Clinical Consultation in Social Work:
An Exploratory Study of a Dynamic Learning Model

Nancy L. Saks

1989

CLINICAL CONSULTATION IN SOCIAL WORK: AN EXPLORATORY STUDY OF A DYNAMIC LEARNING MODEL

A dissertation submitted to the

California Institute for Clinical Social Work

in partial fulfillment of the requirements

for the degree of

Doctor of Philosophy in Clinical Social Work

by

NANCY L. SAKS

June 25, 1989

ABSTRACT

Clinical Consultation In Social Work: An Exploratory Study of A Dynamic Learning Model

by

Nancy L. Saks

Existing research on social work clinical consultation is atheoretical and addresses the process within the context of an agency setting. Little effort has been made to understand the precise nature of the learning that occurs during the consultation process.

The purpose of this exploratory study was to examine what is learned as well as the factors that influence learning during individual, for fee consultation. In an attempt to provide a theoretical framework in which to understand the clinical consultation process Andragogy (Knowles, 1970a, 1970b, 1972, 1975, 1978, 1980) was used as a model of adult learning.

A qualitative research design was used. Each of the seven social work consultees was seen individually during which a semi-structured, in-depth interview was conducted. Data was analyzed according to the grounded theory method.

Findings suggest that Andragogy is an effective theoretical model that can be used to understand the

learning process that occurs during clinical consultation. Further, it was found that consultants were selected based on specific criteria and that consultation was requested not only to address a particular practice problem but to enhance self esteem. Common to all seven subjects was a need to manage the uncertainty of "not knowing". Learning was found to be both didactic (content) and non-didactic (process). Dynamic factors that facilitated learning were the development of the learning alliance, the emergence of an optimal learning environment, the interactive nature of the consulting relationship and the length of time in consultation. In addition, a complementarity between learning and self-development was found which encouraged growth on both a personal and a professional level. Growth was defined by consultees as change in their thinking, feeling, attitudes and/or actions which increased their competence. The nature and extent of this change was related to length of time in consultation and the relationship between consultee expectations and the consultant's approach toward realizing those expectations. Implications for practice and future research are suggested.

THE CALIFORNIA INSTITUTE FOR CLINICAL SOCIAL WORK

We hereby approve the dissertation

Clinical Consultation in Social Work:

An Exploratory Study of a Dynamic Learning Model

by

Nancy L. Saks

candidate for the degree of

Doctor of Philosophy in Clinical Social Work

Doctoral Committee

Beatrice A. Sommers Chairperson	Ph.D. title	5/16/89 date	Beatrice A. Sommers signature
Sylvia Sussman Committee member	Ph.D. title	5/12/89 date	Sylvia Sussman signature
Gertrude Harrow Clemens External member	Ph.D. title	5/16/89 date	Gertrude Harrow Clemens signature

This study is dedicated

in memory of my father,

Harold Saks,

who taught me how to be

playful.

ACKNOWLEDGMENTS

The acknowledgments for this study should include all the significant people in my life. I can name here only those who directly helped to make this inquiry possible.

First, my appreciation to the subjects of the study. Their ability to be so open about their learning, and the manner in which they shared their growth, deepened my own.

Next, I am grateful to my committee members for their special contributions to the work.

Dr. Beatrice Sommers, chairperson, who provided a collaborative consulting relationship and supportive friendship. Her common sense approach and ability to make that which is difficult appear "simple", have greatly influenced me. My heartfelt appreciation and gratitude for such a meaningful learning experience throughout my years of affiliation with the Institute.

Dr. Sylvia Sussman for her meticulous research expertise and wisdom. Her ability to provoke and challenge my ideas helped organize and clarify the study. I am appreciative of her time and guidance.

Dr. Gertrude Harrow Clemens for agreeing to be on my committee and for her thorough and thoughtful evaluation of my material. I continue to value the benefit of her experience and expertise, in my personal and professional development.

Dr. Jennifer Munnell Rapaport for unfailing encouragement, and responsive and resonant editorial consultation.

Dr. Bruce Gale for generously offering his time and computer knowledge.

Acknowledgement and appreciation are extended to my family and friends. Their acceptance of my long working hours and provision of unshaken faith in my capabilities, in spite of my own doubts, helped me remain determined to complete this project.

Special thanks to my mother, Estelle Saks, who was there when called upon and needed. My brother, Richard Saks, a reliable friend who, with delicious humor, helped me enormously. Brother, David Saks, and sisters-in-law Maggie and Janice, as well as nephews Joshua, Jeremey and Michael who have patiently tolerated my absence.

Step-daughters, Kelli Hammond and Kendra Shinn for their steadfast belief in me, and that the project would be completed. I continue to be profoundly moved by the mutuality of our love, and friendship.

For his wisdom, attunement, and spontaneity I want to especially thank Dr. Timothy B. McCaffrey. He has lovingly helped me to learn not to take myself so seriously and to recognize what it is that I "know" and "don't know". I have been genuinely touched by the constancy of his sustenance.

I am appreciative of the gracious helpfulness and

reassurance offered by Irene DiRaffael. Her empathic befriending helped me endure the total immersion and consuming involvement this project demanded. Most of all, she helped me learn that a style is a style is a style.

To my buddy and fellow author, Deborah H. Kahane, who assisted in the "dress rehearsal" for the interviews. Her frolicsome nature and compassion were bountiful.

I am greatly indebted to my stimulating colleague, Dr. Loren D. Woodson, who throughout the years has succored my professional and personal development with generous offerings of time and encouragement.

For her understanding and support, I wish to thank Dr. Judith Simon. Her critiques of the early drafts of the proposal were most helpful.

My special family of friends, Chris, Peter, Heather and Annie Weingold and Renee, Joshua and Jessica Kaplan were always patiently there during the "4 D's." I am particularly grateful for the acceptance and consistent experience of belonging offered by Dr's. Monica Deitel, John Altman, Dr. David and Debbie Sack, and Brian and Beverly Conlan.

Finally, a very special pat on the back for Irv, who never left my side and a moment of tender reflection for Sally, who would have been there had she been able.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER I

INTRODUCTION

"Learning throughout life is a nurturing process, in which the individual seeks, participates, contends, aggressively demands, or passively expects" (Towle, 1954, p.65).

Most clinicians tend to see consultation as an integral component of clinical practice and value its contribution to professionalism and continued growth. When a social work clinician seeks a social work consultant, a particular type of experiential learning encounter is desired.

The experience and process of learning within the clinical social work consultation model is unique for several reasons. First, consultation is at the request of the consultee. Secondly, it is the consultee who identifies the areas for discussion and who determines its usefulness. The consultant then must work with the consultee's material to understand and clarify the nature of the problem presented given the accumulated life experience and training of the consultee. Learning, to a large degree, is contingent upon the motivation of the consultee and upon the consultee's ability to implement what is learned to enrich his/her current understanding of theoretical issues and/or clinical technique. Learning takes place within the context of a helping relationship that is both collaborative and advisory in nature. Thus, clinical social work consultation is potentially a multi-level learning experience for self

development that can include aspects of professional and/or personal growth.

The clinical consultation model incorporates elements of social work education and training. More specifically, social work education stresses the importance of addressing the whole person, including an appreciation for the life experiences brought by the student/clinician. The educational process then, is a profoundly personal one that 13 fosters emotional, social and psychological growth (Reynolds, 1942; Towle, 1954). Reynolds captures the essence of the process when she observes that learning is a dynamic, enduring, ever-changing experience involving taking new experiences into the self and deeply and intensely reflecting on them in order to make them one's own. Towle (1951) adds that when a clinician seeks consultation to further his/her learning needs, s/he is selecting a process that is not only designed for the person who is to learn but for the situation that is to be mastered.

Clinical social work education as a practice based approach is consistent with adult learning theory (Houle, 1972; Kidd, 1973; Knowles, 1980; Lindeman, 1936, 1962; Rogers, 1969; Tough, 1967, 1971) in its emphasis on learning, rather than teaching. Practice learning occurs within the context of the supervisory setting of the field placement. Within this one to one relationship with the supervisor, the student/clinician begins to develop a conscious

awareness of what is actually known, and more specifically, an awareness of what is yet to be mastered. Similarly, within the consultation relationship the intent is to clarify the needs of the consultee and to tailor the consultation accordingly. It is therefore imperative that the consultant and consultee determine the sources of the questions raised. That is, does the consultee lack theoretical knowledge to deal with the problem, and/or does the consultee have the knowledge but cannot for some reason utilize it? Is it a lack of personal experience, and/or professional development?

Adult learning theory can provide a theoretical framework for clinical social work education and training and also serve as a theoretical base for clinical social work consultation. There is one model of adult learning that seems to pertain specifically to the clinical consultation setting. This model, Andragogy, developed by Knowles (1970a, 1970b, 1972, 1975, 1980), suggests that the most meaningful learning occurs when the learner experiences a need to know something. Learning is seen to involve not only the intellect, but "feelings and/or personal meanings which have relevance for the whole person: It is significant, meaningful and experiential learning" (Rogers, 1969, p. 4). Motivated by the need for knowledge for immediate application, the adult learner often seeks a collaborative relationship in which s/he can actively

participate (Kadushin, 1977; Knowles, 1980; Rogers, 1969; Tough, 1967, 1971). The significant other in the learning relationship is considered to be a facilitator of learning, not a fountain of information as in traditional education (Knowles, 1970a, 1970b, 1980; Rogers, 1969).

Statement of the Problem

Though social work consultation is assumed to be non-didactic, collaborative and experiential, existing research approaches this learning experience as if it was primarily a didactic one. Moreover, social work clinical consultation is a modality of service that sprung from clinical practice rather than from a theoretical base. This may help to explain why the research addressing social work consultation does not consider learning within a theoretical context. Indeed, the research tends to focus on process dynamics, specific phases and effectiveness of the consultation without a theoretical frame (Grady, Gibson, & Trickett, 1979; Mannino, 1969b, 1986; Mannino, McLennon, & Shore, 1975; Mannino & Shore, 1971). The data, for the most part, is derived from survey and effectiveness studies completed in human service settings where the consultation service is provided for the consultee. None of the studies attempt to define the nature of the learning experience as it occurs between social work clinicians working dyadicly where one has sought consultation and has assumed the responsibility for payment.

In terms of existing research, studies addressing the effectiveness of consultation are limited. That is, most studies attempt to measure specific knowledge goals. Goals are defined in terms of specific learning, learning of theoretical knowledge, learning of skills or learning about focusing on a particular problem. While an effort is made to see the goals in terms of specific objectives, findings in terms of defining general measures of effectiveness are not significant. Finally, since the existing research is atheoretical, is it not premature to attempt to address the process of consultation and/or its efficacy?

It is suggested that social work education, specifically within the context of clinical consultation, does indeed have a theoretical base within adult learning theory. More specifically, the theoretical point of view offered by Andragogy, a model of adult learning developed by Knowles seems to pertain.

Purpose

The purpose of this study is to explore the process of clinical consultation from the consultee's perspective in order to describe the specific elements that further learning. An effort was made to determine if the consultee perceived multi-level learning (learning for self development that included professional and personal growth) within the context of the consultation experience. These elements were understood within the parameters of social

work education as it pertains to clinical consultation and Andragogy.

Central Research Questions

The central research questions were designed to help elucidate the nuances of what transpires within the clinical consultation process and to demonstrate that this can be understood within the context of adult learning theory, most notably, Andragogy. The literature suggests that Andragogy as a theoretical model is consistent with the clinical social work consultation experience. Accordingly, the following questions are posed:

1. What are the dynamic components of the consulting experience that facilitate adult learning?
2. Can one identify what is actually learned in consultation and the factors that influence the learning process?

For the purpose of this study, clinical consultation is defined as a time limited, collaborative relationship between two clinical social workers, working dyadicly. The consultant is selected by the consultee, is more experienced and is paid a fee. It is assumed that consultation is a non-didactic, experiential, and dynamic learning process that facilitates cognitive and affective learning. Further, clinical consultation is seen as a clearly recognizable activity which uses the helping relationship as its base. In this study it is differentiated from supervision and

psychotherapy. Supervision is an educational experience in which one person is accountable and responsible for the professional training and performance of the other. Psychotherapy has a treatment focus and intent.

Significance

It is hoped that this study will increase our understanding of the consultation experience as it is utilized by social work clinicians. Clarification, in turn, may enable consultants to function more effectively. Additionally, it is hoped that this study will stimulate discussion and increase self awareness among the users and providers of social work clinical consultation. Finally, suggestions for further research are presented.

Summary

In the current study the nature of the learning process within the clinical consultation experience is examined. The consultee's perspective of his/her own experience is explored and an emphasis is placed on what was actually learned together with what the consultees described as the components of the consulting process that facilitated their learning.

As a learning model, Andragogy provides the theoretical context for the analysis and interpretation of the data. A qualitative research design is used. Semi-structured, in-depth interviews were conducted with seven social work consultees who were interviewed individually. The broad

range of data produced is analyzed for emergent themes common to the learning experience of the subjects. The analysis is both descriptive and comparative. New categories and themes were generated.

Presentation of the Dissertation

In Chapter II relevant literature pertaining to clinical consultation, social work education and training, adult learning, and consultation research is reviewed. The qualitative research design and constant comparative method of investigation are discussed in Chapter III. A description of the consultee's learning process over the course of the consultation experience follows in Chapter IV. In Chapter V, it is demonstrated that Andragogy is an appropriate theoretical base for clinical social work consultation. The relationship of these findings to Self Psychology together with implications for clinical practice and future research are also discussed.

CHAPTER II

LITERATURE REVIEW

Introduction

It is assumed that consultation between social workers is a collaborative and experiential process, and that in this form of adult learning a non-didactic model is operative. Based on our understanding of how learning is viewed and implemented by social work educators (Reynolds, 1942; Robinson, 1949; Towle, 1954) one might conclude that Knowles' (1970a, 1970b, 1972, 1975, 1980) learning model, (Andragogy), would be applicable to learning in a social work consultation setting. However, research studies of consultation appear, on the whole, to approach this type of learning experience as if it was a more didactic one (Aiken, 1957; Rieman, 1963; Rosenthal and Sullivan, 1959).

Before we can look at social work consultation within the context of an Andragogical model, it is first necessary to understand the nature of social work clinical consultation as well as its perspective of adult learning. It will become evident that the social work position is incongruent with existing research which presupposes that adult learning is a didactic process and that efficacy can be determined without a theoretical frame. Finally, Andragogy, a formal model of adult learning is described. Its relationship to the social work perspective of education is demonstrated. Indeed, it is seen as a theoretical

framework from which to explore the learning that takes place within the course of the clinical consultation process.

Clinical Consultation

For more than a century, consultation between social workers has been an integral aspect of social work continuing education. Consultation began with the founding of the Charity Organization Societies in the 1870's and the establishment of settlement houses a decade later (Goldmeier & Mannino, 1986; Kadushin, 1977; Kutzik, 1978). In spite of this impressive tenure, explicit identification of a methodology inherent in social work consultation was not forthcoming until after the second World War. It was with social work's increasing collaboration with psychiatry, the expansion and specialization of social service programs and the development of community psychiatry that a distinguishable identity for social work clinical consultation emerged (Gilmore, 1963; Gorman, 1963; Kadushin, 1977; Siegel, 1963; Smith, 1975).

Traditionally, social work clinicians employed in child guidance clinics, family service agencies, community mental health centers, and in private practice sought clinical consultation from psychiatrists. The role of the psychiatrist/consultant was to assist, through clinical and educational functions, in the clarification of the psychodynamics of cases, and formulation of diagnoses and treatment plans.

Improved understanding of technical problems encountered in case management and reassurance and support were additional benefits that the social worker/consultee received from the psychiatrist/consultant (Bartlett, 1961; Boehm, 1956; Coleman, 1947, 1953, 1968; Kadushin, 1977; Kutzik, 1978; Leader, 1957).

Today, clinical consultation occurring between social work practioners is founded on a psychodynamic perspective as articulated by pioneers in traditional mental health consultation (Bindman, 1959, 1966; Caplan 1955, 1959a, 1959b, 1963, 1964, 1970; Coleman, 1947, 1956). To be discussed below is the work of Caplan.

Caplan derived a typology for mental health consultation from his experience with youth programs in Israel (Caplan, 1955, 1959a) and his work at the Harvard Schools of Public Health and Medicine (Calplan, 1963, 1964, 1970) where he attempted to address the work related problems of schoolteachers, public health nurses and social workers. He developed a fourfold model that includes: 1)client-centered case consultation, 2) consultee-centered consultation, 3)program-centered administrative consultation, and 4) consultee-centered administrative consultation. Only the first two of these are relevant to the current study.

Client-centered case consultation is the traditional form of specialist consultation. The consultee's work

difficulty relates to the management of a particular case or group of cases.

The consultant helps by bringing his specialized knowledge and skills to bear in making an expert assessment of the nature of the client's problem and in recommending how the consultee might choose to deal with the case. "The primary goal of the consultation is for the consultant to communicate to the consultee how this client can be helped" (Caplan, 1970, p. 32).

Consultee-centered consultation is, according to Caplan, sought by the clinician as a means to improve his/her handling of a particular case. That is, it is an educational process designed to help the consultee understand and remedy work difficulties. Improvement in the client is a secondary gain. Discussion of the client's difficulties is used by the consultant as a vehicle to enhance consultee self awareness and self understanding and to identify and remedy whatever problems there may be with the client. The focus then, is both affective and cognitive:

> The consultee's difficulty may be due to lack of knowledge about the type of problem presented by the client, lack of skill in making use of such knowledge in order to answer the question, lack of self-confidence so that he is uncertain in utilizing his knowledge and skills, or lack of professional objectivity due to the interference of subjective emotional complications with his perceptual and planning operations (Caplan, 1970, p. 32-33).

The consultant must determine which of the above mentioned difficulties will be the focus of attention so as to effectively help the consultee. If the consultee's knowledge, skills, confidence and/or objectivity can be increased such that the consultee is enabled to be more effective with the client for whom s/he sought the consultation, it is anticipated that the consultee will be able to generalize from this learning opportunity and be able to apply this experience to similar cases in the future.

