Searching for the Whole Truth: Considering Culture and Gender in Forensic Psychiatric Practice

Susan Hatters Friedman, MD

Contemporary forensic psychiatrists practice in a system that has gender and cultural biases. Though we are only one small piece of the criminal justice system, learning about cultural and gender concerns is critical so that we properly engage and fulfill our mission of striving toward objectivity. Paternalism or chivalry are not the answer when faced with gender questions, as presuming color-blindness is not the answer when faced with cultural questions. Rather, we need to examine our own biases and educate ourselves. Many opportunities for teaching and public health exist in our field, each of which can help address these challenges on a larger scale as well.

J Am Acad Psychiatry Law 51:23–34, 2023. DOI:10.29158/JAAPL.220114-22

Key words: forensic psychiatry; culture; gender; bias; #MeToo; battered women

> "Change does not roll in on the wheels of inevitability, but comes through continuous struggle."[1]
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> —Martin Luther King, Jr. (1956 sermon "The Dead of Evil upon the Seashore")

Forensic psychiatrists have, at many points in time, considered the quest for truth within our field. We have struggled with the matter of objectivity at least since Isaac Ray in 1851.[2] In esteemed presidential addresses to AAPL, both Charles Scott and Michael Norko focused on the search for truth. Scott focused on the importance of more objective scientific methodologies.[3] Norko focused on forensic psychiatry as a spiritual practice.[4] I am referring to truth as the whole experience, which is informed by culture and gender. In this discussion, I will focus on our search for truth as forensic psychiatrists, considering the importance of both culture and gender (our own and those of the evaluees and forensic patients we see) within contemporary forensic psychiatric practice.

No one can doubt that we practice in a flawed world, in a flawed system. There are inherent biases in our justice system. There are disparate arrests and sentencing for the same offense. The death penalty is disproportionately meted out to Black men. Women and gender minorities struggle for rights. It was not too long ago that some citizens were granted a most basic right, to vote, in America. The 15th Amendment, ratified in 1870 soon after the abolition of slavery, afforded men of all races the right to vote, though exercising this right would be another matter. The 19th Amendment, for women's suffrage, was ratified in 1920.

The last several years have seen incredibly trying times around the world. Even our shared distress of COVID is experienced differently depending on our culture, our immigration status, our gender, and our socioeconomic class. COVID exposed global disparities in resources among minoritized groups, further igniting a need for change.

Forensic psychiatric topics are in the daily news, from intimate partner violence (IPV) to sexual assault

Published online February 2, 2023.

Dr. Hatters Friedman is the Phillip Resnick Professor of Forensic Psychiatry and Professor of Psychiatry, Reproductive Biology, Pediatrics, and Law (Adj), Case Western Reserve University, Cleveland, OH, and Honorary Associate Professor of Psychological Medicine, University of Auckland, Auckland, New Zealand. Address correspondence to: Susan Hatters Friedman, MD. E-mail: SJH8@Case.edu.

Dr. Hatters Friedman is involved in the editorial leadership of The Journal; however, she did not participate in any aspect of this article's review and acceptance.

Disclosures of financial or other potential conflicts of interest: None.

to racial profiling. These are continuously evolving areas. At this time in history, forensic psychiatry is so relevant, not merely for our opinions on individual cases, but for our leadership in services and for our educational roles, as we are increasingly present in the media and culture. Misunderstandings of culture and gender are a global problem as well as a problem in our field.

Considering culture and gender is integral to our forensic psychiatric ethics. Our ethics are linked to compassion for those in front of us, which includes understanding their lives and values, our shared humanity.[5] In his presidential speech, Norko discussed spirituality, including compassion, empathy, and humility.[4]

Let me be clear: I am not suggesting that we can ever know the whole truth. We must be humble and recognize it may be impossible to ever know.[6] But without examining ourselves, including our knowledge and personal biases about culture and gender, we cannot hope to move any closer to doing so. As forensic psychiatrists, doing our day-to-day work, we are responsible for managing our own bias, but on a larger scale, we must also play an educational role with our specialized knowledge.

Culture

Recently, many cultural concerns and injustices have been at the forefront in America, including immigration and calls for police reform in the wake of the murder of a Black man, George Floyd, by a White Minneapolis police officer. Chaimowitz and Simpson[7] recently discussed the importance of rehabilitation and recovery in forensics and challenged us to consider our roles. They recognized that as forensic psychiatrists, "from our unique vantage point, we can see some of these structural difficulties in our society, some of the embedded racial disparities and prejudices, systemic racism, and stigmatization" (Ref. 7, p 159). They sharply note, "The skills or attributes of objectivity and truth telling make for awkward bedfellows in the face of some of the truths we see unfold before our eyes" (Ref. 7, p 157).

Minority individuals often receive treatment from doctors who are in the majority group, the group referred to as the "dominant" group. It has been well demonstrated that Black people are more often diagnosed with psychotic disorders whereas Whites are more often diagnosed with mood disorders.[8,9] Race also affects how dangerous physicians perceive a person to be.[9] Shadravan and Bath[10] thoughtfully described the importance of understanding the history of American psychiatry, pseudoscience, and racism. The diagnosis of "Negritude" (the only cure for which was to become White) was created by Dr. Benjamin Rush, and the diagnoses of "Drapetomania" (causing a desire to escape enslavement) and "Dysaethesia aethiopica" (causing Black people to become unprincipled rascals) by Dr. Samuel Cartwright.[10] As this has perpetuated over time, Black race itself is often considered a risk factor for violence. Shadravan and Bath note "consequently, forensic psychiatrists reading this literature, while taking their own objectivity for granted, unconsciously equate blackness with irrationality and simultaneously evade all responsibility for perpetuating this disparity" (Ref. 10, p 4).

Similarly, recent research has considered bias in forensic pathologists' decisions about manner of death, with racial disparities in determining whether child deaths are by accident or by homicide.[11] This has been contentious[12] but should certainly give us further pause as forensic psychiatrists.[12]

In 1998, Ezra Griffith noted that "dominant/nondominant issues are in play at every step of a judicial process obviously controlled by the dominant group" (Ref. 13, p 178). Studies continue to demonstrate that, in arrests, use of force (whether or not mental illness was involved), bail, and sentencing,[14] Black and other minority men and boys are more disadvantaged at every step in the criminal justice system, and the term "cumulative disadvantage" has been used.[14] Trestman noted "the challenge we face is what to do with this knowledge" (Ref. 14, p 417).

Griffith's Cultural Response

The renowned debate between Alan Stone[15] (writing in 1984) and Paul Appelbaum[16] (in 1997) focused on whether forensic psychiatrists belong in the courtroom and centered on our profession's ethics. Griffith[13] added to this (in 1998), the importance of the cultural component.

