New Directions for Cultural Formulations in Forensic Psychiatry

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Forensic psychiatrists have called for greater attention to cultural and racial topics in assessing examinees. While suggestions for new methods are welcome, they can ignore the extent of scientific progress if existing assessments are not accurately appraised. This article analyzes the arguments of two recent publications in The Journal that mischaracterize the cultural formulation approach. Contrary to the idea that forensic psychiatrists have received little guidance on assessing an examinee's racial identity, the article shows that forensic psychiatrists have contributed to scholarship on assessing racial identifications through cultural formulations that elicit how minoritized ethnoracial examinees interpret their illness experiences and legal involvements. The article also seeks to dispel misunderstandings about the Cultural Formulation Interview (CFI), which clinicians have used to complete person-centered cultural assessments, including in forensic settings. Conducting research, practice, and educational activities on the cultural formulation can be ways for forensic psychiatrists to combat systemic racism.

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Like other journals, The Journal has encouraged readers to combat structural racism after George Floyd's tragic murder highlighted attention to the discriminatory treatment of Black, Indigenous, and People of Color (BIPOC) individuals throughout society and prompted international protests in 2020. Martinez and Candilis have argued, "We can no longer ignore how our best intentions fall short of cultural and racial understanding, moral endeavors that should be central to our awareness as we practice" (Ref. 1, p 428). They suggest "the need to appreciate the cultural factors in which we work, to understand the intrinsic dynamics of power and disenfranchisement, and to remain aware of how we participate in perpetrating racism and prejudice" (Ref. 1, p 430). Asserting that patients and practitioners are positioned differentially in imperfect medicolegal systems, Chaimowitz and Simpson have asked whether forensic psychiatry "serves as an agent of the system that oppresses many or as a solution to their oppression, and is engaged in research on these questions" (Ref. 2, p 158). And discussing how forensic practitioners can be attentive to racism, sexism, and sexuality, Cerny-Suelzer and Friedman recommend that, "Training program policies should be scrutinized for both intentional and unintentional discrimination. In our professional organization, all presenters for our annual meeting should be encouraged to address racism and other social determinants of health and justice that relate to their topics" (Ref. 3, p 9–10).

Such calls raise a foundational question of how to conceptualize racism in mental health settings, a task that the American Psychiatric Association (APA) resisted for decades during the DSM-III and DSM-IV revisions.[4] The APA apologized in 2021 for its complicity with structural racism in the criminal justice system, in acts that included diagnosing Black Americans who did not wish to remain enslaved with *drapetomania*.[5] Working with an Ethnoracial Equity and Inclusion Work Group, the APA published DSM-5-TR last year; it defined racism in the following manner:

> At the personal level, racism gives rise to internalized stereotypes and experiences of threat, devaluation, neglect, and injustice that affect individuals' health and well-being.

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> At the interpersonal level, racism includes not only explicit behaviors but also microaggressions, which are everyday slights and offenses that communicate negative attitudes toward specific stigmatized groups, with stress-inducing and traumatizing consequences. Systemic/institutional racism refers to the ways that discrimination is embedded in everyday practices of institutions or organizations, including health care and psychiatry. Systemic racism may not be expressed in overt racial ideologies but may be maintained by implicit and unintentional biases, habits, routines, and practices that result in misrecognition and inequity (Ref. 6, p 17–18).

While The Journal authors cited previously agree that forensic practitioners must examine their behaviors, biases, habits, routines, and practices to avoid perpetuating racism, there is no consensus on how to accomplish this work. In recent publications, Heilbrun *et al.*[7] and Khan and Simpson[8] have persuasively argued for the need to complete racial and cultural assessments with examinees, respectively. The justifications for such assessments are compelling and not analyzed here. Both articles underrepresent the extent of progress in conducting such assessments, however. Specifically, Heilbrun *et al.*[7] do not mention how forensic psychiatrists have completed racial assessments through cultural formulations, whereas Khan and Simpson[8] mischaracterize the cultural formulation scholarship. While the cultural formulation approach is not a panacea for assessment, and more work certainly needs to be done, it has generated sustained interest over decades as cultural psychiatrists apply it to forensic settings, evaluating its strengths and weaknesses.