Of the four possible difficulties that the consultee may present, Caplan (1970) found that lack of objectivity seemed to be the most common problem the agency and institutions based consultees presented:

> The consultee's difficulty with his client is caused by defective judgment based upon a lack of professional objectivity and a loss of normal "professional distance." The consultee, as it were, gets either too close or too distant from one or more actors in the client's life drama, so that he is not able to perceive them accurately enough to carry out his task. Another way of describing the situation is that personal subjective factors in the consultee invade his role functioning, distort his perceptions, and cloud his judgment, so that in this current case he behaves less effectively than is usual for him and thus is not able to utilize his existing knowledge and skills. By the time he comes for consultation, this situation is usually aggravated by his feelings of confusion and frustration engendered by the impasse in the case and by a greater or lesser feeling of professional failure and consequent lowering of self-esteem, all of which add to his loss of professional poise (p. 131-32).

The Educational and Training Component of Consultation

The clinical consultation process has at least two components, teaching and learning (Smith, 1975). Towle (1970) suggests that the consultant advises, instructs and teaches the consultee and therefore should be knowledgeable of learning theory as well as the principles of teaching. Abramoitz (1958) agrees with Towle and states that the methods and principles of consultation must be based on an understanding of the teaching-learning process. Finally, Silverman (1974) and Strommen and Aleshire (1979) found that consultation tends to go beyond a collaboration. They suggest that it has a pronounced effect on promoting motivation for new learning.

Several studies have been conducted in an effort to identify the specific aspects of learning theory and teaching essential to consultant competence. Lippitt and Lippitt (1978) obtained data from 32 consultants regarding their own estimation of key areas of consultant competencies. Three significant areas were identified as knowledge, skill, and attitude. However the range within each area was vast. As the Lippitts note, "Any list of the professional capabilities of a consultant is extensive--something like a combination of the Boy Scouts' laws, requirements for admission to heaven, and the essential elements for securing tenure at an Ivy League college" (p. 94). Nonetheless, the Lippitts did attempt to delineate each of the three areas.

Knowledge areas:

1. Knowledge of educational and training methodologies.
2. Knowledge and understanding of human development.
3. Knowledge and understanding of human personality, attitude formation and change.
4. Self knowledge of ones motivations, strengths, weaknesses, and biases.

Skill areas:

1. Communication skills: listening, observing, identifying and reporting.
2. Teaching and persuasive skills: ability to effectively impart new ideas and insights and to design learning experiences that contribute to growth and change.
3. Counseling skills to help others reach meaningful decisions on their own.
4. The ability to form relationships based on trust and to work with a great variety of people from different backgrounds and personalities.
5. The ability to use a variety of intervention methods and
6. to diagnose problems with a client, to locate sources of help, power, and influence, to understand a client's values and culture, and to determine readiness for change. And, finally,
7. the ability to be flexible.

Attitude areas:

1. Attitude of a professional: competence, integrity, feeling of responsibility for helping clients cope with their problems.
2. Maturity: self confidence, courage to stand by one's views, willingness to take necessary risks.
3. Open-mindedness, honesty, intelligence.
4. Possession of a humanistic value system: belief in the importance of the individual. (Lippitt & Lippitt p. 96-97)

While the knowledge and skill areas are important, to be sure, the more personal qualifications of the consultant have received the most attention, perhaps because of the profoundly interpersonal nature of consultation (Kenney, 1986). For the most part, the research looks at these attributes in terms of client satisfaction and consultee

effectiveness. For the purposes of this study, only role definition, consultant selection, and the consulting relationship will be discussed.

The Role of the Consultant

In general, the consultant must be nonjudgmental, empathic, trustworthy, and have the ability to relate in a purposeful manner (Towle, 1970). S/he should be able to develop rapport and working relationships and be at home with his/her expertise and authority. Moreover, the consultant should possess an analytical mind and the ability to be flexible, generate enthusiasm for new ideas, and confidence in his/her own work. Finally, the consultant should possess sufficient professional education and experience, knowledge, and skill basic to the utilization of a problem-solving approach, and the ability to establish and sustain a purposeful working relationship.

During the course of a consultation, the role of the consultant may vary from moment to moment depending upon what seems to be most appropriate for the client, the situation, and the helper's own style (Gibb, 1959; Lippitt & Lippitt, 1959; O'Keefe, 1958). Lippitt and Lippitt (1975) have developed a descriptive model that presents the consultant's role along a directive/nondirective continuum that alternates contingent upon changing circumstances:

> Behavior varies in its degree of directiveness. In the more directive consultant role, the consultant assumes leadership and directs the activity. In the nondirective mode, the consultant provides

> data for the client to use or not, as a guide for the client's self-initiated problem solving. These roles are not mutually exclusive but may manifest themselves in many ways at any stage in a particular client situation. We see these roles as spheres of competence rather than as a static continuum of isolated behavior (p. 29-30).

This nondirective/directive continuum proceeds from reflector/, process counselor/, fact finder/, alternative identifier and linker/, joint problem-solver/, trainer-educator/, informational expert/, and advocate.

A study that helps to illustrate the Lippitts' continuum is a survey of social work consultants done by Kadushin and Buckman (1978). Respondents were asked for a brief description of their most recent experience in consultation and then sought an explanation of what the consultant did to help the consultee. Subjects were members of the National Association of Social Workers who listed consultation as the primary function of their job. A 21 page questionnaire mailed to 970 social workers received a 60% response rate (483 complete and usable surveys). In terms of demographics, 64% were female and 36% male with a mean age of 47 years. Ninety five percent (95%) of the respondents achieved an MSW or higher, and each had 15 years paid experience in social work and 10 years as a consultant.

The questionnaire contained a list of possible interventions. Subjects were asked to check those they had used in their last consultation. More than twenty-three percent (23.5%) stated that they provided information or acted as a

resource person while twenty-one percent stated that they helped the consultee to identify and clarify the problem by asking appropriate questions. More than nineteen percent (19.6%) reported helping the consultee to think of different ways to resolve the problem. Listening carefully, making suggestions and offering advice were noted by 14% of the sample, while more than ten percent (10.5%) noted that they provided an opportunity for consultees to express their anxieties and frustrations. Those reporting a personal difficulty that was interfering with a work related problem accounted for more than three percent (3.6%) of the responses. The remaining two percent (2%) of the consultants attempted to educate or motivate the consultee toward a more effective use of consultation.

The multi-dimensional role of the consultant can be understood, at least in part, by the variety of reasons reported for seeking consultation and the consultant's effort to address these needs (Caplan, 1970; Kadushin & Buckman, 1978; Robbins & Spencer, 1968). Caplan (1970) suggests that the principal motivating factor for seeking consultation is the need for help with a work-related problem. The problem however may have a number of different dimensions including seeking consultation: to share the emotional burden and responsibility for a difficult decision, to gain acceptance and support from a

knowledgeable expert, or, inappropriately, to seek help with one's own personal problems.

In their 1976 survey, Kadushin and Buckman (1978) reported on the motivation for seeking consultation from the consultant's perspective. They found that the most significant factor was the consultee's recognition that s/he had a problem and needed help. An outsider's objective assessment was the second most reported motive.

Finally, in their 1968 study, Robbins and Spencer found three factors to be the most frequently mentioned motives for seeking consultation. They were: to be helped to solve a specific problem, to obtain information, and to build technical skills. Moreover, forty-seven percent (47%) of the consultees noted that the consultant should "present direct, concrete answers" (p. 363). Findings suggest that motivation and desired intervention presuppose a didacticly oriented process. This structured format may reflect, at least in part, a desire to have the consultant help them contain their anxiety.

Regardless of the specific role of the consultant and/or the motivation for seeking consultation, there is unanimity among all writers in the practice of consultation that the consultant must accept and encourage the consultee's freedom to accept, modify, and/or reject his/her counsel.

Selection of the Consultant

Little specific information about criteria for selecting a consultant has emerged from the research except in the more general studies of the consultant-consultee relationship, particularly as it pertains to the realm of business.

Included in the criteria for the selection of the consultant are expertise, specific personality traits, familiarity with or referral from a trusted source, and/or the congruence of goals among both participants in the consultation (Alpert, 1981; Frankenhuis, 1977; G. Lippitt, 1959; R. Lippitt, 1959; Lippitt & Lippitt, 1975, 1978). Moreover, a "goodness of fit" (Glidewell, 1959) in terms of both congruence in values and complementation of roles, including the resolution of conflicts, seems to be essential.

The Consulting Relationship

Given the anxiety likely to be present when consultation is sought, it seems to be essential that the consultant provides an opportunity for learning to take place within the context of a relationship that, as noted above, may bring about a change in feelings, attitudes, thinking, and/or action. More specifically, consultation is a special instance of the more general category of interpersonal interactions between a person seeking help and a person offering help (Galleisch, 1982; Kadushin, 1977). That is,

the consultant-consultee relationship is a professional one that is influenced bi-directionally. It requires mutual cooperation and effort on the part of both participants in order to achieve a positive learning alliance.

While the consulting relationship appears to be a crucial factor affecting the outcome of a consultation, the specific components of the relationship are very difficult to analyze. In general, the research suggests that there must be a high level of congruence between the role expectations and the task perceptions that the consultant and consultee bring to the relationship. Age, sex, professional training, and therapeutic orientation have all been examined as possible determinants of effective outcome but the results are either contradictory or equivocal. Significant factors are discussed below.

Caplan (1970) suggests that the emotional relationship that develops between the consultant and consultee is essential to consultation outcome. "This (relationship) not only motivates the consultee to maintain the contact but is the vehicle for the consultation process itself" (p. 81). Medway (1979) also identified the positive learning alliance as the key to successful consultation. Indeed, the consultant must convey a sincere and nonjudgmental attitude. A safe environment which is growth oriented and encourages spontaneous input by the consultee is thus provided. Once mutual trust is established, feelings and thoughts can be

openly expressed. Similar to, yet distinct from the therapeutic relationship, the consultant begins at the consultee's ability level.

Factors essential to beginning at the consultee's level were identified by Hansen (1964) in his study of psychotherapists as consultants. First, the consultant must know what s/he knows and what s/he does not know. Second, s/he must answer the question asked, and not some question that exists in his/her own mind. Third, s/he must realize that the request for consultation implies anxiety in the consultee. Hansen concluded that these factors serve as organizing principles for the consultant and influence the directionality of his/her approach.

James et al. (1986) found that giving information, relating to the consultee in a supportive manner, and generally being able to give what the consultee requests were essential to consultation outcome. Moreover, the importance of the consultant's preventing the consultee from feeling intimidated and losing self respect was stressed. Similarly, Parker (1962) determined that offering emotional support to the consultee suffering from incipient anxiety and/or guilt was important to consultation efficacy.

In their study of consultation to a social service agency, Robbins and Spencer (1968) identified complimentary consultee and consultant behavioral patterns as being essential to effective consultation. They suggested that

efforts to define the presenting problem and diagnose educational needs draw upon the consultant's knowledge and skills which are directed toward understanding the consultee's difficulty in dealing with the problem. The development of this interactive process was found to emerge in phases. During the "expositional" phase, the consultant listens as the consultee presents information. In the "reactive" phase, the consultant attempts to clarify and offer suggestions concerning the presenting problem, the patient's current situation and the consultee's dilemma in dealing with it. Robbins and Spencer suggest that the dialogue inherent in this phase facilitates complementarity in consultant/consultee behavioral patterns which in turn effects outcome.

Perhaps the most complex form of complimentarity is parallel process. In Doehrman's (1976) study of the supervisory process, she identified this form of interpersonal interactions as being essential to effective consultation. More specifically, transference and countertransference within both the supervisor/supervisee and supervisee/patient dyads influence these relationships in a cybernetic fashion. Understanding this interaction in turn has the potential to facilitate the patient's treatment.

Finally, Caplan (1970) determined that sharing the burden of a difficult case(s) and receiving support and

encouragement from an "expert" or "authority" increase the consultee's confidence in himself and in his role. Gaupp (1956) suggests that the consultant has informal or ascribed power because he is considered to be an expert and brings with him the influence of his ideas and knowledge. Maddux (1955) adds that while there is no directive authority, there is the authority of the consultant's knowledge, special skill, and professional conscience. Similarly, Kaslow (1978) posits that the consultant's authority is inherent in his/her expertise, competence and comportment.

Green (1983) concludes that, "the sine qua non of consultation skill is effective management of the consultant/consultee relationship" (p. 75). Smith (1975) adds that the consultant must have an understanding of and a proficiency in the methods, processes, procedures, and techniques related to maintaining a relationship.

Social Work Education and Training

Much of the social work literature addressing the process of learning at the beginning stages of professional development pertains to the experienced practioner who seeks clinical consultation. There are several aspects of this literature that are relevant to the current study, most notably, the philosophy of social work education and the nature of the adult learning process.

Intrinsic to the social work philosophy of education is the perspective that learning is a dynamic, and ever-chang-

ing process. Further, education is seen to be a lifelong endeavor with the intent of helping one to adapt and to change. That is, the individual is valued as a human being with potential for growth. More specifically, the goals of social work education and training are to increase understanding, extend knowledge and have the student acquire and expand skills. Optimal conditions for the realization of goals include: (1) beginning at the student's current level, (2) accepting and using past experience to increase current education and training, and (3) continuing to supplement new learning as it is assimilated and applied (Reynolds, 1942). Learning then, is a process that involves the whole person with regard to his/her affectual and cognitive states.

One specific aspect of social work education is learning clinical skills. Like social work education as a whole, learning clinical skills has both a cognitive and an affective component (Amacher, 1976; Clemence, 1965; Ekstein & Wallerstein, 1958). Further, clinical learning is often an emotional experience that takes place within a feeling state. Clinical training focuses upon the person who is to learn in addition to the situation that is to be mastered.

The learning process for practioners is best described by Reynolds (1942). She delineates a five stage process in which conscious attention facilitates the necessary assimilation and mastery of knowledge and skills. Within each stage the experience of the learner and the concomitant role

of the teacher is described. In the first stage, insecurity is aroused by the new and unfamiliar situation. If danger is perceived, there may be feelings of inadequacy followed by a retreat to familiar response patterns in an effort to regain a sense of security. The instructor's role during this stage of learning is to assist the learner in regaining his/her equilibrium with security-giving interventions. In the second stage referred to by Reynolds as "sink-or-swim", the learner's preoccupation with him/herself is somewhat lessened by an awareness of the instructor's expectations. Nonetheless, fears and rigidities may prevail. During this stage there may be considerable dependence upon the approval or disapproval of the instructor. Through reassurance and mobilization of existing knowledge and skills, the instructor encourages the student to trust and use his/her spontaneous responses. As trust develops, the student begins to "find" him/herself.

In the third stage, there is a lessening of the preoccupation with the self and an increased ability to concentrate on the situation as it is. This is an organizing period when new ways of working are consciously beginning to be mastered and assimilated. The acquisition of skills may be uneven. The role of the instructor is to reassure and help the student see him/herself realistically. According to Reynolds, relative mastery occurs during stage four. Conscious intelligence and unconscious responses work

together. There is a sense of understanding and control. What was new initially is now familiar and the student can begin to use him/herself as his/her own instrument. In the final stage, one learns to teach what has been mastered. There is a shift in preoccupation from subject matter to an ability to understand and empathize with the difficulties of the person who is now learning.

Sommers (1979) cogently observes that the student needs to learn to develop the self-awareness that is essential to the therapeutic task. To achieve this, the educational process must be highly individualized and accommodate the student's unique readiness for self understanding in relationship to others. Learning then, is essentially an ego process involving the total personality (Bandler, 1963; Clemence, 1965). Indeed, Ekstein (1969) comments that mature learning is learning for the sake of learning rather than for approval, love and external rewards. He believes that a psychoanalytically oriented learning and teaching philosophy provides a system which promotes experiences for growth. Similarly, Towle's (1950, 1951, 1953, 1954, 1970) understanding of learning, which is essentially an ego psychological perspective, suggests that learning patterns are related to maturational processes reflecting the student's struggles to master new content. Learning occurs:

> ...in light of understanding of human needs, wants and strivings, in terms also of knowledge of growth and development and in relation to knowledge of the part played by environmental pressures

> and cultural conditioning on personality formation. Theories of behavior are theories of learning (1954, p. xv).

Borrowing concepts from John Dewey and Alfred North Whitehead, Towle emphasizes the establishment of an enduring learning process that stresses individuation, the concept of the whole person, a person-centered approach (as distinguished from a subject or procedure-centered approach), the place of emotions in learning and the importance of self-activity and the freeing of the individual for expression of his/her capacities (Towle, 1954). Agreeing with Towle, Bandler (1963) stresses that learning is mediated by the ego and that educating the professional social worker requires an integration of intellectual understanding and affective comprehension.

The Student/Teacher Relationship

The student/instructor relationship in the clinical training of social workers is noteworthy. Serving as the vehicle for clinical learning in social work training, the student is encouraged by a mentor, a person who has the distance and objectivity, to see the gestalt. Towle (1954) notes that it is the "individual and collective teaching, helping and administering relationship with the student that is the core of his preparation for the professional relationship" (p. 21). She adds that it not only helps the learner:

> to work purposefully with people in ways appropriate to the profession... but also facilitates the

> development of... the helping relationship between practitioner and recipient, ... collaborative work with colleagues,... and... relationships with subordinates and persons in authority within his/her own professional hierarchy" (p. 21).

Neither dependency nor identification are fostered, although their presence is accepted as natural responses to the situation. That is, the relationship between the learner and teacher provides the medium for growth. A good teacher appreciates the student's individuality, avoids intrusion between the learner and the content and provides, within the parameters of the relationship, a facilitating environment that affirms the student's growth by strengthening ego and superego integration.

The mentor/student relationship can develop in a number of ways. Clemence and Allan (1960) discuss teaching case-work theory in terms of utilizing the transference as a means of increasing the student's self-awareness, security, and learning readiness. It is within this mentor relation-ship that the student must adapt to changes in him/herself and the environment, attempting all the while to balance and titrate his/her anxiety and regression in the service of the ego and the learning tasks.

In addition to the above noted anxiety associated with change inherent in the learning process, there is also the anxiety that stems from "not knowing". Recognizing and identifying what one "doesn't know" requires self awareness and the ability to determine a plan of action to find out.

The outcome of learning once one has decided to seek help is determined by the individual's motivation, capacity, and the opportunity afforded to attain his/her aims.

