

Ethics, Empathy, and Detached Concern in Forensic Psychiatry

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Clinical medical ethics are ruled by the principles of beneficence and non-maleficence. In forensic psychiatry, however, the duty to serve as an agent of the justice system overrules these principles; thus, examination subjects may indeed experience harms incurred by the psychiatrist's testimony. Alan Stone argued more than 30 years ago that the participation of psychiatrists in legal proceedings runs two essential and opposing risks: skewing justice to serve patients and deceiving patients to serve justice. In this article, we review the major lines of response and critique stemming from Stone's article. We focus on the use of empathy in examination and evaluation, a topic central to the ongoing discussion and debate. We then describe detached concern, a concept with a long history in medical education but new to discussions of ethics and empathy in forensic psychiatry. We conclude by proposing this concept as a useful addition to thought, discussion, and, above all, practice. We argue specifically that detached concern can help practitioners, seasoned and novice alike, to avail the benefits and manage the ethics risks of using empathy in evaluations.

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Clinical medical ethics are based first and foremost on the principles of beneficence and non-maleficence: to strive above all to benefit, and not to harm, the welfare of the individuals whom physicians examine and treat. It is generally recognized that forensic psychiatrists, as both physicians and agents of the justice system, straddle two very distinct areas with regard to ethics. This situation either excuses them from or complicates their relationship with these core principles of medical ethics. For more than 30 years, the profession has debated the appropriate ethics foundations of the discipline and the balancing of individual welfare and service to society through justice. The complex concept and practice of empathy have assumed a central, though not always obvious, position in this debate.

Empathy overlaps with concepts like compassion and concern and, popularly, has altruistic connotations. It is a central tenet of psychiatric practice,

where it is also a technique for developing a therapeutic alliance and encouraging patients' disclosures in the service of healing. In forensic evaluations, however, empathy has special ethics implications. The fulfillment of the evaluative function appears to demand a detachment of empathy from active concern for the evaluatee's welfare, at least the kind of concern rooted in the traditional clinical role. It may be that skilled forensic psychiatrists use the technique of empathy, or something like it, to fulfill their evaluative duties, although they are not seeking to benefit and may sometimes inadvertently harm the evaluatee.

In this paper we present a review of some of the key positions of the last 35 years regarding the ethics foundations of forensic psychiatric practice, with a particular focus on empathy and its implications for ethics. Starting with Alan Stone's seminal critique of the ethics of forensic practice,¹ we trace a broad outline of the major responses to the ethics challenges at the core of the discipline. We then discuss pragmatic strategies proposed for avoiding the pitfalls of the dual role, culminating with Paul Appelbaum's 1997 ethics framework.² We examine critiques of Stone's and Appelbaum's positions, focusing on the presumed dichotomy between positive concern for individuals and the pursuit of truth in service of justice.

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Finally, we describe two potential alternatives to therapeutic empathy that may better capture the use of this concept in forensic practice: Kenneth Appelbaum's notion of forensic empathy,³ and the concept of detached concern. Expanding on the latter, we propose detached concern as an illuminating and useful way of approaching the ethics challenges encountered in evaluative practice. We propose the resurrection of this term in the teaching and training of students and fellows to illustrate the basic distinction between the forensic psychiatric method and what they have learned in general psychiatry.

In this article, we specifically refer to ethics dilemmas inherent in third-party forensic psychiatric evaluation. We recognize that forensic psychiatrists take on several roles, including treatment roles (e.g., treating physicians for a mentally abnormal offender), advocacy roles (e.g., advocates for increased services for persons with mental illness in jails⁴), and increasingly new roles (e.g., participants in therapeutic jurisprudence). We also recognize that in these various roles, psychiatrists may be called upon to acknowledge and respond to inequities and inherent biases based on race, gender, or other principles that may affect justice and health. We acknowledge that an ethics framework for forensic psychiatry includes provisions for these various roles; however, the totality of this ethics framework is outside the scope of this article.

