Caplanian Mental Health Consultation: Historical Background and Current Status

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Abstract: This article traces the historical roots of Caplanian mental health consultation and lists nine aspects of the model that have proved valuable over time. A relatively new development, mental health collaboration, is discussed with reference to the internal consultant. The role of mental health consultation in primary prevention is briefly reviewed, and it is argued that consulting psychologists who conduct organization development would do well to consider explicitly the preventive aspects of their work. The paper concludes with some thoughts regarding potential problems of working through intermediary caregivers to achieve the goals of primary prevention.

Introduction

The genesis of Caplanian consultation occurred in Israel in 1949 when psychiatrist Gerald Caplan, overseeing a small staff of social workers and psychologists, was given the responsibility to care for the mental heath needs of 16,000 immigrant adolescents located at more than 100 residential institutions. Caplan soon realized that the usual practice of providing individual client referral/diagnosis/psychotherapy was not feasible, given the substantial number of referrals (about 1000) which were received during the first year, and Israel's rough terrain and generally poor roads which made it difficult to transport referred clients to a central clinic location.

These circumstances gave rise to an alternative, indirect method of providing mental health services. Rather than meet clients at a clinic, Caplan and his staff traveled to the individual institutions and meet with referred adolescents and with their caregivers to discuss the latter's perceptions of the clients. These collegial discussions often revealed a caregiver's stereotyped, inaccurate perception of an adolescent that impeded the solution of presenting problems. Following sympathetic and objective discussion with the staff member, the caregiver (i.e., consultee) often returned to his or her duties with a new perspective and broader range of possibilities in working with the client. In focusing efforts on improving the functioning of caregivers through this method, it was believed that the mental health of many more clients could be improved than was possible through a direct service method.

Although this practice was originally termed "counseling the counselors," it was renamed "mental health consultation" to reflect that the welfare of the clients remained the ultimate professional concern, and the consultees were not undergoing psychotherapy. Caplan also discovered that meeting caregivers in their own institutions-- originally borne of necessity--was an integral part of the method. The consultees' work settings provided much relevant information that enabled clinical staff to see critical issues more readily. Furthermore, consultees were much more likely to speak candidly about their perceptions of problems while at work than at a clinic (Caplan & Caplan, 1993).

The development of mental heath consultation techniques continued during Gerald Caplan's tenure at the Harvard School of Public Health (1952-63) and Harvard Medical School (1964-77). Caplan and his associates refined consultation methods for a variety of consultees, including public health nurses (Caplan, 1970) and Episcopal Church clergy (R.B. Caplan, 1972). By the mid-1960s, consultation was established as a major means of delivering mental health services, due in large measure to its listing as one of five mandated services under P.L. 88-164, the Community Mental Health Centers Act. The weakening of the community mental health movement by the late 1970s did not signal the end of mental heath consultation, however, as many human service specialists embraced consultation as a primary professional activity (Erchul & Schulte, 1993).

Others have written about the impact of the Caplanian model of consultation on the practice of school psychology (Knoff & Batsche, 1993; Meyers, Brent, Faherty, & Madferri, 1993; Oakland, 1994), community psychology (Iscoe, 1993;

Kelly, 1993; Trickett, 1993), and community mental health (Backer, 1993; Mannino & Shore, 1971; Schulberg & Killilea, 1982). Because of its decided mental health orientation, the impact of the model on organizational development in the for-profit sector perhaps is more difficult to document. However, as Levinson (1993) observed, Caplan (1970) considered many psychological issues affecting organizational functioning long before they were dealt with in the organization development literature.

The reasons why Caplanian mental heath consultation has influenced the practice of psychology in schools, communities, and organizations may be as diverse as the settings themselves. However, among these reasons are the model's: (a) focus on preventing mental illness and promoting mental health; (b) coordinate, nonhierarchical relationship orientation between consultant and consultee; (c) clear delineation of four major types of consultation (i.e., client-centered case, consultee-centered administrative consultation); and (d) emphasis placed on both individual and environmental factors in achieving change (Erchul, 1993a).