> Thus, throughout the student's educational experience, educators aim to afford him a relationship which affirms growth through strengthening the ego-superego integration. This implies a relationship which affords security with out fostering dependency, one which energizes his emancipation from old authority-dependency ties, hence one which widens his relationship span and patterns him to individualize those whom he serves. Such a relationship eases the anxiety and tension implicit in learning to become a helping agent and lowers the need for defenses. As the student is enabled to contain anxiety or to deal with it in ways which do not complicate learning, his emotions become purposively engaged. He thus becomes increasingly perceptive, selective, self-aware, self-regulative, objective in his relationships, and realistic in his goal striving. The relationship with mentors thus serves as one means to widen the student's integrative capacity, so that it may equal and exceed the task. As this occurs, he gains increased confidence through competent performance and has some margin for creative effort (Towle, 1954, p.156).

Clinical training within social work education is very complex indeed. The teaching process is designed to help the student grow in a step-wise progression that fosters mastery of the content and integration of the ego. One may question these basic principles in terms of their theoretical underpinnings and their empirical validity. Can they be understood in terms of what we know about the adult learning process? It is to this that we now turn.

Adult Learning

Characteristics of Adult Learners

The research suggests that the adult learning process differs from that of children. Kadushin (1977) notes that adults have the ability to postpone gratification, to participate on a maximal level, to possess a long attention span and to possess the ability to relearn, unlearn and to seek new learning. Knowles adds that:

> As individuals mature, their self-concept moves from one of being a dependent personality toward being a self-directed human being; they accumulate a growing reservoir of experience that becomes an increasingly rich resource for learning; their readiness to learn becomes oriented increasingly to the developmental tasks of their social roles; their time perspective changes from one of postponed application of knowledge to immediacy of application, and accordingly, their orientation toward learning shifts from one of subject-centeredness to one of performance-centeredness (Knowles, 1980, p. 44-45).

Knowles concludes that the self-directed adult learner is an active initiator who brings to the learning experience his/her own background, style, and values. He/she is engaged intellectually and emotionally and moves at his/her own speed prompted by internal processes.

Lindeman (1936, 1962), a pioneer in adult education who had a direct impact upon the practice of social work, also stresses the importance of being motivated by one's internal processes:

> I am conceiving of adult education in terms of a new technique for learning, a technique as essential to the college graduate as to the unlettered manual worker. It represents a process by which

> the adult learns to become aware of and to evaluate his experience...My conception of adult education is a cooperative venture in nonauthoritarian, informal learning, the chief purpose of which is to discover the meaning of experience; a quest of the mind which digs down to the roots of the preconceptions which formulate our conduct; a technique of learning for adults which makes education coterminuous with life and hence elevates living itself to the level of adventurous experiment" (p. 53).

Lindeman, like Knowles, suggests that life is a perpetual experience of active learning. That is, adult learning is an actively acquired process that occurs through absorption and interpretation of experience and seems to be valued more than that which is acquired passively (Brunner, 1959, 1961; Knowles 1972, 1975, 1980; Rogers, 1969). Similarly, Carl Rogers (1969) in Freedom To Learn cogently observes that experiential learning:

> Has a quality of personal involvement--the whole person in both his feeling and cognitive aspects being in the learning event. It is self-initiated. Even when the impetus or stimulus comes from the outside, the sense of discovery, or reaching out, of grasping and comprehending, comes from within. It is pervasive. It makes a difference in the behavior, attitudes, perhaps even the personality of the learner. It is evaluated by the learner. He knows whether it is meeting his need, whether it leads toward what he wants to know, whether it illuminates the dark area of ignorance he is experiencing. The locus of evaluation, we might say, resides definitely in the learner. Its essence is meaning. When such learning takes place, the element of meaning to the learner is built into the whole experience (p. 5). (underlines are the authors)

The Role of the Facilitator

Possessing mastery of a particular skill, or knowledge of subject matter is not sufficient criteria for a facilitator nor will acting as merely a transmitter of information suffice. Knowles (1972, 1975, 1980) sees the critical function of the facilitator as creating a rich environment from which the student can extract learning and then guiding the interaction so the student can maximize learning from it. Kidd (1973) lists the qualities of genuineness, trust and respect, and the ability to sensitively and accurately listen as essential to the role of the facilitator. Similarly, Tough (1967, 1971) in a study to determine how adults learned "naturally", that is, without a teacher, found that in the learning experience the adult learner almost always turned to somebody for help. The helpers were generally people who were not trained as teachers. Unencumbered by pedagogical theory, they were, according to Tough, more readily able to follow the adults' natural sequential steps of learning.

The facilitator then, focuses attention on the learning process. S/he must be aware of and help the learner articulate the learning need (even, and especially, when the need isn't exactly clear in the mind of the learner). Additionally, the facilitator should be aware that there is often tension aroused by the need. The facilitator is therefore not a transmitter of content, but a facilitator of the

learner's inquiry. As an engaged facilitator of learning, rather than a "remote expert", the facilitator is often viewed as a more authentic person and a co-learner in the transaction.

Kidd (1973) concludes that the instructor raises relevant questions and develops habits of self-questioning, clarifies difficulties, demonstrates processes, draws parallels or finds relationships, reflects feelings, expresses agreement and/or support, and develops the learner's capacity for self-evaluation.

Andragogy, A Model of Adult Learning

Andragogy is a theory of adult learning developed by Knowles (1970a, 1970b, 1972, 1975, 1980) that effectively integrates educational and psychoanalytic theory in a way that is useful to clinical social work training. According to Knowles (1980), adult learning theory is an active process. That is, learning implies change. Change may occur in terms of more effective performance and/or skill, in behavior, or attitudes. Knowles posits that the deepest need an adult has is to be related to respectfully as a self-directed individual. The art and science of helping adults learn is self-directed inquiry or self-directed learning. Andragogy then not only emphasizes the psychology of learning, rather than teaching, but suggests that education is a lifelong process of continuing inquiry.

Knowles' (1980) model of Andragogy focuses on an

adult's need to learn how to learn, in contrast to a child's experience of learning how to be taught. Andragogy then is a process model that occurs within the context of a learning transaction between the learner and the facilitator of learning (otherwise known as the "teacher"). Each of the participants bring a set of assumptions and perceptions about one another, themselves and the situation. Knowles sees the educator's over-riding responsibility as helping learners to discover their need to know. In order to accomplish this task, Knowles maintains that the facilitator must create the proper conditions and provide the right tools and procedures. To address their assumptions and perceptions and to help learners acquire information and skills, Knowles (1980) outlined the following steps:

1. Establish a climate for learning.
2. Involve the learner in mutual planning for the time spent together.
3. Diagnose the learning needs.
4. Assist the learner to formulate learning needs into objectives.
5. Evaluate the learning outcome(s).

This model facilitates clarification of the essential, basic question--What are the learner's needs and how can the learning interaction be tailored accordingly?

The process of Knowles' Andragogical model is elaborated further in R. Lippitt's (1958) description of the phases which occur with planned change.

Phase I: The learner discovers the need for help, sometimes with the aid of the facilitator.

Phase II: The helping relationship is established and defined.

Phase III: The problem is identified and clarified.

Phase IV: Alternative possibilities for change are examined.

Phase V: Change is generalized and stabilized.

Phase VI: The helping relationship is ended, or a different type of on-going relationship is defined.

The motivation to learn is, according to Knowles (1972), generated internally by factors such as the desire to achieve, the urge to grow, to develop self-esteem, and to satisfy one's curiosity. The task and problem-centered learning experience is paced by the reality that each individual learner has a different level of readiness to learn. A heightened readiness to learn is often a response to the pressure one faces in coping with current problems.

Clearly, Knowles' humanistic approach to the understanding of complex dynamics of the growth and development of individuals within the context of their interaction with the environment, is very compatible with that of social work philosophy. Indeed, the Andragogical model appears to be analogous to the social work perspective on learning in numerous respects. A parallel can be seen in the shared view of learning as a dynamic, lifelong process. Social work education and training values the adult learner's potential for growth maximized by cognitive and affective

learning experiences. Both recognize the importance and place of emotions in the learning interaction. Another feature that appears to be shared by Andragogy and social work is the perspective that the motivation for learning is a function of the learner's experience. This reflects the person-centered approach rather than a subject and/or procedure centered approach.

The features of the learning situation that Tough (1967, 1971) found to be so critical to the learning needs of his subjects is comparable to the social work philosophy of education and training. Similarly, the ability not to interfere in the natural progression of a learner's path is reminiscent of Reynolds' (1942) position that educators can most effectively facilitate growth in learning by providing conditions favorable to it and by removing obstacles from the student's path.

Additional features shared by Andragogy and social work training are a basic understanding of the needs and interests of the learner, an awareness and understanding of the situation in which the student finds him/herself, and an appreciation and acknowledgement of the student's cumulative life experiences, together with an expectation of the full participation by the learner in the learning situation. Finally, both Andragogy and social work emphasize that the relationship is the vehicle for the learning experience.

Andragogy then not only appears to be analogous to the

social work view of education and training, but it appears to be an effective model for social work clinical consultation as well.

Assumptions that Andragogy makes about adult learners seem to be compatible with assumptions about clinical consultation. Both emphasize the affective and cognitive processes and the effects of those processes on interactions within and between individuals in interpersonal situations. Both suggest that people become ready to learn something when they experience a need to learn it. Finally, both Andragogy and clinical social work consultation suggest that adult learning is an active process in which change occurs. Since consultation is sought by the consultee, and since the consultee, by definition, takes responsibility for his/her learning by determining what is to be discussed, s/he enters the relationship with active participation and deep ego involvement.

Clearly, Andragogy provides a theoretical foundation upon which we can understand experiential learning within the context of the collaborative relationship that occurs during the course of clinical consultation.

Consultation Research

Empirical studies to date have not addressed the non-didactic learning process of the social work consultation experience. Rather, the research focuses on the process of consultation and its effectiveness. The studies discussed

below concern the professional and/or personal growth goals of the consultee. Enhanced professional growth is said to reflect an increase in knowledge, skill and/or objectivity while increased confidence reflects evidence of personal growth and may affect one's ability to be more objective. Consultee/subjects are comprised of social workers, teachers, and nurses. The consultant/subjects are primarily social workers.

The Consultation Process

Studies of the consultation process address the events that characterize the course of consultation. They include factors that both lead to and impede progress in consultation. They have also focused on factors which best describe the phases of the consultation process itself.

There have been two methodologies utilized in studying the process of consultation. Paper and pencil surveys attempt to gather data about the attitudes, opinions, or perceptions of the participants. Data collection generally occurs after the consultation and consists of primary data collected specifically for the research, and secondary data collected for other purposes, such as inclusion in case records. In each study the focus is identification of the elements of change. The second approach combines interactional analysis and participant observation in an effort to examine the actual behavior of the consultant and consultee during the consultation.

Several studies have attempted to understand the consultation process. Robbins and Spencer (1968) observed and analyzed the behavioral interaction of consultants and consultees who were concerned with program planning and implementation. They observed and tape recorded 35 ongoing consultations from a county health department. The subjects were 45 consultants from the State Department of Health and 82 county public health consultees. Included in each group were social workers, psychologists and nurses. The researchers were concerned with what happened during the consultation between the participants as well as what the levels of interaction looked like. Levels of activity for participants changed over the course of the consultation. They found that the participants behaved in a fairly identifiable and typical pattern. The complementary pattern evidenced itself in the following manner. In the early part, or expositional stage of the consultation, the consultee used most of the time giving out information. In the middle, or reactive stage, Robbins and Spencer found that the consultant became active by interpreting, clarifying and bringing perspective to the problem. The last stage, jointly used, was for summarizing, making decisions and, as needed, making future commitments. Tetreault (1968) also attempted to identify general characteristics of the consultation process and to identify whether school social workers emphasize the affective or cognitive needs of

teachers. A structured questionnaire was administered by means of a personal interview to 25 school social worker consultants. The importance of the consultant making contact with the consultee's affective needs in addition to their cognitive and educational concerns was identified and stressed. A significant relationship was found between the choice of a particular technique and a phase of consultation. Tetreault defined the techniques in terms of: sustaining procedures, ventilation, clarification, and direct influence. These techniques appear to be consistent with Robbins and Spencer's findings regarding levels of interaction and corresponding activity.

Similarly, Mannino (1969) in his study of the consultation process, asked social work consultants and social work consultees from a family service agency what they considered to be the helpful and nonhelpful aspects. He used a questionnaire immediately after the consultation to obtain the data. Both the consultant and consultee emphasized the importance of the consulting relationship. However, their evaluations appeared to be a function of their respective roles. That is, the consultees emphasized the affective component of the relationship while the consultant placed more of an emphasis on the development and maintenance of the relationship.

Aiken (1957) on the other hand, used case records of two family service agencies to study social work consultee's

perceptions of the process of consultation. She concluded that the consultant functioned primarily as a teacher. The educational functions of the consultant could be evidenced in a) the formulation of the client's personality structure, b) assessment of the client's functioning, c) specific recommendations for treatment, d) identification of the actual problems, and e) formulation of the prognosis. Absent from this study, which appears to be based on a didactic model, is an analysis of the learning experience as well as an assessment of the learning process itself.

Consultation Effectiveness

Inherent in the evaluation of the effectiveness of consultation are some highly complex problems. Studies measuring consultation effectiveness have generally been outcome studies that ask the question, Does it work? Some efforts have been made to determine the factors that hinder or facilitate effectiveness but there appears to be no general measures of success. Instead, criteria are derived from specific goals for a particular consultation. Evaluation tools and techniques measuring consultation effectiveness vary, but most are subjective and impressionistic (Kadushin, 1977; Smith, 1975). Moreover, Beisser (1974), Theimer (1972), and Argyris (1961) indicate that the effectiveness of consultation can only be assessed if the objectives can be ascertained. Accordingly, goal attainment

assessment is the method most commonly used to determine consultation efficacy (Kenney, 1986).

In a survey of empirical studies conducted between 1958-1972 that were designed to examine the effects of consultation, Mannino and Shore (1975) found that studies of goal attainment are indeed dependent upon being able to clearly define the goals one sets out to accomplish. Of these effectiveness studies, most focused on changes in the consultee and certain aspects of his/her personality structure or function. Positive change of some kind was found in 24 of the 35 studies (69%). Of the 23 studies that focused on consultee change either separately or in combination with other factors, 17, (74%) found statistically significant changes. While there was wide variation in the consultation settings, results suggest that consultation as an intervention technique does have a positive effect. The specifics of how change occurred or what happened in the learning experience was not directly addressed.

Five studies conducted between 1959-1968 focused on social work consultants providing individual or group consultation to agency based consultees comprised of social workers, nurses, or teachers (Farley, 1963; Macarov, 1968; Rieman, 1963; Rosenthal & Sullivan, 1959; Schmuck, 1968). Rieman (1963) studied the effect of social workers offering group consultation to nurses. In a focused interview with the consultees, he found that consultation resulted in a

greater understanding of human behavior, and an increased recognition of the importance of the relationship in professional activity.

In a similar study, Rosenthal and Sullivan (1959) assessed two psychiatric social workers' consultation to fourteen different social workers in a public child welfare agency. Evaluation of the results was based on self-reports from consultees and their supervisors and tended to be indefinite. Workers and supervisors did however express satisfaction with the consultation and indicated that they thought the professional growth of the consultee was attributed to the consultation.

Like Rosenthal and Sullivan, Farley (1963) looked at consultation effectiveness. He solicited feedback on an anonymous questionnaire in order to study the effect of social work consultation with nurses. Respondents indicated that consultation not only helped to increase their understanding of their patient's, but also helped to increase their self-awareness.

In a related study, Macarov (1968) looked at social workers functioning as consultants to 39 social work consultees administering programs for the chronically disabled. The consultees reported that "41% of the problems were solved and that an additional 41% were partially solved following the consultation" (p. 54). The consultees also

reported personal growth and helpful substantive and procedural information as an outcome of consultation.

Finally, Schmuck (1968) studied the effects of consultation on teachers who received consultations from social workers. One consultant was assigned to fifteen teachers. Forty teachers (the experimental group) received consultation and twenty teachers (the control group) from another school did not. The consultants attempted to assist the teachers with problem oriented difficulties from the classroom. Changes in the teachers were derived from anecdotal material and four questionnaires. Schmuck concluded that the consultees self perception and approach to handling classroom problems improved.

While professional growth [specifically addressed by Rieman (1963), and Rosenthal & Sullivan (1959)] and professional and personal growth [addressed by Farley (1963), Macarov (1968), and Schmuck (1968)] were reported in each of these studies of social workers providing consultation, the researchers did not define or note a theoretical framework or specific model of learning. A description of what actually occurred in the learning experience was also lacking.

A more sophisticated attempt to assess factors that influenced the outcome of consultation was done by Robbins and Spencer (1970). Their focus was on consultation given in the planning and carrying out of new community health

programs. Four methods of data collection were used. A brief questionnaire was administered before the group consultation, and the consultation was observed and tape recorded. A brief reaction form was administered immediately following the consultation, and a follow-up interview with the respondent, deemed to be the principal "client", was conducted two or three weeks after the consultation.

Several hypotheses regarding the factors which influence the outcome of program oriented consultation were posited. Using a correlational experimental design, the researchers found that there appeared to be a positive relationship between the following variables: 1) consultant preparation and client satisfaction (r=.46), 2) consultant interest and consultee satisfaction (r=.40), 3) consultant praise and client satisfaction (r=.41).

Robbins' and Spencer's data are limited to group consultation provided for program planning and implementation. However, their findings in regard to consultant variables may be applicable to the present study and will be considered in a discussion of the findings.

Effectiveness of consultation and teacher growth has also been assessed by Teitelbaum (1961). A group of 120 pairs of teachers were assigned to 40 special schools in lower-class Black and Puerto Rican neighborhoods of New York. A consultant was assigned 15 experimental teachers. The consultant worked with the teachers on their handling of

the children in the classroom. The teachers and the consultants maintained separate logs of the consultation. School principals completed rating forms on the degree of teacher growth. The results suggest that the teachers who sought consultation were more confident in their ability to function and demonstrated greater professional growth than those who did not. Similarly, R. Lippitt (1959) studied the effectiveness of a consultation workshop in a school of nursing. He administered a questionnaire to a group of nurses following two, five day workshops. Thirteen of the 14 nurses responded. Most of the nurses felt that self-development and self-change took place as a result of the workshops.