Contrasting Ethics Codes

Professional medical ethics are based on the duty to patient welfare and usually are characterized as altruistic, based on empathy and concern for individual patients' well-being and suffering. The American Medical Association's *Code of Ethics*⁵ describes the physician's ethics duties and derived ethics codes as being "developed primarily for the benefit of the patient" and the physician's ethics obligation being "to patients first and foremost." According to this formulation, while physicians may have additional professional ethics obligations, when they conflict with their obligation to the welfare of individual patients, the latter must always take precedent. Even in general clinical practice, this tension may exist, such as in the treatment of patients with psychiatric interventions that may produce severe side effects (e.g., metabolic syndrome or tardive dyskinesia), thus causing harm to the patient. This tension is generally resolved by discussing the risk-benefit ratio of the intended treatment with the patient. Additionally, the

American Psychiatric Association Ethics Committee⁶ noted that a psychiatrist not working directly with patients but employed as a utilization reviewer for an insurance company has a primary obligation to the company and a secondary obligation to the patient. In this context, although the ultimate ethics authority appears singular and clear, deciding how to observe it in practice may be less so.

The forensic psychiatrist's ethics obligations are complex and do not always align clearly with the principle of placing an individual's well-being ahead of all else. The American Academy of Psychiatry and the Law (AAPL) acknowledges in its *Ethics Guidelines for the Practice of Forensic Psychiatry*⁷ that the discipline's unique position at the intersection of psychiatry and the law requires practitioners to balance "competing duties to the individual and society." In fulfilling the forensic role, the practitioner's duty to justice and society is considered of equal or greater importance than the duty to the evaluatee's welfare. The AAPL guidelines diverge from the traditional imperative of medical practice to put patients first and foremost. The guidelines specify respect for persons as a fundamental principle, along with honesty, justice, and social responsibility rather than individual welfare. Empathy, therefore, when explicitly conceived as a form of compassionate identification with a subject, is displaced in importance.

Questioning the Foundations

The balance between multiple principles described in the AAPL guidelines⁷ conceals a rich history of ethics debate within the profession. Much commentary published in the last 30 years can be traced to a provocative article written by Alan Stone in 1984.¹ In his writing, Stone lays out what he considers the inherent ethics problems of forensic psychiatric practice. He argues that forensic practice lacks any stable ethics foundation by which to judge practitioners' actions. Stone sees forensic practice's straddling of two ethics systems that oppose each other as damning. In attempting to fulfill the medical imperative of patient beneficence, Stone reasons, the practitioner risks "twisting justice" by losing sight of or distorting the truth.

Conversely, by serving the needs of the justice system, the practitioner may harm subjects, such as by playing a role in their incarceration. Critically, Stone sees such conflicts as intrinsic, inalterable traits of the forensic role, most evident in the evaluative

interview. In an evaluation, therapeutic strategies like rapport building and empathy are used to elicit disclosures that may result in harm to the subject when they are brought to light in court. Stone's critique thus takes aim at the morality of using the psychiatric technique of clinical empathy in work that may harm the subject.

The Ethics Challenges of Empathy

Like Stone, Shuman⁸ identified ethics dilemmas at the heart of forensic practice stemming from the fulfillment of both therapeutic and legal roles. While Shuman's critique of forensic practice is less stark than Stone's, he details several of the problems related specifically to the use of empathy, focusing on its use in examinations during criminal proceedings. Like Stone, Shuman characterizes the use of empathic behavior in treatment or evaluation as a form of deception and thus as an infringement on subjects' autonomy. For Shuman, while this seduction is not ethically neutral in a therapeutic context, it is justifiable because it is employed for the patient's well-being under conditions of confidentiality.

Shuman argues, however, that there is no such justification in the context of a forensic evaluation. Because benefit to the examination subject is not a primary consideration, divulgence may prove harmful to the subject, and confidentiality is not guaranteed. This ethics problem is compounded, he argues, by the fact that interviewees may be emotionally or mentally disturbed, and isolated, and made vulnerable by prosecution and confinement. Consequently, Shuman finds the delivery of a formal warning prior to an interview woefully insufficient, arguing that it places an unreasonable burden of vigilance on the subject.