This article reviews the arguments of Heilbrun *et al.*[7] and Khan and Simpson[8] for assessment in relation to the cultural formulation approach from my vantage point as a cultural psychiatrist. Research in cultural psychiatry consists of examining mental health service delivery for minoritized individuals in multicultural societies by drawing upon the social sciences, namely, anthropology, psychology, and sociology.[9] Although hundreds of definitions for culture exist,[10] this article adopts the latest definition in DSM-5-TR written by psychiatrists, psychologists, and anthropologists so that there is a single analytical framework throughout this article:

> Culture refers to systems of knowledge, concepts, values, norms, and practices that are learned and transmitted across generations. Culture includes language, religion and spirituality, family structures, lifecycle stages, ceremonial rituals, customs, and ways of understanding health and illness as well as moral, political, economic, and legal systems. Cultures are open, dynamic systems that undergo continuous change over time; in the contemporary world, most individuals and groups are exposed to multiple cultural contexts, which they use to fashion their own identities and make sense of experience. This process of meaning-making derives from developmental and everyday social experiences in specific contexts, including health care (Ref. 6, p 860).

From a cultural psychiatry perspective, psychiatric diagnosis and assessment are cultural acts that make sense of experience in health care contexts: in the absence of laboratory or radiological biomarkers, an examinee must first interpret personal experience through language before the examiner interprets that interpretation through personal behaviors, professional knowledge, and institutional routines.[11] The forensic examiner exercises power in using professional knowledge, concepts, values, norms, and practices to comprehend an examinee's identity and experience as multiple interpretations to explain an examinee's behavior compete for official recognition within legal systems, especially those that are adversarial.[12] Therefore, completing cultural or racial assessments with examinees are not just acts of social justice; they can add essential information upon which forensic examiners construct their interpretations. The article first reviews how racial topics have been addressed in forensic assessments through cultural formulations, appraises both articles for their recommendations, and considers future challenges and opportunities of cultural formulations in forensic mental health settings.

Cultural Formulations Address Race

Heilbrun *et al.*[7] assert that guidelines in forensic psychiatry do not equip the examiner with assessing an examinee's race. They have written, "Currently, forensic psychiatrists receive no direct guidance on point from the AAPL [The American Academy of Psychiatry and the Law] Ethics Guidelines or the AAPL Ethics Committee, beyond the general observation that the Guidelines are grounded in respect for persons, honesty, and social responsibility" (Ref. 7, p 480). They claim that neither forensic psychiatry nor forensic psychology "appears to have directly addressed the use of racial identity in FMHA [forensic mental health assessment] as an approach to appraising the impact of race on the legally-relevant characteristics of examinees" (Ref. 7, p 480). An alternate reading of scholarship in forensic psychiatry shows a tradition of considering race through cultural formulations. Introduced in 1994 with DSM-IV, the Outline for Cultural Formulation (OCF) consists of five

sections for clinicians to organize information: the cultural identity of the individual, cultural explanations of the illness, cultural factors related to the psychosocial environment and functioning, cultural elements of the patient-clinician relationship, and an overall cultural assessment for diagnosis and care.[13]

Griffith pioneered use of the cultural formulation in forensic psychiatry nearly 25 years ago. Translating it for a forensic context, Griffith argued, "The intent of using the cultural formulation in the forensic context is to enhance one's understanding of the subject being evaluated and the subject's experience, as well as to improve the appreciation of the subject's psychosocial environment. The cultural formulation should serve to construct a fuller story of how the forensic event occurred" (Ref. 14, p 181). Rejecting the notion that mere membership in the same demographic (i.e., racial or ethnic) community as the examinee is sufficient grounds to complete an evaluation, Griffith underscored the cultural formulation's utility in his experience as a Black examiner examining a Black examinee: "I paid maximum attention to establishing a cultural formulation of the data and ultimately arrived at a conclusion that did not support Ms. Brawley's claims" (Ref. 14, p 182).

Since Griffith's groundbreaking article, others have expanded the cultural formulation for forensic use. Aggarwal[15] and Kapoor *et al.*[16] have developed practical questions for examiners to use in correctional settings. A case study reported on the cultural formulation's usefulness during the assessment of a BIPOC individual charged with homicide and the preparation of a court report for expert witness testimony.[17] In a section titled "Cultural Factors in Forensic Evaluations," AAPL's Practice Guideline for the Forensic Assessment relates racial topics to cultural formulation: "Culture should be integrated into assessment and service delivery. In the United States, the evaluator is often of the dominant group while the forensic evaluee may be of a minority ethnic or racial group, and the effect of this diversity should be considered in interactions with the evaluee" (Ref. 18, p S40). This Guideline also states: "It is widely accepted that mental health clinicians must possess an ability to provide a cultural context and formulation for clinical and forensic work, to provide effective assessment and treatment of diverse populations. Cultural formulation skills are rapidly becoming accepted in all aspects of psychiatric practice, including forensic psychiatry" (Ref. 18, p S39). Consequently, it may be an overstatement to suggest that racial identity has not been addressed when completing assessments in forensic psychiatry. Heilbrun *et al.* advise that, "If a more specialized tool appropriate for use in FMHA becomes available, then examiners could consider whether to use it" (Ref. 7, p 484). The cultural formulation is one such tool with a growing evidence base in clinical and forensic psychiatry.[19]

