staff began to resent Dr. Andrews's position, but they filed no complaints and requested no other consultant because Dr. Andrews was doing such a "fine job." In short, Dr. Andrews and the staff had grown comfortable together at the expense of future staff development.

The problem in this consultation was that Dr. Andrews's position was becoming permanent. He had been asked to consult for staff development in the family area. Instead of maintaining an "outsider" relationship with Advent, he had moved into the organization and was settling down as a permanent resident. Advent was in danger of not developing their own staff to work flexibly in a comprehensive and integrated manner with families, as they had done with the schools and legal system. The staff could fall back on Dr. Andrews rather than pushing themselves into new ventures.

For his part, Dr. Andrews had difficulty distancing himself from Advent, in part because of his emotional ties to the primary concern of the program. From personal experience, Dr. Andrews knew what it was like to live with a drug-abusing teenager. He had a personal commitment, a mission, to help families with these struggles because his own family had never received professional assistance in their long struggle. In some sense, Dr. Andrews wanted more for these families than they wanted for themselves. Consequently, he could not terminate his consultation.

*A sign that a consultation has been effective is an absent consultant.* A readiness to look for the exit sign should begin with the question: "What needs to happen in order for me to leave this place?" Although the consultant may occasionally visit again, such "visitations" are far different from becoming a permanent resident in the system. A consultant-in-residence implies that the system cannot take care of itself.

# 4

# LOSING YOUR WAY AS A CONSULTANT

TIMOTHY T. WEBER

LYMAN C. WYNNE

SUSAN H. McDANIEL

*University of Rochester School of Medicine and Dentistry*
*Rochester, New York*

The previous chapters have outlined the primary principles and tasks of systems consultation. Such outlines can be deceptively simple. The reader may have the illusion that by following this approach, a successful outcome is assured. Life is seldom so tidy, especially in systems consultation where the complexity of the field affords ample opportunities for failure.

Our conceptualization of systems consultation has become clearer to us the more we have examined our failures; these failures have helped us to refine our methods, strategies, and techniques. What follows are seven brief case examples that illustrate typical failures we have encountered in systems consultation and exemplify the issues and principles that we believe were involved. Each of these examples illustrates failures that have occurred across one or more of the phases of consultation discussed in Chapter 3.

## FAILURE #1: LOOK BEFORE YOU LEAP

With much enthusiasm the Family Clinic at Southern Hospital opened its doors to the public. The clinic's mandate was not only to provide clinical services to patients within the hospital and the community, but also to offer educational resources to organizations in the area and to other services within the hospital. The clinic's first major thrust beyond its own borders was to further a working relationship with other hospital services, partly to increase its service to the hospital and partly to enlarge its referral base. Ms. Melinda Gray, a nurse in the Oncology Clinic, had expressed an interest in working more closely with the Family Clinic and had mentioned

the possibility of involving the staff of the Family Clinic in future research projects and in clinical case consultations.

One afternoon Ms. Gray called one of the family therapists in the Family Clinic to request specific help with a patient and her family. The Oncology Clinic had been following 18-year-old Tracy Boston, an attractive college freshman who had developed a brain tumor 5 years before. During much of the 5 years, the oncology staff believed that treatment might be successful. The staff had taken great pride in their professional expertise and had admired Tracy's zest for life. Likewise, Tracy's family had become close to the clinic staff, especially in the early years when Tracy's pain was great and the prognosis was uncertain.

Within the last 6 months, the tumor had begun growing again, and was now to the point where the clinic staff rapidly was losing hope for Tracy's recovery. They were becoming highly distressed not only for Tracy but also for Tracy's family, which was having trouble coping with the possibility that she was going to die. Despite the staff members' awareness that Tracy's condition was bleak, they seemed to be frozen in their ability to work with Tracy and her family about the problem of her impending death.

Ms. Gray was close to desperation when she called the Family Clinic one afternoon. As she spoke to a family therapist in the clinic, she phrased her request as follows: "I am working with a family that is having trouble accepting their daughter's imminent death. Can you help us?" Ms. Gray elaborated the details of Tracy's condition and mentioned that she was having difficulty broaching the subject of Tracy's serious condition with the family. Tracy's parents had been concerned that their daughter should not lose hope despite the prospect of her dying; they wanted to avoid talking about it among themselves and with Tracy. Ms. Gray was uncertain how to proceed with this family and requested the family therapist's assistance.

