MAPPING TRANSPARENT CONSULTATIONS WITH HEALTH AND PROTECTIVE SERVICES TEAMS

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The role of consultant is different from that of being a supervisor or a therapist, even though the relational consultant uses similar skills. Experienced psychotherapists have the privilege of consulting with teams of professionals. This brief article offers a stage model to organize a collaborative, participatory, and transparent form of consultation in complex organizational settings, like child protective services and community health care agencies. Staging is not a normative process to the consultation process. However, offering a clear sense of the stages that occur in a collaborative consultation may make facilitators more accountable to the consultation practice and thus start construing evidence about these activities. The stages described in this brief attempt at systematizing the consultation practice with teams working with families are: Introductions → Meaning-Making → Resonances → Alternatives Meaning → Planning and Implementation → Evaluating.

Usually, by the time a system seeks consultation, true dialogue has stopped; system members are caught in repetitive “monologing,” endlessly restating their positions (Anderson & Goolishian, 1988). Variety in thinking has dried up, leaving them with relatively flat, anemic ideas about themselves and one another. A marvelously ingenious aspect of the eliciting stance is that the therapist invites greater variety in system members’ thinking, not by countering their ideas or by suggesting alternatives, but by simply asking individuals to focus their attention on constructs that may have received only scant attention before. (Real, 1990, pp. 260–261)

Transparency as a concept is a complex and difficult process to grasp in the predominantly expert position adopted by professionals in human services and health care. Transparency encompasses a wealth of relational discourses (Roberts, 2005), from pragmatics to discursive intentions; behaving transparently requires thinking

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as if any participant connected to the problem-situation is listening to our stream of thoughts. Transparency, a central element of a collaborative approach, calls for the relational consultant to explicate the intention of the interviewer, to make overt the source of the consultant’s assumptions, which take the form of meeting procedures, questions, statements, etc. Narrative therapists have described this process: to situate the person of the professional (Freedman & Combs, 1996; Madigan, 1991) in the political, institutional, and cultural intersecting contexts. Doing otherwise, the situated therapists suggest, precludes genuine collaborative engagement with those requesting the help of the therapist (Monk & Gehart, 2003).

Accentuating transparency processes is particularly central in the case of consultation with teams of professionals working within large social services or health services systems from which I drawn some lessons in this paper. This paper accentuates the work with the professionals in the context of larger institutional demands. For the most part, the work of collaborative-language therapists has accentuated the dissolving language capacity of conversation with clients and families with professionals, but not in the web of institutional demands (i.e., Anderson & Gehart, 2007). In a collaborative approach, the foundation of clinical effectiveness is “the attitude, stance, or emotional posture we take in relation to clients” (Madsen, 2007, p.19). When we ask a question, not situating its underlying premises fosters relationships that presume that a relational consultant’s question is really a form of advice hidden in a question. Transparency, then, demands an honest sharing of what the relational consultant is thinking rather than an orchestrated “curious” questioning that should lead to a studied outcome.

Margarita is an eight-year-old Guatemalan immigrant girl attending elementary school at an urban setting in Massachusetts who is presenting some learning and emotional difficulties at school. A caseworker from child protective services is working with the family after a teacher reported the family for suspected child neglect. The therapist believed the various professionals within protective services and other institutions, like the school, were not communicating well. The consultant suggested to the family therapist having a meeting in which all professionals attended. The meeting included caseworkers, their supervisors, the school team (teachers, school counselors, special education personnel), the family’s attorney, and the therapist, too. Organizing the meeting itself was a complex task. Negotiating time, space, and an agenda was complex. In asking the questions, I acknowledged the privileged position of the relational consultant as an outsider, as someone who could take on a “neutral” position, strip from institutional allegiances, not having had a history of commitments to the case. In asking the questions, I recognized that everyone in the room could see this position as “easy,” since the relational consultant does not have to experience the limitations of the institutional roles imposed vis-à-vis the case. Despite the privileges of being an outsider, I also suggested that the lack of knowledge about the situation could be helpful in moving forward for what we could probably agree was the wellbeing of the child and her family.
THE SETTING OF COMPLEX CONSULTATIONS

