Commentary: General Residency Training—the First Forensic Stage

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Training in Forensic Psychiatry, as described by Dr. Pinals, requires the gaining of knowledge, expertise, and confidence as part of a process of professional transformation and identification with a new psychiatric role. Training in General Psychiatry does, however, include placing the resident in situations and roles that are either formally forensic in nature, or at least, forensic-like. We will argue that these experiences from general training can be used by forensic supervisors to help ease the resident into the forensic role by building on the resident's existing expertise and making the forensic environment less foreign.

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Among the most challenging aspects of forensic training for new fellows is adapting to the forensic roles of nonhealer and truth-seeker for parties other than the patient. As Dr. Pinals[1] observes, it is indeed a paradigm shift for general residency training graduates, with all the implied clinical, legal, and ethics-associated dimensions.[2] We will argue, though, that this paradigm is not entirely new for trainees. Aspects of the forensic role are present in the general residency experience and these general residency experiences can serve as useful analogies to the novel forensic demands. They can be a foundation on which trainees can build their growing forensic expertise.

Psychiatric training itself requires taking on a unique perspective. First- and second-year general psychiatry residents on their first inpatient service often find their chosen field disorienting and even disturbing.[3] Working with psychotic patients for the first time may induce anxiety, fear, and even questions about one's own assessment of reality. More to the point, the rookie resident is faced with the challenge of caring for patients whose opinion about their needs differs from that of the resident. For example, the clear-cut need for medication to treat paranoid symptoms may not be what the patient sees as a solution to the problem of a neighbor's sending messages into his apartment through the air conditioning ducts. The resident's expectation that clinical practice consists of collaborative working relationships with appreciative patients is challenged from day one in psychiatry.

The noncollaborative clinical relationship is even more forensic-like when the behavior associated with the psychosis requires containment, such as verbal limit-setting, seclusion, and physical restraint. Nondangerous, but socially unacceptable conduct may demand cognitive/behavioral redirection that, to the novice, may feel like mind control or social engineering. In these examples, the resident is acting as both treating clinician and ombudsman for societal norms and the community's need for safety and orderliness. Indeed, some have argued that this latter role is at the heart of psychiatry's problem in defining its place in the community.[4]

While these are not the only clinical roles that a resident may play, such experiences will have already exposed the graduating resident to not always seeing eye to eye with an individual whom she is evaluating, and also to meeting needs of others, in addition to those of the patient. Thus, while the graduating resident may not be familiar with the terms *parens patriae* and police power, she will have had the everyday experience of integrating these state/hospital interests at morning rounds, team meetings, discharge

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planning conferences, individual sessions, and interventions in the emergency room and inpatient ward.

Aspects of the forensic role are even more formally experienced when patients require specific legal intervention (e.g., civil commitment and medication over objection). While the hope is that ultimately the resident and patient will have a working clinical collaboration, in such moments the relationship is adversarial, and the role of the resident is to communicate clearly to the court (either directly or through an attending physician who has standing therein) the whole truth about the situation, so that justice can be served (i.e., so that the state can meet its burden to override the liberty interests of the patient in the matter at hand). In the unlikely event that a resident never has a case that proceeds to court, every resident has filled out civil commitment papers in an emergency room setting and thus has had at least the experience of applying clinical information to legal standards.

Another nonjudicial setting in which a resident gets a taste of the forensic role is during her rotation on the consultation-liaison service. The capacity decisions that residents are called on to make routinely, and often independently, are also a useful platform for future forensic learning. The resident is placed squarely in her future forensic role as she decides whether a patient can leave the ER at 2 a.m., opines on a patient's understanding of his need for a CT scan, or attempts to identify the reason for a patient's refusal to accept the need for life-saving surgery. She is being brought in as a consultant/evaluator with no direct therapeutic relationship with the patient. Subjects other than specific clinical treatment are at issue (e.g., patient rights, clinician duties, hospital liability) and must be addressed. Moreover, all of these situations must be communicated in jargon-free language to a psychiatrically uninformed audience of clinicians and/or administrators—an encounter clearly analogous to forensic work.

The "transformation" stage does indeed have many new aspects, as delineated by Dr. Pinals. However, as just described, the well-trained general resident entering a forensic fellowship should also find many tasks that are familiar and that can be useful as frames of reference for the more specific forensic tasks she is taking on. Supervision that builds on these analogous experiences from general residency—third-party considerations, adversarial stance with the patient, and communication with nonpsychiatrically trained individuals and court personnel—allows the novice fellow to negotiate the transition more efficiently, with less anxiety, and with greater confidence.

The building of confidence and identification that are developed in stages 2 and 3 of the schema are also not unique to forensic training or indeed to professional training in general.[5] There are, however, unique forensic aspects of each that are worth noting.