As Ms. Gray continued to talk about the case, the family therapist realized that this could be the ideal entering point for the Family Clinic to establish its credibility with the Oncology Clinic. Without considering the benefits of assuming the meta position of a consultant in this case, the family therapist immediately accepted what seemed to be a referral. He invited Ms. Gray to participate as a cotherapist, sensing that he would need some assistance with this problem, and asked her to invite the entire family for the first interview.

The first session with the entire family (Tracy, her parents, and her siblings) moved very slowly and at times seemed to be at the point of a quick termination even before the session concluded. Mrs. Boston, Tracy's mother, moved restlessly in her seat throughout the session as she periodically glanced in disgust at the family therapist and Ms. Gray. Occasionally



she commented that it was important for people to have hope and that it was unfortunate that hope could be taken away so easily. All the family members and Ms. Gray seemed to stray far afield from the topic of concern: Tracy's serious condition.

Because the session seemed stuck, the family therapist retreated to a private discussion with Ms. Gray in another room. Only at this point did he find out why the referral for therapy had been made. He learned that Dr. Stone, the attending physician in the Oncology Clinic who had diagnosed Tracy as terminally ill, had refused to talk to Tracy and her family about her dying. Consequently the responsibility (and anxiety) for work with Tracy and her family had been passed to Ms. Gray who, in desperation, had passed on the anxiety and responsibility to the Family Clinic, specifically, to the family therapist. While the family therapist was well aware that this family had difficulty facing Tracy's imminent death, he had not inquired about complications within the clinic staff and was unaware of how he had welcomed the clinic's anxiety with open arms. The family therapist and Ms. Gray returned to the family and brought the session to a swift conclusion. The family therapist then shifted to a consulting role and worked with both the clinic staff and the Boston family. Seven weeks later, Tracy died.

The major problem in this case was that the family therapist had prematurely assumed the role of therapist, surrendering the meta position of a consultant. Instead of looking over the system to determine what role would be best for the particular problem, he quickly leaped into the specific role of family therapist, taking both the responsibility and anxiety for dealing with this family. Had he taken the role of a consultant instead of immediately accepting this referral for therapy, he would have met with Ms. Gray and other staff in the Oncology Clinic to discuss the dimensions of the problem, their attempts to solve the problem, and what could have been done within their own program, realizing that therapy might become indicated at a later time. The pressing problem was between the Boston family and the Oncology Clinic. Members of this system were denying the imminence of Tracy's death and the implications of failure. This crisis within the oncology staff, mixed with the feelings of a desperate family, prompted everyone to look for someone else to bear the burden. The family therapist, intent on helping those who needed help, was a likely candidate.

It is wise to look before leaping, *to define oneself in a consultant role and to retain this role until it is clear what is being specifically requested* and how the particular needs of the system can best be addressed. Starting from the meta position of a consultant makes it easier to reach a consensus about appropriate later roles.

## FAILURE #2: A CASE OF MISTAKEN IDENTITY

"I need your help, James. I think you'd be real good with the problem I'm working on now. Do you have a moment to talk?" Beth Dercum's request was sufficiently attractive to lure James Hastings into a brief meeting. Beth and James were both family therapists on the staff of the Family Service Center, a community agency within a large metropolitan area. They had been on the staff of the Family Service Center for several years now and had collaborated on a number of educational projects. James had several more years of experience than Beth and, in addition, had received extensive training in family therapy at well-known training institutes. Beth respected James's therapeutic skills and thought that he might be just the person to help her.

Beth explained her predicament to James: "A few weeks ago I began to teach a small class of university students who wanted to gain more exposure to family therapy during this quarter. I thought it would be valuable for them to see a live session with a family, and so I invited the students to come over next week to observe a family session from behind a one-way mirror. My problem is that I would like to sit behind the mirror with the students and comment on someone else working with the family. When I thought of the person who could best show these students how to work with a family, I thought of you."