Stone,[15] a White psychiatrist, had told two stories: one about Dr. Leo, a Jewish physician testifying in a criminal case in 1801 to help his Jewish patient in the context of rampant antisemitism; and a more personal story of testifying about a Black sergeant's larcenous crimes. Stone questioned the value of psychiatrists in the courtroom, including our ability to remain objective in an adversarial system, and discussed reconciling the obligation to justice with the

desire to serve the patient's best interest. Appelbaum[16] focused on truth-telling and respect for persons and proposed an ethics framework that now underpins American forensic psychiatry. Griffith[13] entered the debate and brought focus to the cultural aspects in the cases Stone had described, and the importance of Appelbaum's precepts with a cultural framework "illuminated by the political reality of dominant/nondominant group interaction" (Ref. 13, p 181). Rather than suggesting that psychiatrists are activists in the courtroom, Griffith explained that psychiatrists should be advocates for the evaluee's narrative.

Thus, in 1998, Griffith[13] noted that he was introducing the cultural formulation. Regarding the misinterpretation that all those in a specific nondominant group see the world in the same way, Griffith subsequently beautifully described that "the task of adapting to the dominant white group is open to interpretational adjustment, regardless of what our own personal preferences may be" (Ref. 17, p 373). The concept of "belonging," perhaps the direct opposite of "othering," is critical for all people of various nondominant groups in a healthy society. Griffith uses a description of belonging as "a total and confident sense of being a member . . . . It is markedly different from the feeling of being tolerated, or, worse, the feeling that you are an uninvited guest" (Ref. 17, p 376).

In asking whether one's own group identity is valuable to the dominant group, and whether friendly relationships should be sought with the dominant group, Griffith[13] described the outcome of acculturation, either with full integration if both questions are answered affirmatively, with marginality if both are answered in the negative, or with resistance or marginalization. Griffith argued that forensic psychiatrists in the modern day, have a "duty to be culturally connected" (Ref. 18, p 430). Griffith extolled "let us tell the truth. But let us also be concerned about telling the truth in processes that may be unfair" (Ref. 18, p 430).

AAPL Guidelines and Culture

The 2007 AAPL Practice Guideline regarding competency to stand trial discussed cultural considerations in competency evaluations.[19] It discusses how most forensic psychiatrists identify with the dominant culture's view that criminal proceedings are reasonably fair, while those from other cultures may not. They assert "psychiatrists must strive to feel comfortable with and accepting of an evaluee's cultural identity" (Ref. 19, p S30).

The AAPL Practice Guideline for the Forensic Assessment[8] includes a lengthy section about culture in forensic evaluations. We wrote about cultural factors in forensic evaluations, including contextualizing culture, race, and ethnicity; disparities in diagnosis; culture as part of formulation; cultural identity; diagnosis questions cross-culturally; language concerns; psychological testing and the mental status examination; and specific types of evaluations. We discussed that each of us in the legal process may have our own value systems and preconceived notions. To start, we must acknowledge our own potential for bias. But there is much more work to be done.

Considerations in Cross-Cultural Evaluations

The Practice Guideline notes "competence in cultural formulation includes respect for and knowledge of other cultures, as well as self-assessment to guard against cultural biases" (Ref. 8, p S40). Because cultural and racial minorities are overrepresented in forensic populations, and because forensic psychiatrists tend to be of the dominant race, forensic evaluations themselves are often cross-cultural. Not recognizing this obscures our search for truth. We must, as individual forensic psychiatrists, understand our own cultural identity, be humble about our limits, and be aware of power dynamics. Our goal should be equitable care in diagnosis and treatment. Our potential biases are limitless: race, culture, religion, immigration status, gender, gender identity, socioeconomic status, age, and more.

Cultural competence requires self-awareness, a core knowledge of other groups, recognizing our own knowledge limitations, and using our unique forensic skills in a culturally appropriate way to understand the individual in front of us.[9,20] Cultural formulations include understanding cultural identity, cultural explanations of illness, and culture relevant to psychosocial environment and the doctor-patient relationship.[21] Kirmayer and colleagues noted "supplying the cultural context of behavior changes its meaning and renders the individual's reasoning more transparent. In effect, it allows the judge to reconstruct imaginatively the affective logic of the defendant's cultural world" (Ref. 22, p 100).

It is critical that we reflect on the effect of culture in specific scenarios in forensic psychiatry. As noted in the Practice Guideline "the forensic psychiatrist

must first identify the traditions, values, and behavioral norms of the evaluee that are pertinent to the consultation questions" (Ref. 8, p S39). For example, when completing competency evaluations, we often begin with a worldview of the dominant culture that our criminal justice system is fair and just. Other cultures, both from inside America and outside, may not share this view. And yet other cultures may not speak out against those in power.[9,19] In another common evaluation, sanity at the time of the act, we must consider actions within the cultural context, wrongfulness in the culture versus the impact of mental illness.[8,9,21,22] In the United States, the Indian Child Welfare Act allows different standards for Native American families, prior to a Native American child being placed with a non-Native American family.[23] AAPL's Task Force on Understanding Disparities in Evaluations and Addressing our Biases in Forensic Practice, led by Simpson and Chaimowitz, is currently hard at work on evidence-based practice guidelines in this area.[24] To do so, they are rigorously reviewing literature about race and culture in the criminal justice system.

International Lessons from my Sabbaticals

I previously wrote about my first sabbatical, in New Zealand.[25] In the last several decades, New Zealand has embraced its Māori heritage, as opposed to the treatment of aboriginal native peoples in many other countries. As in English, Māori words are used in everyday conversation as well as within mental health. In New Zealand, mental health professionals talk not only about the biopsychosocial formulation, but about the biopsychosociocultural formulation. *Whanau ora* includes interpersonal dependencies and relationships; it involves inclusiveness.[25]

Yet in New Zealand, as everywhere else, persons of nondominant cultures are overrepresented in forensic psychiatry. Practice of forensic psychiatry in hospitals, on community teams, and in prisons, as well as research, is steeped in culture and cultural understanding.[20,26] Forensic recovery in New Zealand occurs, purposely, in the context of identity and culture.[25] Cultural advisers are valued members of mental health treatment teams.[25] Considering culture is a strength, leading to feelings of belonging, coping, spirituality, and pride.[27]

On my other sabbatical trips, I have visited services in Australia, England, Wales, Japan, Italy, Canada, several New Zealand locales, Hawaii, and other American locales. I visited forensic hospitals, women's hospitals, outpatient programs, inpatient youth services, and women's prisons. I met with service leaders, and I met with cultural staff conceptualizing healing in a cultural context. In Hawaii, I saw an amazing breadth of culture in healing; for example, the traditional hula in the women's correctional facility.[28] Hula has been used to tell stories for centuries. In Japan, I learned of pathological gamblers of Pachinko, in a very different culture to ours, which "helped consolidate my beliefs about the importance of understanding what various cultures bring to our field" (Ref. 29, p 3). In Italy, I saw "innovative thinking despite obstacles. And, it helped further my thinking about the importance of international understanding and relationships" (Ref. 30, p 3). Overall, on these visits, I found that the services I worked in (in New Zealand, in Cleveland), had a lot in common with struggles of other services, but that we also had a lot to learn and share. As forensic psychiatrists, looking at solutions by other cultures and systems, facing similar struggles as we are, can be invaluable. We must have humility and openness to others, and engage in lifelong learning about other cultures, to do our work effectively.