There have also been two studies that have attempted to assess the effectiveness of Caplan's (1964) conceptual model of consultation. In the first of these, Caplan (1970) evaluated the individual consultee-centered case consultations of public health nurses. The study was designed to demonstrate a relationship between different forms of consultation and changes in the knowledge, perceptions and attitudes of the consultees.

Individual consultation sessions were offered to those nurses who wanted them, once every one or two weeks. Eighty-six nurses made use of the consultation service. They discussed a total of 416 cases in 487 sessions. Consultants kept process records of each interview. The process record-

ings were used for four different studies: 1) an evaluation of the process of theme interference reduction, 2) changes in consultee objectivity during a consultation, 3) whether the consultation assisted in lowering the consultee's tension, and 4)changes in interview responses from before to after the consultation program.

Caplan found that education, and support/reassurance increased nurses' objectivity in their work. Theme interference reduction improved objectivity in significantly greater numbers when compared to the other consultation techniques.

In the second study, Newfield (1972) observed 42 consultees who were divided into six consultation groups, led by four consultants using the Caplan model for 1 and 1/2-hour sessions, over a five week period. The research design consisted of eight a priori hypotheses, control for each group, and a multitract-multimethod validity analyses of the data. Six pre/post tests were administered to measure knowledge, skill, confidence, and objectivity. Supervisory and self ratings were also used. Results suggested that all the nurses improved over time but consultation seemed to accelerate the process in the specific areas of objectivity, skill, and application of knowledge.

The Caplan and Newfield studies suggest that consultation is an effective collaborative experience wherein multilevel learning can occur.

Summary

Whether consultation was studied to determine it's effectiveness, or to understand it's process, findings suggest that positive change in the individual consultee's professional functioning and/or self perception occurred. Moreover, many of these results not only suggest that consultation is a viable avenue for continuing clinical knowledge and skills but each also identified areas for future research. It should be noted however, that none of the existing research attempts to describe the nature of the learning experience itself or to look at learning within the context of a theoretical frame and/or to examine the non-didactic model inherent to adult learning. Assessment of consultation and its efficacy as a learning model then, seems to be premature. In the current study clinical consultation as an aspect of adult learning is explored within the context of a theoretical frame. As noted above, inherent in Knowles' model of Andragogy are the basic principles of both adult learning and clinical social work training. An effort is made to understand the components of the consultation experience that facilitate growth in the professional and/or personal self of the learner within the context of Andragogy. Of particular interest is the way in which consultees perceived and described the content and experience of learning that takes place during the course of clinical consultation.

CHAPTER III

METHODS AND PROCEDURES

Introduction

For purposes of this phenomenological study, social work consultees were interviewed to elicit their perspective of the learning process that takes place during the course of clinical consultation. Further, an effort was made to determine what was actually learned and to generate a description of the components of the consultation experience that facilitate this learning. As noted in Chapter II there is a paucity of research in this area and none of it was conducted within a theoretical framework. Moreover, from a methodological perspective, existing studies have been dominated by the application of survey methods (Mannino & Shore, 1969, 1971, 1975) and effectiveness studies (Farley, 1963; Macarov, 1968; Rieman, 1963; Robbins & Spencer, 1970; Rosenthal & Sullivan, 1959; Schmuck, 1968). In an effort to address these limitations, the current study used Andragogy as its theoretical base and the grounded theory method as its research design. More specifically, the empirical reality of the consultee's learning experience was examined the way it actually appeared to the consultee. Categories emerged from the observation of the natural system under study (Glazer & Strauss, 1967), rather than from a pre-existing set of categories or instruments. An interview and a brief demographic questionnaire were used for the collec-

tion, analysis and interpretation of data which in turn were understood from an Andragogical perspective.

Research Design

The study is exploratory in nature. It was designed to develop and refine concepts, as well as to raise questions and hypotheses for subsequent investigation (Selltiz, Jahoda, Deutsch, & Cook, 1976). According to Kerlinger (1973), an exploratory study's strength lies in its realism, social significance and heuristic quality. That is, it allows for the generation and analysis of a broad range of data that can be understood in its naturally occurring context rather than abstractly. Moreover, an exploratory study assumes that the process of knowing can best be achieved initially by qualitative investigation with a description of phenomena that in turn can contribute to the building of models and theories (Babbie, 1979). Glazer and Strauss (1967) have developed systematic delineations regarding theory-building properties and the application of exploratory design. They set forth a phenomenological approach to discovering theory by purposefully and systematically generating it from qualitative data. According to Glazer and Strauss, qualitative research is the best method of obtaining the type of information required for contending with the difficulties of an empirical research situation. Known as grounded theory (because it is grounded in the data), this approach stands in contrast to the logico-

deductive approach in which theory is deduced from assumptions. An exploratory approach seeks to discover and revise insights, ideas, and concepts by minimizing preconceived a priori concepts. Rather than an end product, theory is regarded as an ongoing and ever-developing process. Glazer and Strauss argue that generating theory from data provides assurance that the theory will fit and work since it arises directly from the data it describes or explains. Categories or their properties are generated from data; then the evidence from which the categories emerge is used to illustrate the concept.

Sample Selection

The sample consisted of seven social work consultee subjects. Glazer and Strauss (1967) suggest that the number of cases are less crucial when one's purpose is model and theory building. "A single case can indicate a general conceptual category or property; a few more cases can confirm the indications" (p. 30).

Sussman (1984) provides a rationale for the small sample size:

> Small or single sample studies are not done for the purpose of generalization or prediction; usually, they are used for in-depth and pilot work specifically to illustrate and describe; or even to try to explain the nature of the phenomenon under investigation by delineating the factors which appear to be at work in the single case or few cases (Sec. 3, p.2).

The sample was derived from what Polkinghorne (1983) refers to as "exemplar" rather than random cases. That is, this study concentrated on a description of organizing structures rather than a description of cause and effect relationships among variables.

Seventy-five social work clinicians were selected from the directory of the California Society For Clinical Social Work in the Westside Los Angeles and San Fernando Valley areas. The selection was limited to those members who had at least "general" standing in the Society. "General" members were selected because they all have Masters degrees in Social Work and have been licensed for at least two years. The criteria for selection of potential subjects was based on the following condition: that the clinician had purchased individual consultation from a social work consultant within the past year. The time limit was presented in order to insure recall of the experience.

Recruitment was initiated by an Introductory Letter (see Appendix A) inviting practioners to participate in a research study to explore the way in which social work clinicians use consultation to further their learning needs.

The clinician was asked to return a statement to the researcher indicating whether s/he was willing to participate in the study. The statement and a return self-addressed stamped envelope were included with the Introductory Letter. The sample was determined to be "not at risk"

according to the Department of Health, Education and Welfare Policy on Protection of Human Subjects guidelines as adopted by the California Institute for Clinical Social Work.

The Interview

Data for this research was collected through individual interviews with social work consultee subjects. Madge (1965) suggests that:

> The interview...is popularly regarded as the method 'par excellence' of social science. After all, what social scientists are interested in are people, and if you want to find out something about a person, surely the best way is to ask him or one of his friends (p. 162).

Additionally, Polkinghorne (1983) notes that "the face-to-face encounter provides the richest data source for the human science researcher seeking to understand human structures of experience" (p. 267). Moreover, Loflond (1971) suggests that the interview, when used to collect qualitative data, provides a "guided conversation to enlist rich, detailed material that can be used in qualitative analysis" (p. 76). Finally, Spradley (1979) sees the "ethnographic interview" as a series of "friendly conversations" which convey to the interviewee the message that:

> I want to understand the world from your point of view. I want to know what you know in the way you know it. I want to understand the meaning of your experience, to walk in your shoes, to feel things as you feel them, to explain things as you explain them (p. 34).

Use of the interview as a process of social interaction enabled the researcher to utilize her social work interview-

ing skills while satisfying the objectives of this study (Goode & Haat, 1952; Warwick & Lininger, 1975). That is, the researcher was able to establish a relational context in which the subjects felt free to reveal his/her situation as it was experienced (Polkinghorne, 1983; Tripodi & Epstein, 1980). The reality and perception of the interviewee, rather than that of the researcher, was used to define the problem. As a result, grounded theory emerged in the process of the generation of accumulated data (Glaser & Strauss, 1967).

A semi-structured, open-ended Interview Guide (see Appendix E) based on clinical experience and the literature review was developed to explore and understand the subjects' learning experience within the clinical consultation process. Subjects responded with "retrospective introspection" of their perceptions of what occurred (Merton & Kendall, 1946). Flexibility, depth, clarification and probing are all advantages of open-ended items (Issacs & Michael, 1981; Selltiz, Jahoda, Deutsch,, & Cook, 1976).

Open-ended questions put a minimum of restraint on the subjects' answers and their expression. Phillips (1966) notes that descriptive analysis of open-ended questions provides a "feel" for the phenomena under investigation which might prove to be suggestive within the context of discovery. According to Selltiz et al. (1976), open-ended questions are particularly well suited to research that is

interested in the exploration of a process. Open-ended questions yield the subject's own formulation of the issue and promote depth in regard to the affective, cognitive and evaluative aspects of the experience.

The structure of the Interview Guide was derived from content analysis of consultation and adult learning theory and research. Merton and Kendall (1946) outlined a content analysis procedure that this researcher used to produce several general topic areas.

> Persons interviewed are known to have been involved in a particular concrete situation. The hypothetically significant elements, patterns, and total structure of this situation have been previously analyzed by the investigator. Through this content analysis he has arrived at a set of hypotheses concerning the meaning and effects of determinate aspects of the situation. On the basis of this analysis, the investigator has fashioned an interview guide, setting forth the major areas of inquiry and the hypotheses which locate the pertinence of data to be obtained in the interview (p. 541). (underlines are the authors')

The interview questions then were prepared as a guide in anticipation of the subjects bringing up many of the topics in the course of their own narrative style. Topic areas were selected to elicit the consultee's learning experience within the consultation setting. The researcher began with questions about the consultee's motivation for seeking and expectations of clinical social work consultation. This identified the consultee's objective(s) and type of "not knowing" difficulty. The significant attributes

desired and the selection of the consultant were examined in order to explore how the consultee selected and secured the help s/he determined was necessary. To understand the consultee's views of the important components of the consultation process that facilitate personal and/or professional growth and development, the following topics were explored: consultant role, consultant activity and methods, and the nature of the consulting relationship. Finally, an evaluation of the consultee's learning experience was investigated under the topic headings content and outcome. The subjects were also encouraged to raise their own special areas of interest and concern.

The interview occurred in one meeting which lasted for approximately one hour and fifteen minutes. Procedures for the interview followed American Psychological Association ethical standards and guidelines for the treatment of human subjects. The researcher introduced the subjects to the interview (see Appendix B) and requested that the subjects complete an Informed Consent Form (see Appendix C) and a brief demographic questionnaire (see Appendix D).

The demographic questionnaire provided the researcher with identifying information about the consultee's age, marital status, religion, theoretical orientation and job affiliation. Information was also sought regarding the number of years the consultee had been in clinical practice. The consultees commented on the various learning methods

s/he used. Additionally, frequency of use of consultation and the amount of the fee were indicated. Finally, the consultees were asked to approximate the consultant's age and note his/her gender. It was not clear whether there would be any differences in these demographic categories. However, the researcher wanted to take the opportunity to note any significant trends that might exist, recognizing that there are not enough subjects to obtain statistical significance. All of the demographic information was sought to further the analysis and interpretation of the data.

Pilot Study

Three consultees selected in the same manner as the study subjects were interviewed for the purpose of conducting a pilot study. The demographic questionnaire was given to the pilot subjects as well.

The pilot study provided the researcher with an opportunity to become comfortable with the nature of the research interview process. It afforded an opportunity to order and test the questions for sequence, clarity and smoothness of flow. With some questions the order of words was changed for simplicity and redundancy was eliminated. To prevent the researcher from leading the consultee the introductory question regarding motivation was changed. An additional question was added under consultant activity and methods to elicit responses relevant to the Andragogical model. It was anticipated that the pilot study would also provide an

opportunity for unanticipated ideas and approaches to emerge that increased the effectiveness of the Interview Guide during this period of "trial and error" (Goode & Haat, 1952; Isaac & Michael, 1981; Madge, 1965). Indeed, aspects of the learning alliance and differentiation between professional and personal growth and development were identified as recurring themes and were susbsequently incorporated into the Interview Guide used in the main study.

Data Analysis

The researcher used the constant comparative method of qualitative analysis (Glaser & Strauss, 1967) to generate and suggest categories and their properties as well as the hypotheses to be analyzed. Analysis began in the data-gathering phase. Glaser and Strauss regard concurrent collection, coding and analysis of the data as crucial:

> The generation of theory, coupled with the notion of theory as process, requires that all three operations be done together as much as possible. They should blur and intertwine continually (p. 4).
>
> By joint collection and analysis, the sociologist is tapping to the fullest extent the in vivo patterns of integration in the data itself; questions guide the collection of data to fill in gaps and to extend the theory--and this also is an integrative strategy (p. 109).

At its completion, each interview was reviewed and scrutinized for important issues and themes. Data was interpreted within the theoretical context of adult learning theory as defined by Knowles in his model of Andragogy. A summary was then made. Unanticipated significant

information or categories that arose from the analysis during the data collection were incorporated into the following interview in order to ask subsequent subjects about it. In this way, the data collection was constantly informed by the ongoing data analysis. The process continued until each of the categories were saturated and a pattern was established that clarified the essential nature of the learning experience for each of the consultees.

Themes were coded into as many categories of analysis as possible. The researcher used an index-card system to record and retrieve coded data. Analytic memos were written on the index-cards. The memo writing was guided by the emergent analytic framework (Glaser & Strauss, 1967). Patterns emanated from the classification of categories and themes. The researcher was looking for a pattern of shared experience among the consultees. In order to analyze the interviews for common themes and patterns, a summary of each interview (noting its categories and their properties) was compared with each of the previous interviews. A comparison within and between categories followed. Similarities and differences in the data were noted and examined. The discovery and development of the relationship among the categories furthered the integration of them.

The categories were then analyzed to explore their relevant theoretical properties. Identification of the themes and patterns that appeared across the examples are

presented in Chapter IV. Finally, in Chapter V, these themes are culled in an effort to generate hypotheses about the relationship between Andragogy, Self Psychology and learning as it occurs during the course of clinical consultation.

Limitations

This study is limited to individual clinical social work consultation. Consultants are in private practice and the consultee pays the fee. It therefore excludes individual and group consultation practiced in agency settings and institutions.

This study calls for retrospective introspection on the part of the consultee rather than measuring the actual behavior during the consultation. "The retrospective nature of the interview may introduce memory error and/or contamination because of intervening events and biasing factors which increase with time" (Isaac & Michael, 1981) Therefore, a further limitation is that the subjects reported on their perception of what happened, not necessarily what actually happened in the consultation.

While the study will draw inferences about clinical social work consultation, it is not meant to provide generalizations about the learning experience in consultation beyond the subjects of the present study.

Rather, its intent is to suggest a structure relevant to their specific experience and raise certain hypotheses about the structure that might be tested on larger samples.

CHAPTER IV

FINDINGS

Introduction

It was suggested that learning in clinical consultation can be understood within the contexts of social work education and Andragogy. Interviews were designed to elicit the subject's own experience of learning as it takes place during clinical consultation. The purpose of this research was to discover the nature of the subject's learning experience in terms of the following questions:

1. What are the dynamic components of the consulting experience that facilitate adult learning?
2. Can one identify what is learned in consultation and the factors that influence the learning process?

The ultimate intent was to determine if learning, as described by the subjects, can be understood theoretically in terms of Andragogy or if an alternative learning model is necessary. The first step then was to analyze the data in an effort to answer the research questions. Briefly, findings suggest that four dynamic components facilitate adult learning: the development of a learning alliance, the establishment of an optimal learning environment, the interactive nature of the consulting relationship, and length of time in consultation. The dynamic component within the learning alliance was found to be the

consultant's ability to begin at the consultee's level of clinical and theoretical knowledge. An analogue to the social work and Andragogical construct of the facilitator, this component seems to enable the development of an optimal learning environment and the unfolding of the consulting relationship. In an effort to understand the nuances of the optimal learning environment and the consulting relationship, specific dynamic components were identified. They include a highly personalized experiential process in which there is both mutuality and mirroring. Further, the consultee's expectations together with the consultant's approach toward realizing those expectations effect the consultee's ability to be vulnerable, to learn and to grow. Finally, the length of time in consultation was found not only to be a determinant of the nature of the consulting relationship but of what was actually learned.

This brings us to the second research question, "What is learned, and what are the factors that influence the learning process?" Clinical consultation was found to potentiate multi-level learning for self development that included aspects of both professional and personal growth. Two types of learning were found to occur. They are the "content" and "process" of learning. It is important to differentiate between them. Content learning refers to what is learned. It is concrete and specific and tends to be more didactically oriented. Process learning, on the other

hand, is a non-didactic construct. It refers to an appreciation and awareness of the underlying dynamic factors within an experiential context, that is, the interpersonal tone of the relationship and the climate. The consultant's approach to content and process learning also differ. In the non-didactic mode the consultant appears to "guide" the consultee's self directed inquiry while in the didactic format she tries to "manage" the content of the learning. Both content and process learning play an important part in determining not only what is learned but the degree and level of meaningfulness the consultation holds for the consultee.

Factors that seem to facilitate learning in the consultation experience were found to depend at least in part, on the learning needs and expectations of the consultee. Additionally, motivation and length of time in consultation seem to effect what is actually learned. More specifically, the two subjects, "Lee" and "Glenn" who had been in consultation for the least amount of time (10 and 2 sessions respectively) sought an informational content focus and level of discussion. They specified that they wanted a more didactic experience with the consultant functioning in a directive, theoretical/informational giving mode. The subjects (5; mean = 44 sessions) who had been in the consultation process for a longer period of time on the other hand, wanted a more fluid, non-didactic approach.

