TOWARDS A CULTURE-BOUND SYNDROME-BASED INSANITY DEFENSE?

ABSTRACT. The American Psychiatric Association’s recent inclusion of a Glossary of Culture-Bound Syndromes within DSM-IV draws upon decades of medical anthropological and cultural psychiatric research to afford culture-bound syndromes (CBSs) a newfound legitimacy within professional Western psychiatric nosology. While DSM-IV’s recognition of the CBS concept as a category of psychosocial distress has important clinical implications for mental health care practitioners throughout the world, it also has significant legal implications. Given that several CBSs involve a degree of psychological impairment that may satisfy the standard for legal insanity under certain circumstances, this essay focuses on the potential emergence of an insanity defense based on the claim that an immigrant or minority defendant was suffering from a CBS at the time of his or her criminal act. Aimed at initiating interdisciplinary debate over the reification of the CBS concept, the essay discusses the theoretical ambiguity and status of CBSs within professional Western psychiatry, describes what a CBS-based insanity defense might look like, and considers the relevant challenges facing medical anthropologists and cultural psychiatrists, on the one hand, and legal practitioners, on the other. The essay identifies a pressing need for interdisciplinary debate concerning the validity, scope, and viability of CBS-based insanity defenses.

INTRODUCTION

The American Psychiatric Association’s (APA) recent inclusion of a Glossary of Culture-Bound Syndromes within DSM-IV (APA 1994a: 844–849) constitutes an extraordinary step in recognizing a class of mental disorders long marginalized as an exotic footnote to the universalizability of psychopathological processes and categories. Although still relegated to an appendix following the text of the Manual itself, DSM-IV’s new Glossary draws upon decades of medical anthropological and cultural psychiatric research to afford culture-bound syndromes (CBSs) a newfound legitimacy within professional Western psychiatric nosology. As one component of a more culturally sensitive DSM “designed to enhance [its] cross-cultural applicability” and “assist the clinician in systematically evaluating” individuals from diverse cultural backgrounds (APA 1994a: 844), the Glossary has important clinical implications for mental health care practitioners both throughout the United States and abroad (Mezzich et al. 1996).

As a newly articulated category of psychosocial distress within professional Western psychiatry’s state-of-the-art diagnostic manual, however, DSM-IV’s
Glossary also has significant legal implications. Most notably, CBSs may soon find their way into the criminal defense strategies of attorneys who represent minority and immigrant offenders. While a criminal defense attorney may conceivably call upon the Glossary to support a variety of mitigating or exculpatory arguments, this essay focuses on the possible use and abuse of an insanity defense on the basis of the claim that a defendant was suffering from a CBS at the time of his or her criminal act. Indeed, aimed at initiating interdisciplinary debate over the ongoing reification of CBSs within the American legal context, the essay illustrates how DSM-IV’s Glossary inadvertently provides criminal defense attorneys with a new and potentially productive tool of legal advocacy in the form of the CBS-based insanity defense.

Significantly, the potential emergence of CBS-based insanity defenses poses difficult challenges not only for the legal profession, but also for the medical anthropologists and cultural psychiatrists upon whose research and expert testimony these defenses will depend. In the wake of DSM-IV’s publication, many of these interdisciplinary challenges are at odds with one another, creating a tension that is evidenced throughout this essay. Most notably, for medical anthropologists and cultural psychiatrists, DSM-IV’s Glossary is an imperfect and incomplete translation of an eclectic amalgamation of ethnographic, epidemiological, and clinical research into the discourse of the biomedical model that dominates contemporary professional Western psychiatry. Viewed as such, both the process of translation and the translation itself combine to expose important theoretical ambiguities with respect to CBSs, the complex relationship between culture and mental illness, and, ultimately, the nature of psychiatric diagnosis itself. For legal practitioners, on the other hand, the incorporation of CBSs within DSM-IV serves to reify the CBS concept as a definitive classificatory entity within the bounds of professional Western psychiatry’s scope of expertise. As a result, like other DSM-IV diagnostic entities involving varying degrees of psychological impairment, it merits concerted evaluation regarding its capacity to assist in the legal task of assigning blame.

In order to generate discourse spanning this vast interdisciplinary divide, this essay begins with a brief overview of the historical development of CBSs, the debate over their definition within the research literature, and their controversial status within professional Western psychiatry itself. The essay then reviews the standard for legal insanity in the United States, and considers how a criminal defense attorney might argue that a client suffering from a CBS meets this standard. The essay subsequently turns to one particular CBS, that of amok, and examines two court cases that incorporated (or could have incorporated) this CBS into an insanity defense strategy. After identifying additional CBSs whose symptoms could arguably support a Not Guilty by Reason of Insanity (NGRI) plea, the essay then explores some of the interdisciplinary implications of CBS-based
insanity defenses, ultimately identifying a pressing need for serious debate over their validity, scope, and viability.

WHAT ARE CULTURE-BOUND SYNDROMES?

Scholars interested in the interplay between culture and mental illness have long been aware of the existence of a wide variety of culturally specific forms of psychopathology. Originally documented by late nineteenth century missionaries and ethnographers who encountered unusual manifestations of psychological distress among the peoples whom they proselytized and studied, researchers have variously labeled these phenomena as psychogenic psychoses, ethnic psychoses, ethnic neuroses, hysterical psychoses, exotic psychoses, and culture-reactive syndromes, among other classifications (Hughes 1985a). The specific conception of culturally peculiar mental disorders as being “culture-bound,” however, first entered into the psychiatric discourse during the Third World Congress of Psychiatry when Yap (1962) introduced the phrase “atypical culture-bound, psychogenic psychosis,” and subsequently reformulated it as “culture-bound syndrome” (Yap 1965).

Generally speaking, the phrase “culture-bound syndrome” refers to a pattern of psychosocial distress, or syndrome, that emerges only within, or is bound by, a particular culture or cultural context. However, there is no single agreed upon definition of CBSs throughout the medical anthropological and cultural psychiatric literature. While some scholars argue that CBSs are best conceptualized as “systems of implicit values, social structure, and obviously shared beliefs [that] produce unusual forms of psychopathology that are confined to special areas” (Yap 1969: 38), others suggest that they constitute “folk diagnostic categories—categories that supply coherent meanings to recurrent and remarkable sets of experiences and observations” (Simons and Hughes 1993: 75). Similarly, while some scholars advocate a more expansive definition of the CBS concept (Jilek and Jilek-Aall 1985), others argue for the need to limit its scope (Low 1985; Prince 1985). Others still reject the CBS concept altogether based on its “solipsist premise, making cross-cultural comparison impossible” (Hahn 1985: 165).

