Ethnicity, Race, and Forensic Psychiatry: Are We Color-Blind?

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Race, ethnicity, and culture have an effect on all aspects of mental illness. Forensic psychiatrists and psychologists should consider these issues when performing evaluations for legal purposes and when providing treatment to the special populations with whom they work. This article defines race and ethnicity and reviews the available literature on the impact of race and ethnicity on diagnosis, dangerousness assessment, involuntary commitment, competency, criminal matters, evaluation of children and matters related to them, and tort issues. Also discussed is the effect of ethnicity on the role of the forensic evaluator in his or her interactions with the subject and the justice system. Forensic evaluators are encouraged to develop specific skills related to competency in dealing with cultural matters.

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In his 2001 supplement to the U.S. Surgeon General's Report on mental health, then Surgeon General Satcher examined the impact of culture, race, and ethnicity on all aspects of mental health, illness, and treatment.[1] He concluded that the scientific data on their impact are inadequate, but that available evidence suggests that members of ethnic minority groups experience mental illness in different ways and receive disparate care compared with white Americans. Do these differences and disparities have any impact on the practice of forensic psychiatry? Do forensic psychiatrists need specific expertise when dealing with ethnic matters? In a recent highly publicized case, a psychiatric expert was selected because he was experienced in "multicultural issues in the forensic psychiatry field".[2] To my knowledge, this is the first article to review the available literature on the effect of race and ethnicity in forensic psychiatry.

In this article, I do not review the literature on the impact of ethnicity on treatment (except briefly, as it relates to the potential for medical liability), because such information is reviewed in detail in the U.S. Surgeon General's Report. However, forensic psychiatrists provide clinical care in correctional and forensic hospital settings where issues related to ethnicity are not only relevant but are also accentuated, because of the greater proportion of ethnic minorities in these settings.[3] There is also some evidence that members of ethnic minority groups may be underserved in correctional settings.[4]

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Definition of Race and Ethnicity

The terms race and ethnicity are rarely defined in articles in which they are used. Race refers to genetic heritage, at least in theory. In practice, race is typically assigned based on biological traits that are presumed to be inherited and visibly evident to others, such as skin color, hair texture, and eyelid folds. Historically, race has often been defined in an unscientific fashion, as in the "one-drop rule" in America, which defines an individual as black on the basis of having any black ancestors, regardless of the proportion of white ancestors—a delineation that remains a common practice.

Genetic studies have called into question the validity of the concept of race. The average genetic variation between individuals of the same race is as great as any genetic variation between racial groups. As one geneticist has observed, "Every population is a microcosm that recapitulates the entire human mac-

rocosm, even if the precise genetic compositions vary slightly (Ref. 5, p 29)." As a result of historical migrations and interbreeding (forced and voluntary, ancient and recent), genetic components in populations overlap significantly. Approximately one-third of white European genetic heritage is derived from African admixtures, and 30 percent of African-American genetic heritage is derived from white American admixtures (Ref. 5, pp 74–5). In light of such evidence, it would be unwise to presume much about an individual's genetic make-up based on racial appearance.

Ethnicity refers to cultural rather than genetic heritage. An ethnic group may be defined by its shared place of origin, history, language, religion, arts, cuisine, and other cultural factors. For example, the Hispanic ethnic category refers to individuals who have their personal or ancestral origins in Latin American countries (Spain and Portugal are sometimes included) and who are often united by the Spanish (or Portuguese) language. Hispanic individuals may be racially white, black, American Indian or, commonly, an admixture.

Research rarely distinguishes among these potentially overlapping categories or identifies how racial or ethnic assignments are made. In clinical practice, the patient is rarely asked how he or she identifies himself or herself. Clinician assignment of race or ethnicity leads to predictable errors, such as the classification of a Trinidadian woman of Indian (South Asian) ancestry as black (author's experience with a referral for consultation by an internist). There are research validity questions, even when a patient is asked to identify his or her ethnic background, since an individual's degree of identification with (or rejection of) components of his or her background may vary over time. A study of Brazilians at risk for HIV infection showed that 12.5 percent of subjects provided a different racial self-identification at a six-month follow-up from the one they had provided at the initial examination.[6] In a psychiatric setting, there is also the issue of delusional identification with an ethnic group to which the patient does not belong by any objective measure.