James's curiosity peaked as he thought about the proposed interview. He asked Beth to continue. "What's interesting, James, is that a family I worked with about 2 years ago just called me and requested to return to therapy. Ed and Ruth Smith are the parents, and they have two children: Tom is 17 years old and Ann is 14. Ruth Smith called me the other day and said that they were having problems with Tom again, and they thought they needed some help."

James asked Beth about her work with the Smith family 2 years ago. With an undertone of frustration, Beth told James that her work with the Smith family had not gone as well as she had hoped: "The first time they came in, the parents were having problems with both Tom and Ann who were unruly, weren't interested in helping around the house, and had poor grades at school. It seemed to me that the parents, Ed and Ruth, were having a very difficult time talking with each other. After meeting with the family for a few sessions and with Tom and Ann, I suggested to the parents that we meet together and work out difficulties that they were having with each other. They came to a few sessions together, and then the wife came alone for a few more sessions; but she failed to continue. I had a lot of trouble trying to get the family to come to the meetings and finally I couldn't even get the parents to come in. I really don't understand why they want to come back to see me now. But they did call, and we've made the first appointment for next week."



It was agreed that during the demonstration family interview Beth would comment on James's work with the Smith family and, after the interview, James and Beth would meet and discuss the interview with the students. James stipulated that Beth first get the consent of the Smith family to be interviewed in front of the university students. Beth immediately called the Smith family and got their consent.

In the days before the interview with the Smith family, James thought about what he wanted to accomplish in this exercise. He thought of himself as a consultant to Beth. He wanted to help her get a fresh start with the Smith family and to avoid some of the pitfalls that had impeded treatment in the past. He knew that it would be important to frame the problem in such a way that the parents would not feel blamed for the problems of their children, especially because Beth had seemed to underscore their marital difficulty prematurely in the first round of therapy two years ago. It also seemed useful to relabel the family's difficulties as a developmental crisis around Tom's leaving home for a distant college. Besides serving as a consultant to Beth, James envisioned his role to the university students as that of a teacher who would demonstrate some basic principles of engaging the family, interviewing the family, and diagnosing the problem from a systems orientation in a nonblaming manner.

Because the Smiths had already consented to be interviewed in front of the university students, little time was spent before the interview in discussing the procedural arrangements. James and the Smiths walked into the interview room, and Beth and her university students went into the room behind the one-way mirror. The interview progressed as James had expected. He engaged the family, asked for a specific definition of the problem by all family members, supported each family member when he could, and gently nudged them toward viewing the problem as a developmental one, with the challenge of reorganizing themselves in new ways. He conducted the interview with only mild intensity, hoping to link the family back into therapy while demonstrating to the university students some of the basic principles of family interviewing. He thought that some of the more subtle notions of how he viewed the problem and some possible treatment strategies could be communicated to Beth at a later point.

As James was concluding the interview, he told the Smiths that he would be consulting with Mrs. Dercum about the interview. He wished the Smith family success in their work with Mrs. Dercum and said that he hoped that they would be able to pursue the goals that they had identified in this consultation interview. Before James was finished, Mrs. Smith abruptly interrupted him: "Hold it! Aren't *you* going to be our therapist?" Mr. Smith

then reinforced his wife's claim on James: "We thought you were going to continue to work with us! Now that we have something started, we'd like to continue with you." James was flattered, but bewildered. He thought Beth had explained to the Smith family that he was a consultant to Beth and also was demonstrating how to interview a family to the university students. What had Beth told the Smith family about this interview? James excused himself and retreated behind the one-way mirror. After a discussion with Beth, James agreed to continue with the Smith family in therapy. However, a high price had been paid for this first interview. Instead of therapy beginning with clarity, it commenced with confusion.

The problem in this case is that the contract was not clear. James thought that he was serving as a consultant to Beth and secondarily was demonstrating interviewing techniques to the university students. Beth had assumed that James was going to conduct the demonstration interview in a teaching format and implicitly hoped that she might interest James in assuming the role of therapist for this family. When she approached James with her consultation request, she essentially had masked an important part of the request; "Take this problem off my hands." James's emotional investment in demonstrating his interviewing skills undoubtedly undermined his ability to identify Beth's underlying agenda. The Smith family thought that James was going to serve as their therapist. They had agreed to be interviewed in front of the university students only because they wanted to start afresh with someone other than Beth.