Gaw’s recent attempt (Gaw 2001) at clarification separates existing understandings of CBSs into two different camps. The first camp is the syndromal approach. This approach “assumes that CBSs are manifestations of a set of universal categories of psychopathology uniquely shaped by specific cultural forms and social structures” (Gaw 2001: 84). Based on this assumption, the syndromal approach searches for a common physiological substrate between various CBSs and already established diagnostic entities, and it draws heavily from the biomedical model. The second camp is the meaning-centered approach. In contrast to the syndromal approach, the meaning-centered approach assumes a generative model of culture and broadly characterizes CBSs as culturally constituted “constellation[s] of
symptoms that together have been categorized as a dysfunction or disease” (Gaw 2001: 86). As a result, the meaning-centered approach emphasizes that CBSs cannot be understood apart from their specific cultural or subcultural contexts (Hill and Fortenberry 1992; Ritenbaugh 1982).

DSM-IV’s characterization of CBSs appears to favor the meaning-centered approach. More specifically, the Glossary defines CBSs as “recurrent, locality-specific patterns of aberrant behavior and troubling experience . . . indigenously considered to be ‘illnesses,’ or at least afflictions” (APA 1994a: 844). The Manual further explains that CBSs “may or may not be linked to a particular DSM-IV diagnostic category,” and it points out that “there is seldom a one-to-one equivalence of any culture-bound syndrome with a DSM diagnostic entity.” As Guarnaccia and Rogler (1999: 1325) have recently noted, DSM-IV thus questions the methodological soundness of the syndromal approach and its attempt to subsume CBSs within already existing psychiatric classifications.

Even more to the point, the Glossary directly states that

Although presentations conforming to the major DSM-IV categories can be found throughout the world, the particular symptoms, course, and social response are very often influenced by local cultural factors. In contrast, culture-bound syndromes are generally limited to specific societies or culture areas and are localized, folk, diagnostic categories that form coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations. (APA 1994a: 844, emphasis added)

According to DSM-IV then, CBSs are not universal categories of psychopathology uniquely shaped by specific cultural forms and social structures, as the syndromal approach posits, but rather distinctive ethnopsychiatric entities that, for the most part, find no counterpart in established Western psychiatric classification.

While DSM-IV's Glossary suggests a meaning-centered approach to CBSs, its primary purpose, of course, is practical in nature. More specifically, the Glossary’s contents include a brief introduction and 25 separate entries. Each entry includes the name of a different CBS, a short description of its most salient features, and an identification of its geographic scope. When applicable, Glossary entries also indicate alternative ethnopsychiatric labels and “relevant DSM-IV categories when data suggest that they should be considered in a diagnostic formulation” (APA 1994a: 845). Clinicians that suspect the existence of a CBS may then refer to the relevant medical anthropological and cultural psychiatric literature for additional information concerning that particular syndrome's etiology, course, outcome, and treatment.

Notably, however, DSM-IV’s Glossary only includes the 25 “best-studied CBSs and idioms of distress that may be encountered in clinical practice in North America” (APA 1994a: 844–845). In fact, medical anthropologists and cultural psychiatrists have documented at least 185 different CBSs throughout the world (Blue and Gaines 1992; Hughes 1985b, 1996), and additional syndromes are
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regularly being identified as researchers come to better understand the dynamics of psychopathology and deviance across cultural groups (Hughes and Wintrob 1995). These additional CBSs encompass numerous Western psychiatric disorders including obesity (Ritenbaugh 1982), anorexia nervosa (Swartz 1985), dissociative identity disorder (APA 1994a: 844), type A behavior pattern (Helman 1987), and even adolescence (Hill and Fortenberry 1992). Furthermore, there has been a recent interdisciplinary resurgence of interest in CBSs.4 Gaw (2001) attributes this to a variety of factors including the trend towards globalization, the development of culturally sensitive mental health care programs for minority and immigrant populations, and an expanding demand for an international system of psychiatric classification. As a result, contemporary clinicians are increasingly exposed to, and must treat, patients from a wide variety of cultural backgrounds (Gaw 2001: 73–74).

As atypical ethnopsychiatric entities that confound established diagnostic classification, however, CBSs continue to present important challenges to biomedicine’s universalist characterization of psychopathological processes and categories. Most notably, although DSM-IV’s meaning-centered approach to CBSs appears to recognize the generative power of culture with respect to these complex psychosocial phenomena, the Manual fails to apply this same critical recognition to the vast remainder of its nosological system. That is, while DSM-IV characterizes CBSs as “localized, folk . . . categories that form coherent meanings for . . . troubling sets of experiences” (APA 1994a: 844), all other DSM-IV diagnoses are implicitly reified as universal categories whose “particular symptoms, course, and social response are very often influenced [but not constituted] by local cultural factors” (APA 1994a: 844, emphasis added). In reality, of course,

Western scientific diagnoses and diagnostic systems are . . . no less “bound” by a particular culture. The syndromes referred to as “culture-bound” are called so only because the cultures they are bound to are foreign to the ordinary cultural expectations of the Western clinician or investigator; hence, their shaping by cultural determinants is more visible. (Simons and Hughes 1993: 75)

Thus, as square pegs that resist being forced into the circular holes of professional Western psychiatry’s diagnostic box, CBSs function to expose the culturally constituted nature of the box itself. Indeed, as the next section illustrates, this thorn in the side of professional Western psychiatry finds an uneasy home—but a home nonetheless—within DSM-IV, the field’s state-of-the-art diagnostic manual.

THE STATUS OF CULTURE-BOUND SYNDROMES IN DSM-IV

The official recognition of new psychiatric disorders by DSM often meets with mixed reactions from both within and outside the psychiatric community. In 1980, for example, the American Psychiatric Association’s publication of DSM-III
formally acknowledged the classification of “Posttraumatic stress disorder” (PTSD) as a subcategory of anxiety disorders (APA 1980). This professional promulgation of PTSD divided psychiatrists, judges, and veterans alike (Davidson 1988: 440). On the one hand, various commentators agreed that PTSD constituted a bona fide constellation of psychiatric symptoms caused by a psychologically traumatic event beyond the range of normal human experience (Burke 1980; Time Magazine 1980). On the other hand, others critiqued this new classification as a fraudulent use and abuse of diagnostic criteria designed to serve the social services and legal needs of American combat veterans (Kurtz 1986).