By convention, in this article I use the terms African American, Hispanic, Asian American, American Indian, and white for the ethnic categories used in most research. It is possible that important, but undefined, distinctions are missed when terms are interchanged. For example, the term black might refer to both Africans and African Americans (and the latter term may or may not include black West Indians). These distinctions are generally not made in the literature reviewed in this article. Increasingly, ethnic subgroups within these broad categories are the subject of research, though not yet in the forensic literature.

Diagnosis

Forensic opinions are grounded in clinical assessment. An invalid diagnosis or clinical formulation may jeopardize the validity of the forensic conclusion. For this reason, forensic psychiatrists must be aware of the impact of ethnicity on diagnosis.

The results of the Epidemiologic Catchment Area Survey conducted in the 1980s showed that mental illness was more prevalent in general among African Americans.[7] However, when the investigators controlled for socioeconomic status, there were no significant differences between whites and African Americans in the prevalence of most major mental illnesses, including schizophrenia, antisocial personality disorder, and drug dependence.

Despite similar illness prevalences, several studies have shown that clinicians presented with a hypothetical clinical scenario make a diagnosis based in part on whether the patient is white or African American, even when unambiguous symptom criteria are presented.[8,9] In one study, it was found that therapists presented with such a scenario rated the behavior of African American adolescents as less clinically significant.[10]

Findings in several studies have shown that African Americans are more often diagnosed with psychosis and whites with mood disorders in emergency rooms and at hospitalization.[11–14] Other studies have shown that elderly African Americans are more frequently given diagnoses of psychotic disorders and dementia and are less frequently given diagnoses of mood disorders than are elderly whites.[15–17] African-American adolescents are more commonly given diagnoses of psychotic disorders and conduct disorder than are whites.[18,19]

Many researchers have considered the factors that might contribute to these disparities, including illness presentation, help-seeking patterns, and clinician bias.[20–22] In one study, it was found that emergency room clinicians failed to elicit enough information about affective signs and symptoms in nonwhite patients.[23] When diagnoses are based on

structured clinical interviews and diagnostic criteria, fewer disparities are observed.[24] Whaley[25] has recommended that feedback from the patient should be a more integral part of psychiatric assessment, because a clinician's tendency toward ethnic stereotyping may preclude a full inquiry into relevant individual factors.

Individuals from ethnic minority groups may present with different signs and symptoms of psychiatric illness or with different ways of communicating their distress. A frequent observation is that Asian Americans and Hispanics may be more likely to report somatic symptoms of mental illness.[26,27] Language difficulties may also interfere with proper diagnosis. According to a recent study from California,[28] bilingual interviews of bilingual Hispanic patients led to more severe symptom ratings by clinicians. Interviews conducted only in English led to lower severity ratings. (The investigators did not try to determine which ratings were more valid.)

One recent study explored whether personality disorder traits are more likely to be perceived as inherently characteristic of particular ethnic groups, thus calling into question the validity of the nosology.[29] In a forced-choice, card-sort methodology, nonclinicians (predominantly white) disproportionately assigned personality disorder characteristics to most ethnic groups: antisocial and paranoid personality to African Americans, schizoid personality to Asian Americans, schizotypal personality to American Indians, and the remaining personality disorders to whites. No disorders were assigned to Hispanics. It should be noted that the methodology left participants no alternative but to assign each criterion to a particular ethnic group, and the results might have been different if they were allowed to designate some criteria as not representative of any particular ethnic group. Nevertheless, the study shows that personality disorder diagnoses, when applied to certain ethnic minorities, may be viewed less critically.

Psychological testing can provide objective data that might reduce the impact of an individual clinician's bias on clinical conclusions. However, psychological tests should be validated for different ethnic groups to ensure that they do not introduce systematic bias. Some disparities have been observed, especially in earlier versions, in the MMPI,[30,31] the Millon Clinical Multiaxial Inventory (MCMI),[32–34] and intelligence tests,[35] and differences continue to be observed in some subscales and in some populations, despite improvements. There is mixed evidence that the Mini Mental State Examination and other cognitive tests may overclassify African Americans as having dementia, even after adjustments for education and type of dementia.[36–40]