In summary, there were contractual misunderstandings between the consultant, the consultee, and the family. James had not clarified what Beth wanted. Furthermore, had James and Beth met with the Smith family prior to the interview and discussed with them the contract more clearly, the Smiths would not have continued with the assumption throughout the interview that James was their new therapist. This case illustrates the crucial importance of *clarifying the consultation contract, specifying the goals of consultation, determining who will do what, and communicating that understanding to the key people in the system*, including those who provide and those who are provided with the consultation.

## FAILURE #3: SECRETS

A family therapist in the community received a call from Mrs. Bonnie Smith, a supervisor at Western Travel Agency. Mrs. Smith had heard this family therapist give an interesting talk on family communication at a workshop in the community several weeks before. She had thought about how his expertise could be useful to the personnel at Western Travel Agency,



and she had called him to request his assistance in helping her colleagues with what she described as "communication problems." Mrs. Smith met with the family therapist/consultant at lunch one day to discuss these problems.

Mrs. Smith explained that she recently had noticed that the 20 employees of the agency had been lagging in their performance. She described how employees seemed to be disgruntled with each other and not as enthusiastic about their work as they had been. Furthermore, conflicts between certain key employees who had been there for a number of years were creating an atmosphere that made it difficult for the employees to serve the customers. Mrs. Smith was interested in having the employees learn how to cooperate rather than compete. She thought that if the employees were to have a better sense of themselves as individuals and greater clarity about their personal goals, their values, and their career interests, they would find more energy for their work.

After his conversation with Mrs. Smith, the consultant began to prepare an elaborate 2-day consultation that emphasized communication skills, self-awareness, life-work planning, and so on. The workshop was planned for Friday night and all day Saturday. As preparations were made to involve all the employees, some of the key employees requested permission to be absent because of prior commitments, exhaustion, lack of time, and so on. Despite the absence of key employees, the workshop was held. During the workshop, the consultant had a difficult time engaging many of the employees around the goals and procedures. Some employees were overheard during one of the breaks commenting: "The last thing in the world we need is one of these touchy–feelie workshops by a shrink." In spite of the consultant's careful preparation and his preworkshop consultation with Mrs. Smith, he found himself exasperated and puzzled as to why his careful plans were being met with such disdain; perhaps he had not prepared carefully enough, or perhaps he had not joined with the employees at the outset of the workshop.

What had contributed to the failure of the consultation with Western Travel Agency? In this case, the consultant had failed to contract with a person with broad enough authority and also had failed to consider possible implicit agendas behind the consultation request. The explicit request was to "help our employees." Had the consultant examined the system from a broader perspective, he would have found that the implicit request was: "I need to show the new bosses of this business that I know what I'm doing, that I'm sensitive to the employees, and that I want to improve their production."

What the consultant did not know was that Western Travel Agency had recently been acquired by a larger travel agency. This parent corporation

had met with the employees of Western Travel Agency and had told them that new roles and positions for employees were under consideration and that those positions would be determined within the next several months. Under the parent corporation's new proposal, several supervisors would now be put under one primary supervisor. The secondary supervisors would be in charge of different tasks within Western Travel Agency, but the primary supervisor would monitor the activities of the secondary supervisors and would communicate directly to corporate executives in the parent corporation.

Knowing that the system was in flux and that the executives of the parent corporation were very carefully looking at all the supervisors, Mrs. Smith decided to seek an "insider's track" by impressing the new management with her organizational sensitivity. Essentially, she was trying to edge out other supervisors for the top spot in the new organization. She had communicated with the parent corporation several times about her interest in bringing in a consultant to help the employees with communication, personal development, and office skills. Rather than having a real interest in any positive outcome of the workshop itself, Mrs. Smith had been more interested in obtaining the consultant's services as a way of establishing her potential expertise in the new organization.