This is not to say that the two learning processes are discrete categories. Indeed, they tend to overlap. For example, while those who were in consultation for a longer period of time were predominately functioning within a non-didactic model and at an interactional level that emphasized process elements, there were nonetheless, occasional requests for specific informational content. Requests were similar to those that Aiken (1957) noted. Specifically, subjects wanted assistance with understanding dynamics and their relationship to psychoanalytic and object relations theory. In this manner, the consultees appeared to be functioning on a dual track, that of simultaneously grasping content and integrating ego functions.

Finally, the motivation for seeking consultation seems to effect what is learned. While several motivating factors were identified, ("the need for an objective point of view" [2 subjects], "couldn't obtain adequate consultation in my agency" [2 subjects]), only one was common to all seven subjects, anxiety about "not knowing". Consequently, only this factor will be discussed below. Each subject felt that consultation helped them to manage the feelings of uncertainty associated with "not knowing" as well as to identify more clearly exactly what it was that they did and did not know. The consultees remarked that they became more objective and were able to learn concrete theoretical knowledge and practical skills. The acquisition of

knowledge and skill seemed to assist them in being better able to organize their thinking about their patients and hence be more effective and useful to them. Efficacy in turn helped subjects to gain self understanding and self acceptance. Finally, increased self esteem seemed to help subjects self disclose so that parallel process could be utilized. It was through this process that subjects were more readily able to appreciate the complexity of the helping relationship.

In sum, results suggest that while each of the subjects interviewed had their own unique style and background, they shared common aspects in their experience of the consultation process not only in terms of the essential dynamic components, but in terms of the multi-level learning that occurred and the factors that facilitated that learning. More specifically, there was a complementarity between learning and self development such that change was apparent in their thinking, feeling, attitudes and/or actions. The shared aspects are organized and presented below as the sum of patterns. These patterns in turn are discussed in terms of "steps" that characterize the learning process as it occurs within the context of clinical consultation.

In the following section demographic information is presented, followed by a discussion of the four "steps" in the learning process that takes place during clinical consultation. Data suggesting the dynamic components that

facilitate adult learning together with what is learned and the factors that may influence this learning are presented within the context of these four "steps". The nature of the learning experience that takes place during clinical consultation is complex and difficult to analyze, however the data provided is extremely rich. The personal context from which each of the subjects responded will be compared and/or contrasted with the literature. Vignettes are used to support each finding.

Demographic Information

Of the 75 social work clinicians who were contacted by mail to request their participation in the research study 45, or 60% responded. Eight additional letters (9%) were returned by the post office. The criteria for selection were that the clinician had purchased individual consultation from a social work consultant within the past year. Of the 45 who responded, only 7 met these conditions.

The study was comprised of 6 women and 1 man who ranged in age from 32 to 54, with a mean age of 42. Six of the subjects are married, 1 is divorced and 1 is single. Four of the subjects have a religious preference of Jewish, 2 had no preference and 1 is Catholic (see Table 1 for a descriptive presentation of the demographic information).

Among the subjects there was an average of 2.50 years post licensure experience with a range of from 2 to 5 years. Of the 7 subjects, all were seeing patients privately.

However, only 1 was in full time private practice. Two of the subjects worked in out-patient clinics, 1 in a mental health clinic and health agency for the elderly, 1 in a family service agency and 1 in a community organization agency. Finally, six of the consultees were psychodynamic and one humanistic/existential in their theoretical orientation. While the sample is small, psychodynamic/psychoanalytic clinicians seem to be making more frequent use of clinical consultation from social work consultants.

Table 1

Demographic Information

Age (years)	N
Less than 40	4
Over 40	3

Religion	N
Jewish	4
No Preference	2
Catholic	1

Years Post Licensure	N
More than 3	3
Less than 3	4

Ethnicity	N
Caucasian	6
Asian-American	1

Theoretical Orientation	N
Psychoanalytic/ Psychodynamic	6
Humanistic/ Existential	1

Marital Status	N
Married	5
Single	1
Divorced	1

Subjects ranked the frequency of their use of various educational resources on a five point Likert scale (1=most frequent, 6=least frequent). Consultation was the most

frequently used, followed by books/journals, seminars/conferences, supervision, and university courses. The amount of time in consultation at the time of the interview ranged from a period of 1 to 36 months (see Table 2). Six of the subjects reported on continuous consultation that they were currently purchasing. The seventh, "Sandra", indicated that she is currently in consultation with a male psychoanalyst, but for the purpose of this study, described her recently concluded consultation experience with a Ph.D. social worker with whom she consulted for six months. It was suspected that the subjects would be using consultation for a short term or on an ad-hoc basis (Bindman, 1959; Gallessich, 1982; Gilmore, 1963; Gorman, 1963; Kadushin, 1977; Rapoport, 1977; Siegel, 1955; Smith, 1975). However, on average, subjects current and/or most recent consultation lasted 16 months. "Lee" added that she was not only purchasing individual consultation, but was also in a for fee consultation group. "Jennie" was purchasing consultation in a group setting with 3 other social workers. She explained that their format allowed each of the consultees a 6 week period in which they present their case, in depth. Since this was not disclosed until we were well into the interview process and since the presentation was continuous, she was retained.

Table 2

Time in Consultation

Subject	Months in Consultation at Time of Interview	Number of Sessions	Frequency of Consultation
"Glenn"	1	2	Bi-monthly
"Lee"	5	10	Bi-monthly
"Sandra"	6	12	Bi-monthly
"Allyn"	24	48	Bi-monthly
"Harmony"	24	48	Bi-monthly
"Jennie"	36	54	Weekly
"Marissa"	14	56	Weekly

The literature suggests that age, gender, professional training and theoretical orientation were found to be contradictory or equivocal as determinants of effective consultation. However, the findings of this study suggest that age, gender and professional training were significant selection criteria. All of the consultants were older than the consultees. They ranged in age (as approximated by the consultees) from 48-56. The "mean age" was 53 compared to 47 years of age for those consultants of the Kadushin and Buckman (1978) survey. In each instance consultant age appeared to reflect the importance consultees placed on selecting a consultant who had more clinical experience than they had. Further, all seven of the consultants are women. While there is no data indicating why there seemed to be a

preference for a female consultant, it is possible that this phenomenon may reflect, in part, a developmental need for the selfobject function of mirroring. Kohut (1971, 1977, 1979) observed that this function is considered to be within the purview of (but not limited to) a female caretaker. That mirroring and "twinship" may be an aspect of the consultation process is further suggested by the selection of social work consultants. Each subject expressed very strong feelings about the importance of finding a consultant who had the same professional training and theoretical orientation. Similarity and familiarity seemed to be essential.

While the subjects were not asked about their own personal therapy, all volunteered that they were either currently (4 of the 7 subjects), or had previously been in treatment. "Lee" succinctly states the sentiment of all, "My dealing with my own stuff is not only helpful but it is vital."

Each of the subjects impressed the researcher as a highly self-aware and capable clinician. They actively engaged and participated in the research interview. In accordance with Phillips (1966) and Selltiz et al. (1976) the open-ended questions of the Interview Guide were well suited to this research which addressed and explored the subject's learning process. All of the subjects acknowledged having high expectations for themselves, in the

treatment as well as the consultation setting. What they described as demanding of themselves in the consultation setting, they demonstrated in the interview. They spoke frankly and candidly, presenting their material in a professional, yet, at the same time, personal manner. Our dialogues were at times very moving.

"Steps" That Characterize the Learning Process

While each of the subjects related to the topics of the interview from their own subjective experience, they did share certain commonalities as they described the process of their learning. Each emphasized many of the same themes and concerns and had strikingly similar means of dealing with them. The data is presented in four "steps". Whether these "steps" are an artifact of the interview format and/or actually emerge from the data is a subject for future research. It is noteworthy that the categories and themes culled from the data support the idea that there are four aspects of the consultation process and that a sequence both within and across these themes seems to be present. In an effort to address these overlapping and intertwining phenomenon, each "step" is presented in the order in which it seems to emerge. The theme within each "step" is then discussed as it first emerges, then as it evolves across time and becomes an ingredient of the new theme emerging in each subsequent "step". It will be demonstrated that as the subjects proceeded through these "steps", their learning

became more profound and growth occurred both professionally and personally. Moreover, the nature and extent of this growth and development was largely dependent upon the length of time in consultation and the degree of consultant/consultee congruence of expectations.

The four "steps" are:

I Recognition of the need for help

II Selection of the helper

III Utilization of the help

IV Evaluation of the help

"Step" I: Recognition of the need for help.

The learning process is initiated with the consultee's recognition of his/her particular needs and objectives. "Step" I identifies the consultee's motivation for seeking consultation as a means to further his/her learning.

As noted in Chapter II, prior research which reports the consultant's perspective of their consultee's motivation for seeking consultation suggests that consultees have a "work problem they need help with" and/or "want an outsider's objective assessment" of a case (Kadushin & Buckman, 1978). In the Robbins and Spencer (1968) study, 47% of the consultees "wanted answers". In contrast, the subjects of this study not only wanted to solve a particular practice problem (to understand and help their patients), but they also wanted to feel better about themselves as psychotherapists. They seemed to address "not knowing" in a

profoundly different way. That is, they were actively willing to struggle with and attempt to work through the angst of uncertainty as it effected both their personal and professional growth. This finding is congruent with that proposed by adult learning theory. Knowles (1972) determined that adults are motivated to learn by the desire to do well, and to grow professionally and personally. All of the subjects initially expressed their need for consultation as twofold: They wanted to feel more confident by having the experience of being more effective. "Glenn's" comment is representative of all of the subjects, "the tools that I had just weren't working...I wanted to feel...a little more secure, a little more confident in myself."

An effort was made to understand the phenomenon of "not knowing" more precisely. Analysis of the data revealed five (5) types of "not knowing". They are: pragmatic, theoretical, clinical, countertransferential and narcissistic. Moreover, a relationship was found to exist between the type of "not knowing" and the length of time in consultation such that pragmatic considerations may be addressed early on. Countertransferential and narcissistic concerns, on the other hand, tend to be discussed only after safety and trust have been established within the context of a highly personalized, intimate, consulting relationship ("Step" III). In the following discussion all five forms of

"not knowing" will be discussed in the order in which they seem to emerge.

The 2 consultees who had the least amount of time in consultation (mean = 6 sessions) observed the need for direction in terms of more pragmatic considerations such as how to end a session, establish fees, etc. As "Lee" noted:

> I really needed help in ordering my sessions so I wouldn't go overtime or focus on their physical comfort.

A level of personal discomfort with regard to a lack of, or deficits in, theoretical knowledge or understanding of the patient was also noted. "Harmony" recalled that when she initially sought consultation she:

> was feeling that since this was my first patient in private practice, ...I was really needing grounding in (a) theoretical perspective...How can I effectively treat my patient without a firm theoretical understanding of her?

Contained within this desire for theoretical knowledge is the need for assistance in analyzing the presenting problem. Subjects reported that this problem tended to occur when a new patient is presented to the consultant. It is not then directly contingent upon the amount of time in consultation per se, but rather the amount of time a particular patient has been discussed. The attempt to address this form of "not knowing" does however seem to follow the resolution of pragmatic considerations.

Three subjects who had been in consultation for a longer period of time (mean = 36 sessions), tended to focus

more on clinical skills and personal growth inherent in the consultation experience. This type of "not knowing" is evident in "Allyn's" comment concerning the intensity of the work:

> I really felt it was important to get consultation because of the intensity of the work. You can end up feeling sometimes overwhelmed with the heaviness of the relationships that you have with your clients...the emotional pain they bring you, the dependence they have on you. There's just so many things that can pull on you, and you can just end up being exhausted. If nobody is feeding you and encouraging you and telling you that you're okay as a person, then you can just kind of get all bent out of shape. You can just get stretched. You can get stretched very thin. There's a danger sometimes if you lose some of your perspective or your grounding, and you start to see your clients more as objects, or on the other side, if you start to relate to them too much.

As can be seen in "Allyn's" comment, "not knowing" is experienced in terms of both professional and personal considerations. If professional boundaries are not maintained through the use of good clinical skills, ("there's just so many things that can pull on you...You can relate to them too much"), one can lose one's sense of self ("...you can just kind of get all bent out of shape").

Five of the subjects who had been in consultation for a longer amount of time (mean = 44 sessions) requested help in dealing with countertransferential concerns. As noted above, the ability to self disclose these conflicts seems to be related, at least in part, to the length of time in consultation and the development of the consulting

relationship (to be discussed below in "Step" III).

"Marissa's" comment is prototypical:

> I need to have somewhere, somebody to help me organize my experiences in the therapy particularly related to helping me process what my experiences have been. Also I have specific problems sometimes and need help in understanding all that I don't know is going on...with the patient, with me and between us. Sometimes I find myself struggling and I feel like I have a need for the concrete, the knowledge. I imagine that is the time when I am feeling critical about myself that I don't know. I am feeling anxious because I don't know. It's easier to focus on the specific acquisition of information when I'm feeling stuck, or because I'm uncertain.

Clearly, "Marissa" is struggling with countertransferential concerns. "I need to have...somebody helping me to process what my experiences have been...and I need to help in understanding all that I don't know is going on with the patient, with me...and between us".

Unfortunately, the literature (Caplan, 1970) on "not knowing" as it pertains to the countertransference suggests that its presence is indicative of a lack of professional objectivity due to the interference of subjective emotional complications as they effect professional and planning operations. Caplan's perspective seems to be somewhat pejorative, if not limiting. According to Caplan, the problem is seen strictly in terms of the consultee and does not include the possibility that the difficulty might also reflect something within the dyad which, if understood, might be beneficial to the patient and his/her treatment.

It seems possible that Caplan's perspective can be understood, at least in part, within an historical context. Our understanding of countertransference has changed dramatically since 1970.

Finally, those subjects (2) who had been in consultation the longest amount of time (mean = 55 sessions) began to address "not knowing" on a more profound level. It became apparent that the request for help carried with it increased anxiety and diminished self esteem intrinsic to managing the uncertainty of "not knowing". "Jennie" revealed this sense of "not knowing" in a very poignant way:

> I often struggle with not knowing. I feel like I <u>should</u> know, and shouldn't have to ask. It's really a problem for me at times because it's so awful to feel so helpless. I struggle with it depending on the patient and depending on how difficult the material is for me. I try to get to the place where I say, well of course I don't understand, and have that be okay. I think it just depends on what gets stirred up. Sometimes I know something is stirred up but I don't know what it is. Sometimes when I am stirred up about my own issues and not aware of what it is, I want to understand the material so that I don't have to deal so much with that anxiety.

"Jennie's" experience of "not knowing" was one of high anxiety..."it's so awful to feel so helpless" . Contained within this feeling of helplessness are specific forms of "not knowing". There are theoretical considerations "I want to understand the material", narcissistic concerns, "I feel like I <u>should</u> know and shouldn't have to ask", as well as

questions concerning the countertransference "sometimes when I am stirred up about my own issues and not aware of what it is...". Once again, the development of the learning alliance seems to facilitate the openness and vulnerability discussed here.

In sum, the uncertainty of "not knowing", whether it stemmed from pragmatic, theoretical or clinical considerations and/or was related to countertransferential or narcissistic concerns, left the consultees feeling that they wanted to grow both personally and professionally. The learning necessary to accomplish this flourished in a relational context rather than a unilateral one. The length of time in consultation together with the nature of the consulting relationship were found to be determinants of the type of "not knowing" that was explored.

Before we can proceed to "Step" II, it is first necessary to back track in time a little to the point at which "not knowing" initially triggered the realization that a suitable consultant was necessary to resolve the problem. It is at this juncture that consultees reported making efforts to find a helper.

"Step" II: Selection of the Helper

In analyzing the data, it became apparent that the selection of the helper has three sequential components. First, the consultee identified a field of consultants. Next, the field was narrowed to social workers. Finally, an

effort was made to determine if there was a "goodness of fit" (Glidewell, 1959). The learning that takes place during this "step" was found to be primarily non-didactic. Subjects needed to search themselves to identify the personal and professional qualities of the consultant that would facilitate the "fit".

The literature (Alpert, 1981; Frankenhuis, 1977; G. Lippitt, 1978, 1975, 1959) notes familiarity, personal characteristics and expertise as being a significant influence in the selection of the consultant. Analysis of the data suggest that familiarity and personality characteristics were important considerations here as well; however, expertise was not found to be a factor. While all of the subjects indicated that they wanted someone who had more experience and more competence than they had, the "degrees held, books written, or courses and presentations made were not important." However, 2 subjects did state that a knowledge of learning theory was essential. This criterion is congruent with the literature presented by Towle (1970) and Abramovitz (1958).

The criterion of familiarity was defined by the consultees as having read a publication of the consultant's or having heard the consultant present at a conference. Four of the consultants were recommended to the subjects by either a colleague, friend, or in one instance, from the subject's therapist. Five of the subjects were familiar

with the consultant. In one instance, the consultee's friend had used the consultant and the consultee had been impressed with the friends comments. Only one subject mentioned logistics as a primary factor.

A number of personal characteristics of the consultant were also identified by subjects to be important to the selection process. They were: to have certain skills, knowledge and attitudes, to have the ability to work with consultees at their own level, an ability to listen and communicate clearly, to be empathic and non-judgmental and finally, and most importantly, to be able to relate well.

Contrary to the literature, personal characteristics and familiarity were not found to be sufficient criteria to select a helper. All seven of the consultees felt that it was important to have a social work consultant because of the similarity in training and a shared professional perspective. Specifically, this perspective reflected a psychodynamic understanding of the patient's inner world together with an appreciation of the external context of the patient's cultural and social milieu. As "Marissa" noted, "there is an orientation that is fundamentally unique to social work." "Glenn" stated:

> We've been socialized professionally in the same way, so I think it's easier for us to relate. We have similar kinds of status, and similar kinds of struggles. It's nice to have similar professional background.

Similarly "Allyn" noted:

> I feel like social workers have more in common with me. They have certain ways of looking at things. They can understand more of my training and what the profession is like, first hand.

Subjects then seemed to feel that being "socialized professionally in the same way", and sharing "certain ways of looking at things", would facilitate "understanding". There seems to be a desire for a certain "twinship" quality in the relationship.