One of the primary sources of tension regarding this debate was concern over the potential emergence of a PTSD-based insanity defense (Walker 1981). Indeed, criminal defense attorneys were quick to ride the wave of PTSD’s new status within DSM-III and argue that, as an acknowledged mental disorder in the professional psychiatric community, PTSD constituted a “mental disease” relevant to determinations of legal insanity (Packer 1983: 126). In State v. Heads, 385 So.2d 230 (La. 1980), for example, a defendant was convicted of first-degree murder in 1980 despite a plea of insanity based on a traumatic experience during the Vietnam War. The conviction was subsequently overturned on a separate issue and the defendant’s case was retried. Between the two trials, however, the publication of DSM-III officially validated the defendant’s diagnosis of PTSD. As a result, Heads was later acquitted by reason of a PTSD-based insanity defense at his second trial (Reisner et al. 1999).

Over the years following the Heads case, insanity defenses based on PTSD have seen some degree of success, particularly among Vietnam and other combat veterans. Past cases have led to findings of legal insanity with respect to charges of murder, attempted murder, kidnapping, and drug smuggling. In addition, PTSD has also been called upon as a mitigating factor with respect to convictions ranging from drug dealing and manslaughter to assault with intent to commit murder and even tax fraud.

Like DSM-III’s controversial incorporation of PTSD, the American Psychiatric Association’s decision to include the Glossary within DSM-IV also met with considerable resistance (Mezzich et al. 1996, 1999). Interestingly, much of this resistance came from within the psychiatric community itself. In 1991, for example, the National Institute of Mental Health (NIMH) sponsored a Culture and Diagnosis Group consisting of 50 of the world’s leading experts in medical anthropology and cultural psychiatry. The primary objective of the Group was to make recommendations to the DSM-IV Task Force concerning how to incorporate cultural considerations into the forthcoming edition of the Manual. The Group made a variety of culturally relevant suggestions, including the text-based incorporation of a Glossary of Culture-Bound Syndromes and Idioms of Distress. In addition to the 25 CBSs discussed earlier, this expanded Glossary also identified...
various “Western culture-related syndromes” and their links to “specific features of Western countries or highly westernized segments of other societies” (Mezzich et al. 1999: 460).

Upon review of the Culture and Diagnosis Group’s recommendations, the Task Force accepted some of its suggestions, but rejected many others. First and foremost, it positioned the Glossary not within the text of the Manual itself, but rather as an afterthought deep within its ninth appendix. In addition, the Task Force also removed the Group’s section on Western CBSs, further exoticizing the Glossary’s exclusively non-Western focus. Moreover, the Task Force cut numerous suggested references to CBSs within the Manual’s cultural considerations section, further isolating the Glossary as separate from the bulk of the Manual’s text. Finally, the Task Force also shortened the title of the appendix from a Glossary of Culture-Bound Syndromes and Idioms of Distress to a Glossary of Culture-Bound Syndromes, thus obscuring a subtle but important theoretical distinction permeating these complex psychosocial phenomena (Mezzich et al. 1999).

In fact, this editorial sleight of hand served an important function with respect to professional Western psychiatry’s larger nosological project. More specifically, it enabled DSM-IV to acknowledge the existence and culturally constituted nature of CBSs, while simultaneously preserving its entrenched paradigmatic orientation around the universalizability of psychopathological processes and categories more generally. Yet despite this biased editorial process, the Glossary itself survived to become the first recognition of CBSs in the history of professional Western psychiatry’s state-of-the-art diagnostic manual. Indeed, as a reification of the CBS concept within DSM-IV, the Glossary merits serious evaluation as a tool that, when applied to the existing insanity defense framework, might assist attorneys, judges, and juries in the legal task of assigning blame.

DEFINING LEGAL INSANITY

The special defense of insanity is one of the most enduring as well as vexing mainstays of the criminal law. Historically, the notion that one’s psychological state may preclude culpability for a criminal act can be traced back to the foundations of Western ethical and legal thought itself (Hermann 1983). While some scholars point to ancient Greek mythology as the earliest record establishing moral agency as a prerequisite to criminal sanctions (Robinson 1996: 8), others characterize the insanity defense as a vision dating back to biblical times (Knoops 2001: 111). Others still point to the compendium of Jewish law known as the Talmud for the first historical example of legal exculpation by reason of mental illness (Quen 1974: 313; Simon and Aaronson 1988: 10; Weiner 1980: 1058). Regardless of its precise origins, however, the insanity defense has been in existence in one form or another since at least the twelfth century (Sendor 1986: 1380), and nearly every
legal system in the world recognizes some form of legal insanity as an affirmative defense today.\textsuperscript{12}

Generally speaking, the theory of criminal law rests on the assumption that, in the words of former American federal appellate Judge David Bazelon, “Our collective conscience does not allow punishment where it cannot impose blame” (\textit{Durham v. United States}, 214 F.2d 862, at 866 [D.C. Cir. 1954]). In order to identify and subsequently punish the blameworthy, the criminal law breaks down every crime into two separate components: the \textit{actus reus} and the \textit{mens rea}.\textsuperscript{13} While the \textit{actus reus} is the physical component of the offense and usually contains multiple elements, the \textit{mens rea} is the crime’s requisite mental state and typically identifies a specific degree of intentionality necessary for a finding of guilt.

In most cases, the \textit{mens rea} requirement adequately serves its intended function, namely, the assignment of moral blame based on some degree of intent to commit a criminal act.\textsuperscript{14} In cases involving mental illness, however, the \textit{mens rea} requirement often falls short. This is because while individuals suffering from mental illness are usually capable of acting with intent, and thus forming the requisite \textit{mens rea}, their mental illness frequently precludes them from appreciating the nature and quality of their acts, distinguishing between right and wrong, or conforming their behavior to the requirements of the law. Based on the recognition that the whole of criminal culpability is necessarily greater than the sum of its parts, the insanity defense thus functions to ensure that these individuals are not unjustly subjected to criminal punishment.

\textbf{THE MENTAL DISEASE REQUIREMENT}

Although the test for legal insanity in the United States has varied both over time and from jurisdiction to jurisdiction, a successful insanity defense always requires a finding that the defendant suffered from a “mental disease or defect” at the time of his or her act (Reisner et al. 1999: 536).\textsuperscript{15} The initial question with respect to a CBS-based insanity defense is thus whether the CBS under consideration satisfies this first part of the test. Answering this question depends upon a variety of factors.