Most tests are not adequately standardized for contemporary Hispanic subgroups or are not available in Spanish. The Spanish version of the Positive and Negative Syndrome Scale (PANSS), however, has been validated.[41] The Composite International Diagnostic Interview (CIDI) may overdiagnose somatization in Hispanics, even when administered in Spanish.[42]

The validity of the Diagnostic Interview Schedule (DIS) in various ethnic groups has been called into question.[43] The Maudsley Obsessional Compulsive Inventory may not be valid in nonwhite groups.[44] Substance abuse dependence, as measured by the CIDI-Substance Abuse Module (CIDI-Glazer SAM), has been shown to be equally valid for African Americans and whites.[45] The five-item TWEAK (an acronym for items on an alcohol screening test: tolerance, worry, eye-opener, amnesia, and cut down) and the Alcohol Use Disorders Identification Test (AUDIT) may be more reliable screening questionnaires in most ethnic groups than the four-item CAGE (cut down, annoyed, guilty, and eye-opener).[46,47] Investigators in several studies in the past decade have examined the use of analysis of hair for illicit drugs and have found no evidence of racial bias.[48]

Whether psychiatric diagnoses made in the course of forensic evaluations vary by ethnicity has not been studied. Forensic experts are expected to review historical material in great detail, to seek corroborating information, to conduct lengthy examinations of the subject, and to consider multiple hypotheses, all measures that are likely to improve accuracy, whether or not additional testing is used.

Dangerousness Assessment

Psychiatrists are often asked to assess the dangerousness of individual patients. Although risk assessment has improved, there remains imprecision and ample room for the clinician's bias to influence decisions, with serious consequences.

According to the 1990 General Social Survey of public perceptions, respondents were more likely to identify African Americans and Hispanics as prone to violence.[49] Whether psychiatrists, or forensic psychi-

atrists, are immune to such prejudices as a result of training or the individualized nature of their clinical assessments, has not been tested. In a recent—and admittedly controversial—article, an expert on dangerousness and mental illness attributed the increase in crime over the past four decades to "feral youngsters," most of whom are African American.[50] Such language may inflame fears of ethnic minorities and reinforce stereotypes.

Researchers in several studies have found that clinicians, when asked to predict whether patients will be violent, overpredict inpatient violence by nonwhites and underpredict violence by whites, even though actual rates of violence do not vary by ethnicity.[51–54] In a British study mentioned earlier, psychiatrists presented with hypothetical case vignettes rated black Caribbean patients as potentially more violent than white patients and as more appropriate for incarceration.[55] A chart review study in Great Britain provided evidence that black West Indians were also perceived, in practice, as being at greater risk of acting violently.[56]

A few studies have examined the use of seclusion, restraint, and emergency medication for patients from different ethnic groups. These interventions for the management of aggression may indirectly reflect clinicians' views, in practice, of a patient's dangerousness. Two studies in the 1980s showed that African Americans were more often put in seclusion and, according to one study, given more emergency medications than whites.[57,58] A follow-up study in 1995 revealed no differences in use of seclusion or restraint.[59] This and other studies have shown that African Americans are treated with higher doses of antipsychotic medication than whites,[60–63] though factors other than perceived dangerousness may contribute to this difference.

In a study of discharged patients, there was no effect of the patient's ethnicity on clinicians' predictions of violence.[64] An analysis of data from the MacArthur Foundation's Violence Risk Assessment Study revealed a greater likelihood of violence by African Americans discharged from a hospital, compared with whites, but this finding disappeared entirely when neighborhood disadvantage was controlled for statistically.[65]

Some studies have shown correlations between ethnicity and history of violent behavior in certain samples. One study of hospitalized inmates showed that nonwhite patients were more likely to have a history of violent behavior.[66] In another study conducted at a secure hospital in British Columbia, there was no association between a history of violent offending and ethnicity.[67] An uncontrolled study in New York City of drug users showed that the number of drug-related violent incidents reported and the type of drug associated with that violence varied by ethnicity.[68] African Americans committed more violence while using cocaine, white females and Hispanic males when using heroin, and white males and Hispanic females when using alcohol. The sample was not necessarily representative or predictive, as the authors acknowledged.

