A Consultation Model for Post-Doctoral Training in Forensic Psychiatry

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With the continued growth of the sub-specialty of forensic or socio-legal psychiatry, various models for providing theoretical and clinical experience to the trainee have been proposed.[1-3] In large part, these models for training have been based upon specific assumptions as to the primary function of the sub-specialty. For example, Pollack,[4] who defines forensic psychiatry as "limited to the application of psychiatry to legal issues for legal ends, legal purposes," advocates that the trainee develop specific skills as logician and tactician, as well as clinician, in applying psychiatric knowledge to the service of the law. In contrast, Robey and Bogard[5] describe the 'compleat' forensic psychiatrist as requiring proficiency and communication skills in multiple areas of forensic activity: evaluation, training, teaching, and research. Suarez and Huñt[6] perceive forensic psychiatrists and trainees as needing to develop the strategies for modifying the law so that it will conform more closely to psychiatric expertise. Further, the many 'faces' of forensic psychiatry, as described by Robitscher,[7] symbolize the present confusion surrounding the lack of an organizing conceptual model for clinical practice or training in the sub-specialty. Finally, various surveys of residency and post-doctoral training programs in law and psychiatry by Sadoff *et al.*[8,9] highlight the diverse nature of clinical experience provided, theoretical issues presented and models of training developed. The present paper briefly presents concepts supportive of the adoption of a consultation model for training in forensic (socio-legal) psychiatry. This model is predicated on the assumption that multiple recent developments in the sub-specialty are best integrated within an eclectic, general systems orientation to the field — a perspective ideally suited to the application of a consultation model both for service and training.

Eclecticism and Post-Doctoral Training

Eclecticism in psychiatric theory and practice has gained increasing

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popularity in the past decade, in part because it sanctions pragmatism in approaching complex bio-psycho-social phenomena.[10,11] Simon[12] points out the need for eclecticism as "essentially a meta-theory that would provide a rational basis for the application of other theories and types of practice." The forensic trainee experiences theoretical and clinical confusion in approaching the diversified service systems and scholarly concepts presented in most contemporary training programs. Understandably, the post-doctoral fellow can experience anxiety, diffusion, depression, and even anger as he recapitulates old conflicts about role confusion, initially struggled with as part of the beginning psychiatry training syndrome.[13] Eclecticism presents a theoretical construct which the developing forensic psychiatrist can use as a cognitive framework within which he may more effectively respond to the inherent disharmony encountered in the multiple systems of contemporary socio-legal training.

General Systems Theory and Post-Doctoral Training

General systems theory was initially introduced into the scientific literature by von Bertalanffy's writings in the 1950's.[14,15] Starting with the seminal discussions of Grinker and his colleagues between 1951 and 1956, twelve biannual multidisciplinary conferences held in Chicago led to the publication of a summary text: *Toward a Unified Theory of Human Behavior — An Introduction to General Systems Theory.*[16] Subsequently, the psychiatric and psychological literature has markedly expanded with assessments of the actual and possible inter-relationships of psychiatric theory and practice with principles of general systems theory.[17-19] A system is defined as a totality of elements interacting with one another and general systems theory can be defined as a superordinate system of thought related to a general science of wholeness. A 'holism' in approaching reality underlies a series of specific applications of general systems theory such as field theory,[20] communication theory,[21] transactional theory,[22] and cybernetics.[23]

For the developing forensic psychiatrist, the application of an open systems model,[24] derived from general systems theory, to the understanding of the legal or medical-social milieu is operationally effective. The criminal or civil justice system, the jail or prison, the forensic hospital or clinic all share general systems dynamics capable of analysis and interpretation. Principles of law have many properties analogous to principles of living systems.[25]

> Every living system [*legal system*] is essentially an open system. It maintains itself in a continuous inflow and outflow, a building up and breaking down of components, never being, so long as alive, in a state of chemical and thermodynamic [*legal*] equilibrium but maintained in a so-called steady state which is distinct from the latter. This is the fundamental phenomenon of life [*law*] which is

called metabolism, the chemical [*legal*] process within living cells [*societies*]. (Author's italics.)