In fact, AAPL could update its sections on the cultural formulation in practice guidelines for forensic assessment. DSM-5-TR specifies that cultural formulations can address an examinee's racial identification in two places. Under "Cultural Identity of the Individual," DSM-5-TR specifies, "Describe the individual's demographic (e.g., age, gender, ethnoracial background) or other socially and culturally defined characteristics that may influence interpersonal relationships, access to resources, and developmental and current challenges, conflicts, or predicaments." (Ref. 6, p 861) Under "Cultural Features of the Relationship between the Individual and the Clinician, Treatment Team, and Institution," DSM-5-TR notes, "Experiences of racism and discrimination in the larger society may impede establishing trust and safety in the clinical diagnostic encounter. Effects may include problems eliciting symptoms, misunderstanding of the cultural and clinical significance of symptoms and behaviors, and difficulty establishing or maintaining the rapport needed for accurate assessment" (Ref. 6, p 862) These recommendations underscore how DSM-5-TR advocates cultural formulations to address an examinee's experiences of racism and discrimination within society, including in interactions with the forensic examiner. AAPL's Practice Guideline for the Forensic Assessment was published in 2015, and the time may be ripe for a revision that accounts for contemporary understandings of culture, ethnicity, and race.

Improving Cultural Formulations

Despite being published this year, DSM-5-TR has not remained current with the social science of how to describe an individual's ethnoracial background. Heilbrun *et al.*[7] offer a more nuanced view than DSM-5-TR about the situational context of an examinee's identification. They place their analysis of identity within the theory of intersectionality, which they characterize as, "The idea that a person's identity and how one is perceived and responded to by others may require combinations of identities and how these

identities intersect across multiple categories. In addition, it refers to the multiple levels of oppression and marginalization associated with these intersecting attributes" (Ref. 7, p 479). They define race as "the self-identified membership in a group or groups influenced by national origin and sociocultural influences" (Ref. 7 p 479). The challenge for forensic examiners is that individuals can change their racial identifications, as sociologists and psychologists repeatedly show, but which DSM-5-TR does not account for.

A review of the social science scholarship on racial identifications reveals their complex, dynamic nature. For instance, in a sample of 162 million individual-linked responses across the 2000 and 2010 U.S. censuses, more than 95 percent of non-Hispanic Whites and of non-Hispanic Blacks selected the same racial identification in their census responses, but the number fell to more than 90 percent of Asians, 41 percent for Hispanics, and less than 33 percent for Native Americans.[20] Multiracial Black or White adolescents may change their racial identifications based on their perceptions of race relations in society, with at least one dataset from the U.S. census reporting a 73 percent change rate.[21] Skin color and experiences with discrimination can influence whether Hispanics later identify as non-Hispanic Black, non-Hispanic White, or Hispanic,[22] and whether multiracial Black/White adolescents identify as monoracial Black or White.[23] While racial identification may be an accurate marker of identity at one point in time for some individuals in some groups, it is inaccurate to assume the stability of a chosen racial identification across time for all individuals in all groups.[24]

Moreover, there can be a difference between one's chosen and ascribed racial identifications. Between six and 14 percent of monoracial adults, particularly those from newer immigrant Asian and Hispanic groups, feel an incongruence between their chosen racial identification and the categorizations ascribed by others.[25] Self-identified non-Hispanic Black, Native American, and multiracial individuals report more experiences of discrimination than self-identified Whites based on how others ascribe a racial identity to them.[26] Americans are more likely to ascribe a racial identification that is concordant with what non-Hispanic Whites and non-Hispanic Blacks choose, but there is greater discordance with individuals from Asian, Hispanic, American Indian, Middle Eastern, or multiracial backgrounds.[27]