When a consultant is asked to assist an individual or organization in dealing with a problem, the consultant will be tempted to focus only on the explicit presenting problem as defined by the person requesting the consultation. Lurking behind the explicit problem may be a host of implicit agendas that may be kept hidden from the consultant. The consultant will be trapped if he or she responds only to the explicit problem; *implicit agendas should be fully explored.*

## FAILURE #4: GOING THROUGH THE MOTIONS

After months of negotiations, the contract had finally been awarded. A special committee of the Department of Psychiatry at Parkview Hospital was delighted that the department would be providing consultation services to the New Life Residential Treatment Center. Directors of the Department of Psychiatry and New Life had agreed that the consultation contract would benefit both organizations. The Department of Psychiatry had been interested in both the potential consultation income and in the opportunity to give psychiatric residents experience in working with a community residential treatment center. The management of New Life was under some pressure to demonstrate its effectiveness as a residential treatment center. It had been awarded several contracts by the state and, as part of the agreement,



needed to document that it was receiving consultation services from an outside organization.

Details of the consultation were arranged between the directors of New Life and a special committee of the Department of Psychiatry. The psychiatric residents were assigned to deliver consultation services to the staff at New Life. Although this staff had not participated in defining what type of consultation services were needed, they were given the assignment of welcoming the psychiatric residents and of consulting with them according to the terms of the consultation contract.

The psychiatric residents considered this consultation low on their list of priorities. They were heavily committed to responsibilities at the hospital and with community groups. They had not participated in the contract negotiations and believed that their mentors were only mildly interested in this consultation. There was no faculty coordinator for the consultation and the residents were simply assigned to work with the staff of New Life.

The initial meeting between the residents and the New Life staff was planned and postponed several times. After this tentative beginning, the residents did meet with the New Life staff with the goal of clarifying exactly what help was needed and what resources the residents had to offer. The residents found that the New Life staff members wanted help, but had difficulty describing exactly what their problems were and how they wanted assistance. Staff members described vague problems and highlighted difficulties with the upper management of New Life, which the residents could do nothing about. They also could not help with the staff's criticism of the treatment center, especially that its architecture seemed antiquated and not designed to meet the psychotherapeutic needs of the community. Staff members repeatedly discussed the pressing need for a group room large enough to accommodate the entire population of New Life.

The psychiatric residents had difficulty connecting with the staff. They had little sense of what the problems of the New Life staff were and how they could be of help. Frequently the residents asked themselves why they were there. At the same time, they were reluctant to push the New Life staff to be specific. Exhausted from their other duties at the hospital, the residents fulfilled their consultation obligations by meeting with the New Life staff, but did little else to push for a more effective consultation. Both the New Life team and the team of residents were going through the motions of a consultation. They were fulfilling the consultation obligations without meeting the consultation needs. Each team, however, was looking good to its superiors.

What had kept this consultation from getting off the ground? The initial contracting process was inadequate, with no agreed-upon problems or goals, so the joining process could not be successful. Those who designed

the consultation were not the ones who were to implement it. The contract had been arranged by the upper management of both New Life and the Department of Psychiatry, but the staff members of New Life and the psychiatric residents were the ones assigned to carry out the terms of the consultation. There was little if any personal investment in the consultation among those who were to do the primary work. This was a hand-me-down consultation that evoked little interest or creativity. *Organizational consultation must begin with attention to the administrative context so that consultation goals can be meaningfully agreed upon and implemented.*

## FAILURE #5: HELP, I'M BEING HELPED

The long nights and uneasy days were gnawing at the Reverend Jacobs. His first 3 years at Grace Church had included the usual disappointments. But in the last 6 months, storms had been gathering at Grace Church, and he had been increasingly buckling under the pressure. Jacobs was at the point where he thought he needed some outside help. Although he was somewhat reluctant to do so because of the implication of failure, he called a family therapist he knew and asked for a consultation because of problems in his congregation and his increasing depression. He arrived for the consultation dressed neatly in a tie and sweater, but his face was etched with the marks of discontent and weariness. He thanked the consultant for setting aside some time for him and, after slouching in his seat, explained the events of the last 6 months.