The transferability of open systems dynamics to the analysis of the legal (or medical-social) system is thus easily demonstrated. Post-doctoral fellows, in mastering such basic systems concepts, potentially bring further integration to the highly pragmatic, forensic training process.

The Consultation Model

The consultation model, proposed as a theoretical construct for the conceptual organization of post-doctoral training in law and psychiatry, is derived from both hospital and social/community bases. The earlier work of Lipowski,[26] Schwab,[27] and Mendel,[28] forms the foundation for the rapid development of psychiatric consultation services in U.S. hospitals over the past two decades. Caplan,[29] in numerous texts and articles, has articulated the theoretical principles of the twenty-year-old community mental health center movement. Both categories of consultation psychiatry can be broadly defined as an area of clinical psychiatry which includes the diagnostic, therapeutic, teaching, and research activities of psychiatrists and other qualified mental health professionals in non-psychiatric programs and services. Although significant theoretical and practical differences exist between consultation and liaison psychiatry, for the purposes of this discussion, they will be used interchangeably. Finally, of the numerous models for consultation theory and practice described in the literature, all reduce essentially to the patient-oriented approach, the consultee-oriented approach, or the situation-oriented approach. The training, orientation, and personality style of the consultant (trainee) are differentially tested in these different consultation model subtypes.

Applications to Forensic Psychiatric Training

The adoption of a consultation model in the training of future forensic psychiatrists should facilitate the 'mainstreaming' of forensic education in general psychiatry programs. As emphasized by Dietz,[30] the prerequisites for sub-specialty training in forensic psychiatry must be demonstrated mastery of the basic skills and principles of general psychiatry. Cavanaugh[31] has reported data supportive of the increasing effectiveness of the eclectically trained psychiatric consultant, cognizant of general systems theory, in dealing with mental health issues in a general hospital or ambulatory clinic setting. Likewise, training programs in general psychiatry increasingly are more effective at introducing general psychiatry residents to the principles and techniques of consultation/liaison issues in general hospital programs, as well as in many other health care, social, and educational systems. As a result, the forensic fellowship applicant should be prepared both theoretically and

clinically to apply a consultation model in the acquisition of specific forensic theories and techniques during the post-doctoral fellowship year(s). Finally, with the formulation of a committee on accreditation of fellowships in forensic psychiatry by the American Academy of Psychiatry and the Law,[32] a major effort is now under way to promulgate minimal standards for post-doctoral training. Such a developmental process affords an ideal opportunity and need for the conceptualization of specific models for training in forensic psychiatry. The following subtypes identified within the consultative process can be applied in a consultation model for post-doctoral training.

The Patient-oriented Consultation — A major skill for the developing forensic psychiatrist is the ability to evaluate (and sometimes treat) individuals involved in various stages of both the civil and criminal justice systems when questions of psychiatric or psychological functioning are raised. Consultation to mentally disordered offenders, criminal responsibility and fitness evaluations, child custody assessments, and 'psychic trauma' cases involving workers' compensation or negligence are a few examples of direct services involving patients (clients) with which the fellow must become increasingly more skillful. The major legal cases and forensic issues pertaining to the service being delivered must be mastered in order for the fellow to possess comprehensive awareness of the socio-legal concerns surrounding the specific task. A developing basic science of forensic psychiatry,[33] thereby forms the foundation for the direct delivery of 'clinical' services by the training fellow, much as the basic science of clinical psychiatry forms the foundation for the consulting psychiatrist in the general health care setting. To be effective, psychiatric consultations must be prompt, insightful, diplomatic in analysis, direct in communication, and concise in the findings and recommendations.[34] Numerous studies[35] have documented the non-psychiatrist's expectations of consultations done by the general psychiatrist. Following a process parallel to that of the consulting general psychiatrist, the forensic psychiatrist must comprehend the socio-legal issues involved, possess the clinical skills to gather and organize pertinent data, assess the multiple factors impacting on the clinical issue, and master skills of communication and treatment (where indicated) to successfully complete the patient-oriented consultative process. Forensic training programs must provide multiple 'patient-oriented' service experiences to the forensic fellow within a broad range of delivery systems (hospital, forensic, clinic, jail, law clinic, juvenile court, forensic inpatient unit, *etc.*) in order for a sufficiently intensive exposure to 'patient-oriented' forensic consultation to be possible. The fellow can easily expand upon already developed consultative skills derived from general psychiatric training and practice, or further develop the above described basic principles of the effective patient-oriented consultation as a beginning task in the post-doctoral program. The ability to relate basic general psychiatric skills and