The most obvious factor is one’s definition of the phrase “mental disease or defect.” While the term mental disease is commonly understood to mean mental illness and mental defect is generally thought to connote mental retardation, what counts as a mental disease or defect for the purposes of legal insanity varies according to whom one asks. The American Law Institute (ALI), for example, does not define mental disease or defect at all. Instead, it simply excludes insanity defenses based on “antisocial personality disorder” consisting of “abnormality manifested only by repeated criminal or otherwise antisocial conduct” (ALI 1962: §4.01). According to this formulation,
An insanity defense [may be] based on any diagnosis found in DSM-IV (other than perhaps antisocial personality) that the courts are willing to recognize as sufficiently trustworthy. Presumably, it also allows a defense based on conditions not found in the Manual. (Reisner et al. 1999: 537)

As a result, from a criminal defense attorney’s perspective, any CBS conceivably qualifies as a mental disease or defect under the ALI standard.16 Other authorities, however, articulate a far less inclusive approach. Gerard (1987), for example, suggests that, in addition to a DSM diagnosis, a defendant’s condition must meet three criteria before qualifying for an insanity defense. First, the disorder must be a “traditional” disease as evidenced by a particular symptom profile that is distinguishable from other diseases, and, when untreated, has a scientifically predictable outcome. Second, the disorder must specifically and negatively impact the individual’s capacity to act rationally and according to legal norms. And third, the disorder must consist of a physiological deviation evidenced only when an individual acts compulsively against his own interests, despite environmental influences to the contrary. Given that only four existing DSM disorders meet these considerably more stringent criteria,17 not a single CBS qualifies as a “mental disease or defect” with respect to Gerard’s standard.

A second important factor relevant to the mental disease or defect requirement is the evidentiary law regarding expert testimony where the case comes to trial. There are two main approaches to evidentiary questions of this nature. First, some jurisdictions use the Frye test (Frye v. United States, 293 F. 1013 [D.C. Cir. 1923]), whereby expert testimony is admissible only when its content is “generally accepted” within the relevant scientific community. Under this standard, the admissibility of any given CBS is subject to considerable debate. On the one hand, a criminal defense attorney will point to the fact that DSM-IV now contains 25 different CBSs. As the publisher of DSM-IV, the American Psychiatric Association is clearly the leading professional association in the field of psychiatry and the vast majority of professional psychiatrists belong to it. Similarly, DSM-IV is the APA’s state-of-the-art diagnostic manual and it is common practice for practitioners to consult it on a regular basis. As a result, expert testimony from a respected Western-trained psychiatrist who is a member of the APA, uses DSM-IV, and can vouch for the validity of a particular CBS within the relevant literature should be admissible under the Frye standard.

On the other hand, there is also strong evidence to rebut the argument that CBSs are “generally accepted” within the psychiatric community. Undoubtedly, a prosecuting attorney will call upon experts of his or her own who will denigrate CBSs as “intellectual balderdash” (Scrignar 1984: 172) and “psychiatric junk” (Slobogin 1998). This rebuttal will subject the Glossary to extreme methodological scrutiny, of course, by characterizing it as “a museum of exotica” (Mezzich et al. 1999), and emphasizing that psychiatry’s primary textbooks continue to give
CBSs “only perfunctory recognition: a page or two of text and no inclusion in the index” (Hughes and Wintrob 1995: 580–581). Indeed, the prosecutor will portray CBSs as “extraneous to the work of clinical psychiatrists and other mental health practitioners” (Hughes and Wintrob 1995: 581), and note that many practitioners may not even be aware of the existence of the Glossary at all.

The second approach to the admissibility of expert testimony is the Daubert test (Daubert v. Merrell Dow Pharm., Inc., 509 U.S. 579 [1993]). More specifically, Daubert jurisdictions leave the admissibility of expert testimony to the discretion of the district court judge, who acts as a “gatekeeper” charged with filtering out unreliable evidence. As a result, general acceptance is only one consideration under the Daubert standard. Other relevant factors include whether the research is published, whether these publications are peer-reviewed, and whether the studies are methodologically reliable based on their potential rate of error.

Again, it is highly debatable whether any given CBS would survive Daubert scrutiny. On the one hand, there are well over a hundred scholarly essays discussing the theoretical as well as the empirical bases of CBSs. Many of these essays have been published in the most prominent peer-reviewed psychiatric journals including the American Journal of Psychiatry, the Archives of General Psychiatry, Culture, Medicine and Psychiatry, the Journal of Nervous and Mental Disease, and Transcultural Psychiatry, among many others. While much of this research has been subjected to intense methodological scrutiny, a significant amount of this work has been qualitative in nature and it is often difficult to assess potential rates of error. As a result, the admissibility of expert testimony concerning any given CBS is ultimately up to the judge hearing the case.

THE PSYCHOLOGICAL IMPAIRMENT REQUIREMENT

Despite the problematic nature of defining any given CBS as a mental disease or defect within a court of law, however, it is important to note that the legal definition of insanity hinges less on the label given to a particular condition than the condition’s relationship to the defendant’s degree of psychological impairment at the time of the act. Thus, as LaFave and Scott (1986) note, “Any mental abnormality, be it psychosis, neurosis, organic brain disorder, or congenital intellectual deficiency . . . will suffice if it has caused the consequences described in the second part of the test” (312). Stated otherwise, “The mental disease or defect predicate is relatively unimportant; what is important is whether the individual was so cognitively or volitionally impaired at the time of the offense that exculpation is necessary” (Reisner et al. 1999: 537).

Under the cognitive test for legal insanity found in virtually every jurisdiction, the mental disease or defect must have rendered the defendant unable to appreciate the nature and quality of his or her act, or to distinguish between right and wrong.
Based on this relatively narrow standard, the degree of psychological impairment must be to the extent that the defendant did not know what he or she was doing, or, in the alternative, did not know that what he or she was doing was legally or morally wrong. Several jurisdictions also define legal insanity in broader terms, however, and allow for a showing of either cognitive or volitional impairment. Under this considerably more liberal standard, legal insanity also exists when the defendant’s mental disease or defect renders him or her unable to control his or her behavior. Sometimes referred to as the “irresistible impulse test” or the “policeman at the elbow test,” this volitional standard exculpates defendants who, as a result of a mental disease or defect, would have been unable to conform their behavior to the requirements of the law even if a police officer had been standing immediately beside them (Hermann 1997).

AMOK AS LEGAL INSANITY

The viability of a CBS-based insanity defense thus ultimately depends upon the degree of psychological impairment caused by the defendant’s CBS. While the vast majority of CBSs involve relatively little, if any, psychological impairment, a limited number of Glossary entries are characterized by significant dysfunction. Indeed, from the perspective of a criminal defense attorney charged with the task of zealous advocacy, these CBSs may, depending on the jurisdiction and circumstances, arguably justify pursuing a CBS-based insanity defense.