Forensic evaluators would benefit from exploring these complexities in identity formation and articulation. Since racial identifications can vary for the same individual across contexts, time, and social position, including in relation to interviewers, social scientists recommend focusing on three psychological constructs: concordance between chosen and ascribed identifications, stability over time, and the influence of key situations or other people.[28] In addition to the questions that Heilbrun *et al.* have introduced,[7] the APA's Cultural Identity Supplementary Module to the Cultural Formulation Interview (CFI) that was published in 2013 with DSM-5 includes these questions:

> How would you describe your family's national, ethnic, and racial background?
> In terms of your background, how do you usually describe yourself to people outside your community?
> Sometimes people describe themselves somewhat differently to members of their own community. How do you describe yourself to them?
> Which part of your background do you feel closest to? Sometimes this varies, depending on what aspect of your life we are talking about. What about at home? Or at work? Or with friends?
> Do you experience any difficulties related to your background, such as discrimination, stereotyping, or being misunderstood?
> Is there anything about your background that might impact on your problem, or impact on your health or health care more generally?[29]

These questions address influence, but not concordance or stability. Heilbrun et al. perceptively note that examiner identity "may influence the evaluation process and case conceptualization" (Ref. 7 p 480), and that assessment should include "the awareness of how the examiner may be viewed across multiple contexts" (Ref. 7 p 481). To better account for these insights, as well as those from sociologists and social psychologists, I suggest additional questions:

> Have you changed how you identify by race or ethnicity over time? If so, how?
> Do others see your race or ethnicity differently from how you see it? If so, how? Has that difference ever led to problems for you?
> Have you ever experienced any difficulties related to your background, such as discrimination, stereotyping, or being misunderstood based on how others have seen you?
> Would you identify your race or ethnicity differently with me than with other people in your life? If so, how? And why?

Methodologically, Heilbrun *et al.* point out that "caretakers, teachers, employers, partners, and acquaintances sometimes have information relevant to an identity appraisal" (Ref. 7 p 481), which can be compared

with self-identifications. Questions from the CFI Supplementary Module on Cultural Identity and my additions start to develop the interview guide that Heilbrun *et al.*[7] suggest. Answers to these questions may yield more complete information to the "Cultural Identity of the Individual" section of a cultural formulation. At the same time, it is important to invite debate on methods used to assess identity as the social and health sciences expand our knowledge.

Forensic Psychiatrists Can Use the CFI

Khan and Simpson[8] cite this author's work in several locations to make certain points about the CFI. I wish to clarify areas of difference in my capacity as a consultant to the DSM-5 and DSM-5-TR Cross-Cultural Issues Subgroup for more than a decade and as a co-developer of the CFI.

Khan and Simpson reference a paper that I co-authored to claim, "The CFI itself presented challenges in practice regarding relevance to the presenting complaint, difficulty engaging patients with severe presentations of mental illness, and even discomfort from the patient perspective in discussing culture and religion" (Ref. 8, p 435). That characterization may not be a balanced assessment of scholarship on the CFI. They cite Jarvis *et al.*[30] who summarize one study in this manner:

> For patients, the most common concerns were lack of differentiation from other interviews they had received, discomfort with discussing the past or talking about religion, and difficulty understanding some CFI questions. For clinicians, the most common concerns included lack of clarity about the relevance of the CFI to the presenting problem, diagnostic assessment, and intervention planning; doubts about using the full CFI at the beginning of an evaluation; repetitiveness; difficulty engaging patients with severe illness; and lack of clinician buy-in (Ref. 30, p 42).

Jarvis *et al.*[30] were referring to a study[31] on barriers that patients and clinicians named with reference to an earlier version of the CFI from the field trial before it was revised for DSM-5. Since then, other studies have clarified the CFI's benefits. From that same dataset of 32 cross-cultural, -ethnic, and -racial patient-clinician dyads, patients valued the CFI for helping clinicians express empathy for the complaints they presented, whereas clinicians found the cultural information elicited from the CFI useful in contextualizing symptoms.[32] The CFI's nonjudgmental introduction to patients about there being no right or wrong answers, procedural and reassurance statements to orient communication throughout the interview, and open-ended questions helped clinicians make rapport-building statements as patients constructed narratives.[33] The CFI's utility in building rapport and producing information about the cultural lives of patients with severe mental illnesses has been documented in studies from Denmark,[34] India,[35] Italy,[36] Israel,[37] Sweden,[38] and the United States.[39]

