The Consultative Challenge

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(Special to the Forum)

In a system of fragmented delivery models, it is becoming increasingly popular to use different models of 'consultation' to extend dwindling manpower supplies (Dunn, W., 1989). I suggest, however, that it is a quantum leap from offering a medical or expert model which involves telling others how to solve their problems, to a collaborative model of consultation which truly empowers clients to be able to make their own decisions, giving them the confidence to carry out programs on their own and progress to using the consultant as a resource (Babcock, N.L., Pryzwansky, W.B., 1983). The challenge for all consultants becomes offering information, both verbal and nonverbal, in a manner that is useful and solves issues for clients so that they will be interested in using the information in their own environments. Therefore, success with consultation will rely as much on how information is presented and processed, as on what information is presented.

As a foundation for successful consultation, I would like to present an approach that will challenge readers to consider how their information is both presented and received. Although applicable to any patient population, this article will apply to consultation with families in age zero-to-three programs. Parents of special needs children express frustrations over not being in control. Yet, as clinicians, we notice that in many cases, the parents who are most challenging never seem to show up. We assume that they are irresponsible and not interested, and that they prefer to have no control over their child's program. This is such a common complaint, that in one neonatal follow up clinic I visited, the therapists termed the families NSUs—"Not shown up." An article presented by a psychologist cites a major concern of therapists to be "patients who resist treatment." This frustration may be attributed to the role of the therapist within the relationship. The therapists' view of themselves as "fixers" tended to disempower (I can't) the patient. Yet, the therapists who were "facilitators" had the effect of empowering the patient by supporting his/her own efforts (Schacht, W.D., 1990).

This point of view could apply to parents who feel they have no control when they do attend sessions. These parents do not start out resistant, but become resistant as they withdraw from services that do not enable them to take charge of their infants' progress. Visualize this: in a Parent-Infant Program, a young mother is chattering to her infant, who is sitting in her lap. The mother sits with one ankle crossed on the opposite leg, the infant askew in the hole in her lap. The infant, about seven months old, is supported behind the shoulders by the mother's leg. Therefore, the infant's head is unsupported, and the infant is compensating with shoulder elevation and jutting of the chin forward. Both arms are away from the body and the baby is tipped to one side. The therapist approaches the pair, and gasps at the poor sitting posture, not noticing the interaction taking place between mother and infant. The therapist comes over to the mother and suggests that her way of holding the infant is not correct. The mother explains that her baby can see her and seems perfectly comfortable. The therapist attempts to change the position in the mother's lap, the infant starts to cry, and in frustration, the therapist takes the infant in her arms to demonstrate a more correct sitting posture in the lap. The mother leaves the area at the first opportunity to pick up a friend's crying infant, and does not return.

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The example is not meant to provoke guilt, as I am sure it is not a usual scenario, but serves to illustrate that there are several nonverbal messages being presented to the parent—first, that the mother's perceptions of this situation must be wrong as the baby was taken from her; second, that her own solution of a sitting posture was not skillful, therefore she had to be shown a better posture in the arms of the expert; and third, that the mother's interest in conversation with her infant is less important than the inability of the infant to maintain a good sitting posture. These messages do little to bolster the mother's confidence that she may be able to carry out the program, since

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she is not an expert and may make the wrong choices at home alone. And, as she left the session, she did not learn the correct sitting posture to use during conversation, and will most likely repeat the one with which she felt comfortable, or use none at all. I will return to another possible scenario of this example at the end of this article.

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The successful consultant needs to consider the practicalities of "how and what" information needs to be offered in the consultation session. The following system of problem solving will offer a framework of gathering, planning and presenting your information and can proceed along the following lines:

1. Establishing a common purpose.
2. Changing the format of the relationship.
3. Matching the needs of children to the goals of parents and caregivers.
4. Creating a structure for meeting those goals: The art of therapy matching the art of parenting.
5. Allowing the joy of accomplishment through success in the parents "hands."
6. Letting go.

Establishing A Common Purpose

Establishing a common purpose encompasses several steps of information gathering, through both nonverbal and verbal techniques. First, nonverbal information can be gained through careful and thoughtful observation of the situation before you intervene. (Rule of thumb: any verbal or physical interaction will change the environment.) Observation needs to consider the preferred or comfortable position of the child and the preferred, or comfortable handling habits of the parent or caregiver. These observations can give you information concerning the skill and comfort levels of the child when movement and changes in movement are introduced. The observations also allow you to get a preliminary idea of the skill of the handler. If the parent and child are static, you may offer a cup of coffee to the parent and observe how she or he adjusts the child to both receive the mug and drink from it. The more skillful handler will switch the child to another position on the lap, while a less skillful handler will place the child on the floor. These initial observations can occur in a waiting room or in a group setting if in a school-based program, or while you exchange greetings if you are in the home. After you have observed for a few minutes, ask the parent to bring the child to another area, so you can observe how the child is adjusted as the parent stands up or lifts the child from the floor, and how the child is carried or moves to the other area.

Once you are comfortably settled, start with a prepared set of questions, which specifically cover the information you would like to gain, such as (for a first visit) why the family thinks you are there, what the parent expects or would like from you or your service, what they are hoping to occur next, etc. This information, along with the nonverbal information, can then be used match your goals to those of the parents.