As noted above, consultant competence was also identified as a selection criteria. Competence was defined in terms of knowledge, skills and attitudes they thought the consultant should possess. These aspects of consultant competence were found to be similar to those identified by the Lippitts (1978). The consultees all stressed the importance of the consultant being well grounded theoretically and possessing the ability to synthesize, develop themes and "pull it all together" within the context of working with them at their level. As "Marissa" stated:

> It is important that the consultant have a comfort with the general knowledge of the profession, of the work, the theoretical concepts and an ability to articulate them and integrate them, practice them, to converse about them and to be able to answer questions comfortably.

Once the criteria of familiarity, similarity and competence were met, an effort was made to determine if there was a "goodness of fit" (Glidewell, 1959). This took

time to assess. Criteria included the ability to work at their level, and to mirror and resonate with them. Subjects agreed that they wanted a consultant who was able to accept and work with their current level of professional development. As "Harmony" observed, "I wanted her to be able to accept me where I was and teach me from that point forward". "Lee" explained:

> It was important to me that she be able to understand and accept my style and work with it...stay with me as I travel on it. I think that's hard to do. I need her to have a way of working with me that is not overpowering and allows the development of what is very uniquely my way of being, and doing...what's going to work for me...not trying to change me. I need to have a consultant understand and appreciate that this is my style and that it isn't a deficit, which I've been made to feel before.

Subjects seemed to find it important that the consultant see them, indeed mirror them, and their therapeutic "style" and work with them "at their own level". While mirroring was present early on, its full effect did not seem to be felt until the establishment of the learning alliance ("Step" III).

Consultees also stressed the importance of the consultant's ability to listen well and communicate clearly. "Sandra" expressed her view about the consultant's skills:

> I have to feel that I'm really being understood. To that extent then, she really has to listen carefully and be able to communicate back to me that which she understands me to be saying. It's a very special kind of listening, like that of the therapist in a session.

The mirroring mentioned above with regard to seeing and appreciating one's style is here expanded to a desire for resonance of a quality found in the early maternal dyad. This experience of resonating with the consultant was generally not found to exist on a regular and consistent basis until the consulting relationship emerged ("Step" III).

More specific aspects of this ability to resonate were identified by each of the consultees. There was a need for the consultant to be empathic, flexible, non-judgmental, and not-critical. "Jennie" observed:

> She has this incredible ability to tolerate and understand my not knowing as much as she does and helps me come to feel okay about it.

The quality of the relationship then seems to transcend those found in everyday life. There is a mirroring, a respect and an attunement operating at an exquisitely sensitive level. "Allyn" captures the essence of this "good fit" when she observed:

> I didn't ask her to provide me with a resume...you know, you can look real good on paper, but how you come off interpersonally can be totally different. It would make me feel better that she's older than I am and that she has had more experience than I have. Those things are all important but they don't necessarily create someone who's good and who you can work with. I had to go meet with her and see how I felt...if I was comfortable with her. I had to see <u>who</u> the person was I would be relating to, learning from and opening up to and exposing myself.

In sum, in "Step" II, the consultee has recognized a need for help and sets about finding it. There are essentially three aspects to this process. First, a number of potential consultants are identified. Identification has three components, familiarity with the consultant, personal characteristics and competencies. Next, someone in the field who meets the criteria is sought. There seems to be a need to find a relationship that has a "twinship" quality to it. Identification of these qualities requires process learning (introspection). Finally, there is a search for the finer individual qualities that make for the right "fit". The right "fit" is contingent upon the consultee feeling understood and mirrored by the consultant. As the relationship deepens resonance is experienced. It will be demonstrated in the following section that, for those who were in consultation for a longer period of time (mean = 44 sessions) a fine level of attunement developed. Resonance in turn helped to foster a more profound level of learning. Before this can be demonstrated however, we once again need to back track a little in time to the moment at which selection criteria are met.

"Step" III: Utilization of the Help

With a reasonable degree of confidence that the consultant has the ability to meet the consultee's expectations ("Step" II), the help can be utilized. All of the consultees used the consultee-centered consultation model

(Caplan, 1970) wherein improvement in the consultee's handling of the case is the objective. It is within this frame that the optimal learning environment emerges. Essential to the optimal learning environment are the personal characteristics of the consultant, her active role in the consultation process and the development of a learning alliance. As consultant/consultee congruence in expectations increased, consultees were able to progress from the insecurity of "not knowing" to relative mastery over content and countertransferential concerns. This progression was primarily attributed to the use of parallel process. That is, the learning alliance between consultee and consultant begins to parallel the therapeutic alliance (between therapist and patient) such that the dynamics of the therapeutic relationship unfold. The consultant can then help the consultee identify problematic aspects of the therapeutic alliance and facilitate their amelioration by using both didactic and non-didactic interventions. The multi-level learning that occurs is more profound than the learning that takes place in "Step" II as is the nature and extent of the personal and professional growth. While all of the susbjects experienced "Step III learning", the degree is reflected on a continuum based on the length of time in consultation and the nature of the consulting relationship.

<u>The formation of the optimal learning environment.</u> The optimal learning environment was described by subjects as an

"oasis", a "time out for me". "Marissa" observed, "I see it as a breathing space where I can let out some of my fears and questions and tension and have somebody help me." "Harmony" states, "This is the place where I have freedom to be myself and learn". Consultees attributed these feelings to the safe confines of the highly personalized learning environment that was contoured to their individual and unique backgrounds and learning needs.

It was only within this safe and trusting environment or what Knowles (1980) referred to as the "proper conditions and climate for learning" that consultees felt they could risk the self-consciousness and embarrassment inherent in the consultation process. The personal characteristics of the consultant help to facilitate the evolution of the optimal learning environment.

Personal characteristics of the consultant. As noted above, subjects identified specific personal characteristics of the consultant as being essential selection criteria. Findings suggest that these qualities also pertain here. "Sandra" (12 sessions) expresses the essence of these criteria:

> It's so hard to articulate this because alot of it is non-verbal. It was a way about her presentation of herself and the way she took me in. It was a softness, a quality that made it okay, made it safe, and trusting for me. It was just felt. It was a connection...a very deep connection...it would be the way she was looking at me. She would nod, the way she would smile, or, just non-verbally relate, and connect with me.

The "softness" and "profound connection" described by

"Sandra" subsume the sensitive, respectful, empathic, non-judgmental, accepting, and relational qualities identified as being essential selection criteria in "Step" II. Here however, interactive skill was expanded to include not only the ability to convey expertise, but self knowledge as it pertains to the consultant's intrapsychic dynamics and the development of an effective learning alliance. Even "Glenn", who had only two consultation sessions, was able to observe this phenomenon:

> The consultant needs to be aware of what belongs to her and what belongs to me. Sure, she has to be smart, she has to know alot. She has to have had alot of experience. The same kind of knowledge and experience as I have, but more of it! She needs lots of life experience. But this awareness of what's her stuff is very important. It helps if she's been in her own therapy.

"Lee" (10 sessions) added that "It is real important that she have a sense of herself and not need me in any way." In both instances subjects emphasize the importance of the consultant maintaining her boundaries so that individual differences are respected and the consultee's opinions are addressed without prejudice.

Knowledge of learning theory which in "Step" II was a selection criteria, is now, in "Step" III, identified by subjects as being an important variable in the formation of the optimal learning environment. The two consultees, who served as consultants to social work interns placed in their agency setting, actually referred to this aspect in the

terms "adult learning theory". "Harmony" said:

> The consultant must be accepting of the adult learner. She must be aware that the person is there to grow, to learn. She must demonstrate that flexibility and encourage the learner to bring their questions. That's why they're there, after all. If you think about adult learning theory, you know that you have to start where the person is--it's like social work--you start where the person is. It requires someone who can let the person grow as they need to and can handle it.

Indeed, regardless of the length of time in consultation, all of the consultees felt that the consultant needed to be able to work with them at their own level with their own particular learning style, at their own pace without superimposing her own manner or tempo. In "Step" II we saw the inception of this phenomenon. By "Step" III the framework is well established. As such, it helps to provide the safety and trust necessary to multi-level learning.

The role of the consultant. A new theme emerging in "Step" III is the consultant's participatory role in the relationship. More specifically, there is an awareness of and concern with the consultant's actual role. Aspects of this role not only included colleague, therapist, and teacher, but also her approach to the consultation process.

The actual role of the consultant, as experienced by the consultee, was difficult to analyze not only because it was unlike any other "teaching" role they had encountered, but because it is not always possible to distinguish between her role and her personality. Nonetheless, subjects felt

that the consultant needed to be a colleague. That is, they differentiated the consultant from the therapist and the supervisor in ways consistent with the literature (Gallessich, 1982: Kadushin, 1977; Kaslow, 1977; Rapoport, 1963; Siegel, 1955; Towle, 1951). More specifically, in attempting to distinguish between the role of the supervisor and that of the consultant, subjects observed that the supervisor is "someone who has authority over me in my agency setting." "She's someone who is concerned with administrative and policy things." Several of the consultees noted that their agency supervisor was not an especially gifted therapist and was not well equipped to deal with the depth of questions needed to increase their understanding of the therapeutic process. The consultees also observed that because they were being "evaluated" by the supervisor they did not feel that they could "risk discussing some of the more personal countertransferential issues" with which they were struggling. Finally, the consultees noted that the consultant was "friendlier and more self-disclosing" than either a supervisor or therapist. One's therapist was seen as someone who helps with personal problems. While consultees (5; mean = 44 sessions) using the consultation experience to address the counter-transference did find it to have personal therapeutic value, they did not see it as therapy. "Allyn" observed her work with the countertransference as follows:

> I'll identify an area that seems to be a conflict for me with the patient. She allows me to examine my conflicts in a safe setting where I can have feelings of being supported and look at my situation in a new way. As I ventilate, I'm then able to feel differently about myself.

The countertransference then is used to help facilitate self-awareness and self-understanding as it pertains to the clinical material.

The educational aspect of the consultant's role was highly valued by all of the consultees regardless of the length of time in consultation. While subjects did identify the consultants as "teachers" or "educators" their descriptions were not consistent with the role generally associated with former teachers. More specifically, instead of just imparting knowledge, the consultant was seen in terms of "her ability to help me with what I want to learn." Former teachers, in contrast, were described as people "who feed you what they decide you should be learning." This is consistent with the findings of Tough (1967, 1971) and Reynolds who determined that the facilitator of adult learning follows the path of the learner's lead. As "Allyn" observed:

> She doesn't say, "You must learn!" She just allows it to happen. But you see, that's the thing that's so difficult to articulate. It's allowed to happen in this safe place that's created between the two of us that allows me to face whatever and gives me the freedom to present whatever is on my mind, and to ask whatever.

While teaching and learning did occur, "Allyn" draws a distinction between directed, academic education and the consultant who "just allows it (learning) to occur".

"Sandra's" description best clarifies any remaining confusion about the consultant's role:

> I knew that I wouldn't just talk about myself as I would in my own therapy. And yet, it was a fine line. I knew when not to just talk about me and my issues. I don't know how to explain this...It wasn't therapy for me, couldn't be therapy because of the focus of my problems presented was in relation to my patients. It's almost like a student with a teacher, you can be close, you can learn, but there are certain things you can't do. It's not a friendship, you don't hang out together.

The role of the consultant then is multi-dimensional. There seems to be aspects of therapist, teacher and colleague which, when seen as a gestalt, provides a relationship that transcends its component parts.

In analyzing the role of the consultant further, subjects determined that her approach toward their work together was also important. Approach was defined in terms of the consultee's perception of what the consultant does, what her interventions are, how she interacts, and what she offers. First, subjects reported that the consultant provided an overall structure for them. It was within this structure that an identification of the consultee's learning needs was accomplished. The consultees felt free to explore their presenting problem with a level of depth that was syntonic with their theoretical and technical skill. At

times, the consultant addressed the content and didactic considerations while, at others, identifying the problem and how to approach it seemed to be more salient. In both instances, it was the consultee who determined what was to be discussed. None of the consultees felt that their consultant superimposed her own ideas or independently designed or executed the agenda. While working at the consultee's level was determined to be a selection criteria in "Step" II, it will be demonstrated below that the safety and trust established in the optimal learning environment facilitate the in-depth exploration of these learning needs in "Step" III.

A second aspect of the consultant's approach was her readiness to openly consider new variables in her analysis of a problem and revise her position accordingly. This mutuality and collaborative effort was identified by all subjects as being essential to effective consultation. This give and take in turn, was seen as necessary to being able to use the consultant as an effective role model who sanctioned self discovery and personal growth. "Allyn" described the mutuality as follows:

> I've never really experienced a learning situation such as this. All my other learning situations have been formal. You get from point A to point B in a certain amount of time. There isn't any give and take. This is a relationship versus the other where I was a passive learner. Learning this way is a real rounded experience...There's an understanding about your purpose together and why you're working together. It's safe and secure.

Again, while mutuality was identified as a selection criteria in "Step" II, it will be demonstrated below that it becomes an essential ingredient of the collaborative effort necessary to address multi-level learning in "Step" III. It is an active, purposeful process that is dynamic and exciting.

In sum, all of the consultees, despite the length of time they had been in consultation, or the way in which they were utilizing the help, seemed to be looking for a Winnicottian environment with a "good enough mothering experience" (Winnicott, 1975). It was only when subjects experienced safety and security within the consulting relationship that they were able to more fully "utilize the help".

The learning alliance. This safety in turn fosters the development of a deeper relationship with the consultant. Medway (1979) suggests that the learning alliance is central to successful consultation. Subjects determined that active engagement on the part of both the consultant and consultee was essential suggesting consultant/consultee congruence (Kidd, 1973). Several aspects of the learning alliance were identified. They include both technical and personal qualities. Technical aspects include using the Robbins and Spencer (1968) model, applying a multi-variable approach, listening carefully, mirroring and parallel process. Personal qualities are subsumed within the context of the

relationship. They include congruence in consultee/consultant expectations, and time for the relationship to develop. The consultant's "good enough mothering" qualities wherein selfobject and twinship functions play a role, most notably in terms of emotional support, mirroring and praise, were also found to be essential.

1. Technical qualities. One quality that helped to stimulate growth was reminiscent of that reported by Robbins and Spencer (1968). As noted above (Chapter II) their research suggests sequential expositional, and reactive phases during which the consultee initially gives information to the consultant, and the consultant then becomes active by bringing perspective to the problem. "Lee's" comment illustrates this model:

> I start off by presenting her with information about the case. Usually while I'm meandering around filling her in with details, she'll interrupt me with questions...which have a clarifying effect on me. Her questions also help me know that she understands the dynamics of what I'm presenting. It's like she draws it all together...out of the clutter. Then she articulates it very clearly and simply. She does it in such a way that helps you to be able to see what it is. She makes it clearer what you're struggling with.

For "Lee", the sequence began with presenting information. This is followed by the consultant's exposition of the data which has a "clarifying effect". In the reactive phase, she was able to "see what it is". Responding more appropriately

to the patient's difficulty now becomes possible. The final phase of consultation referred to by Robbins & Spencer as "time for summarizing and making plans for future commitments" was not applicable to the current study since these were on-going consultations.

A second technical aspect of the learning alliance was found to be the consultant's approach. More specifically, the consultees described the approach of the consultant in a manner consistent with the Lippitts' (1975) model. The Lippitts identified various approaches along a continuum ranging from nondirective to directive. They described the approaches of the consultant as: reflector, fact finder, alternative identifier, joint problem-solver, trainer-educator, informational expert and advocate (for the consultee). In the current study subjects noted the consultant's approach as: reflector, collaborator, teacher/educator, and "good enough mother". However, subjects did not describe the degree of directiveness found in the Lippitts' study. As noted previously, consultants were not found to assume a leadership role or to direct the activity in the learning transaction. Nonetheless, the considerable variation in the consultant's approach is consistent with both adult learning literature and social work research (Gibb, 1959; Kadushin & Buckman, 1978; Kidd, 1973; Lippitt & Lippitt, 1975; O'Keefe, 1958).

The following description by "Glenn" helps to illuminate the concept of variability in approach:

> Sometimes she'll want to find out from me, what the patient is actually sounding like. What's the patient saying? What's the patient seeing? What are the difficulties? She'll just sort of spontaneously launch into it almost like a role play kind of thing where she actually sort of models what she would say to the patient. It's very exciting!

Clearly, both consultant and consultee are immersed in a constellation of techniques including joint discovery, questioning and giving and returning feedback. Consultees also reported that the consultant seems to reflect back or mirror their feelings in a way that leaves them feeling understood. The quality of the mirroring reported was linked to the nature of the learning alliance and the length of time in consultation. Mirroring helped the consultee's struggle with the anxiety of "not knowing". "Jennie's" (54 sessions) comment is prototypical of those who had been in consultation for a long time (5; mean = 44 sessions):

> She interprets, but she's interpreting what I am saying and she knows that is something that I have to understand. Or, the other way around I will say, "Wait a minute, I don't understand this" and then she will say, "Okay, let's talk about it a different way." Or, if I say that I don't understand it and I keep getting confused between one theory and another, she'll say, "Well, they are confusing so maybe we need to understand it more slowly." So I think she really listens, and analyses and interprets what I am saying.

"Jennie's" frustration is apparent here. The consultant's versatility and struggle to mirror her is a valiant one.

The effect for "Jennie" is one of containing her anxiety and clarifying her approach.

The intervention that was determined to be the most helpful was the consultant's ability to listen carefully and to understand. Understanding was defined as the consultant's ability to help clarify and identify the source of the problem and to appreciate the level of frustration and concomitant countertransferential elements that might be involved. As "Marissa" related:

> I really feel that she is listening to me and I also believe, that she acts as the part of me that doesn't need to be as hard on myself and offers something in a way that is without the self-judgment. I can then slide into that role of seeing the problem and appreciating my part of it rather than judging. It is rather hard to explain because it is very subtle. With her patient listening and demonstrated understanding I'm able to then understand these situations rather than to block my understanding. It is that experience that has helped me to trust and know that she really seems to understand me.

Within the context of the learning alliance, technical interventions fostered personal and professional growth. Personal growth is evident in the transference, "She acts as the part of me that doesn't need to be so hard on myself", and in the countertransference, "I can then (appreciate) my part of it rather than judge (it). Professional growth is also evident. "I'm (now) able to understand these situations". Multi-level learning then occurs on a profound level. Learning is integrated into the self structure such that change may occur personally and professionally.