While not rejecting the use of empathy in forensic examinations altogether, Shuman distinguishes between two forms: receptive and reflective empathy. He allows that the use of receptive empathy, "perception and understanding of the needs of another person" (Ref. 8, p 298), is acceptable, even essential, for examinations, despite carrying ethics risks. In contrast, he categorically rejects the use of reflective empathy in forensic examination, wherein the examiner communicates "a therapeutic alliance or a comfort level that would lead the defendant to slip into a therapeutic mindset" (Ref. 8, p 298).

We have extracted some of Shuman's points to develop an argument. We do not posit that empathy is necessarily or always a tool for deception. Within

the province of forensic psychiatry, there is a role for empathy and compassion. Certain types of empathy, as discussed below, may help the forensic examiner understand the position and follow the narrative of an evaluatee.

Forensic and Therapeutic Practice

In a 1997 commentary, Strasburger and colleagues⁹ explored the particular ethics conflicts inherent in fulfilling both the treating and evaluative roles with the same individual, a situation they referred to as "wearing two hats." They argued that the development of an empathic relationship, essential in treatment psychotherapy, has no place in and will not survive the open and adversarial conditions of court. They acknowledge, however, that empathy may be a feature of a skilled evaluation, though one that, when not tempered by objectivity, can lead to bias. Following Shuman,⁸ they also note that, even when legitimately used, empathy "can lead to a quasi-therapeutic interaction that ultimately leaves the evaluatee feeling betrayed by the evaluator's report" (Ref. 9, p 452).

Gutheil and Simon¹⁰ take a similar tack, outlining the professional risks associated with the evaluation and treatment of individuals who report recovered memories of sexual abuse. In line with previous commentators, they characterize the roles of expert witness and therapist as "clinically and ethically incompatible" (Ref. 10, p 1405), arguing that the therapist's desire to help the patient is out of place in the legal context, a form of "misdirected advocacy" (Ref. 10, p 1403). In particular, they argue that a critical and thorough forensic evaluation aimed at corroborating the patient's account (for example, by interviewing other involved parties) undermines the essential elements of therapy, such as empathizing with the patient and "see[ing] the world through the patient's eyes" (Ref. 10, p 1406). Patients experience corroboratory measures as "disbelief of their statements, as criticism, and as lack of faith in their intelligence or understanding" (Ref. 10, p 1405).

Gutheil and Simon¹⁰ suggest maintaining clarity on the difference between historical and narrative truth and remembering the incompatibility of the forensic examiner role with the therapeutic role. They suggest that a practitioner working in a treatment role should not allow the legal function to bleed into it. Like Strasburger and colleagues,⁹ Gutheil and Simon¹⁰ advise practitioners not to

fulfill a forensic role for a patient they are treating, not even the preliminary step of advising a patient to take legal action.

It is in the separation of therapeutic and evaluative work that we propose the use of detached concern, as we develop below. A consideration of the differences between these roles, and indeed an additional role of the forensic psychiatrist as an advocate for services for a particular population, demands different ethics stances depending upon the situation.

Re-Establishing a Solid Foundation

The theme of medical and legal ethics' incommensurability culminated in Paul Appelbaum's 1997 work, *A Theory of Ethics for Forensic Psychiatry*.² While affirming the existence, undesirability, and unavoidability of conflict between the evaluative and therapeutic roles, Appelbaum rejects Stone's contention that a solid ethics base for forensic psychiatry is impossible. Appelbaum argues that much of the ethics challenge arises from ambiguity and indecision about forensic psychiatry's ruling principles. His solution is for forensic psychiatry to make a clean break from the ethics of therapeutic medicine, clearly establishing the duty to justice as the primary imperative, rather than to patient welfare. Correspondingly, he replaces the core values of non-maleficence and beneficence with those of truth-telling and respect for persons. While the pursuit of objectivity and truth in the service of justice may potentially harm an individual's welfare (e.g., by contributing to the person's incarceration), this is deemed acceptable for the advancement of justice. The pursuit of truth and justice, however, is kept in balance by a respect for persons, the same principle that protects individuals from undue infringements by other agents of the legal system. In Appelbaum's view, respect for persons keeps in check the harm to the individual related to the pursuit of justice; unlike beneficence and non-maleficence, however, it is not in direct conflict with the demands imposed by this pursuit.