The CBS that is most likely to satisfy the standard for legal insanity is the Glossary’s first and probably most recognizable entry, amok. According to the Glossary, amok is

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 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). (APA 1994a: 845)

Notably, the American legal system has a long tradition of using the term “amok” (also spelled “amuck”) to describe an individual acting in an out-of-control manner. As early as 1909, for example, a New York state court reported that

It is common knowledge that insanity may be chronic, yet with lucid intervals, that it is marked by periods of quiet and of storm, that one insane may at times demean himself as if entirely normal, and yet without warning suddenly become as dangerous as a Malay running amuck. (State of NY ex rel. Peabody v. Chanler, 117 N.Y.S. 322, at 325 [1909 NY App. Div. Lexis 213], emphasis added)
While many courts have since followed suit, none has been more eloquent in describing the psychological impairment caused by *amok* than a state court in Pennsylvania, which stated that “If facts spell out intentions, or lack of them, and if circumstances are more convincing than words, it is clear that . . . *Moon* [the defendant] was a man amuck” (*Pennsylvania v. Moon*, 125 A.2d 594, at 605 [1956 Pa. Lexis 392], emphasis added).

Alliteration aside, past defendants have in fact called upon *amok* as part of their criminal defense strategy. In *State v. Ganal*, 917 P.2d 370 (Haw. 1996), for example, the Supreme Court of Hawaii considered the case of a Filipino man who, after learning that his wife was having affair with another man, killed his wife’s parents, injured his wife and their son, and then set fire to the home of his wife’s lover’s brother. Two young children ultimately perished in the flames. At the trial, one of Ganal’s defenses was that he that had “run *amok*” at the time of his acts. More specifically, his attorney contended that Ganal was suffering from a CBS involving a degree of psychological impairment sufficient to meet Hawaii’s standard for legal insanity.21 Ganal’s *amok*-based insanity defense was ultimately unsuccessful, and he was convicted of both first degree murder and attempted murder. Ganal appealed, however, contesting the verdict on numerous legal grounds. Most notably, Ganal objected that the prosecutor had sarcastically trivialized his *amok* defense during the course of the trial. Although the Hawaiian Supreme Court refused to reverse the verdict, it nonetheless strongly criticized the inappropriateness of the prosecutor’s comments and, in doing so, left the door open for future defendants to argue an insanity defense based on *amok*, and perhaps other CBSs as well.

Although Ganal’s defense strategy ultimately did not prevail, it is important to note that his initial trial was held prior to the publication of DSM-IV in 1994. As with the insanity defense aftermath following DSM-III’s incorporation of PTSD, Ganal might have had a considerably stronger argument for legal insanity today. More specifically, Ganal could have called upon the *Glossary* to lend support for his *amok*-based insanity defense. First, as a Filipino male, he clearly fit DSM-IV’s demographic profile of an individual suffering from *amok*. As noted earlier, the *Glossary* states that although the original reports of *amok* were from Malaysia, “a similar behavior pattern is found in . . . [the] Philippines” (APA 1994a: 845). In addition, the *Manual* further underscores that the disorder is “prevalent only among males.” Second, Ganal also clearly fit the *Glossary’s* symptom profile of *amok*. To begin with, his behavior undoubtedly constituted “an outburst of violent, aggressive, or homicidal behavior” (APA 1994a: 845)—he had killed his wife’s parents, injured his wife and their son, and burned down his wife’s lover’s brother’s home, causing two young children to perish in the flames. Moreover, Ganal’s outburst was “precipitated by a perceived slight or insult” (APA 1994a: 845) in that he had recently discovered his wife’s infidelities. And furthermore,
Ganal’s “episode” was followed by a period of amnesia, another symptom of the syndrome according to the Glossary (APA 1994a: 845). Thus, viewed through the lens of DSM-IV, Ganal’s attorney might have convinced the jury that, at the time of his acts, Ganal was suffering from a mental disease involving a degree of psychological impairment that satisfied Hawaii’s standard for legal insanity.

Similarly, in People v. Aphaylath, 499 N.Y.S.2d 823, at 824 (1986), the defendant was a Laotian refugee who had killed his wife by repeatedly stabbing her after she received a phone call from a former boyfriend. During the trial, Aphaylath revealed that, at the time of his act, he had been suffering from “extreme emotional disturbance . . . [rooted in] significant mental trauma, affecting his mind for a substantial period of time, simmering in the unknowing subconscious and then inexplicably coming to the fore” (People v. Aphaylath, 68 N.Y.2d 945, at 946 [1986]). Given New York’s relatively narrow insanity defense, however, Aphaylath pleaded a “cultural defense” instead of NGRI. More specifically, in an attempt to mitigate the charges against him, Aphaylath argued that

Under Laotian culture, the conduct of the victim’s wife in displaying affection for another man and receiving phone calls from an unattached man brought shame on [him] and his family sufficient to trigger [his] loss of control. (People v. Aphaylath, 68 N.Y.2d 945, at 946 [1986])

As a result, Aphaylath asserted that, although he was guilty of the crime, his punishment should take into account his cultural background and its relationship to his violent reaction to these circumstances.

While Aphaylath presented some evidence concerning Laotian cultural norms through his own testimony, he was initially precluded from presenting two expert witnesses on the topic of stress and disorientation among Laotian refugees (People v. Aphaylath, 499 N.Y.S.2d 823, at 824 [1986]). Ultimately, Aphaylath was convicted of second degree murder. On appeal, Judge Doerr of the Supreme Court of New York stated that “jealousy is not a subject beyond the ken of the ordinary juror for which expert testimony is needed” (People v. Aphaylath, 499 N.Y.S.2d 823, at 824 [1986]) and affirmed the lower court’s ruling.

Like State v. Ganal, Aphaylath’s case offers another example of a defendant whose criminal defense strategy could have benefited from the publication of DSM-IV. As a Laotian male, Aphaylath—like Ganal—clearly fit the Glossary’s demographic profile of amok. Similarly, Aphaylath also fit the Glossary’s symptom profile. More specifically, he abruptly stabbed his wife to death (an outburst of homicidal behavior) following a phone call from his wife’s former boyfriend (a perceived slight or insult). Furthermore, while the facts of the case are insufficient to make a definitive determination, it was more than likely that Aphaylath’s “episode” was “accompanied by persecutory ideas, automatism, amnesia, [or] exhaustion” (APA 1994a: 845). Finally, a criminal defense attorney could have easily
characterized Aphaylath’s “extreme emotional disturbance” as “a brief psychotic episode or [as] constituting the onset or an exacerbation of a chronic psychotic process” (APA 1994a: 845). In sum, following the publication of DSM-IV, Aphaylath might have had a strong argument for an *amok*-based insanity defense.