Observer Effect

In physics, the term "observer effect" refers to the effect that the physicist-observer has on a scientific observation, such as in quantum mechanics.[31] We need to consider our own effects on the forensic psychiatric evaluation and in our treatment role. Kirmayer *et al.* noted that "since we are fundamentally cultural beings, cultural concerns are ubiquitous and are not the sole province of people identified as ethnically different" (Ref. 22, p 100). Rather than being neutral observers ourselves, we are "also products of the culture from which we observe" (Ref. 20, p 137). Griffith pointed out, in discussing the Stone debate, that "we must do better at understanding who Dr. Leo is. To dismiss the seriousness of his struggle is to undermine the personal narrative of nondominant group professionals" (Ref. 17, p 379).

As I previously noted, "dominant privilege asserts itself insidiously in many situations, perhaps in viewing nondominant people as the 'other' or with fear." (Ref. 20, p 136). We must be cautious of othering, separating ourselves from others with stereotypes. We cannot think that a certain type of offense is something others of a certain group do. Rather we must strive for understanding. Griffith noted "I am not a forensic psychiatrist who happens to be black" (Ref. 13, p 172); similarly, I am not a forensic psychiatrist who happens to be a White woman.

Intersectionality

Each one of us has multiple intersecting identities. Crenshaw[32] coined the term "intersectionality" in the 1990s, focusing on the exclusion of Black women from White feminism and from anti-racism. Overlays, however, date back to freed slave Sojourner Truth's "Ain't I a Woman?" speech in 1851, in which she examined the dominant White society's treatment of White women versus Black women.[33]

Intersectionality helps us understand that a Black woman may experience racism differently than does a Black man, and sexism differently than does a White woman. Intersectionality is now the theoretical framework considering the overlap and interdependence of disadvantage and discrimination on multiple levels such as gender, race, sexual orientation, and socioeconomic status. Within public health, "acknowledging the existence of multiple intersecting identities is an initial step in understanding the complexities of health disparities for populations from multiple historically oppressed groups." (Ref. 33, p 1267).

Sidhu and Candilis remind us that "approaches that elevate single principles or clusters of principles above others, or take perspectives with a distinct Western viewpoint, are insufficient in a world of diverse peoples, cultures, and genders" (Ref. 34, p 439). Griffith reminded us in 1998 that "mastery of the evaluation of members of certain minority groups does not mean mastery of all minority groups" (Ref. 13, p 182). Sidhu and Candilis recommend gender-sensitive evaluations considering positionality, and thoroughness in evaluations, to overcome inherent bias. Sidhu and Candilis note "Forensic practitioners can start from an original position of skepticism about the system, then check with collaterals, verify records, and explore the data that support the vulnerable individual. This is both a rigorous preparation for cross-examination and a recognition of the vulnerable individual in the control of a flawed social institution" (Ref. 34, p 444).

Gender

As forensic psychiatrists, we must similarly guard against gender bias, which can affect various evaluations, often because of paternalistic chivalry justice and misguided beneficence. Areas in which bias can occur include sexual offending, sexual harassment, stalking, IPV, psychopathy, infanticide, child custody, and female criminality and incarceration more generally. As I noted, "contemporary forensic psychiatry needs to understand women as aggressors, not just presume them to be victims. Otherwise, we cannot objectively understand cases that we evaluate, and we cannot develop appropriate treatment programs and prevention strategies" (Ref. 35, p 276).

As Sorrentino[36] and I noted, "There is no question that gender differences exist in many areas of forensic psychiatry. The relevant question [is] whether these differences are correct or whether they are inaccurate and translate into a distorted understanding of forensic issues" (Ref. 36, p 835). Related to societal gender bias that mothers are the caregiving loving parent, fathers often face child custody struggles. Women benefit from societal misunderstandings about violence frequently, and women are less likely to be arrested and incarcerated than men.[35] Yet viewers of popular television and film who see a myriad of female psychopaths may not have the same misconceptions about gender.[37]

We have previously described many of the differences for women in prison.[38,39] These women more commonly have histories of abuse, poor physical and reproductive health, and difficult relationships.[40] Women in prison are more likely than their male counterparts to have psychiatric disorders, traumatic victimizations and to experience comorbid substance use disorders and personality disorder.[41–45] Incarcerated women are more likely to have been single parents than incarcerated males, which leads to their children being much more likely to go into foster care when the woman is incarcerated.[39]

While women in prison do have unique needs, there are multiple other misunderstandings about women and crime leading to differential arrest and prosecution rates, and differences in insanity findings, which appear to represent some of the system's biases rather than being true differences. As I noted, "forensic psychiatrists cannot be blind to the potential for women to be violent, else they allow violence to continue, underestimate risk, and produce inappropriate courtroom testimony" (Ref. 35, p 273).

Underreporting of sexual offending when there is a female perpetrator makes it difficult to know the true rates.[46,47] Although studies estimate that women make up less than 5 percent of the sex offender population, self-report studies tell a different story.[46] Among men who have been convicted of rape, it is not uncommon that they report having been molested by women when they were children.[48,49] Added to this, police and prosecutors are less likely to pursue charges when

a woman is the perpetrator.[35] Women can be misperceived as harmless, maternal, nurturing, and altruistic, allowing offending to continue unabated.[36,46]

Similarly, depending on the study sample, up to a quarter of stalkers are women.[50] Without similar amounts of study, we risk missing the potential for violence perpetration in this population. Available research demonstrates an increased risk of violence if a stalker (of either gender) exhibits all three of the following: had a prior intimate relationship with the victim; used approach behavior; and made a threat of violence.[50]

Approximately half of filicides are committed by mothers.[35,51] Infanticide and filicide motives are the same, whether perpetrated by a mother or by a father.[52,53] Motives include fatal maltreatment (formerly known as accidental) in which the child is killed as a result of abuse or neglect, which is the most common type of child murder[54]; partner revenge[54] (also known as spouse revenge or the Medea syndrome) in which the parent kills a child to exact revenge on a spouse or partner; unwanted child; altruistic (murder out of love); and acutely psychotic (with no comprehensive motive in the throes of psychosis).[52,53] In two dozen nations (including Canada but not the United States), there is a specific infanticide defense, decreasing the penalty for only mothers, but not fathers, who kill their young children.[52,55] As I previously noted, "This gender bias in the infanticide laws appears to attach reduced significance to the lives of children murdered by women" (Ref. 35, p 275).