Almost 20 years after Appelbaum's framework was produced, Buchanan¹¹ argued that respect for persons was insufficient as an ultimate principle. To make his point, he draws attention to medicolegal circumstances in which autonomy, one of the main elements of personhood, is and must be subordinate to the more fundamental value of dignity. This point is revealed, he argues, when psychiatrists are tasked with judging whether a mental disorder renders a

patient incapable of making competent decisions about care. Similarly, he notes that dignity may be invoked as a higher justification for disallowing self-representation in court. Buchanan extends the individual personhood-based ethic of respect for persons, which is essentially a protective ethic (i.e., one that prevents or limits infringement or harm), into the domain of intrinsic human worth.

Questioning the Implied Schism

Another line of commentary stemming from Stone's challenge to the profession was led by Ezra Griffith. In 1998, Griffith produced a thorough critique of both Stone's and Appelbaum's positions, essentially rejecting the stark dichotomy, assumed by both, between the principles of concern for forensic evaluatees on the one hand and objectivity in the service of justice on the other.¹² He first rejects Stone's contention that the only way to be ethical, given these dueling imperatives, is for psychiatrists to eschew the forensic role altogether. Griffith also criticizes Appelbaum for the blindness of his response to the roles of culture and sociopolitical inequality in the justice system. While he affirms the principles of truth-telling and respect for persons, he rejects what he views as the abandonment of an ethic of concern.

Griffith argues that both Stone's and Appelbaum's positions are particularly insufficient for practitioners from marginalized groups. Focusing on African-American practitioners, Griffith argues that practitioners cannot so readily extricate themselves from a culturally situated sense of responsibility for their people. Griffith regards both Stone's and Appelbaum's responses as forms of avoidance, luxuries available to practitioners from dominant groups who can conveniently ignore or be unaffected by inequality in the justice system.

Griffith proceeds to propose an alternative approach. While adhering to Appelbaum's precepts of truth-telling and respect for persons, he argues that these "must be cast in a framework that is illuminated by the political reality of dominant/nondominant group interaction in the United States" (Ref. 12, p 181). He calls this approach the cultural formulation, which entails acquiring an understanding of the evaluatees' perspectives of the incident under review; their cultural identity; cultural factors relevant to their illness, social environment, and functioning; and "any relevant intercultural elements

between the evaluator and his subject” (Ref. 12, p 181).

Norko¹³ later endorsed Griffith’s response to the ethics dilemmas presented by Stone, finding it more satisfactory than Appelbaum’s. Like Griffith, Norko argues that Appelbaum’s response is flawed in its blindness to social inequality and a justice system stacked against the disempowered. Norko posits that compassion, irrespective of social position and power, is central to the forensic role. Only when motivated by compassion, he argues, can the practitioner be driven to elucidate every evaluatee’s complete psychosocial environment and situation. Like Griffith, Norko effectively reconciles the truth-telling imperative with that of beneficence and rejects the notion, put forward by Appelbaum, that the latter has no place in the courtroom.

In a later commentary, Candilis and Neal¹⁴ also criticized Appelbaum’s approach, which they referred to as “exceptionalism” (Ref. 14, p 26). Like Griffith and Norko, they argue that Appelbaum’s framework fails by its own standard in that justice cannot be served without attending to social inequality. They suggest that strict delineation of forensics, as guided exclusively by the needs of the justice system, impoverishes its ethics foundation. Decisively parting with Appelbaum’s approach, they argue that robust professional ethics cannot only be principle-based but must be sensitive to the particular ethics challenges encountered in practice, including the tension between justice and individual welfare. In effect, they reject Stone’s framing of this tension as something that only undermines the possibility of ethical forensic practice. Ethical practice is depicted as an ongoing challenge that cannot be abrogated.