There has been little published on the validity of risk assessment instruments in various ethnic groups. In a recent study, there was no significant difference between whites and African Americans in overall scores on the Psychopathy Checklist-Revised (PCL-R), a heavily weighted item in most risk assessment instruments, though there were small differences in scores on individual items.[69]

Lack of insight, a factor usually considered in dangerousness assessment, should be studied in greater detail among different ethnic groups. In one study of 169 patients, only 4.2 percent of African-American men with severe and persistent mental illness perceived themselves as mentally ill, compared with 43.6 percent of white men, 36.4 percent of white women, and 37.5 percent of African-American women.[70] Both African-American men and women were less likely to give a medical or biological explanation for their illnesses, than were white men and women. In contrast, in one British study there was little variation by ethnicity in patients' scores on the Awareness of Illness subscale of David's Assessment of Insight.[71] Two studies have shown more religious or spiritual interpretations of mental health problems among African Americans[72] and Japanese Americans.[73] Members of ethnic minority groups may be reluctant to accept diagnoses that they perceive as labels imposed on them by clinicians from a majority group, particularly if they have had experiences with misdiagnosis or mistreatment.

In various studies, differences among ethnic groups have also been revealed in attitudes toward mental health treatment, which may reflect on insight, perceptions of stigma, and compliance. African Americans may be less embarrassed about seeking psychiatric care,[74] but also less satisfied with the care received,[75] than whites. Asian Americans express

more feelings of shame regarding mental health treatment and wait longer to seek psychiatric treatment.[27] Presumably, attitudes toward health care play a role in the risk of elopement from hospitals. In only one study, from Great Britain, the risk of elopement from a psychiatric facility was examined, and no significant difference was found in rates by ethnicity.[76]

Adolescent risk factors may vary by ethnicity. Results in one large interview study of adolescents showed that African-American and Hispanic youth are less likely to have alcohol problems but are more likely to be involved in violence than are whites, even when other social variables are controlled statistically.[77] Another study showed that different variables predict criminal recidivism in white and African-American juvenile delinquents, even though recidivism rates do not vary by ethnicity.[78] White recidivists are more likely to receive a conduct disorder diagnosis and less likely to receive a substance abuse diagnosis. African-American recidivists were younger at the first arrest, more likely to have received a diagnosis of attention-deficit/hyperactivity disorder, and less likely to have received a diagnosis of depression.

There has been some research into the ethnic characteristics of various criminal populations. A study of stalkers referred to a New York City court clinic showed that African-American and Hispanic defendants were under-represented when compared with defendants in all ethnic groups referred to the clinic; most alleged stalkers were white.[79] Data of this sort may be useful in psychological profiling, if not for risk assessment in an already identified offender.

Clinicians' assessments of dangerousness should consider danger to self as well as to others. Results in epidemiological studies have shown that suicide rates are higher among whites than among Hispanics or African Americans, though rates are increasing among the latter group.[80,81] American Indians have suicide rates that are commonly 50 percent higher than the national average, with particularly high rates among adolescents and young adults.[1] It is unclear whether these different base rates are considered in risk assessment or how they should be balanced against individual clinical factors.

Involuntary Commitment

African Americans are hospitalized involuntarily more often than whites,[82] though one study provided no evidence that racial bias contributes to the difference.[83,84] An early study showed that the higher rate was best explained by the greater likelihood that nonwhites would be taken to the hospital by the police.[85] In Great Britain, many studies have also shown that black West Indians are more often admitted involuntarily,[86,87] though some have argued that there are methodological errors in these conclusions.[88] In a Canadian study, researchers found that nonwhite patients were disproportionately admitted to a psychiatric intensive care unit (PICU) within a hospital.[89] Once released from hospitals, nonwhite men had the highest rate of revolving-door readmissions, according to a Chicago study.[90] However, the best predictors of readmission were not ethnicity but substance abuse and noncompliance with medications.