Mothers are more likely to be found insane, whereas fathers are more likely to have more severe penalties.[46,55,56] It is difficult for many to believe that a woman would purposely harm or kill her children.[35] Yet women and men have killed their children for rational motives for centuries.[54,55]

Media representations are consistent with biases among professionals and lay persons regarding parents who kill.[57] Femininity correlates with media portrayals.[58] Cavaglion[59,60] found, in two studies of media representations in Israel, that while paternal filicides were described as rational and premeditated, those of mothers were presented differently. When married Jewish mothers killed, mental illness was emphasized by news reports, whereas they did not do so for mothers who were of ethnic minority, unmarried, or young. As I noted, "fathers, and certain groups of mothers, are portrayed more harshly in the media after a filicide" (Ref. 57, p 87). In vignette studies in which the gender of the parent who committed filicide is changed, both college students and attorneys are more lenient and blame mental illness more often when the parent is described as a mother rather than a father.[57,61–63] Mock jurors had the most severe judgements when vignettes involved Black fathers who used a gun.[61] Thus, there are both gendered and racial narratives about filicide perpetrators.

Although neonaticide (murder in the first day of life) is unusual in that it is virtually always a crime committed by a young woman acting alone,[64] this does not mean that there is a psychiatric diagnosis behind it. The most common motive for neonaticide is that the child is unwanted.[64] These young women are often under tremendous stress and have usually experienced hidden pregnancies, with denial or concealment.[55,64] Premorbid serious mental illness is uncommon.[55,64] Certain cultures have significant prohibitions on premarital sex, and others prioritize male infants. The public response, however, is that there must have been a disorder to explain such behavior. Jurors have difficulty understanding women and aggression.[55]

Consideration of our gender biases regarding sexual and gender minorities is also essential but has been less studied. I will now focus more specifically on misunderstandings about #MeToo and sexual assault, battered women defenses, and pregnancy termination, each of which is a forensic topic that has been in the international spotlight recently.

#MeToo

Myths about sexual assault pervade the public consciousness. It is not merely about victim-shaming, but also about assaults continuing because we, as a society, are not trusting the victims. Forensic psychiatrists, too, have an important role here. Gold[65] discussed biases arising in the assessment of sexual harassment claims. Binder and McNiel[66] provided recommendations regarding forensic evaluations of the credibility of the plaintiff and alleged perpetrator in a "he said-she said" scenario, educating the trier of fact.

The MeToo movement began in 2006, to raise awareness of women who had been abused and to build a community of support.[67] But it came to the forefront in 2017, after being tweeted by Alyssa Milano. Doing so led to increased public awareness of sexual harassment and assault, but #MeToo did not cure misconceptions.

Rape myths pervading popular culture include that most rapists are strangers; most rapes involve a weapon; most victims report rapes immediately; false reports are common; and certain types of victims are not credible. These myths had been manifested in police investigations from the start,[68] as physical resistance has been expected and acts and demeanor of the alleged victim judged. In no other type of legal case do complaining victims find themselves questioned in this way: Why did you allow your house to get robbed? How much had you been drinking when your house got robbed? How long were the drapes?

In actuality, most sexual assaults are perpetrated by someone known to the victim. Most do not involve weapons. Most rapes are not reported, and if they are, there is often a delay. There is simply no single way that every victim responds to a sexual assault. False reports have a low rate of occurrence.[68] Rape can happen to anyone, and victims often have characteristics limiting their perceived credibility.[68–71]

There are various reasons why rape myths persist. The most important may be that believing rapes only happen to certain people who behave in certain ways helps us feel safe from the risk of sexual victimization among ourselves and those we love. It is easier if the usually complex factors in sexual assault appear simple. Sexual assaults that have historically come to attention appeared stereotypical, and the media tends to portray sexual assaults that fit those stereotypes.[68]

But there are serious consequences if the members of a jury, those in the legal system, and those in our field believe these myths. Most obviously, those cases that fit the stereotype are more likely to be prosecuted. Victims who do not fit the mold are not believed, with consequent lack of investigations. Perhaps most importantly, then, offenders are free to repeat sexual assaults.[68]

Perpetrators may evade detection by selecting victims who are vulnerable and accessible, and who appear to lack credibility. Those who seem less credible are those who are young (especially runaways), use alcohol or substances, have mental illness, are homeless, or are in the sexual trade.[68] This can lead to higher rates of victimization in vulnerable populations.

All this leads to a so-called "justice gap" in sexual assault cases. Estimates are that only 0.2 to 2.8 percent result in incarceration for the offender.[72] Cases that are more likely to have charges filed involve those who fit the stereotype: sober White women who had injuries from resisting an unfamiliar man raping them.[72]

Recupero[73] described categories of common allegations designed to obfuscate and suppress women's reports of sexual harassment. These included allegations of a search for attention or publicity; greed; political motivations; scorned woman; "crazy, confused, or exaggerating"; implausibility (e.g., the victim was not attractive); consensual relations; denial; not deigning to dignify the complaint with a response; and complaints about the length of time to reporting. Recupero noted, "we are at an inflection point where women's stories and the social contexts of women's lives may produce a truth that has heretofore been unexplored" (Ref. 73, p 29). We, however, cannot merely believe the woman in completing a forensic evaluation. Instead "the truth of the event and its sequelae cannot be a truth defined by a male perspective. Rather, we need to recognize that the truth in these contexts is complex, and the impact of some events on women shapes a truth that has not heretofore been heard in American jurisprudence" (Ref. 73, p 29).

We as forensic psychiatrists must first understand the truths of sexual assault. Research is essential. National data (e.g., from the Bureau of Justice Statistics) has shed light on these topics. Training (of police, of courts, even of the general public) is vital in combating misinformation about sexual assault. As forensic psychiatrists, we evaluate alleged perpetrators and victims, and we help dispel myths, explaining a range of victim behaviors after assaults, counter-intuitive victim behaviors, and memory during trauma.

Intimate Partner Violence

A forensic psychiatric topic that has been highly visible to the general public in the past year is intimate partner violence (IPV). IPV alleged by both a female partner and a male partner took center stage in the internationally televised 2022 case of *Depp v. Heard*.[74,75] Though psychiatrists testified in the highly publicized case, neither were forensic psychiatrists or women's mental health specialists. Some testimony was surprising, largely related to reliance on antiquated studies. In the 1980s, before the problem of IPV was very well understood by laypersons and physicians alike, the Power and Control Wheel was developed to describe what is now referred to as intimate terrorism or coercive-controlling violence. Much more is known 40 years later, with many reasons described for violence within relationships,[46,76] and society has grown, yet myths about IPV pervade our society.

Misunderstandings about IPV include that it is perpetrated primarily by men; that when men are violent, it is always to coerce and dominate; and that when women are violent, it is only in self-defense. In reality, there are several different types of IPV,[77] including not only coercive-controlling violence and violent resistance, but also situational couple violence (which is the most common and occurs in the context of an argument and poor coping skills) and separation-instigated violence.[78] I previously discussed that "like men, women may be aggressive and have rational though unsavory reasons for horrific offenses. Yet, propensity toward violence is often perceived as a masculine rather than a feminine trait" (Ref. 35, p 273).