Candilis and Neal¹⁴ argue that forensic psychiatry is inextricably bound to its historical roots in the promotion of individuals’ welfare and cannot, and should not, extricate itself from the attendant ethics imperatives. They identify the characteristics of so-called virtuous physicians, which they contend make for better professionals, as extending from self-reflection and education to consultation of practicing within the bounds of one’s expertise. The authors are confident that these virtues are part of what they call robust professionalism that draws on “personal, professional, and community standards together” (Ref. 15, p 342). Drawing upon the literature of professionalism in medicine generally, Candilis defines professionalism as being “about the protection of

vulnerable persons and values, whether the person is our patient or not” (Ref. 15, p 343).

Expanding on Griffith’s earlier work on cultural formulation,¹² Griffith and colleagues¹⁶ applied some of these concepts to the development of the forensic report, with a particular emphasis on the implications of the pursuit of truth. They argue that the forensic report has been oversimplified as a simple, objective representation of previously derived facts. The authors posit that, by the very nature of their work, forensic psychiatrists are bound to the task of creating coherent, persuasive, and performative narratives. They assert that the construction of these narratives should be bound by the ethics imperatives of respect for persons and truth-telling, although they reject the notion that these bounds are at odds with the narrative approach. On the contrary, the authors emphasize that the forensic practitioner’s obligation to truth must extend beyond the requirements of counsel to provide oversimplified accounts that will be persuasive. Again, seeming to reconcile truth and justice with compassion and empathy, they argue that the practitioner is responsible for “bearing witness” (Ref. 16, p 42) and humanizing the subject, explicating circumstances and context to “explain a complex life” (Ref. 16, p 38).

Forensic Empathy

In a subsequent commentary on the paper by Griffith *et al.*,¹⁶ Kenneth Appelbaum makes a brief reference to a possible alternative to clinical empathy, which he calls “forensic empathy” (Ref. 3, p 44). He builds his articulation of this concept on a critique of Griffith *et al.*’s performative narrative concept. While acknowledging the value of well-constructed, aesthetically pleasing reports, he notes the potential of the narrative approach to slide from persuasion into misdirection. Among the concerns Appelbaum raises is the temptation to exclude data that conflict with the author’s coherent formulation. He also notes that a narrative constructed in the practitioner’s own voice may have the effect of muting or co-opting the voices of others. Appelbaum suggests that the effort to produce a narrative may undermine objectivity and obscure the true experiences, feelings, and perspectives of interview subjects. He urges practitioners to allow individuals being interviewed to speak in their own voice, which may contradict their formulation. He notes that, besides being a

measure to achieve historical accuracy, this “forensic equivalent of clinical empathy” (Ref. 3, p 44) provides a form of justice to subjects as it “strives for an awareness of the perspectives and experiences of interviewees” (Ref. 3, p 44).

According to Halpern, William Osler, one of the founding members of the Association of American Physicians and often referred to as the father of modern medicine, felt that physicians should be “imperturbable” and have “equanimity” to see into their patients’ inner lives (Ref. 17, p 301). Physicians traditionally based their concern on the well-being of the patient or a duty or commitment to heal. Indeed, in his farewell address at the University of Pennsylvania based on these twin themes, Osler professed “the need of infinite patience and of an ever-tender charity toward these fellow creatures” (Ref. 17, p 301). Incidentally, he also said “listen to your patient; he is telling you the diagnosis” (Ref. 18, p 1087), an important maxim for any medical practitioner.

Halpern¹⁷ notes that physicians aspired to an idealized empathy that suppressed personal emotions but was motivated by an altruistic concern. She describes how sociologists and patient groups increasingly demanded more empathic communications from physicians, likely in response to the rise in humanism. Halpern warns us, however, that medical empathy “is not always realistic or even best in every medical context” (Ref. 17, p 302). She reviews some situations in which empathy can serve or interfere with good communication. Halpern notes that “in some contexts, patients may want their physician to understand their perspective cognitively but not to be too engaged emotionally” (Ref. 17, p 305). She states that, in various contexts, it is unnecessary for clinicians to engage in any kind of empathy beyond acknowledging the patient is a human being with feelings and worth. She suggests that physicians need to be more reflective about their own emotions and how they affect their clinical judgments. She argues the practicality of what she calls partial empathies.¹⁷