Complex consultations include large bureaucratic organizations, like child protective services, as well as small outreach family therapy teams. In these intricate settings, the relational consultant needs to safeguard a dialogical process (Moore & McDonald, 2000) rather than to impose an outcome on families and their social networks. As a relational consultant, I struggle with my own pre-conceived notions of what should be done or how a system should be working. Establishing a collaborative and participatory process is a way of developing such a process. The temptation to operate as the expert technician who resolves a dysfunctional aspect of the system is tempting, since this is the prevalent discourse about the role of professionals. From a collaborative perspective, the struggle of the relational consultant is “not to know” and to invite the various participants into a fruitful dialogue. Yet, relational consultants have empirical, clinical, experiential, and interpretative paradigms, or are “biased.” A participatory stance does compel us to share that knowledge while ensuring participants that it may be limited and may not apply to the present context and/or situation. Merging the notion of “not knowing” (Anderson, 2001), as well as the expert experiences of a relational consultant, allows for flexibility and safeguarding the needs of all participants through collaboration. The role of the relational consultant is to nurture those who participate in felicitous relationships and to recognize their abilities and capacity to inflict change in the larger system, as well as the micro-practices that trap them in discouraging interactions. Examples of collaborative forms of engagement in difficult and complex larger contexts can be found in the family therapy literature (Madsen, 2007; McGoldrick & Hardy, 2008). In this paper, I intend to advance a particular template for a team consultation interview in similar complex institutional contexts.

A PERPETUAL SCENARIO

All of the various participants in a consultation have a story to tell about their concerns. A protective case worker complains about the functioning of the organization to which she belongs, including her supervisor’s lack of time to mentor and support, the low salary, the complex and always changing paperwork requirements, the crisis oriented model that informs decisions, etc. It is not hard to understand her concerns, because this is one potentially accurate assessment of what practitioners experience in large public bureaucracies.

If the consultant were able to speak with the case worker’s supervisor and she were to trust the consultant, she would talk about being overworked, of having to be available for emergency calls during weekends, having too many meetings, being unable to keep or hire qualified personnel, being afraid of facing a volatile case that reaches the media, and having a general sense of feeling trapped with
requirements coming from superiors and subalterns. In simple words, this professional “feels like being in the middle of a sandwich” or torn by multiple and contradictory demands.

If the consultant has the opportunity to speak with administrators, they are often explicit or share indirectly their concerns with productivity, deliverables, the budget, and public relations.

The consumers or clients, as they are often called by large social service organizations, are often caught in paradoxical relationships with these organizations. This is particularly true if a judge mandates the individual or family, or if the organization is one more among many that is supposed to be designed to help them through a crisis or to find the resolution to problems. People’s distress is often informed not only by difficulties within their family and community context, but also by the compounded demands of health professionals, agents of social control, teachers, etc.

Each of these potential participants in a consultation believes that the problem resides in the other. A cycle of blame (Paul, 1997) is often inevitable, and it is difficult to find participants who in turn construe their participation as pivotal in changing the situation and/or the context. The individuals with a lower sense of agency, consumers and direct care professionals, find themselves in an often untenable and difficult situation. For those closer to the top of the hierarchy, it is often a matter of having the others do “their job and be responsible,” and the possibilities of cooperating appear distant and impossible. The paradox is that the relational consultant is not only faced with the specifics of the motive to consult but often with an institutional structure and organizational culture that sets everybody up for constant failure. The consultant’s role is to investigate and highlight how, at the level of the interpersonal interactions, there is an isomorphic development of constraints that mirror the individual stance and the institutional constraints (Giacomo & Weissmark, 1986; Liddle & Schwartz, 1983). Core systemic family therapy ideas help us understand these vicious but stable systemic processes.

THE CONSULTATION STAGES

After analyzing several consultation sessions and observing other consultants, it has been helpful to name the various moments of how a one-session consultation evolves. It is tempting, but it may also be misleading, to offer orderly or schematic descriptions of a consultation of what are essentially highly contextual events. Nonetheless, it may prove useful to suggest the development of a consultation session template to anchor the ideas shared previously. Being able to provide consultees with a template before the consultation session starts does also provide a structure of how participants may participate and may make them more comfortable. The template is a map and not the territory; a true collaboration will lead to abandoning this schema and creating a new one. However, employing a template aids in stressing accountability and performing evaluative activities.
Students in training, professionals, and faculty and clinical supervisors may also benefit from the use of a similar template in organizing consultation sessions.