Individuals acquitted by reason of mental illness may be committed involuntarily so long as they continue to have a mental illness and to be dangerous. In studies from several states, researchers have looked at factors, including ethnicity, that predict release from the hospital. In Maryland, a longer hospital stay was associated with poor prior employment history, psychosis on admission, and young age, but not with ethnicity.[91] In a study from Missouri, results showed no difference by ethnicity in decisions to grant conditional release, so long as the data were adjusted for diagnosis of antisocial personality disorder.[92] The reasons that African Americans more commonly receive diagnoses of antisocial personality disorder were not addressed. According to a Connecticut study of female insanity acquittees, nonwhite women were hospitalized twice as long, but fewer prior arrests among whites was a possible confounding factor.[93]

A 1983 study in New York State showed that ethnicity was one of nine factors that contributed to a prediction of length of hospital stay after a finding of insanity.[94] However, all nine factors combined accounted for only 11 percent of the observed variance. The direction of the effect of ethnicity was not specified. In a more recent New York study, diagnosis and severity of crime did not predict conditional release.[95] According to a decision-tree analysis, gender, education, ethnicity, and prior forensic hospitalization, in that order, predicted release. Among high-school-educated men, 57.9 percent of white insanity acquittees were released, compared with 31.0 percent of nonwhites.

In summary, there is some evidence that African Americans are involuntarily committed to hospitals, pursuant to either civil or criminal laws, more frequently or for longer periods of time than are whites. However, researchers have had difficulty sorting out all the potential confounding factors. There has been almost no research into the frequency of involuntary commitment or length of stay of members of other minority groups.

Competency

There has been little published that directly addresses the impact of ethnicity on the question of competency.

Stefan,[96] an attorney, has pointed out that African-American men are over-represented in categories associated with incompetence, such as diagnosis of schizophrenia and denial of mental illness and need for treatment (referring in part to findings from the MacArthur Treatment Competence Study[97,98]). She speculated that members of ethnic minorities are also more likely to be perceived as irrational, and their opinions to be discounted, by mental health workers, attorneys, and judges. Forensic psychiatrists should recognize that different illness models and fears of stigma, psychiatric treatment, and the medical establishment, which are more common among African Americans and Asian Americans, may be grounded in historical experience and cultural perceptions rather than a lack of insight *per se*.

Advance health care directives are increasingly used in the mental health arena, having been employed for some time in other medical areas. Advance directives are established while a patient is competent, in preparation for the patient's possibly becoming incompetent. The impact of ethnicity on advance directives for medical care has been explored in several studies. One retrospective hospital chart study of deceased patients showed no differences in the frequency of do-not-resuscitate (DNR) orders by ethnicity.[99] However, the investigators found that nonwhite and non-English-speaking patients were less likely to have been involved in the decision-making regarding the DNR designation. Dupree[100] conducted a qualitative study of attitudes of African Americans toward advance directives and also reviewed previous studies in which low utilization of advance directives in general was found, and perhaps particularly, among African Americans. She found mostly positive attitudes among African Americans regarding establishing advance directives to prevent unconditional end-of-life treatment. Common themes included faith in God and an afterlife, concern for end-of-life dignity, and valued family involvement. The survey was not administered to other ethnic groups for comparison.

Future studies should examine whether ethnicity (or other cultural issues, such as language) play a role when clinicians and nonclinicians (e.g., defense attorneys, judges, family members) question an individual's competency. In the criminal arena, for example, does the ethnicity of the defendant or the ethnicity of the defense attorney impact on decisions to assess the defendant's fitness to stand trial?

Criminal Matters

In an early study, college students were presented with a hypothetical legal scenario in which an insanity plea had been entered against a violent murder charge.[101] When ethnicity and gender were varied, African-American men were more likely to be found guilty. One Canadian study showed that nonwhite defendants sent to a psychiatric unit for forensic evaluation were almost three times more likely than whites ultimately to be convicted of an offense.[102] In contrast, the results of a study of pretrial psychiatric evaluations in Virginia showed no effect of ethnicity on whether charges were ultimately dropped or a plea of insanity was successful.[103] In a study of parricide and attempted parricide cases referred for forensic evaluation in California, white defendants were considerably more likely to receive an insanity finding than African-American defendants.[104]

A recent study showed that jurors may be inclined to assign less responsibility to minority defendants when the jury foreperson is of the same minority ethnicity.[105] Mock jurors, including those later elected as forepersons, initially assigned equal responsibility to white and African-American defendants. Mock jury deliberation did not change rates of assigned responsibility, except when both the defendant and the foreperson were African American, in which case less responsibility was assigned. The authors concluded that mock jurors' opinions were affected by the social desire to appear unprejudiced when ethnicity had become "salient" in deliberation. An alternative explanation, not considered by the researchers, is that the foreperson may have experienced a social desire to represent African Americans positively.