"There has been a small group of ten dissidents within Grace Church who have been causing a great deal of havoc. They've been complaining to other church members about my leadership. They come to me and tell me that I can't do anything right. A number of them are on the church council and are demanding that I give a very specific accounting of my time, to the point where I can't even do what I'm called to do. These dissidents also have been rude and abrupt to the other members. Some of the people who have supported me are leaving the congregation now because they just can't put up with it. No matter what I've tried to do, nothing seems to work. I've tried to talk to some of these dissidents informally, but they don't seem to want to listen to what I have to say. It's come to the point where my personal life is being affected. I can't sleep at night, my eating is terrible, and I'm losing energy to do almost anything in the church. I come home and I tell my wife about these problems, and I don't even know if she wants to listen to me anymore."

Jacobs appeared to be a kind person who was sensitive to how he



displeased others and cautious about facing unpleasant situations. He had been doing what he thought was his best in the congregation, but increasingly was being inundated with a lot of complaints and little support. Jacobs then told the consultant that his current thought was to visit each one of the dissidents in their homes and to gather from them a specific list of their complaints so that he might better understand the problem. In the same breath, Jacobs sighed, as if to say, "I don't have an ounce of energy left for what I want to do."

The consultant was concerned about his client's fatigue and lack of energy. The signs of depression were pronounced. On that basis he told Jacobs that he seriously doubted whether he could or should proceed with his well-intentioned plan. The consultant believed that, as much as Jacobs wanted to understand the problem, any further efforts on his part to deal with these dissidents would only increase his frustration and disappointment. He urged Jacobs to slow down, withdraw, and to nourish himself before charging after others. The clergyman brightened at the consultant's suggestion to abandon his plan for contacting these people. He thought that this was the kind of encouragement he needed to hear, and he left the session as if a weight had been lifted from his shoulders.

The following week, Jacobs called the consultant and immediately apologized for not being able to feel better. He said he had left the consultation feeling encouraged and that the consultant's advice was what he needed to hear. But he added that things were unchanged and that he felt depressed and believed there was nothing he could do to help himself. Jacobs asked the consultant whether he could refer him to a psychiatrist who could prescribe a medication to help him with his depression. Although Jacobs did see a psychiatrist, no medication was prescribed, and the minister returned to the consultant the following week.

What had stymied the Reverend Jacobs? Was it possible that the consultant's advice had served to perpetuate the problem rather than help Jacobs manage his depression? In the following consultation sessions, the answers to these questions became clear. This clergyman was surrounded by supervisors—both formal and informal consultants. The consultant was only one among the many helpers in his life. His wife was one of the informal consultants. Recently she had taken a course on stress and assertiveness and had learned that it was important in stressful situations to charge ahead with action instead of withdrawing. She had been cheerleading her husband to push ahead and not withdraw in disappointment. She told him that if he were more active and assertive and confronted the dissidents, he would feel more competent and less depressed. She encouraged him to confront the dissidents, believing that not to do so was to admit defeat.

The Reverend Jacobs was deeply loyal to his wife, but he also felt obliged to listen to the help of his clergy colleagues with whom he met once a week. From their experience in their own congregations, these colleagues were advising Jacobs not to give any more attention to those dissidents who, they felt, were only steering him away from his ministry in the congregation. "Don't try to placate them because you've already tried that and it hasn't worked. Besides, they'll take advantage of you if you put yourself into their hands."

Other informal consultants besides his wife and his colleagues included some active supporters within Grace Church. Some supporters were saying that he should move ahead and confront the dissidents. Others were telling him not to pay attention to them. Still other supporters were saying, "Watch who you talk to. You can talk to some, but you can't talk to the others." How could Jacobs please all of those who were trying to help him?

What finally confounded the Reverend Jacobs was that his own bishop, acting not as a consultant but as a supervisor, had told him that prior to their next meeting, Jacobs was to visit each dissident and to generate a list of specific complaints that they had about his ministry and the operation of Grace Church. Jacobs had not informed the consultant that his plan to visit the dissidents was, in fact, a demand from the bishop. Unknowingly, the consultant had given Jacobs advice that was directly at odds with the mandate from the bishop.