knowledge to a new sub-specialty area should facilitate the educational process and reduce role shift anxiety[36] in the new trainee. Finally, conveying to the trainee that forensic ('patient-oriented') services are eclectic (pragmatically useful, goal-oriented, *etc.*) and capable of general systems analysis, further anchors sub-specialty training in already accepted psychiatric theory and practice.

The Consultee-oriented Consultation — In general psychiatry, the degree of the patient's psychopathology (*e.g.*, depression, psychosis, organic brain syndrome), is often a less crucial stimulus in referral to psychiatric professionals than are certain non-patient factors unique to the consultee or to the referral situation. The working relationship with non-psychiatrist physicians (or other health care providers) can sometimes influence the frequency of consultation requests and their outcome to a greater degree than the clinical competency of the consultant. Thus, psychological attitudes of the referring physician (consultee) towards the patient, the patient's illness, and psychiatry in general can markedly influence the consultation process.[37] Transposing these factors to the sub-specialty of forensic psychiatry, one can easily see similar dynamics involved between consultee (*e.g.*, lawyer, judge, insurance company, medical examiner) and the forensic consultant. The training fellow needs extensive exposure to multiple consultees in order to gain experience with the process of service delivery, just as a psychiatrist doing consultation in the general hospital must understand the dynamics and attitudes of the referring physician as summarized above. Again, the consultation model provides the forensic trainee with 'maps and compasses' by which to chart interactional strategies with various categories of forensic consultees. Strong academic preparation is again essential as a foundation for the comprehensive understanding of the civil and criminal justice process, pertinent case law, and the socio-legal or pathophysiological issues involved, upon which to build the communication process with the particular consultee(s), for example, in a felony case, a malpractice suit, or a child custody evaluation. The trainee must master the process involved in forensic psychiatric practice which is as important as the content of the service being delivered in determining the overall effectiveness of the proposed forensic 'consultation.'

The Situation-oriented Consultation — With the declining influence of the community mental health movement in American psychiatry, forensic training and experience can allow for a broad spectrum of involvement in complex socio-legal systems previously addressed more extensively by social psychiatrists. Such exposure is more limited today, as general psychiatry residents 'retreat' to the hospital and clinic as the major locus for their clinical learning. By contrast in the 60's, residents were more actively immersed in social and community practice and theory, as a means by which to appreciate the multiple vectors that impact upon human behavioral dysfunction, as well as the public policy that purports

to deal with these dysfunctions. This action-oriented ('situation-oriented') emphasis, well suited to the goals of the community mental health movement: 1) attempts to counterbalance the debilitating effects of institutionalism by improving mental hospitals and by making sustained efforts to treat as many serious cases as possible outside of the hospital in the community; 2) educates the public (including the legal system) to better understand the psychological basis of deviant and dysfunctional behavior; 3) consults with community agencies that deal with social disorganization; 4) provides total psychiatric care for a carefully defined and limited social unit, such as a neighborhood, county, corporation, or university; and 5) participates to the degree possible in the major administrative (legal) and political decisions of our time. As Gerald Caplan[38] has stated:

> The purpose of community psychiatry is to provide services to assist people facing stress, to help their problem-solving by means of governmental administrative action. The object is to influence laws, statutes, regulations, and customs in order to achieve these ends.

Whatever the ultimate legacy of the community mental health center movement to American psychiatry, it did provide mental health professionals with a practical laboratory in which to examine and test new methods for conceptualizing and delivering mental health care. The declining influence of this movement raises the strong possibility of more traditional training for psychiatric residents within a predominantly medical model orientation, potentially devoid of the 'situation-oriented' emphasis of the social and community psychiatry era.