This Journal published a study from South Carolina of death row inmates who had received forensic psychiatric evaluations, comparing them with matched groups of capital murderers who did not receive the death penalty.[106] The results showed that most of the death penalty group was white, while most of the other capital murderers were African American. The more interesting finding was that most of the victims in the death penalty cases were white, while most victims in those cases that did not result in the death penalty were African American. The recently released findings of a government study in Maryland largely support this finding.[107] In a study of approximately 6,000 prosecutions from 1978 to 1999, most victims in cases that resulted in the death penalty were white, in contrast to capital cases that did not result in the death penalty, in which half of the victims were African American. Similar findings from Georgia were cited in the 1987 U.S. Supreme Court case of *McCleskey v. Kemp*.[108] From 1973 to 1980, cases involving an African American defendant and white victim were more than seven times more likely to result in the death penalty than cases involving a white defendant and African-American victim.[109]

Diversion of offenders to substance abuse and mental health treatment should be implemented fairly. Some studies have shown that white adolescents with behavioral problems tend to end up in the mental health system, whereas African-American adolescents exhibiting similar behavior end up in the criminal justice system.[110–112]

The inclusion of culture-bound syndromes in an appendix of the DSM, starting with the fourth edition,[113] raises the question of whether these syndromes should qualify as mental illnesses on issues such as criminal responsibility, extreme emotional distress, mitigating and aggravating circumstances, and competence to stand trial. The answer is likely to vary, depending on the jurisdiction's statutory definition of mental illness, on the scientific evidence regarding the syndrome, and on the individual judge's discretion regarding the relevance of the testimony. Regarding the Southeast Asian syndrome of amok, results in one study indicated that sudden mass assault by a single individual is characterized by similar clinical features (social isolation, loss, depression, anger, narcissism, and paranoia) whether it occurs in Laos or North America.[114] Similar studies might challenge or support the clinical distinctiveness and legal relevance of other culture-bound syndromes.

Child-Related Issues

A literature search revealed that few articles have directly addressed the impact of ethnicity on the forensic practice of child psychiatry. However, cultural background may be particularly important in the assessment of a child in his or her family context. Expert opinions on child custody, child abuse, adoption, and the termination of parental rights should consider relevant cultural issues and distinguish between science, speculation, and stereotypes.

Azar and Cote[115] reviewed the theory and some research suggesting that ethnic background may affect factors commonly considered by evaluators when assessing parental fitness. Most of the research has been on culture and parenting in general; conclusions about impact on fitness assessment remain indirect.

Adoption agencies generally attempt to place children with families of the same ethnic background, and policy and laws have often discouraged what is commonly referred to as transracial adoption (TRA). Brooks and Barth[116] reviewed the research in this area, which has been controversial, but which has generally found no difference between transracial and inracial adoptees on psychological measures of adjustment. In their own study, they found that African-American boys adopted by white parents had more adjustment problems than Asian Americans or African-American girls, but fewer adjustment problems than white boys adopted by white parents.

Griffith[117] and Griffith and Duby[118] have argued in this Journal that opposition to TRA has been based on values about ethnic identity and separatism rather than scientifically informed decisions about what is in the child's best interest. He encouraged forensic psychiatrists to enter the debate and bring the scientific evidence to bear when serving as experts in this area. In 1998, the American Psychiatric Association issued a Resource Document on Controversies in Child Custody, noting that the available literature, though scant, did "not support the conclusion that [TRA] should be prohibited or discouraged."[119]

Tort Issues

Discrimination on the basis of race or ethnicity is recognized as a potential cause of personal injury. As

Griffith and Griffith[120] have observed, forensic psychiatrists may play a role in evaluating psychological injury that results from discriminatory conduct. In a recent article in this Journal, Butts[121] called on psychiatrists to recognize that acts of racial discrimination can cause post-traumatic stress disorder, a diagnosis that may provide a rationale for seeking damages. Unfortunately, his argument is supported primarily by anecdotal observations.

In two studies of hypothetical cases, investigators found that clinicians are more likely to breach confidentiality (regarding HIV status or dangerousness) if a patient is identified as African American.[122,123] Even though the duty to protect may serve as an exception to confidentiality, the duty to the patient should not be taken more lightly because of the patient's ethnic minority status.