Although Jacobs was facing the pressure of the dissidents, a greater problem was that he was paralyzed by excessive "support." He was silently crying out, "Help, I'm being helped!" Had all his supporters been giving Jacobs the same message, perhaps he would have been able to proceed with definitive action and his depression might have lifted. Instead of one resounding chorus, the Reverend Jacobs was hearing several conflicting messages that he was not able to reconcile.

A consultant is often only one among the many helpers who are attempting to assist a consultee. There may be several supervisors and a host of both formal and informal consultants who all have taken upon themselves a mission to rescue a consultee from despair. Unintentionally, the helpers may swamp the consultee with contradictory views and competing demands.

*It is crucial for the formal consultant to assess how all of the informal consultants are involved with the consultee.* Rather than binding the consultee even tighter with one more piece of advice, it will be more helpful if the consultant clarifies the overall context of who is saying what to the consultee before trying to formulate a plan of action. Whatever the plan, it is important to remember that the consultee's biggest bind may not be the problem presented, but the well-intentioned solutions offered by helpers.



## FAILURE #6: RISKY BUSINESS

Blue Mountain School was an old, well-established boarding school in the mountains of the Northeast. For decades, it had been one of the premier showcases demonstrating how boarding schools can attend to the full range of academic, physical, and emotional needs of their students. In the past few years, Blue Mountain School had found that the students were manifesting emotional difficulties that the faculty and staff could not handle with their present skills. The headmaster called a psychologist/family therapist and said that the school wanted to have a consultation relationship with someone on whom they could depend. In years past, the school had referred some students to practitioners within the community, but had had little success in developing any close working relationships.

The psychologist began seeing numerous referrals from Blue Mountain School. After several months of psychotherapy with a number of students, she met with the headmaster and the dean of students. At that meeting, she suggested that the school employ a residential counselor who would be a liaison between her and the school, and who could also manage the less critical and more informal counseling needs of the students. The psychologist's aim was not simply to accept referrals, but to help the school by developing a prevention program.

The consultant's proposal was accepted by the executive committee at Blue Mountain School, and the search began for the person who could fill the position as resident counselor. The consultant assisted in the search process and also interviewed members of the faculty and staff as to what kind of person they might want for a resident counselor.

As the school conducted its search over the next few weeks, the students being seen by the psychologist began to present with more complicated and difficult crises. Some students were reluctant to participate in therapy as they had before. Other students mentioned that their advisers were eager to speak with her about problems that the students were having in school. She found that students wanted to take the role of intermediary between herself and the advisers at the school. Several of the students whom the psychologist was seeing were found to have broken school rules and had been brought before the discipline committee, which seemed to take extreme measures to restrict the students' privileges. Although she had had a reasonably good working relationship with the student discipline committee before, she now found herself at odds with their decisions and she quickly registered her concern with the head of the committee.

In the course of several weeks, the crises in these students' lives had multiplied, and the consultant had found herself bristling at the school's response to the students' minor infractions. Moreover, she found herself not

nearly as effective in negotiating solutions with the student discipline committee. The consultant finally was given a clue as to what was going on when she made a brief phone call to one of the nurses at Blue Mountain School. The consultant had called to straighten out an upcoming appointment with the nursing staff at the school. In the process of talking to this nurse, she discovered that her suggestion to hire a resident school counselor had had major repercussions among the faculty and staff.

The nurse said, "There has been a lot of change around here lately." The family therapist asked, "What do you mean?" The nurse explained that historically the nurses in the school had been used by the students as informal counselors. Students would come into the infirmary and discuss with the nurses their personal, family, and academic problems. The nurses had always seen themselves as the "school counselors," even though this role was not part of their official job description. The consultant had never considered that there might be informal school counselors. She discovered that the students' advisers had also served as informal counselors for students. Some advisers were more interested in academic guidance, but many of them had regarded themselves as surrogate "aunts" and "uncles" and had taken these roles with the utmost seriousness. The nurse ended the conversation by expressing regret that Blue Mountain School had begun this search for a resident school counselor. An important role for her and others was being taken away.

The consultant had failed to assess the consequences of consultation for the system. Her suggestion that the school employ a full-time resident counselor had been supported by leaders of Blue Mountain School. Their encouragement had reinforced her perspective and limited her perception of other parts of the system, specifically the school nurses and student advisers. Valued roles that they had occupied for many years were now being stripped from them and delegated to a newcomer.