**OTHER POTENTIAL CBS-BASED INSANITY DEFENSES**

As the Ganal and Aphaylath cases illustrate, *amok* is an example of a CBS that may involve the degree of psychological impairment necessary to satisfy the standard for legal insanity. It is important to recognize, however, that *amok* is not unique in this respect. In fact, DSM-IV’s *Glossary* includes five additional CBSs that, from a criminal defense attorney’s perspective, may also fall under this rubric. These syndromes include: *ataque de nervios*, a Latino idiom of distress characterized by a “sense of being out of control” often involving symptoms of “uncontrollable shouting[,]... verbal and physical aggression,” and sometimes “dissociative experience” (APA 1994a: 845); *boufee delirante*, a West African and Haitian syndrome consisting of a “sudden outburst of agitated and aggressive behavior... accompanied by visual and auditory hallucinations or paranoid ideation” resembling “Brief Psychotic Disorder” (APA 1994a: 845); *locura*, a Latino term referring to a “severe form of chronic psychosis” involving “incoherence, agitation, auditory and visual hallucinations, inability to follow rules of social interaction, unpredictability and possible violence” (APA 1994a: 847); *pibloktoq*, an “abrupt dissociative episode” observed in Native Canadian and Alaskan communities wherein “the individual may tear off his or her clothing, break furniture, shout obscenities, eat feces, flee from protective shelters, or perform other irrational or dangerous acts”; and *zar*, a general term employed by some North African and Middle Eastern societies to describe the experience of spirit possession and “dissociative episodes that may include shouting [or]... hitting [one’s] head against a wall” (APA 1994a: 849).

Moreover, as noted earlier, DSM-IV’s *Glossary* only describes 25 out of the 185 or more existing CBSs documented by medical anthropologists and cultural psychiatrists. Hughes (1996) has published a useful “symptom distribution” list for this larger universe of syndromes. While this list must be viewed with caution given the early stage of research on many CBSs, it is nonetheless noteworthy that many of the syndromes are characterized by significant psychological impairment: 15 involve dissociative experience; 14 involve visual or auditory hallucinations; 13 involve “psychotic symptoms”; 12 involve feelings of being bewitched; 7 involve mental confusion; 7 involve feelings of being possessed; and another 5 syndromes involve paranoid or persecutory ideas. Furthermore, several CBSs are also characterized by behaviors that are likely to bring individuals into contact with the criminal justice system: 18 involve angry or aggressive
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acts; 7 involve homicidal behavior; 4 involve other kinds of violence; 9 involve compulsivity or obsessiveness; 5 involve bizarre or unconventional conduct; 4 involve irritability or quarrelsomeness; and another 4 involve wandering or running away.

Of course, these figures do not suggest that violence is a common, much less a defining, feature of either CBSs in particular or mental illness in general. In direct contrast, analyses of the psychiatric literature reveal that there is no compelling scientific evidence that individuals with mental illness are any more likely to commit acts of violence than the population at large (APA 1994b). Nonetheless, from the perspective of a criminal defense attorney charged with the professional obligation to vigorously advocate on behalf of his or her client, the above figures do suggest that, under certain circumstances, pursuing a CBS-based insanity defense may constitute a viable strategy for representing minority and immigrant clients facing the possibility of criminal incarceration.

INTERDISCIPLINARY IMPLICATIONS

The newfound viability of CBS-based insanity defenses following the publication of DSM-IV has significant implications not only for the legal community, but also for medical anthropologists and cultural psychiatrists. More specifically, these “cultural experts” will be asked to serve as witnesses and consultants when CBS-based insanity defenses come to trial. For example, according to a recent practitioner’s manual designed for attorneys who defend culturally diverse clients in criminal matters,

In order to effectively represent defendants from other cultures a practitioner should familiarize himself or herself with culturally related syndromes from her client’s culture. Whenever counsel is confronted with a case where she suspects that a culturally related syndrome has played a role, she should consult with a cultural expert. (Renteln 2000: 7.12 – 7.13, emphasis added)

Clearly, as researchers conducting health and mental health research among the peoples of the world’s cultures, medical anthropologists and cultural psychiatrists are the “cultural experts” being referred to here.24

Indeed, anthropologists, in particular, have a long history of being called upon by attorneys who seek to incorporate cultural factors into their criminal defense strategies (Winkelman 1996). Perhaps the most notable example of this kind of testimony involves the controversial “cultural defense” mentioned earlier in this essay. Although the cultural defense has not been officially recognized by any American jurisdiction, it typically employs ethnographic expertise to argue that a defendant’s acts must be judged through the lens of cultural relativism (Harvard Law Review 1986). As a result, cultural defenses argue that sentencing must consider
the appropriateness of certain behaviors when viewed within their cultural context. They may assert, for example, that the traditional Japanese custom of parent–child suicide (oyako-shinju) or the ancient Hmong practice of marriage by capture (zij poj niam) cannot and should not be placed on equal footing with the crimes of first degree murder or rape.

Although criminal defense attorneys first began raising cultural defenses in the mid-1980s, serious anthropological debate on the topic did not emerge until the annual meetings of the American Anthropological Association in 1990. While some anthropologists argued that the cultural defense misused ethnographic expertise in order to justify domestic abuse in minority and immigrant contexts, others argued in favor of the defense, noting that it could serve the useful purpose of exculpating mothers facing child abuse charges as a result of controversial, non-Western socialization practices (Winkelman 1996: 154–155). Unfortunately there has been little sustained disciplinary discourse on the topic, and anthropologists have few professional guidelines when asked to serve as consultants and expert witnesses in cultural defense cases.

While the development of such guidelines clearly implicates larger disciplinary debates about the nature of anthropological activism and its place in the courtroom, I suggest here that medical anthropologists and cultural psychiatrists should take a more proactive role with respect to the potential emergence of CBS-based insanity defenses. More specifically, given the fact that these defenses are still very much in the process of defining themselves, I believe that the interdisciplinary community of cultural experts has an obligation to debate their validity, scope, and viability prior to the full-fledged emergence of this criminal defense strategy, rather than after the fact.