Available evidence suggests that members of ethnic minority groups receive psychiatric care that is different from that received by whites, though the causes of these differences have not been fully elucidated. African Americans appear to have their conditions commonly misdiagnosed, to be administered higher doses of antipsychotic medication, not to receive proper antidepressant or other psychotropic treatment,[124–128] and to have higher rates of tardive dyskinesia[62] (though one earlier study showed equal rates of tardive dyskinesia[129] between whites and blacks). Mental health problems are less likely to be detected by primary care physicians when the patient is Hispanic or African American.[130] Disparities in access to care are seen for most ethnic minority groups, as described in detail in the surgeon general's report.

Are these differences cause for individual or class malpractice actions? Such findings have consequences in the political sphere, if not in the court, and researchers or administrators may be reluctant to examine their systems because of the fear of uncovering embarrassing discrepancies and liabilities.

In civil suits, forensic psychiatrists are asked to define the standard of care in psychiatric practice. Increasingly, psychiatrists should be expected to be culturally competent in evaluating and treating patients. In the past decade, the mental health community has published many guidelines and informative articles with the aim of increasing competence in cultural matters, including the American Psychological Association's Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations in 1993,[131] a special series on the needs of nonwhite populations in the journal *Psychiatric Services* starting in 1999, and the recent U.S. Surgeon General's Report. The American Psychiatric Association's Practice Guideline for Psychiatric Evaluation of Adults states that psychiatrists must consider cultural issues in their formulation, be aware of their own potential cultural biases, and seek consultation when lacking knowledge or skill in working with a patient of a particular cultural background.[132] DSM-IV (and the subsequent Text Revision edition) includes an appendix proposing an outline for cultural formulations and listing many culture-bound syndromes.[133] Each major illness section also includes a discussion of gender, age, and cultural factors, often including variable presentations in different ethnic groups.

Though the standard of care is sometimes defined according to practice in the local community, it is unlikely that practitioners in any community are completely insulated from cultural issues. According to the 2000 U.S. Census, nearly one-third of Americans currently define themselves as members of ethnic or racial minority groups.[134] Even in communities where whites predominate, one cannot assume cultural uniformity among patients or between patients and psychiatrists. For example, many psychiatrists are foreign born and may have an ethnic background different from most of their patients.

Psychiatrists might also be called on to determine, in a variety of arenas, whether an individual's seemingly racist beliefs stem from mental illness, personal experience, or culturally sanctioned stereotypes.

The Expert Witness

Cultural differences that complicate clinical interactions are likely to play a role in forensic evaluations as well. As some researchers have pointed out, transference and countertransference may be accentuated in forensic evaluations of subjects from an ethnic minority group.[135] The forensic evaluator may experience fear, unease or identification with the subject. The subject may be more suspicious and mistrustful of a white evaluator, who might be perceived as an instrument of the majority-dominated justice or mental health systems. A subject may also have unrealistic expectations of favorable treatment from an evaluator who belongs to an ethnic minority group.

Though the attitude of courts toward psychiatry is far from uniform, judges often give considerable def-

erence to psychiatric experts. Stefan[136] has argued that this deference, combined with vague statutes, creates room for the unconscious biases of psychiatrists to influence matters pertaining to punishment and infringements on basic civil rights.

Ethnicity has been at the center of one of the most interesting debates in forensic psychiatry: the ethics of the expert witness. In a series of articles, Stone[137,138] and Appelbaum[139,140] have debated the feasibility and permissibility of separating clinical and forensic roles. To illustrate the dilemma, Stone presented, in his 1980 presidential address to the American Psychiatric Association,[137] the Parable of the Black Sergeant, which describes the unintended consequences of exploring the cultural context of a defendant's criminal behavior. Appelbaum countered by proposing that truth-telling and respect for persons are the values that define forensic ethics, in contrast to the medical values of beneficence and nonmaleficence.