Halpern¹⁷ further notes that empathic understanding and empathic communication are distinct goals and need to be contextualized. She argues for a type of empathy that she calls engaged curiosity, in which “the clinician’s cognitive aim of understanding the patient’s individual perspective is supported by affectively engaged communication” (Ref. 17, p 302). She notes that empathic communication is important to effective treatment and involves gaining

patients’ trust so that they adhere to their treatments, thereby making their medical care more effective. Halpern also cites studies reporting that emotionally engaged listening helps patients cope with hearing a serious diagnosis, such as cancer. She thus argues that empathic communication improves medical outcomes and also plays a direct role in healing. These functions refer to and are related to medical treatment, as distinct from evaluation, to which we are specifically referring in this article.

There is no single definition of empathy. Batson¹⁹ notes eight distinct phenomena that have been called empathy. Cognitive empathy involves knowing what another person is thinking and feeling. The second form of empathy involves responding or matching a response with sensitivity and care to the suffering of another. The third involves feeling as another person feels. The fourth involves intuiting or projecting oneself into another’s situation. The fifth, psychological empathy, involves imagining how another is thinking and feeling. Batson cites pity, compassion, and sympathy as the last three phenomena.

According to Noriko,²⁰ Bloom supports the kind of empathy that enables an expert to understand another person’s experiences but cautions against the kind of empathy that prevents objectivity and rational decision-making by absorbing the suffering of others. Jordan and colleagues, including Bloom,²¹ differentiate between feeling what you believe that others feel and caring about the welfare of others, which they state is often described as compassion or concern. They developed two scales, which together form an empathy index. These concepts are consistent with the concept of detached concern, upon which we will expound.

Noriko²⁰ divides empathy into cognitive and affective. He defines empathy as a step toward the expression of compassion. He defines compassion as an approach to justice that allows us to attend to and engage the humanity of the subjects of our evaluations. He goes on to say that compassion is an essential element of the clinician’s spirituality. He attempts to create a portrayal of forensic psychiatry as a “spiritual practice, a journey in which we recall our vocation, wherein we are present to give witness to suffering, where we regularly exercise empathy and compassion in all aspects of our work, and whereby we seek to discover and attest to larger and fuller truths with humility and self-compassion” (Ref. 20, p 22).

Detached Concern

With regard to forensic evaluation, we argue that detached concern is an illuminating and useful concept for navigating forensic psychiatry's ethics tensions.²² To our knowledge, the term detached concern has not been highlighted in the forensic literature; however, the concept has a long history in medical education and has been observed in a variety of contexts, including emergency departments, intensive care, paramedicine,²³ and forensic nursing. Developed in the 1950s and 1960s,¹⁷ detached concern denotes the maintenance of "a simultaneous emotional distance from and sensitivity toward [. . .] patients" (Ref. 24, p 944). It suggests a dynamic balance between clinical empathy and rationality, with practitioners self-monitoring and dynamically adjusting between these two attitudes. Regehr²⁵ characterizes detached concern as a type of "cognitive empathy," which she defines as "the ability to accurately imagine the plight of another without actually experiencing it" (Ref. 25, p 222). She contrasts this with emotional empathy, which she refers to as "a vicarious emotional experience, or a sort of emotional contagion that has both biological and social roots" (Ref. 25, p 222). Cognitive empathy is one of the eight distinct phenomena defined by Batson¹⁹ earlier in this article as types of empathy; emotional empathy corresponds to Batson's psychological empathy.

In the clinical contexts in which the concept is usually applied, detached concern is intended to function as a means of both limiting and managing a provider's emotional distress and for safeguarding objectivity and clinical problem-solving.²³ In principle, detached concern allows a professional to focus on the task at hand rather than being influenced or overcome by a narrow emotional response to the plight of others.²⁵ This is not to say that detached concern does away with emotional empathy altogether. Rather, it continuously maintains the distance necessary to safeguard one's mental health and clinical objectivity.