Validity

In the spirit of kicking off such a debate, the threshold issue, of course, is the validity of CBS-based insanity defenses in the first place. That is, to what extent are criminal defense attorneys justified in calling upon the CBS concept as a tool of legal advocacy on behalf of their clients? As noted earlier, despite decades of medical anthropological and cultural psychiatric research, making theoretical sense of CBSs remains an elusive endeavor and scholars continue to debate their fundamental status as “syndromal” or “meaning-centered” psychosocial phenomena (Gaw 2001). Indeed, as an imperfect and incomplete representation of these distinctive ethnopsychiatric entities that, for the most part, find no counterpart in established Western psychiatric classification, DSM-IV’s Glossary problematizes the often taken for granted assumption that psychopathological processes and categories are universal across cultural groups. At the same time, however, DSM-IV’s incorporation of CBSs serves to reify the CBS concept as a bona-fide diagnostic
entity within the scope of professional Western psychiatric practice. As a result, like other DSM-IV diagnoses, the Glossary invites application to the legal task of assigning blame. Thus we are still faced with the challenging question as to whether an insanity defense based on a CBS is a justified criminal defense strategy under any circumstances.

Clearly, there are no easy answers to this query. On the one hand, if we accept the basic premise of the insanity defense (i.e., that establishing criminal culpability requires something more than mens rea alone), CBS-based insanity defenses potentially constitute a sorely needed and highly desirable form of culturally sensitive representation for defendants who actually experience psychological impairment at the time of their criminal acts. Indeed, the mere fact that professional Western psychiatry has deemed a defendant’s psychological impairment as “culture-bound” should not preclude him or her from pleading NGRI. As a result, CBS-based insanity defenses may thus prevent the unjust imprisonment of culturally different offenders who, because of a lack of moral blame, simply do not deserve to rot away years or even decades of their lives in prison.

On the other hand, there is clearly a darker side to CBS-based insanity defenses. Most notably, while these defenses may take one step forward in the name of culturally sensitive representation of individuals, they may also take two steps backwards with respect to the larger sociopolitical concerns of the minority and immigrant communities from which these individuals come. Inevitably, overzealous defense attorneys will abuse CBS-based insanity defenses in the name of vigorous, and perhaps desperate, advocacy on behalf of their clients. The media will undoubtedly mischaracterize these atypical syndromes as evidence of the hot-blooded, overly emotional, or otherwise mentally inferior characteristics of minority and immigrant groups. The public will be outraged by yet another excuse for the criminal acts of others who live in America but refuse to play by its rules. In turn, this outrage will fuel an already overwhelming influx of nativist and racist sentiment in contemporary American society. Ultimately, then, the promulgation of CBS-based insanity defenses may serve to reify otherness by confirming rather than dispelling negative stereotypes. Clearly, this backlash process will translate into significant costs for the interdisciplinary community of cultural experts, the individual communities with whom they work, and the larger society within which they exist.

Scope

If a reflective cost-benefit analysis reveals that CBS-based insanity defenses are justified under certain circumstances, however, a second issue for interdisciplinary debate concerns their scope. More specifically, to what extent should CBS-based insanity defenses be limited in scope, if at all? As a medical anthropologist and an
attorney, my own view is that such defenses must be evaluated on a case-by-case basis both with respect to the individual defendant and the particular CBS under consideration. Although such an approach ultimately fails to clearly delineate the bounds of CBS-based insanity defenses, I believe its situational flexibility makes it far preferable to a more rigid black-and-white analytic process that compromises justice for the sake of clarity.

With respect to the individual defendant, it is particularly important to assess the individual’s relationship to the cultural context within which the CBS exists. Clearly, not every Malaysian, Laotian, Filipino, Polynesian, Puerto Rican, or Navajo who goes on a killing spree in the United States automatically qualifies for an amok-based insanity defense. On the other hand, when a defendant is sufficiently immersed in the appropriate cultural milieu and fits the relevant demographic and symptom profile, pursuing a CBS-based insanity defense may be justified. Additionally, while some CBSs are characterized by dissociative or psychotic experience, not every individual suffering from one of these syndromes will necessarily manifest these particular symptoms. As expert consultants and witnesses in CBS-based insanity defense cases, therefore, medical anthropologists and cultural psychiatrists must carefully evaluate the defendant’s past ethnopsychiatric history, family and community contexts, degree of acculturation, and symptom manifestation. Ultimately, these cultural experts must be able to identify the likelihood that the defendant was actually suffering from a CBS at the time of his or her criminal act.

With respect to the particular CBS under consideration, it is important to explicitly recognize that every criminal defense attorney is trained to “think like a lawyer.” As a result, these attorneys will invariably attempt to disaggregate the symptoms of various CBSs and categorize them as insanity defense candidates in order to apply an overly simplistic and formulaic legal analysis. While many CBSs are indigenously conceptualized as illnesses, however, some syndromes are not locally defined as psychopathological. Among various Latino populations, for example, ataque de nervios is best understood not as a form of mental disorder, but rather as a culturally sanctioned manifestation of psychosocial distress that responds to particularly oppressive life circumstances such as family disruption, migration, and poverty (Guarnaccia 1993). Similarly, among various North African and Middle Eastern societies, zar typically involves a long-term relationship with a possessing spirit. While this genre of relationship may appear deviant from an etic perspective, DSM-IV notes that “such behavior is not considered pathological locally” (APA 1994a: 849). Thus, as these CBSs suggest, additional research must clarify whether, and to what extent, indigenous interpretations of these distinctive ethnopsychiatric entities justify their wholesale importation into the insanity defense context.
Viability

A third issue for interdisciplinary debate is the viability of CBS-based insanity defenses within criminal proceedings. That is, assuming that the defenses are justified for certain defendants under certain circumstances, how might medical anthropologists and cultural psychiatrists help overcome common misunderstandings of and resistance to the concept of CBSs within the courtroom? Two comments from the audience following my delivery of an earlier version of this essay (Parzen 2001) help to illustrate some of the relevant barriers.

The first comment responded to my discussion of the potential emergence of CBS-based insanity defenses by characterizing it as yet another variety of misguided criminal defense strategies focused on exogenous etiological factors. Framed in this way, this commentator was comparing CBSs to the likes of “television intoxication,” “black rage,” “urban survival syndrome,” and “the abuse excuse,” among others (see Slobogin 1998). Implicit within his comment was the belief that while culture may influence one’s behavior, even culturally influenced behaviors involve a degree of choice, and that the choice to commit a criminal act merits punishment. My own belief is that this represents a falsely limited characterization of culture as mere environmental influence and grossly underestimates the culturally constituted nature of human experience. Indeed, I would suggest that it is the very existence of CBSs themselves that highlights the utterly inextricable relationship between culture and biology within the context of mental disorder.