Battered women syndrome (BWS) was initially defined in 1979 by Lenore Walker, EdD.[79] The nonmedical syndrome, which is only diagnosed in a legal rather than clinical context and usually after she has perpetrated a murder, is problematic.[35,77] And, like the Infanticide defense, the BWS defense is only for women. BWS has not been supported by rigorous research, nor is it included in the DSM.[77] Yet, forensic psychiatrists are asked to opine whether a female defendant has this unclarified syndrome, to provide opinions not based in specialized knowledge. Perhaps this is another example of misplaced beneficence.

Pregnancy Termination

In 2022, the U.S. Supreme Court overturned *Roe v. Wade* and the half-century of rights afforded women, in *Dobbs v. Jackson Women's Health Organization.*[80] Forensic psychiatrists, as well as reproductive psychiatrists, general psychiatrists, and child and adolescent psychiatrists will all have their practices in some way affected by the limitation on safe and legal pregnancy terminations.[81] Both the treatment roles of forensic psychiatrists (in forensic hospitals, corrections, and community corrections because of unwanted pregnancies) and the evaluative roles (both civil and criminal: medical decision-making capacity assessments, alleged fetal harm) will be affected.[82] Forensic psychiatrists will need to consider their own biases when conducting these evaluations, to be effective and objective neutral evaluators and appropriate treaters.

Bias and Objectivity

In his address, Scott[3] reviewed potential biases. He noted that because forensic psychiatrists may be less objective than other forensic scientists who examine DNA, for example, that we are at potentially higher risk of being influenced by biases, of which we may not even be aware. Scott reviewed biases of anchoring, attribution, confirmation, conformity, halo effect, hindsight, observer, and overconfidence. Regarding anchoring bias, Scott noted "forensic psychiatrists should consider and consciously address potential influences of early impressions on their ultimate opinions" (Ref. 3, p 28), which may be particularly relevant when we are evaluating people of a specific gender or culture, based on our own unexamined beliefs. Attribution bias is similarly relevant to the current discussion, related to the many studies indicating that Black people are more likely to be diagnosed with schizophrenia, and to have higher violence risk based on factors such as apparent paranoia or suspiciousness. I have previously noted "preconceived notions about presentation may lead to a skewed, albeit subconscious, belief about diagnosis. One must strive to recognize and manage these tendencies, else they result in misinterpretation and continued cultural stereotyping" (Ref. 20, p 138).

Goldyne[83] described bias as it came from both emotional and nonemotional factors. Among the nonemotional factors listed was one's fund of knowledge, and Goldyne further noted that bias "may reflect the effects on fund of knowledge of personal factors, including the expert's race, sex, religion, culture, ethnicity, sexual orientation, or early-life exposure" (Ref. 83, pp 62–63). AAPL can help with increasing our fund of knowledge on these topics, as the frequent articles and presentations by the Gender Issues and the Cross-Cultural Issues Committees seek to do.

Goldyne proposed a proactive approach to minimizing bias, such that the forensic psychiatrist "actively attempts to discern potential sources of bias, rather than passively awaiting an inkling of them" (Ref. 83, p 63). Goldyne suggested "deliberate adherence to the attitude that objectivity is compromised unless proven otherwise" (Ref. 83, p 64). Griffith described multiple potential ways examiners could approach their role in racially-intense evaluations.[13] Wills[84] recommended a method of formulation, revision, and identification of limitations of opinions. Forensic education about the history of psychiatry and about bias is important. Self-examination and reflection are critical, and peer review has been recommended.[3,10,20,83,85] As Goldyne[83] noted, we must be vigilant to consider bias and resist defensiveness, and courageously confront motivations.

AAPL's competency practice guideline, now resource document, notes "if the psychiatrist approaches an interview with prejudicial and hostile ideas regarding the evaluee's ethnic membership, the forensic assessment and conclusions may be jeopardized. A psychiatrist's unexplored or unconscious fears about an evaluee's culture may interfere with data gathering and objectivity and ultimately may affect conclusions" (Ref. 19, p S30; Ref. 86, p S32). I would caution that prejudicial ideas about women being maternal, and the Madonna-whore dichotomy of women is just as dangerous in our forensic evaluations.

Misguided Beneficence in Evaluations

It is critical that we strive not only for objectivity in evaluations, but also for understanding of cultures and genders different from our own. With both culture and gender, there is a risk of misguided beneficence. If we are blind to culture, we cannot objectively understand the situation of the defendant, the plaintiff, and the patient in front of us.[9,20] There are limited data about risk assessments cross-culturally, and in women. Add to that the cultural and gender biases in diagnosis and in determination of dangerousness.[9]

When we do not seek true understanding, when we keep coming back with biased views and preconceptions, we (unconsciously) compromise our evaluations, our recommendations, and our treatment plans, based on our biased views and misunderstandings. As I have previously noted, "an approach that does not consider culture oversimplifies life experiences and meanings, and risks incomplete explanations to the court" (Ref. 20, p 138).

Stangle described "chivalry justice" related to the observation that "violence does not comport with societal conceptions of femininity" (Ref. 87, p 706). Such bias avoids understanding of women's motives and future risk. Women are seen as the fairer sex and are often dichotomized as Madonna or whore. When women kill their children, the narrative often becomes one of the "mad" or "sad" mother, rather than the narrative of the "bad" father who is a "monster."[55,57] They may be seen as "mentally unstable because their actions conflict drastically with traditional maternal roles" (Ref. 63, p 5). We previously noted, "it is accepted as truth that hell hath no fury like a woman scorned, but society often fails to appreciate that women may be motivated by the same reasons as men to commit crimes, especially murder" (Ref. 56, p 525). Paternalistic evaluations with misguided beneficence allow all the aforementioned tragedies to go unchecked, from sexual offending against imperfect or vulnerable victims to misguiding the trier of fact.

Kirmayer and colleagues noted that "misguided beneficence may inadvertently make people second-class citizens and impede their integration into the community" (Ref. 22, p 101). Rather, as forensic psychiatrists, we must actively guard against gender bias and cultural bias. We must critically analyze whether the perceived differences are derived from data or from our own assumptions and stereotypes.

Our Roles as Forensic Psychiatrists

Our search for the whole truth requires humility, and a sense of curiosity which implores us to question what we know. Norko[4] reminded us that compassion, born of empathy, is a core forensic value. As forensic psychiatrists, we have roles in evaluation and in treatment, but we also have larger roles in society as educators and as a force for positive change. At the AAPL, two task-forces are presently at work on resource documents of relevance, one regarding culture and the other regarding reproductive forensic psychiatry. As previously noted, training and organizations must seek to "better understand the intersectionality of our practitioners, patients, and evaluees" (Ref. 88, p 11). Research in our field needs to appropriately and sensitively consider gender and cultural differences and biases as well. We need to better understand how to assess risk and interpret testing across genders and cultures. As I previously noted, "forensic psychiatrists cannot be blind to the potential for women to be violent, else they allow violence to continue, underestimate risk, and produce inappropriate courtroom testimony" (Ref. 35, p 273).