While all the subjects reported that the Robbins and Spencer model, a variable approach, and listening and mirroring were useful in helping them to contain their anxiety associated with "not knowing" those who had been in consultation for a longer period of time (mean = 44 sessions), reported that working with parallel process was the most useful method. Using this technique, a gain in professional knowledge and skill and the personal insight necessary to help the patient was noted. "Marissa" (56 sessions) describes parallel process as follows:

> What I need to learn is how to deal with the situation with the patient and work it out with the consultant in the consultation....many times it's a re-enactment of something and only later does it become clear.

The dynamics of the therapeutic relationship are "recreated" in the consulting room in an effort to understand them. In discussing the anxiety associated with the uncertainty of "not knowing" "Allyn" (48 sessions) reveals the dynamic components of parallel process:

> She listened to my material. She would stop me in the beginning, the middle, whatever, and she interpreted what I did, she asked what I was feeling at the time, what my thoughts were, why I said that, what my understanding of what was going on in the room at that moment, why I didn't say something, why I thought it, things like that. And then she would talk about her reactions to the patient's material, transference and what I might be struggling with at that moment.

The therapeutic alliance then is transferred to the learning alliance. Time for the relationship to develop and for

safety and trust to form are necessary to permit this level of vulnerability and self disclosure. The elements of the learning alliance that facilitate this process are contained within the relationship and the personal qualities of the consultant.

2. Personal Qualities. As noted above, the data suggest that the personal qualities of the consultant, her role and technique determine the nature of the learning alliance. The alliance in turn affects the nature and quality of the consulting relationship. This relationship was found to be the single most significant component facilitating multi-level learning. This finding is supported by the perceptions of consultants (Caplan, 1970; Green, 1983; Glidewell, 1959; Mannino, 1969; Robbins & Spencer, 1978; Smith, 1975). Analysis of the data helps to reveal the nuances of this phenomenon. A high level of congruence was found to exist between the consultee/consultant role expectations and the task perceptions brought by both parties to the learning transaction. Of particular note was the consultee's expectations and perception of the role of the consultant. That is, when genuine admiration and respect for the relationship was felt, consultees reported that the relationship was both comforting and helpful. In describing the special qualities of this relationship, "Sandra" said:

> It's a very personal and unique relationship. It would be a waste of time if it wasn't. I really

> want to stress that, because it's different than any other kind of professional or personal relationship a therapist can have. She let me idealize her at times. She was very comfortable with my projections of her. Without it being therapy, she was comfortable in what I needed her to be at the time. She was a very instrumental person in my life, a mentor, a role model, teacher, friend, kind of. With her, I began to feel competent as a therapist and began to grow. I could see that in myself. I wouldn't feel like a student, necessarily, or a little kid. I felt stronger as a result of the relationship. I think her validation and support, the special rapport we had in this very unique, very deep, very intense relationship allowed me to grow. It really allowed me to grow.

"Sandra's" perception is representative. Clearly, the extraordinary relationship fostered both personal and professional growth and included within it learning on both a cognitive and affective level which emerged during the course of a technically sophisticated and personally compassionate consultative experience.

That the depth of this relationship is something that evolves gradually is reflected in "Marissa's" (56 sessions) comment:

> ...it is much more the process of the relationship that helps me learn, and to take in. As I have grown and developed, I am able to make use of the consulting relationship in a different way.

While "good enough mothering" was determined by all subjects to be essential to the formation of the learning alliance, a richer experience that develops gradually, over time, was identified here as being necessary to the deepening of this relationship. More specifically, subjects now reported that

the consultant was able to tolerate and support their state of confusion. They seemed to have "endurance for their ventilation and frustrations", were able to provide "nourishment", and bolster and "lend support to their egos". The measures taken were similar to those reported by Tetreault (1968). "Harmony's" (48 sessions) comment is representative:

> The consultant lends support to my developing sense of pride and accomplishment in the work. In discussing my cases I found I was doing really good work without knowing why. She encourages me to accept myself and what I have to offer to my patient."

As can be seen from "Harmony's" comment, the ego support offered is increasingly internalized and serves a selfobject function. "Sandra's" (12 sessions) comment expands on this phenomenon:

> Sometimes when I left, I would think, how am I going to translate that into my case? Sometimes I would ask that because I think I struggled with wanting to say exactly what she said to the patient and I couldn't... I can't. It's never the same. So I had to learn that what I understood and did was okay because I was taking bits of her with me.

The subjects then, found the consultant's approach to be beneficial and something they could refer to and use in the therapy setting. They were reflective about the consultant's questions and comments. None of the consultees attempted to imitate the consultant, although each "tried on" ideas generated by the discussion to see if they would "fit". The discussions were most useful when the consultee

had a way of assimilating the information in order to apply it for a "next time".

Subjects also felt that emotional support and praise were essential to the consulting relationship. They determined that it was needed to preserve the integrity of their "learning equilibrium." The anxiety surrounding the uncertainty and of "not knowing", the fear of losing face, and of being potentially humiliated were identified as the central factors threatening that equilibrium. Findings are congruent with the work of Caplan (1964), James, et al. (1986), and Parker (1962) who, reporting from the consultant's perspective, note that emotional support is offered in an effort to prevent feelings of intimidation and loss of self respect.

Praise was found to be essential not only in the development of the consulting relationship, but in a positive outcome of the consultation as well. "Marissa" (56 sessions) expressed the sentiments of all when she observed:

> I feel that this consultant has taken a real interest in me, in my professional development and feels excited about who I am and has demonstrated it by a willingness to work with me in any way.

The subject's perception of the consultant's encouragement is supported by the consultant's perception of the same phenomenon (Robbins & Spencer, 1968). Perhaps the most poignant illustration of resonance was made by "Jennie" (54 sessions):

> She listens to what I am saying and will say, "This is something that I know is hard for you" In a way it's like she is listening to me and it's like being on the couch with her.

There are few relationships where exquisite attunement exists on a level more profound than that found in the analytic relationship. That "Jennie" was able to achieve this degree of resonance within the consultation experience is remarkable. That it is a key factor in determining efficacy will become apparent in "Step" IV.

In sum, in "Step" III we saw that the dynamic components in clinical consultation effect what is learned and the way in which that learning takes place. More specifically, learning was both affective and cognitive and fostered personal and professional growth. Essential to this process was an optimal learning environment and a learning alliance. The personal qualities, technical skills, and role of the consultant within the context of this Winnicottian environment facilitated the development of a profound relationship where mutuality, collaboration and vulnerability were possible. Vulnerability in turn was necessary in utilizing parallel process to understand the therapeutic alliance. Further, the use of parallel process helped to foster a deeper level of understanding effecting both personal and professional growth. That is, when learning was primarily didactic, consultees were generally

in the initial phase of the consultation process (2; mean = 6 sessions) and learning was, for the most part pragmatic and clinical. For those who had been in consultation longer (5; mean = 44 sessions) and for whom there was consultee/consultant congruence of expectations, together with a consultant who provided selfobject functions, learning was more likely to occur on a more profound level in that it tended to be integrated into the self structure and as such facilitated personal and professional change.

"Step" IV: Evaluation of the Help

In "Step" IV the subjects evaluate the outcome of their learning experience within the clinical consultation setting. Kenney (1986) and Mannino & Shore (1975) note that goal attainment assessment is the method most commonly used to evaluate consultation effectiveness. It is noteworthy that subjects in the current study reported on the efficacy of the consultation but did not identify specific goals. This can be understood in part by the uniquely continuous nature of their consultation rather than the time limited process reviewed in the above research. Additional variables that may effect this finding are the private, for fee arrangement which stands in sharp contrast to the assigned, free, time limited consultation provided in agency settings.

Efficacy in the current study was defined in terms of professional and personal growth. The interrelationship between these two different, albeit intertwined types of

learning was noted. That is, subjects observed that the consulting relationship provided them with a holding environment in which they could flourish. This finding is consistent with consultant's perspective of the same phenomenon (Farley, 1963; Macarov, 1968; Schmuck, 1968; and Teitelbaum, 1961). Results from these studies suggest that management of the relationship at a safe and comfortable distance prevented barriers from being erected and hence facilitated self disclosure and learning personally and professionally. In the current study, professional growth was described by the subjects as content learning. Its focus is more cognitive, with a change in the function of the role of clinician as its objective. It is considered to be didactic and theoretical learning where knowledge, skill, and objectivity are the focus. Personal growth, on the other hand, is considered to be more of an affective experience with an emphasis on the process of learning. It is experiential and non-didactic and change in the person is its objective. This learning experience is distinctive in that it encourages self knowledge that can be both personal and professional. It facilitates the development of enhanced self confidence, self esteem, and may also effect one's ability to be more objective. Objectivity in turn, provides a connective link in that it falls in both content and process categories. Personal and professional learning objectives can be seen in Figure 1.

Figure 1

Learning Objectives

Knowledge--Familiarity with a particular subject acquired from readings and assimilated with theory, combined with practical clinical experience.

Skill--The integration of theoretical knowledge and clinical experience one develops to deal effectively with psychotherapeutic issues.

Objectivity--The state or quality of having "good enough" self awareness and self understanding to sufficiently contain one's personal feelings and/or prejudice in order to differentiate boundaries and preserve the necessary clinical distance for effective treatment.

Confidence--A trust and/or belief in oneself that promotes autonomy and self esteem.

In Figure 2 below, it can be seen that the relationship between content and process learning, professional and personal growth, didactic and non-didactic learning suggests that concept learning, or learning about clinical technique (the acquisition of knowledge) may be a point of entry to assist consultees to think more clearly and to organize their feelings. To learn what one already "knows" and to internalize that knowledge implies learning at a deeper level and the potential for more profound personal and professional growth.

Figure 2

Types of Learning

Content or Concept Learning	Process or Personal Growth and Development Learning
cognitive	affective
didactic	non-didactic
theoretical	experiential
change in professional functioning	change in self view

In terms of the specific content and process of their learning, the candor and degree to which subjects readily explored their experience as well as their psychotherapeutic dilemmas was surprising. This can be understood, in part, in terms of the limited opportunities many therapists have to talk about their work and their role in it. Perhaps in the role of subject, a forum was provided for them to speak openly, personally, and confidentially.

One aspect of personal growth was increased self-confidence. All of the consultees reported feeling more confident. Increased confidence was defined in terms of an enhanced self concept vis-a-vis competence and effectiveness as a therapist. Confidence was also bolstered by a sense of increased self awareness and self acceptance related to self

demands and expectations. The interactional quality of personal and professional growth as it pertains to confidence is captured in "Allyn's" statement:

> In our profession we need to know about ourselves. We don't get better by learning how to design better computer chips. We get better by becoming more sensitive to others who we're trying to help. And you don't get better at that if you cannot deal with your own stuff, or if your stuff is in the way. Doing so can provide objectivity, and you need a certain amount of objectivity in the process, because if you just use other people to connect with yourself and not deal with yourself, then, you can have too much countertransference interference.

Understanding and helping the patient then was seen to be related, at least in part, to one's self knowledge. Personal and professional growth was also reported in terms of an increase in cognitive/theoretical knowledge, technical competence and process skills. Like the consultant's reports of their consultees in Teitelbaum's (1968) study, learning occurred on both a cognitive and affective level. While all of the consultees reported a subjective experience of elevated confidence, an increased sense of competence, growing self acceptance, and an expanded awareness of effectiveness, the degree varied with the length of time in consultation and the degree of congruence in consultant/consultee expectations. Each of these are discussed in more depth below.

Self development of a personal and professional nature was defined in terms of the acquisition of competence in

their perception of themselves as psychotherapists. This includes the practical aspects and nuances of providing intensive psychotherapy. "Jennie's" (54 sessions) and "Marissa's" (56 sessions) comments are illustrative of these points:

> She has opened up a door now that I didn't see before. I think I sort of had a little beginning of that in my own work, but the development of it and what she has presented to us and how to expand on your own feelings and thoughts and your work with the patient is what is happening and feels so good in my perception of myself as a therapist.
>
> I'm developing, forming, really, my professional identity and what that means and how I envision myself as a clinical social worker.

Like the other consultees, "Jennie" and "Marissa" experienced an increased sense of confidence and competence as a result of their consultation experience. Learning was both affective, "...feels so good" and cognitive, "...the development of my work".

Another aspect of the personal and professional growth was an expanded self awareness. "Sandra" (12 sessions) described this process as follows:

> I needed to learn to be more myself with patients. To not be so rigid, to be more relaxed, to be more human, to laugh, to be playful at times. This was very important for me. My consultant was very helpful in this. I would notice that she would be playful and spontaneous and humorous and fun and it was okay. It wasn't upsetting me. It wasn't changing the atmosphere of consultation. I used to be so serious. I still am, kind of, but not as bad. She made it okay to bring out the child in me. My patients have benefited from this more relaxed way that I can now be with them.

"Sandra", like the other consultees, discovered, during the course of consultation, new aspects of herself that helped her to expand personally. Affective and cognitive learning were expressed in terms of personal growth, ("I used to be so serious...I still am kind of but not as bad") and professional growth ("my patients have benefited").

Finally, consultees reported a greater appreciation, expression and functional use of their latent inner resources. They attributed this growth to the nature of the consulting relationship and the role of the consultant in helping them to realize their potential. "Harmony's" (48 sessions) comment captures the essence of these feelings:

> I leave feeling more confident, professional, grounded in theory. She reinforces the ability I have had all along. I find that I know more than I thought I knew...She conveys that I'm intelligent, insightful and that I have all the tools.

In sum, with an increase in feelings of competence, confidence and an expanded awareness of effectiveness, subjects noted an improvement in their self esteem. Consultation seemed to provide a means to pursue their learning which as a dynamic, interpersonal process helped them to sort out the difficulty they were experiencing with their patient and/or with themselves. The advantage of this kind of personalized learning experience which heightens the integration of intellectual understanding and affective comprehension was contrasted with the impersonal setting of a course, and the lonely setting of independent study.

"Sandra" (12 sessions) noted that she can take "all the seminars and classes there are...but unless I'm willing to look into my own self in a very, very deep level and be open and willing to do the work, it's just a bunch of professional jargon."

For these consultees then, learning by doing was reported to be the most meaningful way to learn. As "Marissa" (56 sessions) observed:

> I come out feeling empowered to make use out of what I was struggling with. It's very exciting. It helps me to appreciate the profession, and what can happen within the parallel process of the consultation setting in terms of professional growth. To really feel, and see the impact of that movement and growth is encouraging and rewarding.

Commentary

While there was a preponderance of satisfaction expressed by the consultees, there were several criticisms presented as well. All of the consultees shared the common concern that there was not enough time to spend in the consultation setting. This was influenced not only by the cost of the consultation but also by time constraints. "Marissa" (56 sessions) exclaimed, "It is not enough. I would like it every day. I would like to go for that hour, every day." Also referring to time, "Lee" (10 sessions) stated, "I wish I had started consultation sooner because it has been so helpful in my ability to build and maintain my practice".

A second concern was expressed by one subject who objected to the consultant talking about her own cases. "Lee" stated:

> I just want to talk about my own cases. Consultants always have a tendency to go off on their own cases. They want to talk on that and they want to do a comparison or show you something. I don't like that. My time is really limited and it's not helpful for me at all. Once in a while it might be as a metaphor or something, but it's not helpful so I'll get agitated when that happens. I can barely wait to go right back in, which I do.

The remaining consultees however, found the consultant's comments to be helpful because the consultant was seen as a role model whose example could be usefully applied. In addition, under these circumstances the consultant seemed to be more vulnerable, a factor which in turn seemed to help deepen the relationship with her and facilitate the learning process.

Finally, the subjects independently addressed the question of quality control for both consultants and consultees. There was a consensus that they should have their own psychotherapy or psychoanalysis. "Allyn" (48 sessions) stated:

> If you don't deal with your own stuff, I think at worst, you could really do damage. Most of us don't, thank goodness. However, in more subtle forms you can harbor hostility towards a client perhaps for years and using your own dynamics, your own conflicts, your own issues against this person, and it can be a very unhealthy relationship. So, you don't want to do that. You want to get clear of yourself. Therefore, training for clinicians really needs to include therapy.

With varying degrees of intensity, all of the subjects also stressed the value and necessity of consultation for clinicians. As "Glenn" noted:

> The consultant needs to be aware of what belongs to her and what belongs to me...This awareness of her stuff is very important. It helps if she's been in her own therapy.

Two of the consultees were adamant in their belief that consultation should be a requirement for licensure. "Jennie" (54 sessions) said:

> It's disturbing to think that there are lots of people out there practicing who haven't even had their own therapy and... aren't getting consultation, even on an "as needed" basis. They're just sitting there, winging it! How can they even know what the experience is like? I wish there was some way to let practioners know what an important component consultation is. You can't force people, unless it's made a part of the conditions of licensure, which it probably <u>should</u> be! You should have to prove that you have been in therapy and in on-going consultation!

Clearly, for these subjects, the use of consultation in their practice and for themselves personally, reflects a perspective and commitment to on-going, lifelong learning. "Allyn" (48 sessions) concluded:

> One can always grow more and I... I'm not expecting her to make me more aware of say, how to be more like Minuchin, or how to be more like Satir, or how to be more like whomever. I guess I would like her to continue doing what she's doing, which is helping me discover myself. And by that... doing that, I can just learn to be aware of that and not have that as a block for me so that I can approach anything that I want to in a much clearer, more comfortable way. There's always going to be blocks that need to be cleared away or dissolved or, diminished. But you're always going to have them. You can't just say, okay, I'm cured now. I've been in consultation for a couple of

> years now, and I feel okay. But it's a life long process. I like that she helps me with the process of self-discovery and she's been doing an incredible job. I really have to give her alot of credit!