Trainees in forensic psychiatry can conceptualize much of their field experience as a sub-type of social or community psychiatric practice in which the socio-legal situation (*e.g.,* prison, forensic clinic, juvenile offender program, law school 'mock trial') forms the basic system for their conceptualization and subsequent intervention. The 'consultation' in this context is seen as more related to the general system (situation) being confronted than to any specific component ('patient') within the system or to the particular authority (consultee) requesting the intervention. Successful intervention in any socio-legal service system is not exclusively related to either the 'patient-oriented' or 'consultee-oriented' dynamics described above. Appreciation of the 'situation-oriented' variable (general systems relationships) involved in the specific forensic problem under analysis is a fundamental skill necessary for the trainee to acquire. With a declining emphasis on such analytical techniques (previously available in social/community psychiatry programs) within the general residency training process, an exposure by the forensic trainee to the ideologies and methodologies of community and social psychiatry (as outlined above) seems highly desirable.

Forensic training programs (at both the pre- and post-doctoral levels) are capable of attracting students and trainees interested in more comprehensive bio-psycho-social approaches to problem-solving techniques in complex human service systems at a time when general psychiatric training is returning to a more traditional medical model orientation. Borrowing from the sub-specialty of community and social psychiatry, a 'situation-oriented' model of consultative intervention should be effective in organizing aspects of the post-doctoral forensic training program, as well as again relating the training process of forensic fellows to already established psychiatric theory and practice.

Conclusions

The usefulness of the consultation model as an organizing perspective for post-doctoral forensic training is briefly presented. The role confusion confronting fellows seeking advanced training in a still somewhat poorly defined sub-specialty is a strong stimulus for faculty to better conceptualize the training process. Other models for training are available[39] and differing definitions of the sub-specialty of forensic psychiatry have been briefly reviewed. As well stated by Pollack,[40] the *ideal* outcome of specialty training in forensic psychiatry is a reflection of the specific philosophy of the specialty program embodied in the operational functioning of the *ideal* forensic psychiatrist on the staff. In the final analysis, effective role modeling after mature psychiatric teachers clearly has the most powerful influence on the behavior and professional identification of the resident or post-doctoral fellow. Brody[41] described the process as:

> . . . the unconscious acquisition (following some conscious imitation) of their ways of thinking, feeling, and acting. Such identification and its eventual dissolution, leaving key residuals integrated with precipitates of other important relationships, is an essential aspect of the maturation process without which learning is merely the cross-sectional reception of information.

The exposure of post-doctoral fellows to faculty skilled in and knowledgeable about a consultation model of forensic training should facilitate this developmental process.

References

1. Barr NI, Suarez JM: The teaching of forensic psychiatry in law schools, medical schools and psychiatric residencies in the United States. Am J Psychiatry 122:612-616, 1965
2. Zusman J, Carnahan WA: Psychiatry and the law: Changing the system through changing the training. Am J Psychiatry 131:915-918, 1974
3. LeBlang TR, Henderson MD: Forensic psychiatry: A comprehensive residency program at Southern Illinois University School of Medicine. Bull Am Acad Psychiatry Law 7:363-380, 1979
4. Pollack S: Forensic psychiatry — a specialty. Bull Am Acad Psychiatry Law 2:1-6, 1974
5. Robey A, Bogard WJ: The compleat forensic psychiatrist. Am J Psychiatry 126:519-525, 1969