There seems to be little debate that the CFI can capture perspectives on religion and spirituality from patients who practice Semitic and non-Semitic faiths.[36,40,41] In 2013, the APA published a Supplementary Module on Spirituality, Religion, and Moral Traditions[42] with DSM-5 for clinicians who wish to explore these domains beyond the core CFI's 16 questions. Still, Khan and Simpson[8] call attention to an emerging tension about whether all patients and clinicians in all practice settings can understand the CFI's questions on personal identity. The CFI's questions on identity begin with a prompt so that clinicians avoid making stereotypical assumptions that race or ethnicity is the most salient identity for the examinee:

> Sometimes, aspects of people's background or identity can make their problem better or worse. By background or identity, I mean, for example, the communities you belong to, languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, or your faith or religion.
> For you, what are the most important aspects of your background or identity?
> Are there any aspects of your background or identity that make a difference to your problem?
> Are there any aspects of your background or identity that are causing other concerns or difficulties for you? (Ref. 6, p 753)

Two studies demonstrated challenges when clinicians with insufficient training asked these questions. Researchers in Mexico noted, "Patients responded as if they did not understand how their 'background or culture' might be part of their illness experience. Providers, in turn, tend to view 'culture' in relation to indigenous heritage or affiliation, thus patients who are not members of indigenous communities are not viewed as having 'culture'" (Ref. 43, p 481–2). Still, the same researchers suggested that better training could improve information gathering, writing that, "In clinical contexts in Mexico, where a majority of patients identify with a mestizo or mixed-race heritage, mental health care providers may need to be encouraged to think of culture broadly and dynamically (as previously discussed) so as to avoid confusion

of 'culture' with indigeneity" (Ref. 43, p 482). Likewise, investigators in Denmark acknowledged, "Several providers seemed to adopt an outdated and static understanding of culture, e.g., as something the patient 'grew up with.' This and other findings of our CFI multisite study suggest that some providers seemed to conflate culture with ethnicity or migration status" (Ref. 44, p 750). But like the researchers in Mexico, the Danish team did not reject the CFI and came to the opposite conclusion: "We argue that the cultural questions of the CFI represent a courageous and welcome opening to a more nuanced culturally informed care, which is gradually becoming recognized and requested in Danish and Nordic health care systems" (Ref. 44, p 750). In Mexico, the study clinicians were psychiatry resident trainees who were only given a copy of the CFI to read before using it with patients;[43] clinicians in Denmark also watched a video of the CFI being used in a training session that lasted an hour.[44] Neither research team followed the two-hour training protocol from the DSM-5 CFI field trial that also included interactive behavioral simulations for clinicians to practice the CFI through sample cases and observing clinicians practicing the CFI to personalize feedback.[45] More research is generally needed as to whether the type and length of training affect how clinicians use the CFI, including in forensic contexts.

Finally, Khan and Simpson do not include a study on the CFI's implementation in a forensic setting. They write, "We were interested in reviewing the evidence from the published literature on the integration of culture into the delivery of FMHS [forensic mental health services], including interventions, rehabilitation, and recovery-based services . . . Unfortunately, there were no studies that formally evaluated how forensic services addressed culture explicitly" (Ref. 8, p 435–6). In contrast, one study compared clinicians' perceptions of using the CFI on an inpatient service that accepts civilian and forensic patients within the New York State Office of Mental Health system, finding that forensic clinicians wanted more training, reduced administrative burden, and the flexibility to use it when patients were clinically stable.[46] This study examined the organizational culture of the inpatient service and how the service already implemented cultural assessments before the CFI was introduced. This study, along with others on the cultural formulation approach cited earlier, shows how cultural work has been productively integrated within FMHS.

Challenges and Opportunities

Readers may wonder whether there are too many challenges to completing cultural formulations with examinees. Some examiners may doubt whether they have sufficient funds to pay for thorough training. To avoid criticisms from cultural psychiatrists and psychiatric anthropologists that the APA is advertising the cross-cultural validity of its diagnostic manual primarily to make profits in new markets abroad,[47] the APA has disseminated training videos for the core CFI[48] and its supplementary modules[49] free of cost for clinicians. A fidelity instrument to the core CFI is also available free of cost for clinicians so that they can assess their adherence and competence to all 16 questions, along with how accurately patients respond.[50]

Other examiners might conclude that they do not have enough time to complete cultural formulations. This argument is less compelling when forensic examiners charge retainer fees.[18] In correctional settings, coordination with service administrators so that cultural formulations can be integrated within existing workflows and billed to third-party payors has been one solution.[46] Some could claim that racial or cultural topics are not relevant. In this scenario, readers can reference Heilbrun *et al.*'s[7] stepwise process for a relevance review in which the examiner asks the examinee if such topics could affect the legal question before the examiner makes a decision about relevance.