Changing the Format of the Relationship

Changing the format of the relationship is done through the interview techniques that you use, so that you establish your role as a seeker of information, not just a giver of information. But asking questions is not enough. The questions need to be open ended so that they require more than a "yes" or "no" answer. Listen carefully to the answer and select one word or idea to build your next question upon (Province, 1990). This will give the parent several messages: first that you are listening; and second, that you are listening for specific information that may help determine where to proceed next. People who are actively listened to are more likely to increase their end of the conversation. Most people respond

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when they are rewarded with a good listener. Being an active listener does not mean, however, that the parent takes over and rambles. You can take the lead by carefully focusing on the comment or observation which specifically answered your question, repeating it back to the parent, and then moving on to the next question.

Matching the Needs of Children to the Goals of Parents and Caregivers

Matching the needs of children and the goals of parents requires carefully putting together all the information that you have gathered through your observations and interviews. At this point, it takes skill and the willingness to compromise to work on what parents are interested in achieving while working toward the physical goals that you feel are important for success for the child. In our example, it could be guessed that the parent was interested in getting her infant to 'talk' to her, with less interest in the child's posture. Yet, good sitting posture and alignment, and support of the head and neck, are necessary prerequisites for good initiation of sounds. (EIP, 1987) When looking at a goal to work on, good sitting posture would be a prerequisite short-term goal, while working toward the parents' long-term goal of speech. Phrasing your goals within the context of the parents' goals tells them you consider their goals the most important, which serves as a confirmation that they really do know what is best for their child.

Creating a Structure for Meeting Those Goals

Creating a structure for meeting goals requires that the environmental routine supports the planned activity. Planning involves considering how the infant or child spends his or her day—at home, at a babysitter or day care center, or in a school program? How is the day organized? Are there regular eating, nap and play periods? Also consideration of the physical structure of the home or center allows for opportunities to put activities into the normal course of each daily routine. As you select the appropriate activity to meet the parents' goal, you can then brainstorm together on when, where and how this activity will fit into the daily routine. If it can't be made part of the routine, it won't get done. Also consider how the parents feel about the activity. Parents are not comfortable when asked to *be* the therapist, and since they do not have the background to be therapists, this will set them up for failure. But parents do appreciate activities which allow them to be a parent and which involve activities parents usually do, such as lifting, carrying, feeding, or reading to their child.

Success in the Parents' Hands

Perhaps the most challenging component of a consultation model is not placing your hands on the child. Instead you need to teach the parent handling techniques with the child in her or his arms. This is a very skillful accomplishment, both for the parent to handle and the therapist to teach, if you consider the amount of years it takes a therapist to learn handling skills. But this gives several important messages. First, the parents do not see your expert handling as intimidating, which would make them feel that since they cannot do as good a job (*be* a therapist), they will opt for no job at all. As soon as a therapist takes the child away from the parent, this disempowers the parent, since it changes who is in control. Secondly, parents need to have the opportunity to know that they are successful while you are assisting them, to have enough confidence to continue when you are not there.

Letting Go

Letting go, or decreasing your direct input, makes this model fun! It is rewarding to witness the development of the parent as well as the successes of the child. As with any area of learning a new skill, parents will learn handling at a different rate. As parents learn, they will initiate more carryover to other parts of their lives and will begin to develop into assertive and skillful handlers. Often, parents will teach the therapist a thing or two once you have been working together for about a year.

If this problem-solving strategy had been applied with the example outlined in the beginning of this article, the session may have proceeded as follows:

Mother and infant are talking together in one part of a room as part of a Parent-Infant program. The therapist approaches the pair noticing the interaction, which is very much led by the mother. The therapists notes the poor sitting posture, and opens the conversation with greetings and an offer of a drink, which the mother accepts. The mother takes the coffee and does not alter either the infant's, or her own, position. The therapist then asks if they can move to a quiet area and begin the session with a few questions. The mother grabs the infant under both arms and places her on one hip, holding her mug in the other hand, further demonstrating the poor postural control of the

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child when movement is introduced. The answers to the questions reveal that the mother would like her baby to start saying 'ma ma,' and that sitting is not a problem, since the infant can sit propped with pillows. The therapist observes that the infant is not stable in sitting, and has very limited locomotor skills. The therapist explains that a good sitting posture will provide a more supportive trunk for the initiation of sounds, in addition to being a good base for crawling which will come later. The mother agrees that it will be a while before the infant gains the physical skills to move, and is interested in trying a good sitting position in her lap. The infant responds with some throaty sounds after repeated attempts and waiting on the mother's part. The mother comments she feels she is on the right track and looks forward to working with the therapist.

Conclusions

The consultation model is very challenging, since most therapists are programmed to think that their contribution must be "physically" hands on. But hands off can also be viewed as "facilitating" the relationship, through the parents' hands on the child. The joys of meeting the 'consultation' challenge are very rewarding, if sufficient time and effort go into using a problem-solving strategy. One such strategy has been presented in a very brief outline form to encourage readers to think about the information that they are gathering through verbal and nonverbal methods, and the impact a plan of approach can have on how the parent processes the information that is shared with him or her. The most powerful messages shared with parents are often nonverbal messages, and the therapist's manner, approach and planned strategies will be critical in assuring carryover by parents in their own environments.

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