Striving for objectivity and honesty is a fundamental concept of the forensic psychiatric evaluation. Application of the concept of detached concern reflects Halpern's concept of partial empathies¹⁷ and also responds to her urging to be aware of our own emotions and how they affect our clinical judgment. This concept may even be relevant at the earliest stages of an evaluation. Self-reflection is an important step when forensic psychiatrists are first retained on a case. They

must avoid being retained on a case in which they may have personal resonance, since this is likely to prevent the forensic psychiatrist from being objective.

Concerning the central ethics dilemmas under consideration, unfettered emotional empathy can have profound ethics consequences. It can undermine the objectivity needed to serve truth and, thereby, justice. Unfettered empathy can also result in a transgression of the principle of respect for persons because of its seductive potential, which the practitioner must avoid. It also risks obscuring the voice of the evaluatee with the voice of the evaluator.

We argue that detached concern is a useful, practical principle for navigating the aforementioned ethics tensions in forensic psychiatry. First, it allows us to continue to use empathy as a tool for getting at the truth, both historical and narrative,¹⁰ in evaluative work while avoiding over-identification and the impaired judgment and manipulation that can result. This reasoning can be applied to the forensic psychiatric evaluation, as it has the advantage of preserving the centrality of empathy for forensic practitioners through conscious application within the evaluation while simultaneously maintaining objectivity. It may also protect against the compounding consequences of vicarious trauma.²⁶ Detached concern allows the qualities of respect and dignity while simultaneously serving justice. In other words, we posit detached concern as a useful concept in approaching forensic evaluations that is teachable to our trainees and serves as a method of achieving the overarching principles of truth-telling and striving for objectivity.

Second, we contend that the ability to modulate emotional empathy, rather than edging it out of existence, is precisely what can allow it to retain its fundamental place in our professional and personal identities. We hypothesize that the detached concern of the evaluator can provide a balanced understanding of the stance of the evaluatee without leaving that person with a false sense of being automatically believed (and ultimately betrayed).

It is undesirable to strive for an ethics that is completely devoid of emotional empathy. It is equally difficult, however, to imagine an ethics in forensic psychiatry in which emotional empathy is the sole ruler. The ability to modulate emotional empathy dynamically and put it in perspective facilitates the compassion that Noriko¹³ calls us to practice. It allows us to have concern for our evaluatees while maintaining a balanced detachment that is sufficient

to strive for objectivity in the truth-telling exercise, thereby serving our obligation to justice. It enables us to attend to the ethics imperatives to which we must be true. Being aware of this delicate balance may help us be sensitive to the plight of individuals in different social and interpersonal situations, and even to give them a voice, while remaining faithful to the truth and objectivity required in the ultimate task of formulating conclusions and analyses.

Finally, a discussion about truth and objectivity in an evaluation would not be complete without talking about implicit bias. Research shows that people can act on the basis of unconscious attitudes and stereotypes without intending to do so. It is not uncommon for implicit biases to develop on the basis of individual characteristics, such as race, gender, age, and appearance. They can have deep-rooted origins stemming from early life and propagated through a variety of social constructs. Confronting implicit bias within the justice system is a topic of broad interest because such bias has the potential to erode objectivity and unconsciously work against an evaluatee at multiple stages within criminal proceedings, including in a third-party forensic assessment. The question of whether detached concern may have a corrective effect on any such bias is an interesting one and a topic for future debate.

Conclusion

In conclusion, we argue that the principle of detached concern is an illuminating and practical addition to the ethics frameworks and tools available to guide forensic mental health practice. Our reasoning for this addition builds on a rich history of ethics commentary and debate from within the discipline. We believe that detached concern adds particular practical value to the management of ethics challenges in forensic practice because it denotes an earnest, dynamic balancing of competing ethics demands, all of which sit at the heart of the discipline. It also has the advantage of being a concept that our trainees and students will find intuitive and with which they will be familiar. We hope that this addition can help us teach trainees in the field how to approach our profession's delicately balanced ethics principles.

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