I. INTRODUCTIONS

The first stage of a consultation contains a respectful process in which participants and the consultant are invited to learn about who is attending the session. Each participant is asked to introduce themselves with names, professional roles, and any other information they may decide is relevant at that particular time or in those circumstances. It is also the occasion to ask who is absent, a matter the consultant may address again towards the end, as the group plans ahead: asking who else could have attended and who could be a voice of support for those present, as well as imagining how the presence of others would shape the conversation differently. Similar to a family group conferencing meeting (Burford & Hudson, 2000; Pennell & Anderson, 2005), the consultant may attempt to deepen the time for introductions, moving the recognition of the others from just merely individuals to being a part of networks that could sustain healing and resolution of what brings the group together. An important component of this introductory stage is to assess a “natural,” or assigned, leader for those attending, a person seen by all participants as someone they trust to follow through. Further questions invite the involvement of an even larger system and potential resources beyond the specific participants to ground any potential solutions.

During the introductions, the professionals share their concerns and describe the role they have played until that moment in the case. I invite them to also share something that may surprise others and that may have some relevance in relation to the case. Several of the participants share stories of intergenerational family immigration. When the family therapist is asked about who may be a potential resource but is absent, we learn that Margarita’s oldest adult brother had been detained at his workplace four months previously, accused of not having immigration documents to reside in the United States legally.

This introductory phase ends with a summary of why the consultant may have been asked to facilitate this conversation. As the introductions move participants to talk about the problem or problems, reflecting team (Andersen, 1990, 1992) type of questions is useful at the start to foster participants’ ownership of the consultation. The questions may include: How would you like to use the session today?: What would you hope to achieve in the meeting today?: Have you considered any other ways of discussing the problem?: and Do you have any comments about what has been said? The emphasis here is not on the formal aspects of the questions over the relational importance of questions genuinely asked for the purpose of establishing a collaborative task. A relational understanding and an emotionally contained and respectful stance inform the questions not only at this stage but also throughout the whole conversation.
II. MEANING-MAKING

A second phase includes the exploration of hypothesis and meanings. The situation may have been talked about previously, it could be part of a written report, or one or more of the attendees may narrate it. It is a stage of the conversation in which the consultant asks not to judge which hypothesis or meaning may be more accurate or useful. Two kinds of conversation often emerge in this stage. The most common and potentially distracting development of this conversation is the rush to closure. In this case, after a couple of hypotheses or meanings, the rest of the participants side with one of them and add more elements to corroborate one hypothesis or add complementary ones, stopping further exploration of alternative stories and explanations. In this situation, the hypothesis is often centered on a system or a group of subjects that is not present in the meeting. A second scenario in this stage is the clash of contested meanings. Here there is an overt and tense display of alternative hypotheses. In both cases, the core of the conversation may provide clues as to what is keeping these participants stuck with the situation or case. To transform these attempts at premature closing or polarized disagreement, the consultant can gently encourage participants to continue verbalizing their ideas without necessarily expecting to come up with the most definitive one or the hypothesis that seems easy to corroborate. The consultant sustains as much as possible a form of curious and irreverent stance (Cecchin, 1987; Cecchin, Lane, & Ray, 1993), in which it is fine to speculate as much as possible, without closing the conversation.

In the case of Margarita, the protective services worker and her supervisor are concerned about the schoolteacher’s reports of neglect. The child has been coming late to class, is often using the same clothing everyday to class, seems lethargic and sleepy in class, and has been withdrawn from peer activities. The teacher reports that written and phone messages are not being answered. Misunderstandings about the roles of parents in relation to the school system are explored in the interview as the consultant shares some of his experiences with Latino immigrants in the context of the American school system.

The consultant, in this stage, helps the group to collect as many pieces together as possible without necessarily creating a unitary hypothesis or meaning. This is also a time for respectful humor and a deliberate and full appreciation of the passion that participants have towards their ideas or practices.