In this brief examination of the Caplan approach to consultation some 45 years after its start, we must understandably be selective in our emphases. For more comprehensive coverage, we refer readers to our two recent books, *Mental Health Consultation and Collaboration* (Caplan & Caplan, 1993) and *Consultation in Community, School, and Organizational Practice: Gerald Caplan's Contributions to Professional Psychology* (Erchul, 1993a). In this article we shall focus on principles of mental health consultation that have stood the test of time, consultation and the role of the internal consultant, consultation as a primary prevention tool, and some potential problems of working through intermediary caregivers to achieve the goals of primary prevention. We trust that our presentations of these aspects of the Caplan model will be of interest to consulting psychologists who work in a variety of organizational settings.

Enduring Principles of Mental Health Consultation

In exploring Caplanian mental heath consultation, one might profitably begin by asking which of its fundamental elements have stood the test of time. Our collective consulting experience suggests that consultants who use the Caplanian model should follow these principles:

Guide the development of consultation by understanding its ecological field

Consultation will be less than optimally effective unless an interconnected field of forces is examined and monitored. This field consists of the organizations represented by the consultant and consultee, the consultant and consultee as individuals, the community, the client and the client's family, as well as the interplay of historical, sociocultural, and psychosocial forces. We mention this principle in part to counter a popular, though inaccurate, belief that Caplanian consultation has an exclusive psychoanalytic focus on the individual and thus fails to consider a larger systems context for consultation.

Explicate all consultation contracts

Consultation must be formalized through successive agreements between the consultant and consultee organizations in order to fulfill the professional missions of both. Without a contact (including sanction from the highest level administrator), consultation interactions are likely to deteriorate into meaningless talk that sooner or later is discarded. This principle in patently obvious to experienced psychologists who consult regularly with business and industry. However, we have known some human service consultants and/or novice consultants who have initiated consultation with poorly developed contractual agreements and little sanction from the host organization. Their outcomes, predictably, have ranged from mild disappointment to genuine disaster.

Keep the consultant relationship noncoercive

The coordinate, nonhierarchical power relationship remains the cornerstone of Caplanian mental health consultation. When the consultee is free to accept or reject whatever the consultant

says, the probability is higher that he or she will embrace and act upon the ideas that make sense in resolving problems. This situation is facilitated when the consultant has neither administrative authority over the consultee's actions nor professional responsibility for the client's welfare. Maintaining this relationship of coordinated interdependence in which there is no power differential between consultant and consultee represents a significant challenge for many consultants (Erchul, 1993b).

Promote consultee-centered consultation

A basic distinction is made within the Caplan model between *client-centered* consultation and *consultee-centered* consultation. A consultee-centered approach focuses the attention of the consultant on remedying shortcomings in the consultee instead of just on addressing the problems of the client. Within consultee-centered consultation, the consultant determines whether consultee ineffectiveness is due to a lack of knowledge, skills, confidence, and/or professional objectivity. If a consultee works in a well-organized institution and has adequate skills and knowledge, a lack of objectivity will account for the majority of his or her work-related difficulties. Lack of objectivity, the result of the distortion of consultee judgment, is caused because certain elements of the work situation may have subjective implications for the consultee. In a case of consultee-centered administrative consultation, for example, a supervisor-consultee may over identify with several young male employees, perhaps because they represent "the sons he never had." This supervisor consequently may treat them more leniently than female and/or older male workers, with the result of creating a unit-wide moral problem. This specific example of the transference also could take the form of theme interference, a concept discussed by Caplan (1963, 1970) and Caplan and Caplan (1993). Helping the consultee restore lost objectivity remains a primary goal of our approach.