In his 1997 presidential address to the American Academy of Psychiatry and the Law, Griffith[141] added to the debate from the perspective of a forensic psychiatrist who belongs to a culturally nondominant ethnic group. Griffith challenged Appelbaum by arguing that the role of a forensic psychiatrist as an advocate for the unique needs of the minority subject cannot be neatly dismissed, at least when the justice system appears to be unfair toward ethnic minorities. Griffith recommended that the cultural formulation be used in forensic evaluation to ensure that the "psychological and sociocultural" truth is told and that the subject is fully respected as a person. By grounding this recommendation in the ethics of truth telling and respect for persons (rather than advocacy or beneficence), Griffith seemed to be expanding on, rather than overturning, the ethical values proposed by Appelbaum.

The Group for the Advancement of Psychiatry has recently released a monograph[142] emphasizing the use of the cultural formulation that was first presented in DSM-IV. In a series of articles discussing individual cases, Silva and colleagues[143–146] have illustrated how the cultural formulation can and should be used when reaching and communicating forensic opinions.

Conclusions

The title of this article is intentionally provocative. Typically, color-blindness is perceived as a positive goal. In the eyes of the law, individuals should not be treated differently on the basis of race or ethnicity. Ironically, color-blindness in psychiatry is a problem. The literature indicates that individuals may receive improper diagnosis and treatment if clinicians do not pay attention to ethnic background and context. In the forensic arena, failure to consider relevant ethnic factors, including potential biases, may lead to inaccurate forensic formulations and opinions, with serious implications for all parties.

Sue[147] has proposed three skill domains that are important in cultural competency: scientific mindedness, dynamic sizing, and culture-specific expertise. The scientific-minded evaluator develops creative ways to test hypotheses and to act on acquired data. Dynamic sizing involves the ability to determine the relative importance of general and individual factors. The cultural context is important, but generalization on the basis of ethnicity can lead to stereotyping. The third skill domain reflects the need of clinicians to be knowledgeable about cultural issues and capable of communicating effectively with individuals from a given culture.

In many ways, these skill domains should be familiar to forensic psychiatrists, since they are similar to skills that forensic evaluators use regularly. Forensic evaluators are experienced at considering multiple hypotheses, doggedly pursuing and acting on data, considering general probabilities without profiling the individual and using specialized knowledge relevant to the legal and clinical case at hand. Extending these skills into the cultural arena should come naturally.

Though the literature is limited, some general recommendations can be made. To gather more information and increase the accuracy of clinical formulations, forensic psychiatrists should strive to interview subjects in their primary language or in bilingual interviews. Structured interviews, psychological tests, and established diagnostic criteria are tools that should increase the objectivity of clinical assessment. Tests should be valid for the ethnic population to which the subject belongs.

Expert witnesses must be vigilant in monitoring their own potential biases. The ethnicity of the forensic psychiatrist, the ethnicity of the subject, and the interaction between dominant and nondominant ethnic groups in the justice system may all affect an examiner's neutrality in complicated ways. Forensic psychiatrists should consider consultation with a col-

league when the possibility of bias has been recognized. The potential impact of ethnicity on decision-making should be discussed openly and regularly in professional gatherings (departmental meetings, case conferences, training seminars) to increase awareness, to decrease defensiveness, and collectively to monitor and reduce our capacity for bias. Cultural competency skills should be taught at various educational forums, including in residency and fellowship.

Expert witnesses are expected to provide courts with specialized knowledge of scientific and clinical data. Forensic psychiatrists should be aware of the validity of the science used as it applies to members of ethnic minority groups. Many areas of psychiatric assessment and treatment have not been studied specifically to confirm their applicability in various ethnic groups, and this should be an acknowledged limitation of the research. As a field, forensic psychiatry should encourage research in the area of race and ethnicity, because it affects the validity of our opinions and complicates clinical care in the special populations with whom we work.

Forensic psychiatrists should keep in mind that following these principles will not eliminate differences of opinion in the courtroom, even when cultural elements are prominent in the case at hand. Qualified experts are likely to continue to disagree on clinical matters, including the extent to which the subject's ethnicity is relevant, and on the application of their clinical findings to the specific legal issue. Experts may also find themselves in the position of presenting culturally informed opinions to previously uninformed or unreceptive fact finders. Judges and juries may have tendencies to stereotype or be ignorant about members of various ethnic groups, just as they may have stereotypic notions about those with mental illness. The effective expert will communicate enough scientific knowledge and information about the individual to leave little room for the exercise of stereotypes or ignorance based on ethnicity.

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