III. RESONANCES

After participants and the consultant agree that new ideas may not be emerging or a period of saturation has been accomplished—repetitive statements about the same meanings—the consultant asks participants to share their “gut feelings.” We explore how the case or situation resonates (Casement, 1991; Elkaim, 1990) with
their personal or professional lives and the current or past situations they have experienced. This is often a stage that changes the rhythm of the conversation. People take their time to talk and there is less interruption. Sometimes it is difficult to start or to involve those who occupy an upper role in the institution or have supervisory responsibilities. But it is often the case that some open up and share their own feelings and non-mediated reactions towards the case. This stage in itself may not necessarily convey new ideas to resolve the issues. It is, nonetheless, important to embrace the participants’ biases and to recognize how “natural” reactions may facilitate or inhibit their interactions with those in need of help. It is always surprising that there are similarities in the reactions among those who may have had a contentious position about the case.

Margarita’s case mobilizes some deep sense of frustration among the team members about the restrictions posed by recent immigration laws that preclude a flexible or humanitarian response to this family. On the one hand, the child needs social and emotional support at home; but those who could provide it are exhausted by work demands that increased after the detention of the main provider. What the agencies are able to offer requires removal of the child from the home, a solution that places the family and the child in an emotionally painful situation. The consultant provides the team time to explore this dimension before moving forward with the next step.

This process is often briefer than the previous one and leads participants to embrace the idea that the observer creates realities. This is an important aspect because the relational consultant’s intent is to consider, together with the participants, the multiple contexts and systems defining the present situation. To allow participants safe sharing of what they may often disavow in professional settings influences not only the consultation but also a larger acceptance of strong emotional reactions on the part of patients towards the institutions in which these same professionals work. It is a stage in which individuals are understood within a larger context that also contains the helping institution(s) as being part of the problem.

IV. ALTERNATIVE MEANINGS

A fourth stage comes as a surprise for those who have not been trained within a systemic perspective. It asks participants to reframe and connote in positive ways the situation and people’s actions (Boscolo, Cecchin, Hoffman, & Penn, 1987; Campbell, Draper, & Crutchley, 1991). The consultant encourages here a collaborative process in which all help others to come up with positive re-descriptions, connotations, and alternative meanings. With this help, participants reframe or connote positively the meanings and hypothesis shared earlier and elaborate new hypotheses that are culturally consonant and relational. Positive deviant ideas (Cameron, Dutton, & Quinn, 2003; Lapping et al., 2002; Mattosinho, Lovel, & Ebrahim, 1996) are easy to comprehend and adopt at this stage, if participants
have been encouraged to think about exceptions to the problem or persons who could lead the family or community in a different direction. This segment has more of an educative content if the participants are less familiar with a relational view. The consultant discourages them from thinking in solely psychological or individualistic terms and suggests ways in which they can see their own participation as intrinsic to the potential and pitfalls of the case. It is also a time when dialogues about intersectionality, the interplay of race, gender, and other social and cultural markers on the issue at stake (Tamasase & Waldegrave, 1993), are grounded in the participants’ lives. From this moment on, participants start discussing almost spontaneously what are other ways of engaging with a family or difficult client or situation.

Since the team has already discussed the socio-political context in which Margarita’s case is located and how it has impacted their work, most of the dialogue in this stage includes a review of what potential interventions by professionals could be iatrogenic and would simply restrict the family’s options as a result of their actions.

Collaborative practices that encourage collaborative consultation occur in what I suggest is always an intercultural domain which is constitutive of any consultation. The intercultural framework as constitutive of a consultation provides a rich metaphor to describe the nature of the consultant’s encounter with others. The complex defining features of the consultant and consultees, plus the characteristics of their relationship, can be better understood within an intercultural framework (Bacigalupe, 2003a; Bacigalupe, 2003b). If we define the consultancy interactions as cultural encounters, we can think about our position vis-à-vis the clients and their “places” and “positions”; their experiences of being dynamically here, there, and nowhere. In this stage, groups diverge in how they want to handle the rest of the conversation or process. If the participants believe they can start implementing some solutions based on this discussion, the consultant may plan for a brief evaluation rather than moving towards the planning and implementation stage. In sum, a relational collaborative consultant develops a style that is easily recognizable by those who engage in the consultation process, and yet it is nonetheless a unique product each time.