Avoid uncovering types of psychotherapy

The mental health consultant should not use the method of interpretation associated with insight-oriented psychotherapy. In drawing direct attention to the specific personal source of the consultee's work difficulty, the consultant

negates the coordinate, nonhierarchical relationship and weakens the consultee's unconscious defenses against rejected ideas. We instead continue to recommend a number of indirect techniques, including verbal focus on the client, use of the parable, nonverbal focus on the client, and nonverbal focus on the relationship (Caplan & Caplan, 1993).

Use the displacement object

A consultee may become overly involved and therefore express his or her inner conflicts by identifying personally with various elements in the client's drama. The consultant can capitalize on this situation by sending potent messages to the consultee-- not by confronting the consultee as some advocate--but rather by focusing on the client-related elements to help the consultee to overcome irrational expectations. Although the consultant's tact in not drawing explicit attention to the consultee's unconscious displacements may be seen as "manipulative, " we regard it as wholly positive and supportive. Manipulation in consultation may be used ethically to avoid forcing consultees to become aware of thoughts and feelings against which they are unconsciously defending themselves. Manipulation having the express purpose of subjugating the consultee, however, has no place in mental health consultation.

Foster orderly reflection

When approaching a consultant for assistance, a consultee typically is in a state of disequilibrium or crisis. Consequently, the consultee's emotional arousal usually distorcognitive operations, narrows perceptual focus, and prevents rational problem solving. Unhurried and systematic reflection during consultation, on the other hand, increases the consultee's awareness of the range of options available, counteracts premature and emotionally based closure, and reestablishes a sense of equilibrium.

Widen frames of reference

Central to the effectiveness of mental health consultation is the aid the consultant offers the consultee in analyzing the latter's work problem within the interpenetrating contexts of

intrapsychic, interpersonal, and institutional psychosocial systems of client, consultee, and consultant. Furthermore, the consultant supports the consultee in conducting these analyses, making him or her feel safe while dealing with issues that often are emotionally sensitive.

Train those who consult to be consultants

Consultation skills must be taught because consulting is a method of professional functioning having a separate body of concepts and techniques. We maintain that consultation is neither modified counseling nor watered-down psychoanalysis. One may be a competent psychologist, but is unlikely to be an effective consultant without additional training. Many others share our views regarding the importance of consultation training (e.g., Alpert & Meyers, 1983; Brown, Pryzwansky, & Schulte, 1991; Gallessich, 1982).

Mental Health Consultation and the Internal Consultant

The original conception of the mental health consultant was of a clinically trained professional whose base of operations was outside the consultee's work setting (see, for example, Caplan, 1963, 1970). As the practice of consultation evolved, however, it became clear that mental health consultants increasingly were being employed as *in-house* staff members of organizations such as schools and hospitals whose non-mental health staff depended on them for professional assistance. Within the organization development literature, others similarly have noted the emergence of the internal consultant role (e.g., Lippitt, 1985; South, 1993; Steele, 1982).

With the rise of the internal consultant came some complications for our approach to consultation. For instance, it is very difficult for a school psychologist (as an internal consultant) to behave non-hierarchically in the hierarchy of a school when knowledge of educational psychology gives the psychologist more expertise about the instructional process than many teachers. It also is extremely difficult for a business manager to consult using our principles of mental health consultation when the manager has an official status superior to that of many potential consultees. Both examples illustrate the fine line between "consultation" and "supervision" that

often exists for the insider consultant. Furthermore, the internal consultant will not find it easy to permit a consultee the freedom to reject "expert views" about a situation when the consultant shares responsibility for the outcome, and when the two are under pressure to promote effective action regarding a case or program. Organizational factors thus oblige an internal consultant to adopt a "hands-on" direct action approach in many instances. Recognition of these constraints of the insider consultant's role led to the development of a different mode of interprofessional communication we term *mental health collaboration* (Caplan & Caplan, 1993).