6. Suarez JM, Hunt J: The scope of legal psychiatry. J Forensic Sciences 18:60-68, 1973
7. Robitscher J: The many faces of forensic psychiatry. Bull Am Acad Psychiatry Law 6:209-213, 1978
8. Sadoff RL, Thrasher JW, Gottlieb DS: Survey of teaching programs in law and psychiatry. Bull Am Acad Psychiatry Law 2:67-72, 1974
9. Sadoff RL: Survey of training programs in forensic psychiatry. Personal communication, 1979
10. Abrams GM: The new eclecticism. Arch Gen Psychiatry 20:514-523, 1969
11. Yager J: Psychiatric eclecticism: A cognitive view. Am J Psychiatry 134:736-741, 1977
12. Simon RH: On eclecticism. Am J Psychiatry 131:135-139, 1974
13. Merklin L, Little R: Beginning psychiatry training syndrome. Am J Psychiatry 124:193-197, 1967
14. von Bertalanffy L: An outline of general systems theory. Br J Phil Sci 1:134-165, 1950
15. von Bertalanffy L: The theory of open systems in physics and biology. Science 111:23-29, 1950
16. Grinker RR: Toward a Universal Theory of Human Behavior: An Introduction to General Systems Theory. New York, Basic Books, 1956
17. Grinker RR: The relevance of general systems theory to psychiatry, in Arieti S (ed): American Handbook of Psychiatry, Vol. 3. New York, Basic Books, 1966, pp. 251-272
18. Gray W, Duhl FJ, Rizzo ND: General Systems Theory and Psychiatry. Boston, Little Brown, 1969
19. Jones M: Psychiatry, systems theory, education and change. Br J Psychiatry 124:75-80, 1974
20. Parsons T: Field theory and systems theory — with special reference to the relations between psycho-biological and social systems, in Offer D, Freedman DX (eds): Modern Psychiatry and Clinical Research. New York, Basic Books, 1972, pp. 3-16
21. Shannon CE, Weaver W: The Mathematical Theory of Communication. Urbana, University of Illinois Press, 1949
22. Spiegel JP: Transactional theory and social change in Offer D, Freedman DX (eds): Modern Psychiatry and Clinical Research. New York, Basic Books, 1972, pp. 17-29
23. Weiner N: Cybernetics. New York, Wiley, 1948
24. Grinker RR: Open-systems psychiatry. Am J Psychoanal 26:115-128, 1966
25. von Bertalanffy L: General Systems Theory Foundations, Development and Applications. New York, George Braziller, 1968
26. Lipowski ZJ: Review of consultation psychiatry and psychosomatic medicine I. General principles. Psychosomat Medicine 19:153-171, 1967
27. Schwab JJ: Handbook of Psychiatric Consultation. New York, Appleton-Century-Crofts, 1968
28. Mendel WM, Solomon P: The Psychiatric Consultation. New York, Grune and Stratton, 1968
29. Caplan G: An Approach to Community Mental Health. New York, Grune and Stratton, 1961
30. Dietz PE: Educating the forensic psychiatrist. J Forensic Sciences 24:880-884, 1979
31. Cavanaugh JL, Flood J: Psychiatric consultation services in the large general hospital: A review and a new report. Int J Psychiat in Med 7:193-207, 1977
32. Rosner R: Report of the committee on accreditation of fellowships in forensic psychiatry. Presented at the 11th Annual Meeting, American Academy of Psychiatry and the Law, Chicago, Oct. 16-19, 1980
33. Dietz PE: Toward a scientific forensic psychiatry. J Forensic Sciences 22:774-780, 1977
34. Abram HS: Interpersonal aspects of psychiatric consultations in a general hospital. Int J Psychiat in Med 2:321-326, 1971
35. Schwab JJ: The psychiatric consultation: Problems with referral. Dis Nerv Syst 32:447-452, 1971
36. Klagsbrun S: In search of an identity. Arch Gen Psychiat 16:286-289, 1967
37. Krakowski AJ: Liaison psychiatry: Factors influencing the consultation process. Int J Psychiat in Med 4:439-446, 1973
38. Caplan G: Principles of Preventive Psychiatry. New York, Basic Books, 1964
39. Tanay E: Forensic psychiatry as a vehicle for teaching clinical psychiatry. Bull Am Acad Psychiatry Law 2:242-245, 1974
40. Pollack S: Observations on the outcome of specialty education and training in forensic psychiatry. Presented at the 11th Annual Meeting, American Academy of Psychiatry and the Law, Chicago, Oct. 16-19, 1980
41. Brody E: Models in psychiatric education. J Nerv Ment Dis 154:153-156, 1972