As Chaimowitz and Simpson noted, "There is more for us to do as forensic psychiatrists to improve the lot of our fellow human beings than articulating the contribution of mental disorder to the offense and the law and unpacking and reciting law and case law" (Ref. 7, p 159). Halpern and colleagues believed that AAPL should demonstrate leadership by its advocacy on positions of social importance, focusing on the death penalty but also mentioning abortion and immigration.[89] AAPL is currently working on a practice resource document regarding death penalty evaluations, intended to educate members, not as a position statement. Regardless of AAPL's lack of a formal position on topics of culture and gender,

AAPL has sought through resource documents and committee writings and presentations to educate members about these topics and their importance to our practice. We must both be evidence-based in our practice and current with sociocultural concerns facing our evaluees and our patients.

We must also be more visible in doing the important forensic work that we do. As I have previously noted,[90] the public is more likely to have seen some version of forensic psychiatrists in film or television rather than to have seen what we do in real life. We must work to educate the public (who become jurors), as well as judges and attorneys, about the realities within the aforementioned cultural and gender concerns, to promote fairness in the justice system.

Although there are no conclusive data on the most effective way to manage bias in forensic psychiatry, we must proceed. We must recognize these forces that cause us to deviate from the truth, and then attempt to do better. Locally at Case Western, our forensic didactic series includes multiple sessions on gender, culture, and bias. Forensic psychiatrists are active in Fatality and Homicide Review Teams[91] where we can help other health, justice, and social service professionals understand mental health topics and help guard against biases. Mother-baby units are of great promise for the female prison population,[39] and forensic psychiatrists can play an important role in their planning, with knowledge of both maternal mental health and risk assessment. Forensic psychiatrists also have a role[14,92] working with police, helping inform their work with those who are mentally ill and helping vanquish bias in confrontations, supporting community safety.

Conclusions

In conclusion, we cannot ignore the realities of the modern world, as we go about our evaluations and forensic treatment roles. Culture and gender concerns are in the ethos daily. And justice is not blind.

As I noted, "culture and gender, and their intersection, is critical in all of our work" (Ref. 24, p 3). We must be thoughtful in our work in this space. As I noted, "if we are blind to culture, we cannot objectively understand a person's situation, beliefs, and experiences. We risk misunderstanding, perpetuating fear with potential overestimations of risk and inappropriate testimony" (Ref. 20, p 136).

We need to consider the cultural and gender concerns in our evaluations, and in ourselves. We should seek to more deeply understand the experiences of our evaluees and forensic patients. One might argue that addressing these concerns means that people of other cultures or genders are demanding of exculpation; however, this is not what I am suggesting. Rather, we need to consider the cultural and gender facets of our evaluations and in ourselves if we are to arrive at the truth. As forensic psychiatrists, we should all seek to educate ourselves about these realities and carefully consider our own potential for bias. As Griffith noted, "our work takes on a different tone when truth-telling, respect for persons, and objectivity are leavened with humanity and generosity" (Ref. 17, p 381).

To be ethical, we must use our knowledge about gender and culture, such that we do not misguide the court or the general public. We must examine our misperceptions about race, culture, mental illness, and dangerousness. Similarly, it is not trivial when gender bias and paternalism are allowed to run free; it is not being generous to women. There are dire consequences of not examining our potential biases, including perpetuating injustices to minorities, and continuing the victimization of vulnerable populations.

Acknowledgments

I wish to thank Renée Sorrentino, Andrew Howie, Josh Friedman, and Elise Friedman for their thoughtful feedback on earlier drafts of this manuscript. I thank Mike Norko and the anonymous reviewers for their thoughtful recommendations. I also thank my mentors, Phil Resnick, Mim Rosenthal, and Sandy Simpson for the many discussions on related topics.

References

1. King ML. Jr. The Death of Evil upon the Seashore, sermon given at the Cathedral of St. John the Divine, New York City [Internet]; 1956 May 17. Available from: https://www.birminghamtimes.com/2015/01/marin-luther-king-jr-black-history-quotes/. Accessed August 31, 2022
2. Weiss KJ. The subject of objectivity, subjectively considered. J Am Acad Psychiatry Law. 2021 Sept; 49(3):422–7
3. Scott CL. Believing doesn't make it so: Forensic education and the search for truth. J Am Acad Psychiatry Law. 2013 Mar; 41(1): 18–32.
4. Norko MA. What is truth? The spiritual quest of forensic psychiatry. J Am Acad Psychiatry Law. 2018 Mar; 46(1):10–22
5. Norko MA. Compassion at the core of forensic ethics. J Am Acad Psychiatry Law. 2005 Sept; 33(3):386–9
6. Gutheil TG, Hauser M, White MS, *et al.* The whole truth" versus" the admissible truth": An ethics dilemma for expert witnesses. J Am Acad Psychiatry Law. 2003 Dec; 31(4):422–7
7. Chaimowitz GA, Simpson AI. Charting a new course for forensic psychiatry. J Am Acad Psychiatry Law. 2021 Jun; 49(2):157–60
8. Glancy GD, Ash P, Bath EP, *et al.* AAPL practice guideline for the forensic assessment. J Am Acad Psychiatry Law. 2015 Jun; 43 (2 Suppl):S3–53