The central issue is that many of the assumptions on which Caplanian mental health consultation is based are impractical or difficult to achieve when both consultant and consultee are members of the same organization. Among these assumptions are the consultee's complete freedom to accept or reject advice, the observance of confidentiality of communications, and the specialist-consultant's lack of responsibility for case or program outcome. The major differences between mental health consultation and mental health collaboration are that in collaboration: (a) the consultee-collaborator does not have the freedom to accept or reject advice because the best possible course of action must be chosen and implemented in order to achieve optimal results; and (b) the specialist-collaborator shares equal responsibility for the overall outcome of the case or program, but primary responsibility for the mental health-related aspects.

In terms of the general process of mental health collaboration, the specialist-collaborator establishes a partnership and a co-worker, group, or network of professionals in an organization. The specialist becomes an active team member, serving as a hands-on clinician or adviser as needed, and making the best use of his or her specialized skills to improve mental health outcomes of the case or program. Because the specialist-collaborator (unlike the external consultant) is held jointly accountable for final outcomes, he or she is expected to direct colleagues' attention to relevant aspects of their efforts to ensure positive outcomes, persuading and cajoling them when necessary. At times, the specialist-collaborator additionally will attempt to effect appropriate changes in the management and administration

of the organization that will improve mental health outcomes for individual clients and/or for entire programs.

We have argued elsewhere (Caplan, 1993; Caplan, Caplan, & Erchul, in press) that mental health collaboration must replace mental health consultation as the most frequent mode of interprofessional communication used by mental health specialists who are staff members of an institution. Our consulting experience in a variety of human service settings supports this assertion. However, as Goodstein (1978), among others, has stated, there are major differences between human service delivery systems and business and industrial organizations. Thus, we acknowledge that the ultimate importance of mental health collaboration for the in-house consultant operating in a profit-making organization is less clear at this time. At the very least, this discussion of mental health collaboration serves to highlight the significant differences in the role functioning of internal versus external consultants and the complexities of the consultant-consultee relationship. Table 1 summarizes the major points of comparison between mental health consultation and mental health collaboration.

Mental Health Consultation as a Primary Prevention Tool

Throughout his five decades as a child and community psychiatrist, Gerarld Caplan has advocated the importance of preventing mental illness and promoting mental health (see, for example, Caplan & Bowlby, 1948; Caplan, 1961, 1964, 1989). Central to his approach has been a consideration of which specific risk factors lead to mental disorder, and which specific interventions on the part of the specialist lead to the primary prevention (i.e., reduction in the incidence) of mental disorder. Caplan (1986) summarized much of this thinking in the "recurrent themes model of primary prevention," depicted in Table 2.

The recurring themes model of primary prevention is so named for the many components that interact or "reverberate" in a complex manner. Within the model, past risk factors (i.e., biopsychosocial hazards) interacting with intermediate variables (i.e., competence, crisis reac-

tions, and social supports) result in improved or worsened mental health outcomes. Interventions employed to facilitate primary prevention efforts include community social action, mental health consultation and collaboration, education, crisis intervention, and social support promotion. Given the major focus of this article, we wish to underscore the importance of mental health consultation *in the service of primary prevention*.

Given this established linkage between mental health consultation and primary prevention, we were surprised to find, in our sampling of recent and classic works in organizational consultation and organization development, no mention of the term "prevention." This state of affairs led us to ask, does the typical organizational consultant work only to solve existing problems rather than prevent future ones from arising? If so, this situationstrikes us as understandable, but most unfortunate. It is understandable, given the accounts by Backer (1993) and others that depict the constant barrage of crises that many organizations endure. There appears to be no better way for some organizations to operate than to extinguish on fire before moving on to the next. It is, however, still lamentable that a golden opportunity to harness the holding power of organizations to further the aims of primary prevention is apparently ignored, even by sophisticated consultants. Recognizing American psychology's most recent efforts to advocate a preventive orientation (e.g., Coie et al., 1993), we see the organizational setting as an excellent one in which to carry out an agenda of primary prevention. Organizational consultants thus should accept the challenge to recognize and promote explicitly the preventive aspects of their work.