Others may remain unconvinced about the CFI's value. In this respect, the difference between completing a cultural formulation and completing a CFI is critical to understand. DSM-IV's OCF, which Griffith introduced into forensic psychiatry,[14] listed domains for clinicians to consider in completing cultural assessments, but its vagueness led to six cultural consultation services around the world developing interviews that clinicians can use with patients.[51] A dilemma soon arose: the different interviews of varying lengths showed that the OCF fulfilled an unmet need among clinicians for cultural assessments, but the lack of a single interview prevented generalizable conclusions from being drawn about improved clinical outcomes resulting from a standardized intervention.[52] The CFI was produced during the DSM-5 revision process by drafting an initial interview that psychiatrists from the six cultural consultation services co-authored, field testing it with 321 patients and 75 clinicians in six countries, and revising that initial interview based on patient and clinician feedback.[53] The CFI has the largest evidence base among

clinician-led tools for completing patient cultural assessments,[30] but it is an interview to gather information, not a cultural formulation by itself. As DSM-5-TR states: "DSM-5-TR includes an expanded version of the Outline and an approach to assessment using the CFI, which has been field-tested among clinicians, patients, and accompanying relatives and found to be a feasible, acceptable, and useful cultural assessment tool" (Ref. 6, p 861). Therefore, an examiner can complete a cultural formulation without the CFI by using other methods of cultural assessment.

Based on my consultative work for DSM-5 and DSM-5-TR, I remain convinced that forensic mental health settings are intriguing contexts in which to argue for and against the scholarship in cultural psychiatry. Drawing from the meaning-centered tradition of medical anthropology, cultural psychiatrists often invoke the distinction between illness as a patient's experience of discontinuity in life circumstances or role performances and disease as abnormalities in organ states or functions.[54] The psychiatrists, psychologists, and anthropologists who developed the OCF for DSM-IV wanted cultural formulations to be narrative accounts of a patient's subjective experience of illness that could sensitize clinicians to the impact of suffering beyond the discipline's increasing neurobiological emphasis on discrete symptoms associated with a disease.[55] But circumstances are more complex in forensic settings. For example, an examinee may not believe there is an illness, as can happen with certain neurocognitive, personality, or psychotic disorders, but the examiner postulates the existence of a disease to explain behaviors. Another example is when an examinee exaggerates an illness, for example, in factitious disorder or malingering, when the examiner doubts that there is a disease. Situations where the examinee and examiner have different interpretations should spark dialogue on what it means for cultural formulations to be person-centered and whether there are limits to patient-centeredness.[53] Moreover, cultural formulations, and the CFI specifically, assume that a single clinician is performing all clinical tasks. Research has yet to determine how cultural formulations can be conducted in team-based settings, especally with interpreters and cultural brokers. It would also be helpful to to determine how cultural formulations change clinical outcomes such as diagnosis or treatment, an examiner's interpretations of an examinee, and legal outcomes. Answering such questions heeds Chaimowitz and Simpson's call[2] for forensic psychiatrists to conduct research in the criminal justice and social services systems that produce disparities in outcomes for BIPOC individuals.

Conclusion

Forensic psychiatrists wishing to assess cultural, ethnic, and racial topics with examinees could benefit from the cultural formulation approach. For two decades, forensic psychiatrists have completed cultural formulations to understand how examinees use ethnic, racial, and other group-based identifications to make meanings out of their experiences. Newer tools such as the CFI and assessment techniques from the social sciences call attention to the dynamic, situational contexts of identities that forensic examiners should elicit in their work. Training programs for fellows and continuing medical education in cultural formulation could advance the cultural and racial understanding of clinicians.[1,2] Although clinicians may not be able to eliminate all forms of racism and discrimination, they can strive to establish trust and safety with examinees through respectful, curious inquiry. Those who resist such opportunities should ask whether their implicit and unintentional biases, habits, routines, and practices risk misrecognition and inequity, elements which DSM-5-TR cautions as contributing to systemic racism in health care and psychiatry.

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