The second comment came from an audience member who asked whether, in the final analysis, CBSs were not actually just universal categories of mental disorder getting played out within alternative cultural contexts. Reiterating a point made explicit in my presentation, my response referred the commentator back to DSM-IV’s position that

There is seldom a one-to-one equivalence of any CBS with a DSM diagnostic entity . . . [and that] . . . CBSs are generally limited to specific societies or culture areas and are localized, folk, diagnostic categories that form coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations. (APA 1994a: 844)

The commentator appeared unconvinced, however, and remained committed to his assumption that psychopathological processes and categories are universal across cultural groups.

While the above comments came from law and psychology scholars within the context of an academic conference, they nonetheless reflect some of the misunderstandings of CBSs that are likely to emerge among attorneys, judges, and juries evaluating CBS-based insanity defenses. Indeed, if medical anthropological and cultural psychiatric expertise is to have any impact on the viability of CBS-based
insanity defenses, this interdisciplinary community of cultural experts must work together to develop sophisticated strategies for translating ethnographic and epidemiological knowledge not only into the clinical context of the biomedical model, but also into a legal context that is cognizable to attorneys, judges, and juries alike.

CONCLUSION

An important legal implication of DSM-IV’s Glossary of Culture-Bound Syndromes is the potential emergence of CBS-based insanity defenses. Despite the theoretical prematurity of importing CBSs into the American legal context, it may only be a matter of time before savvy defense attorneys who represent minority and immigrant clients incorporate CBSs into their arsenal of criminal defense strategies. Given that CBS-based insanity defenses are still very much in the process of defining themselves, however, it behooves the interdisciplinary community of cultural experts to anticipate these defenses, rather than merely react to them. Indeed, as scholars uniquely positioned to make or break CBS-based insanity defenses, I believe that medical anthropologists and cultural psychiatrists have an interdisciplinary obligation to engage in serious debate concerning their validity, scope, and viability.

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NOTES

1. The other primary component, of course, is the Outline for Cultural Formulation, also found in Appendix I (APA 1994a).
2. The Glossary may be relevant, for example, to arguing a cultural defense, a diminished capacity plea, or as a mitigating factor during the sentencing phase.
4. See, for example, the recent issue of Transcultural Psychiatry (38: 4) devoted to various CBSs.
5. See Young (1995: 107–116) for an excellent cultural analysis of DSM-III’s process of incorporating PTSD.


9. The Glossary does note, however, that “some conditions and disorders have been conceptualized as culture-bound syndromes specific to industrialized culture (e.g., Anorexia Nervosa, Dissociative Identity Disorder) given their apparent rarity or absence in other cultures” (APA 1994a: 844).

10. See Nichter 1981 for the seminal discussion defining idioms of distress.

11. As Norval Morris wrote over thirty years ago, “Rivers of ink, mountains of printer’s lead, [and] forests of paper have been expended on the issue” (1968: 516) of the insanity defense.

12. An affirmative defense is a defense that is pleaded when an individual admits committing the crime or act in question, but has a legal justification or excuse precluding the attachment of guilt or liability.

13. The exception to this general rule is the strict liability offense, which does not contain a mens rea requirement.

14. This degree of intent may also include unintentional mental states such as recklessness and negligence.

15. Some jurisdictions require an additional finding that the mental disease or defect was also “severe.” See, for example, the insanity defenses of Alabama (Ala. Code § 13A-3-1 (1988)), the United States Military (10 U.S.C.A. § 850a (1986)), and the United States Federal Government (18 U.S.C.A § 17 (1984)).

16. As Packer (1983) notes, however, in his discussion of PTSD, “Even if we grant that some disorders (e.g., schizophrenia) are so disabling as to be considered ‘mental diseases’ it does not follow that all disorders recognized in [DSM-IV] should be so considered” (126). In order to illustrate his point, Packer discusses an individual who unsuccessfully attempts to kick a cigarette smoking habit of over one month’s duration and is diagnosed as suffering from “tobacco dependence.” Although tobacco dependence is generally accepted by psychiatric professionals given its status as a DSM disorder, no self-respecting defense attorney would argue that it constitutes the type of “mental disease” necessary for asserting an insanity defense.

17. These qualifying disorders include moderate or worse mental retardation, schizophrenia, bipolar and major depression, and brain syndromes not induced by intoxication.

18. In the United States, Idaho, Kansas, Montana, Nevada, and Utah are the only states to have abolished the insanity defense. Even within these jurisdictions, however, a finding of criminal culpability still demands proof that the defendant formed the requisite mens rea of the offense.

19. In Vermont, for example, an individual is not responsible for criminal conduct if “as a result of mental illness or defect [the actor] lacks adequate capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law” (Vt. St. Ann. Tit. 13, § 4801 (1957)), emphasis added). States with a volitional prong to their insanity defenses include: Arkansas, Connecticut, Georgia, Hawaii, Kentucky, Maryland, Massachusetts, Michigan, New Mexico, Oregon, Rhode Island, Vermont, Virginia, West Virginia, Wisconsin, and Wyoming.
20. Special thanks to Michael Ryan for pointing this out.
21. According to Hawaii’s insanity defense, a defendant is not responsible if “as a result of physical or mental disease, disorder, or defect the person lacks substantial capacity either to appreciate the wrongfulness of the person’s conduct or to conform the person’s conduct to the requirements of the law” (Haw. Rev. Stat. §704–400 [1972]).
22. See also, People v. Aphaylath, 68 N.Y.2d 945 (1986).
23. In New York a defendant is not criminally responsible if “as a result of disease or defect, he lacked substantial capacity to know or appreciate either (1) the nature and consequences of such conduct or (2) that such conduct was wrong” (N.Y. Penal Law §40.15 (1984)).
24. Although this essay conflates medical anthropologists and cultural psychiatrists as scholars who study CBSs, these two fields clearly differ regarding their scope of expertise. More specifically, while the ethnographic research of medical anthropologists can help illuminate the indigenous explanatory models associated with various CBSs, cultural psychiatrists are better positioned to comment upon their clinical manifestations. Furthermore, as one anonymous reviewer pointed out, the implementation of a CBS-based insanity defense may also demand an interdisciplinary understanding of the complex relationships among culture, self, subjectivity, awareness, and intent. As a result, the expertise necessary for these defenses may ultimately exceed the combined resources of both medical anthropology and cultural psychiatry.
25. See, however, Kandel (1992) for a useful general guide for anthropologists serving as expert witnesses.

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