9. Simpson AIF, Friedman SH. Culture and forensic psychiatry. In Rosner R, Scott CL, editors. Principles and Practice of Forensic Psychiatry, Third Edition. Boca Raton, FL: CRC Press; 2017
10. Shadravan SM, Bath E. Invoking history and structural competency to minimize racial bias. J Am Acad Psychiatry Law. 2019 Mar; 47 (1):2–6
11. Dror I, Melinek J, Arden JL, *et al*. Cognitive bias in forensic pathology decisions. J Forensic Sci. 2021; 66(5):1751–7
12. Starr D. The bias hunter. Science. 2022 May; 376(6594):686–90
13. Griffith EE. Ethics in forensic psychiatry: A cultural response to Stone and Appelbaum. J Am Acad Psychiatry Law. 1998 Jun; 26 (2):171–84
14. Trestman RL. Is justice really blind? Nondominant groups in the American justice system. J Am Acad Psychiatry Law. 2018 Dec; 46(4):416–8
15. Stone AA. The ethical boundaries of forensic psychiatry: A view from the ivory tower. J Am Acad Psychiatry Law. 1984 Sep; 12 (3):209–19
16. Appelbaum PS. A theory of ethics for forensic psychiatry. J Am Acad Psychiatry Law. 1997 Sep; 25(3):233–47
17. Griffith EE. Personal narrative and an African-American perspective on medical ethics. J Am Acad Psychiatry Law. 2005 Sep; 33(3):371–81
18. Griffith EE. Truth in forensic psychiatry: A cultural response to Gutheil and colleagues. J Am Acad Psychiatry Law. 2003 Dec; 31 (4):428–31
19. Mossman D, Noffsinger SG, Ash P, *et al*. AAPL practice guideline for the forensic psychiatric evaluation of competence to stand trial. J Am Acad Psychiatry Law. 2007 Dec; 35(Supplement 4):S3–72
20. Friedman SH. Culture, bias, and understanding: We can do better. J Am Acad Psychiatry Law. 2017 Jun; 45(2):136–9
21. Ajaz A, Owiti J, Bhui K. Using a cultural formulation for assessment of homicide in forensic psychiatry in the UK. Int Rev Psychiatry. 2014 Oct; 26(5):607–14
22. Kirmayer LJ, Rousseau C, Lashley M. The place of culture in forensic psychiatry. J Am Acad Psychiatry Law. 2007 Mar; 35 (1):98–102
23. Wills CD, Norris DM. Custodial evaluations of Native American families: Implications for forensic psychiatrists. J Am Acad Psychiatry Law. 2010 Dec; 38(4):540–6
24. Friedman SH. President's column: "The times, they are a-changin." Newsletter Am Acad Psychiatry Law 2022 Winter; 47(1): 3, 27
25. Friedman SH. No worries, mate: A forensic psychiatry sabbatical in New Zealand. J Am Acad Psychiatry Law. 2013 Sep; 41(3): 407–11
26. Cavney J, Friedman SH. Culture, mental illness, and prison: A New Zealand perspective. In Mills A, Kendall K, editors. Mental Health in Prisons: Critical Perspectives on Treatment and Confinement. Cham, Switzerland: Palgrave Macmillan; 2018. p. 211–34
27. Hays PA. Addressing cultural complexities in practice: A framework for clinicians and counselors, Third Edition. Washington, DC: American Psychological Association; 2016
28. Friedman SH. Travel makes one modest. You see what a tiny place you occupy in the world. Newsletter Am Acad Psychiatry Law. 2018 April; 43(2):3
29. Friedman SH. Many of the truths we cling to depend greatly on our own point of view. Newsletter Am Acad Psychiatry Law. 2017 Sept; 42(3):3
30. Friedman SH. Arrivederci. Newsletter Am Acad Psychiatry Law. 2018 Sep; 43(3):3
31. Baclawski K. The observer effect. In 2018 IEEE Conference on Cognitive and Computational Aspects of Situation Management (CogSIMA); 2018. p 83–9
32. Crenshaw K. Race, gender, and sexual harassment. S Cal l Rev. 1991; 65:1467–76
33. Bowleg L. The problem with the phrase women and minorities: Intersectionality—an important theoretical framework for public health. Am J Public Health. 2012 Jul; 102(7):1267–73
34. Sidhu N, Candilis PJ. A feminist perspective for forensic practice. J Am Acad Psychiatry Law. 2018 Dec; 46(4):438–446
35. Friedman SH. Realistic consideration of women and violence is critical. J Am Acad Psychiatry Law. 2015 Sep; 43(3):273–6
36. Sorrentino RM, Friedman SH. Gender issues in forensic psychiatry. In Rosner R, Scott CL, editors. Principles and Practice of Forensic Psychiatry, Third Edition. Boca Raton, FL: CRC Press 2017. p 835–44
37. Cerny C, Friedman SH, Smith D. Television's "crazy lady" trope: Female psychopathic traits, teaching, and influence of popular culture. Acad Psychiatry. 2014; 38(2):233–41
38. Friedman SH, Tamburello AC, Kaempf A, Hall RC. Prescribing for women in corrections. J Am Acad Psychiatry Law. 2019 Dec; 47(4):476–485
39. Friedman SH, Kaempf A, Kauffman S. The realities of pregnancy and mothering while incarcerated. J Am Acad Psychiatry Law. 2020 Sep; 48(3):365–375
40. MacDonald M. Women prisoners, mental health, violence and abuse. Int J Law Psychiatry. 2013 May; 36(3–4):293–303
41. Jordan BK, Schlenger WE, Fairbank JA, Caddell JM. Prevalence of psychiatric disorders among incarcerated women: II. Convicted felons entering prison. Arch Gen Psychiatry. 1996 Jun; 53 (6):513–9
42. Teplin LA, Abram KM, McClelland GM. Prevalence of psychiatric disorders among incarcerated women: I. Pretrial jail detainees. Arch Gen Psychiatry. 1996 Jun; 53(6):505–12
43. Warren JI, Burnette M, South SC, *et al*. Personality disorders and violence among female prison inmates. J Am Acad Psychiatry Law. 2002 Dec; 30(4):502–9
44. Lynch SM, DeHart DD, Belknap JE, *et al*. A multisite study of the prevalence of serious mental illness, PTSD, and substance use disorders of women in jail. Psychiatr Serv. 2014 May; 65(5):670–4
45. Friedman SH, Collier SA, Hall RCW. PTSD behind bars: Incarcerated women and PTSD. In Martin C, Preedy VR, Patel VB, editors. The Comprehensive Guide to Post-Traumatic Stress Disorders. Cham, Switzerland: Springer Publishers; 2016. p. 1497–512
46. Sorrentino R, Friedman SH, Hall R. Gender considerations in violence. Psychiatr Clin North Am. 2016 Dec; 39(4):701–710
47. West SG, Friedman SH, Kim KD. Women accused of sex offenses: A gender-based comparison. Behav Sci & L. 2011 Sep; 29(5):728–40
48. Petrovich M, Templer DI. Heterosexual molestation of children who later became rapists. Psychol Rep. 1984 Jun; 54(3):810
49. Mendel MP. The male survivor: The impact of sexual abuse. Thousand Oaks, CA: Sage; 1995
50. Strand S, McEwan TE. Violence among female stalkers. Psychol Med. 2012 Mar; 42(3):545–55
51. Friedman SH, Horwitz SM, Resnick PJ. Child murder by mothers: A critical analysis of the current state of knowledge and a research agenda. Am J Psychiatry. 2005 Sep; 162(9):1578–87
52. Resnick PJ. Child murder by parents: A psychiatric review of filicide. Am J Psychiatry. 1969 Sep; 126(3):325–34
53. Friedman SH, Resnick PJ. Child murder by mothers: Patterns and prevention. World Psychiatry. 2007 Oct; 6(3):137–141
54. Friedman SH, Cavney J, Resnick PJ. Child murder by parents and evolutionary psychology. Psychiatr Clin North Am. 2012 Dec; 35 (4):781–95
55. Friedman SH, Cavney J, Resnick PJ. Mothers who kill: Evolutionary underpinnings and infanticide law. Behav Sci & L. 2012 Sep; 30(5):585–97
56. Friedman SH, Hall RC, Sorrentino RM. Women, violence, and insanity. J Am Acad Psychiatry Law. 2013 Dec; 41(4):523–8