In accepting this challenge, consultants should be motivated to seize upon available opportunities for achieving positive and enduring organizational changes. These opportunities often are created by the current disequilibrium of a work predicament in which their help is invoked. In responding to these crises, organizational consultants can mount efforts to promote the following:

1. Identify and lower the intensity and duration of frequently occurring hazardous biopsychosocial circumstances (stressors) that may overburden members of the organization.

Table 1

Mental Health Consultation and Mental Health Collaboration Contrasted on Key Dimensions

Dimension	Mental Health Consultation	Mental Health Collaboration
Location of consultant's home base	External to the organization	Internal to the organization
Type of psychological service	Generally indirect, with little or no client contact	Combines indirect and direct services, and includes client contact
Consultant-consultee relationship	Assumes a coordinate and nonhierarchical relationship	Acknowledges status and role differences within the organization, and thus the likelihood of a hierarchical relationship
Consultee participation	Assumes voluntary participation	Assumes voluntary participation, but acknowledges the possibiliity of forced participation
Interpersonal working arrangement	Often dyadic, involving consultant and consultee	Generally team-based, involving several collaborators
Confidentiality of communications within relationship	Assumes confidentiality to exist, with limits of confidentiality (if any) specified during initial contracting	Does not automatically assume confidentiality, given organizational realities and pragmatic need to share relevant information among team members
Consultee freedom to accept or reject consultant advice	Yes	Not assumed to be true, as a collaborator's expertise in his or her specialty area is generally deferred to by team
Consultant responsiblity for case/program outcome	No	Shares equal responsibility for overall outcome, and primary responsibility formental health aspects of case or program

Table 2

Recurring Themes Model of Primary Prevention

Past risk factors	Intermediate variables				Outcome
Bio-psycho-social hazards (episodes or continuing)	Teaching of competence	Competence (constitutional and acquired)	Reaction to recent or current stress (crisis)	Social supports	
Examples Genetic defects Pregnancy problems Birth trauma Prematurity Congenital anomaly Developmental problems Accidents Illness Hospitalization Poverty Cultural deprivation School failure Family discord Family disruption Parental mental or physical illness Sibling illness	Parents and teachers provide opportunities for child to learn self-efficacy and problem-solving skills. Exposure to increasing stress while providing guidance, emotional support, and teaching skills.	Self-efficacy Quality of self-image and identity. Expect mastery by self and support by others. Tolerance of frustration and confusion. Problem-solving skills Social and material.	Bio-psycho-social hazard Bodily damage. Current or recent life change events: loss, threat, or challenge. Adaptation by *Active Mastery* versus *Passive Surrender.* Hopeful perserverance despite cogni tive erosion and fatigue. Containment of feelings. Enlisting support.	Cognitive, emotional, and material Supplement ego strength in problem solving. Validate identity. Maintain hope. Help with tasks. Contain feelings. Counteract fatigue.	Sense of well-being. Capacity to study, work, love, and play. Enhanced or eroded competence. Actual psychopa-thology (D.S.M. III)
	Types of Intervention				
Social action in health, education, welfare, and legal services **Consultation collaboration, and education for** professionals	**Education of** parents and child-care professionals	**Education of** children and parents	Crisis intervention by anticipa tory guidance and preventive intervention	Promote supports Convene network Convene mutual-help couple. Help mutual-help organizations. Support the supporters.	
	Preventive intervention to target populations (highest risk groups)				

2. Develop mechanisms for immediate crisis intervention in the organizational setting by offering anticipatory guidance and help with the practical tasks of coping with expected predicaments.

3. Mobilize psychosocial supports that will be energized whenever individuals and their families become involved in psychologically hazardous circumstances.

When Helping Harms

As noted in Table 2, the recurring themes model of primary prevention (Caplan, 1986) requires the widespread dissemination of measures to reduce stressors and to increase psychosocial supports among the population through the intermediation of a host of community-based caregiving professionals (Caplan, 1989). In this endeavor, our method of mental health consultation continues to play a central role, although we have learned that implementing the method demands careful monitoring. We shall close by mentioning several problematic aspects of reliance on the caregiver as an intermediary to implement psychological interventions.