V. PLANNING AND IMPLEMENTATION

In the final stages, the consultant invites a dialogue about the various alternatives that exist for the future, what to plan and how to implement what the group envisions as potential solutions or ways of dissolve the problem. In some interdisciplinary groups, offering a family group conferencing modality is a possibility that strengthens the consultation process and furthers the goals outlined in the consultation. In other cases, using a variation of a reflecting team approach is offered. In more traditional scenarios, the participants develop a specific plan to overcome
the hurdles that originated the consultation and, in those cases, the scheduling of another meeting may relate to the periodic revision of difficult situations, cases, or engagements between professionals and consumers, patients, or clients.

The team utilizes the last part of the consultation to outline a report to establish what sort of support the family would require to have Margarita rejoin the family in the short term. The team also agrees that supporting the family on behalf of the incarcerated adult child would translate to a better relation with the family, besides advancing the case in the immigration court.

No matter how pragmatic the plan, this is an occasion in which the team works towards some form of envisioning (Cooperrider, Whitney, & Stavros, 2008; Hammond, 1996) or innovation it is willing to embrace. It is also a time in which the consultant may share personal biases and beliefs (and frame them as such) that may not have had a space in the conversation. For example, it may be the juncture to raise some concerns about how a specific voice was not heard or how a group or individual social context may have precluded them from expressing their ideas or thoughts. These comments are often informed by assumptions about inequality—gender, race, social class, disability, etc. Consistent with the overall approach, any formal writing (reports, letters, invitations) is included as part of the consultation (Bacigalupe, 1996). This writing may summarize the outcomes, invite other potential participants, make a referral, and serve as a “forensic report” for the family or patients.

VI. EVALUATING

Finally, participants and the consultant evaluate what has been accomplished. Group process and content is evaluated and feedback (oral and written) provided. The emphasis is on a frank and honest review of the consultant’s work and stance, as well as an appreciative assessment of participants’ efforts on the part of the consultant. Decisions may be made about further time or meetings to discuss these issues, in addition to who else could participate from the conversation. If the participants mentioned in the meeting were not there, it is a time to discuss how they will be included next. This is a suggestion that often emerges from the group conversation rather than from the consultant.

CONCLUSION: TRANSPARENCY, POSITIONING, AND CULTURE

How do practitioners learn to perform as consultants within a collaborative framework? Consulting is like many professional crafts, an evolving reflexive process (Schön, 1987) that requires a continuous back and forth between practice and reflecting upon that practice. This reflexive process is, in the case of consultation,
part of the activity itself. Consulting requires a high level of transparency about the methodologies, and our epistemological and axiological stances. We are not just neutral-questioning brains or clean mirrors in which participants find their experiences reflected. We are part of that activity and as such accountable for its course as much as other participants are; consulting should not force a construction of reality on the other. The consultation space should provide participants with new ways to envision their relationships as much as new tools to reshape the social and institutional contexts that inhibit nurturing relationships.

A consultant is constantly searching for a meaningful place and a sustainable position. Sometimes this is a place at the edge, sometimes at the center, or in a dialectic bridge of both. This search for a place resembles the immigrant’s early efforts at understanding the host society and the ongoing quest for a unique and plastic identity. Being a consultant has been a professional endeavor of mine, but my own immigrant experience informs such a reflexive position—a very useful one in the context of a consultation.

Positioning is indeed at the core of various theoretical models that are helpful in steering us away from the primacy of theories that insist on grouping individuals within one particular set of static characteristics. This approach has been shaped in my professional interaction with immigrant families impacted by trauma and violence exerted from within and outside their own homes and the individual clinicians and human services organizations working with them. Often these are families who have lived through chronic forms of abuse and neglect and survived the threats of economic, cultural, and political demise. In these cases, the intercultural domain is often obvious to the professionals interacting with these families because of salient cultural differences. However, the intersecting role of those differences and inequality is often unexamined, undermined, and assessed with pathological lenses. In its more brutal forms, when professionals have been trained to examine deficiencies, their skill often condones subtle and overt forms of discrimination and racism. In the more benign forms of professional socialization, the sensibility and sometimes the celebration of difference is not enough because it conceals a denial or silence about disparities and the pernicious impact of paternalistic approaches towards these families. Consulting in the child protective system, for instance, requires a continuous evaluation, as the consultant negotiates a coherent theoretical framework. My own work is a personal recognition of my evolving bicultural immigrant identity, and the organizational underpinnings of what can become a crisis for families and professionals as well as a source of generative opportunities.

REFERENCES