57. Friedman SH. Fathers and filicide: Mental illness and outcomes. In Wong G, Parnham G, editors. Infanticide and Filicide: Foundations in Maternal Mental Health Forensics. Washington, DC: American Psychiatric Pub; 2020. p 85–107
58. Easteal P, Bartels L, Nelson N, Holland K. How are women who kill portrayed in newspaper media? Connections with social values and the legal system. Women's Studies International Forum. 2015 Jul-Aug; 51:31–41
59. Cavaglion G. Bad, mad or sad? Mothers who kill and press coverage in Israel. Crime, Media, Culture. 2008 Aug; 4(2):271–278
60. Cavaglion G. Fathers who kill and press coverage in Israel. Child Abuse Review: Journal of the British Association for the Study and Prevention of Child Abuse and Neglect. 2009 Mar; 18(2):127–43
61. Dunn KF, Cowan G, Downs D. Effects of sex and race of perpetrator and method of killing on outcome judgments in a mock filicide case. J Appl Social Pyschol. 2006 Oct; 36(10): 2395–2416
62. Orthwein J, Packman W, Jackson R, Bongar B. Filicide: Gender bias in California defense attorneys' perception of motive and defense strategies. Psychiatry Psychol & L. 2010 Nov; 17(4):523–37
63. Collosso T, Buchanan B. Media bias in cases of maternal vs. paternal filicide [Internet]; 2012. Available from: https://metamorphosis.coplac.org/179d1c79-9dba-4c78-a546-89e3220e6838. Accessed September 26, 2022
64. Friedman SH, Resnick PJ. Neonaticide: Phenomenology and considerations for prevention. Int J Law Psychiatry. 2009 Jan; 32 (1):43–7
65. Gold LH. Addressing bias in the forensic assessment of sexual harassment claims. J Am Acad Psychiatry Law. 1998 Dec; 26(4):563–78
66. Binder RL, McNiel DE. "He said—she said": The role of the forensic evaluator in determining credibility of plaintiffs who allege sexual exploitation and boundary violations. J Am Acad Psychiatry Law. 2007 Jun; 35(2):211–8
67. me too. History and inception. Available from: https://metoomvmt.org/get-to-know-us/history-inception/. Accessed August 31, 2022
68. Lonsway KA, Archambault J. Dynamics of sexual assault: What does sexual assault really look like? End Violence Against Women International [Internet]; 2021. Available from: https://evawintl.org/wp-content/uploads/Module-1_Dynamics.pdf. Accessed August 31, 2022
69. Morgan RE, Kena G. Criminal victimization, 2016: Revised [Internet]; 2018. Available from: https://bjs.ojp.gov/content/pub/pdf/cv16.pdf. Accessed September 26, 2022
70. Archambault J, Lonsway KA. Reporting methods for sexual assault cases [Internet]; 2019. Available from: https://evawintl.org/wp-content/uploads/Module9_ReportingMethodsModule8-11-2020.pdf. Accessed August 31, 2022
71. National Sexual Violence Resource Center. False reporting overview [Internet]; 2012. Available from: https://www.nsvrc.org/publications/false-reporting-overview. Accessed August 31, 2022
72. Lonsway KA, Archambault J. The "justice gap" for sexual assault cases: Future directions for research and reform. Violence Against Women. 2012 Feb; 18(2):145–68
73. Recupero PR. The notion of truth and our evolving understanding of sexual harassment. J Am Acad Psychiatry Law. 2018 Mar; 46 (1):23–30
74. Friedman SH, Sorrentino R, Rosenbaum KB. In Depp v. Heard, forensic psychiatry took the stand. Let's correct the record [Internet]; 2022. Available from: https://www.statnews.com/2022/06/03/in-depp-v-heard-forensic-psychiatry-took-the-stand-lets-correct-the-record/. Accessed August 31, 2022
75. Sorrentino R, Friedman SH. Depp v. Heard and uncovering the truth about intimate partner violence [Internet]; 2022. Available from: https://www.kevinmd.com/2022/05/depp-v-heard-and-uncovering-the-truth-about-intimate-partner-violence.html. Accessed August 31, 2022
76. Friedman SH, Loue S. Incidence and prevalence of intimate partner violence by and against women with severe mental illness. J Womens Health (Larchmt). 2007 May; 16(4):471–80
77. Friedman SH, Sorrentino R, Landess J. Ending the cycle of abuse in battered women defenses. J Am Acad Psychiatry Law. 2022 Sep; 50(3):381–7
78. Kelly JB, Johnson MP. Differentiation among types of intimate partner violence: Research update and implications for interventions. Fam Ct Rev. 2008 Jul; 46(3):476–499
79. Walker L. The Battered Woman. New York: Harper & Row; 1979
80. Dobbs v. Jackson Women's Health Organization 142 S. Ct. 2228 (2022)
81. Ross N, Landess J, Kaempf A, Friedman SH. Pregnancy termination: What psychiatrists need to know. Current Psychiatry. 2022 July; 21 (8):8–9
82. Friedman SH, Landess J, Ross N, Kaempf A. Evolving abortion law and forensic psychiatry. J Am Acad Psychiatry Law. 2022 Dec; 50(4)
83. Goldyne AJ. Minimizing the influence of unconscious bias in evaluations: A practical guide. J Am Acad Psychiatry Law. 2007 Mar; 35(1):60
84. Wills CD. The CHESS method of forensic opinion formulation: Striving to checkmate bias. J Am Acad Psychiatry Law. 2008 Dec; 36(4):535–40
85. Parker G. Come see the bias inherent in the system. J Am Acad Psychiatry Law. 2016 Dec; 44(4):411–414
86. Wall BW, Ash P, Keram E, *et al*. AAPL practice resource for the forensic psychiatric evaluation of competence to stand trial. J Am Acad Psychiatry Law. 2018 Sep; 46(3):373
87. Stangle HL. Murderous Madonna: Femininity, violence, and the myth of postpartum mental disorder in cases of maternal infanticide and filicide. Wm & Mary L Rev. 2008; 50(2):699–736
88. Cerny-Suelzer CA, Friedman SH. Be woke, choose growth. J Am Acad Psychiatry Law. 2022 Mar; 50(1):8–12
89. Halpern AL, Halpern JH, Freedman AM. Now is the time for AAPL to demonstrate leadership by advocating positions of social importance. J Am Acad Psychiatry Law. 2004 Jun; 32(2):180–3
90. Friedman SH. Pop culture, stigma, and our role as forensic psychiatrists. Newsletter Am Acad Psychiatry Law. 2022 Spring; 47(2):3,10,14
91. Lewis TC. Commissioner Megan Testa discusses police officer wellness. WOVU: Our Voices Today [Internet]; 2021 April 29. Available from: https://clecpc.org/category/in-the-news/. Accessed August 31, 2022
92. Friedman SH, Beaman JW, Friedman JB. Fatality review and the role of the forensic psychiatrist. J Am Acad Psychiatry Law. 2021 Sep; 49(3):396–405