The enterprise of community mental health generally and mental health consultation specifically dictates that psychiatric and psychological knowledge be "given away" (Miller, 1969) to a variety of front-line caregivers. A problem we have seen increasingly is that concepts promulgated by sophisticated mental health specialists are implemented inadequately by some psychologically unsophisticated caregivers/consultees who, as a result, do more harm than good. Awareness of this issue of distortion in dissemination has recently led us to publicize the need for greater quality control in primary prevention (Caplan & Caplan, in press).

One of the unforeseen dangers of using non-mental health specialists to intervene preventively has proven to be the subjection of people who are already in trouble to stressors artificially created by the caregiving system. Caregiving professionals, often with the best intentions, intervene uninvited in situations that they define as abnormal, or as predicting the development of later psychopathology because the cases fall into a statistically high-risk category. Such interventions may in fact be unnecessary and uneconomic,

recruiting cases that might have been resolved by themselves. But more seriously, they can be positively harmful, adding pathogenic influences and an extra dimension of trouble to the lives of people, thereby mocking the whole purpose of primary prevention.

To do no harm during proactive interventions requires much knowledge and experience. When techniques and theories are oversimplified by non-mental health specialists, the latter may undervalue and elbow aside inherent, idiosyncratic, but otherwise effective coping mechanisms. By labeling life problems such as parental divorce as statistically hazardous to future mental health and therefore ripe for professional attention, they focus on the results of potential weakness and poor coping skills that may afflict 30-40% of cases. But clinical experience suggests 60-70% of cases manage perfectly well on their own. Most mental health specialists are trained to identify and respect natural sources of strength and to realize that a family coping with crisis (e.g., substance abuse, unemployment) may be potentially stronger than one that has never been challenged.

As long as troubles remain private, people only need to deal with the actual crisis at hand. But when privacy is removed by proactive professionals, when we still lack valid criteria that can be used as infallible markers to predict the development of pathology, an unnecessary burden is added--that of struggling with and fending off the caregivers themselves. This is not only harmful in itself (e.g., embroiling people in the expense and tension of court hearings to counter the challenge of the welfare services to the custody of their children), but energy and resources are sapped that would be more appropriately focused on the original problem. Mental health professionals have been trained to be cautious and not to take over the lives of clients, and consequently they are apt to do less harm than the non-mental health caregivers.

More specifically, caregiver characteristics that can cause genuine harm to clients are of two basic types. First, a caregiver may not possess a sufficient level of understanding or skill needed to carry out a psychological procedure the same way a trained mental health specialist would. This is a matter of treatment integrity, a topic discussed in the school consultation literature

(e.g., Gresham, 1989). During a crisis, for example, a well-intentioned consultee may not implement preventive intervention very well in working with a client, with the effect of raising the client's negative emotional arousal rather than lowering it.

A second type is perhaps more complex, serious, and difficult to correct: a skilled caregiver who has self-perceptions of great competence but who lacks the professional judgment needed to use skills appropriately. This caregiver will fail to perceive the larger ripple effects of his or her professional actions and the client's welfare will suffer as a result. For example, a school counselor may choose to counsel students with major depression instead of referring them to a clinical psychologist or psychiatrist. When the outcomes of counseling are that some of these clients attempt suicide and others drop out of school, this counselor may lack the insight to recognize the unfortunate contribution to the larger mental health issue.

Despite these potential problems associated with mental health consultation and primary prevention, we maintain our strong endorsement of both. It may be true, as Levinson (1993) has suggested, that the ideas underlying mental health consultation (embedded within a primary prevention framework) will continue to comprise a fundamental base for the practice of organizational consultation for years to come. Consulting psychologists who work in a variety of organizational settings thus would do well to incorporate these concepts into their daily practice.

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