approach to studying ethnocultural diversity. *American Psychologist*, *71*(1), 40–51. doi:10/1037/a0039734

Hays, P. A. (2016). Using standardized tests in a culturally responsive way. In P. A. Hays (Ed.), *Addressing cultural complexities in practice: Assessment, diagnosis, and therapy* (pp. 161–193). Washington, DC: American Psychological Association.

Heilbrun, K. (2009). *Evaluation for risk of violence in adults*. New York, NY: Oxford University Press. Mahwah, NJ: Lawrence Erlbaum Associates.

Hinton, D., & Otto, M. W. (2006). Symptom presentation and symptom meaning among traumatized Cambodian refugees; Relevance to somatically focused cognitive-behavioral therapy. *Cognitive Behavioral Practice*, *13*(4), 249–260. doi:10.1016/j.cbpra.2006.04.006.

Kapoor, R., Dike, C., Burns, C., Carvalho, V., & Griffith, E. E. H. (2013). Cultural competence in correctional mental health. *International Journal of Law and Psychiatry*, *36*(3-4), 273–280. doi:10.1016/j.ijlp.2013.04.016

Krause, I. B. (1989). Sinking heart: A Punjabi communication of distress. *Social Science & Medicine*, *29*(4), 563–575. doi:10.1016/0277-9536(89)90202-5.

Lewis-Fernandez, R., Aggarwal, N. K., Hinton, L., Hinton, D. E., & Kirmayer, L. J. (2016). *DSM–5 handbook on the cultural formulation interview*. Washington, DC: American Psychiatric Publishing.

Mezzich, J. E., Caracci, G., Fabrega, H., & Kirmayer, L. J. (2009). Cultural formulation guidelines. *Transcultural Psychiatry*, *46*(3), 383–405. doi:10.1177/1363461509342942

National Association of Social Workers. (2017). *Code of ethics*. Retrieved December 17, from https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

Otto, R. K., Ogloff, J. R., & Small, M. A. (1991). Confidentiality and informed consent in psychotherapy" Clinicians' knowledge and practices in Florida and Nebraska. *Forensic Reports*, *4*, 379–389.

Ponterotto, J. G. (1988). Racial consciousness development among white counselor trainees: A stage model. *Journal of Multicultural Counseling and Development*, *16*(4), 146–156. doi:10.1002/j.2161-1912tb00405.x.

Ridley, C. R., Li, L. C., & Hill, C. L. (1998). Multicultural assessment: Reexamination, reconceptualization, and practical application. *The Counseling Psychologist*, *26*(6), 827–910. doi:10.1177/0011000098266001.

Ring, J., Nyquist, J., & Mitchell, S. (2016). *Curriculum for culturally responsive health care: The step-by-step guide for cultural competence training*. Boca Raton, FL: CRC Press.

Shepherd, S. M., & Lewis-Fernandez, R. (2016). Forensic risk assessment and cultural diversity: Contemporary challenges and future directions. *Psychology, Public Policy, and Law*, *22*(4), 427–438. doi:10.1037/law0000102.

Snyder, T. A., & Barnett, J. E. (2006). Informed consent and the process of psychotherapy. *Psychotherapy Bulletin*, *41*, 37–42.

State of Washington v. Sisouvanh, V. (2012). 175 Wn.2d 607, 290 P.3d 942 (Wash 2012).

Sue, D. W., & Sue, D. (2003). *Counseling the culturally different: Theory and Practice* (4th ed.). New York. Wiley.

Truong, M., Paradies, Y., & Priest, N. (2014). Interventions to improve cultural competency in healthcare: A systematic review of reviews. *BMC Health Services Research*, *14*, 99

Washington Administrative Code, Title 388, Chapter 865, Section 0150 (2012).

Weiss, R., & Rosenfeld, B. (2012). Navigating cross-cultural issues in forensic assessment: Recommendations for practice. *Professional Psychology: Research and Practice*, *43*(3), 234–240. doi. 10.1037/a0025850.

Whaley, A. L. (1997). Ethnicity/race, paranoia, and psychiatric diagnoses: Clinician bias versus sociocultural differences. *Journal of Psychopathology and Behavioral Assessment*, *19*(1), 1–20. http://dx.doi.org/10.1007/BF02263226

World Prison Brief. (2017). *World prison brief data*. Retrieved Dec 1, 2017, from http://www.prisonstudies.org/map/europe

Yousuf, R. M., Fauzi, A. R. M., How, S. H., Rasool, A. G., & Rehana, K. (2007). Awareness, knowledge and attitude towards informed consent among doctors in two different cultures in Asia: a cross-sectional comparative study in Malaysia and Kashmir, India. *Singapore Medical Journal*, *48*, 559–565.