The confidence building that is one of the challenges of professional development in any field is an even greater challenge in the adversarial environment of forensic consultation. Discussing a case comfortably with a clinical colleague is categorically different from presenting a case from the witness stand.[6] As just noted, the well-trained general resident has already had the opportunity to learn how to communicate mental health information with clinicians and lay people outside the mental health field. However, in the forensic environment, the fellow routinely encounters hostile responses to her opinions and/or questions that challenge her expertise and impugn her bias, her evaluation technique, her diagnostic skill, her basic logic, and her ultimate opinion—all standard fare during cross-examination.

Despite the distinct features of the courtroom environment, here, too, supervision can build on the resident's prior experiences. Most residents have had to find persuasive arguments to convince a resistant patient about a recommended treatment plan. When the resistance stems from a paranoid patient's adversarial stance or a narcissistic patient's devaluing posture, the experience of these previous interactions may be very much like a cross-examination that can leave a resident feeling anxious, incompetent, and less confident in her abilities. Preparing the fellow to anticipate these scenarios and helping her to draw on how she learned to modulate her reaction to similar previous interactions can be useful supervisory interventions as part of teaching the preparation skills necessary to meet the challenges of the courtroom. In this way, forensic confidence can be built on the clinical confidence with which the resident enters the fellowship.

At the same time, both supervisor and fellow must be attentive to the dangers of overconfidence. Some residents approach the forensic experience with so much confidence in their clinical abilities that the

humility necessary for competent forensic work is lacking. They may underestimate the needs and interests of the other parties involved in a particular case and overestimate the extent of their expertise. In forensics, there are always other parties (court, corrections, attorneys, victims) whose roles in a case must be assessed. With each new case, one's expertise must be established anew and one's opinion justified. Frequently, one is asked to stretch the limits of that expertise and opinion. A fellow may miss the essential objectives of a forensic problem because her assessment fails to investigate all aspects of a case. Such a trainee prematurely assumes she knows all the relevant information, only to discover later the consequences of premature closure. Overconfidence can lead to inadequate preparation and inappropriate opinion-making and thus may paradoxically set the resident up for a loss of confidence when she's prepared too little or stretched too far. Tactful but firm case-by-case feedback must be part of supervision that addresses these potential errors.

Just as overconfidence may be a fatal flaw in forensic opinion-making, there are also potential pitfalls in the development of identification that may hinder appropriate forensic professionalism. Appelbaum[7] has noted that it may be appropriate for the forensic clinician to move from the traditional role of treating physician for whom the patient's best interests are paramount and to identify himself as an agent of the justice system with truth-telling as the basic duty. Still, in our cross-system work with powerful agencies of the state, it is easy to become overly identified and too allied with the systems we serve and their values and biases, to the detriment of clinical truth. In the development of professional identification generally, there is a pull to identify and emulate those in positions of power within one's chosen field, in part because of the certainty and confidence that appear to go along with those positions.[8] In forensic psychiatry specifically, the trainee may look beyond senior members of the profession to those with whom she frequently interacts: lawyers, correctional officers, judges, government officials, policy advocates. Inappropriate identification with these powerful individuals may be in evidence when a fellow finds that she has become an advocate for a particular adversarial position in the courtroom, rather than an advocate for her forensic opinion. Other examples include finding that she is always working for the district attorney's office or acting primarily as a stand-in probation officer in her interactions with a patient who is court mandated to treatment. A well-balanced forensic identity can be fostered by supervision that reflects on the roles that forensic psychiatrists play generally and that specifically addresses the attitudes, values, and biases that the fellow brings to the forensic work.

Finally, the process of professional transformation and identification is further complicated by the variety of career paths that a forensic trainee may follow. Just as in general psychiatry, the forensic practitioner may choose to be pure clinician, pure consultant, private practitioner, salaried employee, academician, researcher, teacher, or any combination of these. Each possibility is associated with roles that require different competencies. The incorporation of any one of these forensic roles by the trainee during the fellowship year will have its own trajectory through the stages of training, based on the fellow's caseload, the service assignment, the skills and experiences she brings to the fellowship, and her specific areas of interest. It is therefore impossible to generalize about the timing of these stages for fellows in general or for any particular fellow. During the fellowship year, fellows will progress in some areas and not in others. Frequent bidirectional supervision from a variety of mentors allows the trainee to hear about her ongoing training needs, but also gives her an opportunity to share with others her perception of where she is along the paths of transformation and identification.

Forensic psychiatry is a unique field that may indeed seem alien to practitioners of general psychiatry. Trainees who choose subspecialization in this field often find that, during those first few months, they are confronted with a new area of knowledge and an approach to psychiatric work that differs from their training to date. As Dr. Pinals delineates,[1] periods of reorientation and accommodation are part of the forensic fellow's progression through the stages of training and professional development. We believe that the transition from psychiatric clinician to forensic psychiatrist can be aided by articulating the parallels that exist between the general residency experience and the demands of a forensic fellowship. Despite the unique aspects of forensic training and practice, supervisors and fellows can draw on the general residency experience to make the work feel less foreign and allow trainees to build on the skills

and experiences that they bring with them at the outset of the fellowship.

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