The consultant's failure to assess these risks resulted not only in a lack of support for the consultation proposal, but in the possibility of sabotage by the school nurses and student advisers. More important, those who were affected most directly were the students themselves. Caught between the school nurses and advisers on the one hand, and the family therapist on the other hand, the students found themselves in an atmosphere of increasing tension and mirrored this strife in their academic and personal crises.

Along with the benefits of consultation, there are also risks. The impact of consultation may change an organization in such a way that those who have lived in it for some time find that their roles and responsibilities are significantly shifted in ways that they find undesirable. Any effective consultation not only gives but also takes away. Those who welcome the consultant may soon find themselves packing their bags. *One of the consultant's responsibilities is to assess how consultation will alter the organization of the system and to prepare the system for that change.* Failing to assess these risks of consultation can result in undoing potential benefits of the consultation, or even in its complete failure.



## FAILURE #7: THE PERMANENT VISITOR

Advent, Inc. was an innovative, community walk-in service for adolescents who had run away from home and often were caught up in drug abuse and antisocial activities. The staff members were well trained as group therapists and community outreach organizers, but not as family therapists. They had begun to see that many of the adolescents were still deeply involved with their families, though they usually had many negative feelings. Several staff members had begun to wonder how positive resources in these families could be tapped and how contacts with families could be integrated with peer-group, school, and legal systems contacts. They decided to invite a family therapist to consult with them on these aspects of their staff development.

One of the staff members suggested contacting Dr. Paul Andrews, a family therapist whom he had heard speak on families with teenagers who had drug problems. He had been impressed by how Dr. Andrews shared his personal experiences of having grown up in a family where his younger sister had a serious problem with drug abuse. The staff member thought that because of the family therapist's personal experience and his professional expertise with families, he would be an ideal consultant for Advent. The other staff members agreed. Dr. Andrews subsequently met with the staff as a group, and a consultation contract was set up for staff development. The staff requested help in learning how to identify the specific problems of families in this setting, how to examine alternative solutions, and how to organize a group for these families. Dr. Andrews was enthusiastic about this consultation. He helped the staff contact families and quickly established multiple family groups. Staff members were active in the multiple family groups, but Dr. Andrews clearly was the guiding force. As the months continued, the staff became more and more adept at linking with families and in problem solving with them.

Dr. Andrews's role changed little over the subsequent months although staff competence and confidence was growing. Dr. Andrews believed that his consultation with Advent was now an integral part of their functioning. He maintained a central position in staff meetings while continuing to facilitate the multiple family group meetings, as well as conducting workshops on delinquent adolescents and family functioning. A few of the junior

staff began to resent Dr. Andrews's position, but they filed no complaints and requested no other consultant because Dr. Andrews was doing such a "fine job." In short, Dr. Andrews and the staff had grown comfortable together at the expense of future staff development.

The problem in this consultation was that Dr. Andrews's position was becoming permanent. He had been asked to consult for staff development in the family area. Instead of maintaining an "outsider" relationship with Advent, he had moved into the organization and was settling down as a permanent resident. Advent was in danger of not developing their own staff to work flexibly in a comprehensive and integrated manner with families, as they had done with the schools and legal system. The staff could fall back on Dr. Andrews rather than pushing themselves into new ventures.

For his part, Dr. Andrews had difficulty distancing himself from Advent, in part because of his emotional ties to the primary concern of the program. From personal experience, Dr. Andrews knew what it was like to live with a drug-abusing teenager. He had a personal commitment, a mission, to help families with these struggles because his own family had never received professional assistance in their long struggle. In some sense, Dr. Andrews wanted more for these families than they wanted for themselves. Consequently, he could not terminate his consultation.

*A sign that a consultation has been effective is an absent consultant.* A readiness to look for the exit sign should begin with the question: "What needs to happen in order for me to leave this place?" Although the consultant may occasionally visit again, such "visitations" are far different from becoming a permanent resident in the system. A consultant-in-residence implies that the system cannot take care of itself.