Summary

The findings of this study suggest that the dynamic components of the consultation process that facilitate adult learning can be defined. Moreover, what is learned during consultation as well as the factors that influence this learning process can be identified. Finally, these factors can be understood within the context of four sequential but overlapping "steps". The "steps" are:

I Recognition of the need for help

II Selection of the helper

III Utilization of the help

IV Evaluation of the help

In "Step" I, the consultee wrestles with the feeling of "not knowing" and recognizes that help is needed. The type of assistance sought is one that occurs within the context of a helping relationship. During "Step" II, fundamental and desired characteristics of the consulting relationship are explored as the consultee attempts to find the right "fit". A key element here is the congruence of the consultee's self expectations and the expectations of the consultant. In "Step" III, the learning alliance emerges within the context of the optimal learning environment. Additionally, the consultant's personality, role, and

approach are described as factors essential to the creation of this environment and the subsequent development of a learning alliance. Learning was found to occur in terms of process and content such that both personal and professional growth occur. The safety and trust of this atmosphere in turn, facilitated a deepening of the relationship and the vulnerability and self disclosure essential to parallel process. Finally, in "Step" IV the consultees' perceptions of what occurred in the learning experience and their evaluation of the consultation process is presented. All of the subjects reported an increased self awareness and self confidence on both a personal and a professional level. The depth and extent of this growth and development was, in large measure, contingent upon the length of time in consultation and the nature of the consulting relationship. A discussion of these findings and their relationship to social work education as it pertains to clinical consultation and Andragogy follows in Chapter V.

CHAPTER V

DISCUSSION AND IMPLICATIONS

An effort has been made to further our understanding of the learning process that occurs during the course of clinical social work consultation. In this chapter it will be demonstrated that Andragogy is an appropriate theoretical base for clinical social work consultation. Toward this end findings will be discussed in terms of the relevant social work education literature and its relationship to both clinical consultation and Andragogy. A brief discussion of the correlation of these findings to clinical consultation research will follow. Next, the relationship between aspects of Self Psychology and the nature of adult learning as it takes place within the consultation process will be discussed. Finally, implications for both clinical practice and future research will be considered.

Andragogy as a Theoretical Base for Consultation

The purpose of this section is to see how Andragogy provides an appropriate theoretical base for social work clinical consultation. There are certain features one anticipates finding in the learning experience if Andragogy is applicable as a learning model. These features are the characteristics, motivation and expectations of the adult learner together with the characteristics of the facilitator

and her distinctive approach. Included in this approach are the following steps (Knowles, 1980):

1. A climate for learning is established.
2. The learner is involved in mutual planning.
3. Learning needs are assessed.
4. The learner is assisted in formulating these learning needs into specific objectives.
5. The learning outcome(s) is evaluated.

Each of these five steps will be discussed as they correspond to the data presented in Chapter IV.

Characteristics of the Adult Learner

As noted previously (Chapter II), the Andragogical paradigm is an active, process model in which it is posited that adult learners discover their need "to know". More specifically, Andragogy is characterized by the position that adult learners are self directed individuals who posses a readiness to learn that is performance centered (rather than subject centered). The subjects of the current study presented as self-sufficient clinicians who were struggling with a number of presenting problems, not the least of which was "not knowing". Their readiness to learn was demonstrated by a self awareness of their motivation to be helped in the performance of their role, and to feel more confident as psychotherapists. Their expectations were high. Moreover, they expected to be changed by this personalized learning experience. They were motivated by the need to obtain personal insight as well as information in order to become more effective. They were eager to

absorb, integrate and apply that which they were learning.

Characteristics of the Facilitator

Research suggests that facilitator qualities essential to adult learning are the ability to be respectful and trustworthy (Kidd, 1977; Knowles, 1980; Rogers, 1969; Tough, 1967, 1971). Subjects in the current study reported these qualities to be essential. Additional characteristics were identified. They are: the ability to work collaboratively and relate well, the skill to listen and communicate clearly, flexibility, the capacity to be empathic, non-judgmental and non-critical, the capability for self awareness and self reflection and selfobject functions, most notably mirroring, praise and encouragement. As noted above, each of these qualities were determined by Knowles, in his model of Andragogy, to be necessary to the "role of the facilitator". In the following discussion, the relationship of these qualities to the formation of the optimal learning environment will become clear.

Approach of the Facilitator

Andragogy posits that the facilitator of the learning experience creates an environment with the proper conditions for learning to occur. The facilitator then guides the interaction in a collaborative way so as to maximize the students' learning. Focusing attention on what is happening in the learner, the facilitator is aware and mindful of the tension aroused by the need for help. As noted above

Knowles suggests that the facilitator's approach to the learning experience is a five step process. The relationship between these steps and findings of the current study are discussed below.

1. Establish a climate for learning. The creation of the optimal learning environment as a prerequisite for learning to occur in clinical consultation is congruent with the establishment of a climate for learning in the Andragogical model. It was demonstrated in Chapter IV that the consultees felt that the optimal learning environment provided an atmosphere of safety and trust and as such helped them to contain their anxiety and self doubt. It was within the security of this environment that the consultee's learning process flourished.

2. Involve the learner in mutual planning. Like Knowles, who emphasized the importance of mutuality in the adult learning process, mutuality in the current study was found to be a significant factor not only in the planning stages of the learning process, but throughout the entire consultation experience. For example, subjects reported that the consultant's ability to work at their current level helped to promote active involvement. Moreover, the consultant's role (expected and perceived) as a collaborator and co-learner was determined by the subjects to be essential to the multi-level learning process. Finally, subjects perceived the consultant's interest and mutuality

as significant factors that helped to cultivate and reinforce the learning alliance. This in turn enriched the consulting relationship and ultimately the learning experience.

3. and 4. Diagnose the learning needs. Formulate learning needs into objectives. Learning needs and objectives will be discussed together. In Knowles' model, diagnosis of needs consists first of constructing, from the learner's perspective, a model in which the competencies required in an "ideal" and "good enough" performance are noted. Next, there are diagnostic experiences in which the learner is helped to assess his/her present level of competence in light of those portrayed in the "good enough" performance. This helps the learner to obtain feedback in objectively assessing the strengths and weaknesses of his/her performance and the deficits in his/her knowledge. This approach provides a clear sense of direction for self development. The diagnosed needs then become specific educational objectives, or directions for growth.

In the current study the consultant initially takes a more active role in the process of identifying learning needs and objectives. This may be, at least in part, because the consultant has more objectivity and distance than the consultee who may be momentarily preoccupied with countertransferential concerns. Nonetheless, this primacy does not preclude collaboration. Indeed, all subjects

stressed that mutual cooperation and collaboration were imperative. That subjects did in fact feel that they played a key role in this process is supported by their responses to consultant interventions. More specifically, the kinds of questions the consultant asked in order to obtain clarification; together with her ability to listen, understand, and help the consultee sort out the particular type of "not knowing"; were all aspects of diagnosing the learning need and formulating it into objectives. In this manner, the consultant's perspective helped the subjects to focus and organize their thinking and feelings. Please refer to Figure 1 for a list of the identified objectives.

5. Evaluate the learning outcome. The Andragogical feature of evaluating the learning outcome appears to be a more formal process than was found in the current study. That is, the findings suggest a more informal process of on-going evaluation rather than a structured assessment done at the completion of a course. It seems possible that this difference can be understood, at least in part by the on-going nature of consultation and the cost effectiveness component of a for fee arrangement. While very few of the subjects reported previous consultation experiences, one commented that the consultation ended when she found it to be unsatisfactory.

It should also be noted that the literature on clinical consultation was found to presuppose that adult learning is

a didactic process. As such, the existing body of literature has not helped to illuminate the total learning process in the consultation experience. However, as discussed above, the current study has not only attempted to define the nature of the learning process in clinical consultation but to determine if Andragogy provides a theoretical frame. While results suggest that a non-didactic learning process was operant, there were occasions when a didactic approach was requested by the consultee. This finding helps to further clarify the relationship between Andragogy and the learning process that occurs in the social work clinical consultation experience. That is, when the consultant's attitude and approach are Andragogical in nature, the consultee is empowered to direct his/her own learning. Moreover, the consultee's self awareness together with the nature of the consulting relationship assist the consultee to obtain what is needed (which, as noted, may at times be a didactic experience).

In sum, the above analysis suggests that Andragogy is not only applicable to social work clinical consultation, but that it does in fact underlie the process of learning that occurs during clinical consultation. These results in turn suggest that Andragogy can provide a theoretical context for the form of consultation practiced by social work clinicians. Further, while previous research tended to assume a theoretical framework, it can now be demonstrated

that one does indeed exist and that the learning experience can be approached as a combined didactic and non-didactic measurable experience.

The Relationship Between Andragogy, Clinical Social Work Education and Consultation

Inherent to the theoretical model of Andragogy are the basic principles of social work education and clinical social work consultation. The traditional philosophy of clinical social work education maintains that learning is an active process necessitating full participation and deep ego involvement. Learning is seen as a dynamic process that facilitates adaptation and change (Reynolds, 1942; Towle, 1954). Subjects in the current study described consultation in a manner reminiscent of Reynolds, and Tough (1967, 1971). As reported in Chapter II, Reynolds determined that the learning process for practioners has five stages. Data supporting four of these were identified by subjects of this study. That is, subjects expressed feelings of inadequacy and insecurity while seeking reassurance in an effort to trust their own responses. Self preoccupation was reported to lead to greater assimilation and understanding.

The "steps" identified in the consultation process are in turn analogous to Knowles' (1980) five step model of Andragogy. More specifically, the consultees observed a progression from the insecurity of "not knowing" to relative mastery over content and feelings during the course of their

consultation experience. Learning was seen as an ego function that seemed to facilitate change. Social work educators agree with this position but add that learning has an affective dimension as well. The consulting relationship, as reported in Chapter IV, was found to facilitate both cognitive and affective learning. There seems to be a clear relationship between Andragogy, clinical social work education and consultation such that Andragogy can provide a theoretical frame for social work education and consultation.

The Relationship Between Self Psychology and Learning Within the Context of Clinical Consultation

Several aspects of Self Psychology are relevant to understanding the learning process that occurs during clinical consultation. For example, the data suggest that the optimal learning environment provides an organizing structure for a profoundly personalized learning experience. Within this context consultees search for help with the development of their professional self structure and identity formation. As noted above, shame and humiliation may be experienced as the clinician begins to recognize his/her own internal conflicts unfolding within the therapeutic relationship and/or begins to feel stuck and "not know" why. Further, a clinician may feel a threat to his/her otherwise autonomous functioning with the realization and acceptance of the need for help. An

analysis of subject responses suggests that consultants appeared to provide the selfobject functions of mirroring, praise and encouragement, and at times "twinship merger". The data suggest that during the progressive and regressive stages of the consultation process the consultant's role as selfobject can be growth promoting. That is, regression to a "twinship merger" and/or mirroring seem to facilitate a progressive identification with the consultant. As the mirrored self and other parts are integrated, a more cohesive self structure is formed. That this process did in fact occur is suggested by the reported personal and professional change. This "merger/identification" phenomenon can be understood more completely by looking at parallel process. Wolf (1976, 1980, 1983, 1984) describes how treatment begins when the therapist becomes the selfobject for the patient and the patient becomes the selfobject for the therapist. It seems possible that it is not until the consultant becomes the selfobject for the consultee and the consultee becomes the selfobject for the consultant that self learning of both professional and personal nature can occur.

Implications for Practice

Clearly, the potential impact of the collaborative relationship, as it evolves during the consultation process, is important to the continuing growth and development of social work clinicians. Additional research is essential to

understanding this phenomenon in more depth. Further, from a pedagogical perspective, the interaction and interdependence of elements of social work education and training and Andragogy helps to provide a theoretical framework in which to understand continuing education for social work clinicians generally, and the practice of clinical social work consultation specifically.

The socialization of a professional social worker does not end at the completion of the Masters program. As one subject noted, "when I graduated...that was when I realized it was just the beginning." Clinical supervision is an accepted approach to further the learning and socialization process. Moreover, it is a prerequisite for licensure. For the psychotherapist with an interest in the development and improvement of clinical expertise and personal growth, clinical consultation may be the method of choice.

While the social work profession is structured in such a way that there is provision for and a distinction between supervision and consultation, consultation may not necessarily be obtained to continue the socialization process. Many social workers begin their careers in an agency setting, which remains their primary place of employment. A supervisor is usually assigned. As the subjects of this study indicated, supervision was not adequately meeting their clinical learning needs. This may in part be an artifact of a hierarchal structure wherein the

supervisee, dependent upon the supervisor for either performance evaluations or promotions, may then be reluctant to present sensitive material to him/her. Moreover, the supervisor may be concerned with administrative issues and may not have the time and/or interest in clinical training. A partial solution to meeting supervisory/clinical learning needs has been for agencies to provide consultants from within the agency. While this may seem to meet the needs of the clinician, additional factors may inhibit consultation use. For example, an agency setting carries with it many extraneous pressures and expectations. This factor in turn may effect not only the motivation and expectations of the consultees, but the use and course of consultation as well. Moreover, the consultee is generally assigned to a consultant, a factor that may impede the development of the learning alliance, thereby thwarting the creation of the optimal learning environment.

It is hoped that these findings may help to stimulate further use of outside consultants by social service agencies. Because agency resources are often limited, clinicians may want to pool their monies to purchase individual or group consultation. Supplementary agency funds may be provided when possible. As discussed above, efficacy is dependent to a large degree upon the consultee being able to select, and direct the consultation to meet individual learning needs.

In view of the above, the Board of Behavioral Science Examiners may want to consider consultation as one aspect of a continuing education requirement in an effort to protect the patient/consumer and to insure that practioners keep abreast of new developments in the field. Of particular note is the role of consultation in helping clinicians to develop the therapeutic alliance, to discover what is and is not known, and to deal with the uncertainty of "not knowing".

Additionally, it is anticipated that this study will help to increase our understanding of the consultation experience and further an appreciation of the importance of the learning alliance, and the powerful effect that patients, consultants and consultees have on one another through the dynamics of parallel process. Results may enable consultants and consultees to function more effectively in their respective roles by addressing the value of "learning by doing".

Finally, it is hoped that findings will help to increase our awareness of the value and use of consultation. Consultation offers a valuable dynamic learning process for a particular type of adult learner. Those consultees who purchase consultation appear to be adult learners who have the ability to seek out and use the opportunities available and needed for their own learning. The orientation to learning focuses on and utilizes one's autonomy and self

direction. It encompasses one's own individual style, personality characteristics, and philosophy of learning. It is the essence of immersing oneself in a helping collaborative relationship within the context of meeting particular learning objectives.

Implications for Future Research

It has been my intent to speak of the learning process that occurs in clinical consultation in a clear and recognizable manner. It is hoped that this study's identification and organization of the process of the learning experience in the interaction between consultant and consultee will afford further delineation and understanding of this modality of indirect service.

Findings suggest new areas for further study. Most human learning is extremely complex. Consequently, it is difficult to describe by observable or quantifiable measures. It is hoped that this exploratory study has deepened our knowledge of the directions of growth that consultation can promote. It is further hoped that the findings can be generalized subsequent to replications and variations of the study. For example, how would the structure of this sample's experience compare with that of a larger sample? How would the results compare to a sample receiving group consultation? If the sample were gathered from consultants offering the names of their consultees? To a population that was using consultation for a shorter

period of time? How would the findings compare to a more heterogeneous group of men and women? Would different themes emerge? How would the findings compare to a study of consultees from the fields of psychology and psychiatry?

Findings suggest that the length of time in consultation affects how it is used. Additional research is necessary to further assess this variable. Moreover, the study of consultant/consultee pairs would help to clarify the vicissitudes of the dynamic relationship as well as determine the level of complementarity and congruence of their perceptions about the learning experience. This would be particularly useful as it pertains to the learning alliance, roles, expectations and the creation of the optimal learning environment.

A current survey regarding the use of social work clinical consultation is needed. Information would include Who is using it? Who is providing it? In what form? Under what conditions and for how long? A description of what the social work consultant actually perceives him/herself doing, the way in which they do it, the conditions under which they practice and how helpful and effective it is should also be explored.

Finally, the current study, in contrast to existing research looked at consultation for a fee. What role, if any this plays in terms of social work education, clinical consultation, and Andragogy should be considered in future research.

APPENDIX A

INTRODUCTORY LETTER

Nancy L. Saks
116 North Robertson Boulevard
Suite 604
Los Angeles, California 90048
(213) 659-5213

Dear Colleague,

I am writing to ask for your participation in a research study. I am attempting to explore the process of clinical consultation to develop an understanding of the way in which social work clinicians use consultation to further their learning needs. I am interested in the nature of the learning experience and how it facilitates personal and/or professional growth. There is no better way to understand this than by talking with a consultee who can tell me what his/her experience has been.

This research study is in partial fulfillment of my doctoral degree and is being chaired by Beatrice Sommers, Ph.D. of the California Institute for Clinical Social Work.

If you have purchased individual clinical consultation from a social work consultant within the past twelve (12) months and are willing to participate in an interview arranged at your convenience (lasting approximately one hour and fifteen minutes) would you please fill in the enclosed form and return it to me in the self-addressed, stamped envelope. If you are unable to participate in the study, your response is also requested.

I hope we will have an opportunity to meet.

Yours truly

_____
Nancy L. Saks, L.C.S.W.
Investigator

APPENDIX B

INTRODUCTION TO INTERVIEW SESSION

I want to thank you for giving me this opportunity to meet with you to discuss the nature of your learning experience in the clinical consultation setting.

Our meeting will last for approximately one hour and fifteen minutes. I will be audio-taping our conversation. The tapes will be for my use only, and will be erased after the study is completed. Before starting I would like you to complete this Informed Consent Form and short questionnaire.

APPENDIX C

INFORMED CONSENT FORM

California Institute for Clinical Social Work

I, _____, hereby willingly consent to participate in the Clinical Consultation In Social Work: An Exploratory Study of A Dynamic Learning Model research project of Beatrice Sommers, Ph.D., Dissertation Chairperson, of the California Institute for Clinical Social Work.

I understand the procedures to include a brief demographic questionnaire and an interview concerned with the nature of my learning experience in the clinical consultation process. The interview will be conducted by Nancy L. Saks, L.C.S.W.

I understand that I may withdraw from the study at any time and that I may refuse to answer any questions without penalty. I understand that this study may be published and that my anonymity will be protected unless I give my written consent to such disclosure. I realize that without such consent I will not be identified in any publication or presentation of information gathered as part of the study.

Ms. Saks has informed me that the interview will be taped for purposes of data analysis. I am also advised that my name will not appear on the tape and that at the completion of the study the tape will be erased.

Date_____
Signature_____

APPENDIX D

CONSULTEE INFORMATION FORM

Age_____ Gender_____ Marital Status_____
Religion_____

Highest degree obtained_____

Year awarded MSW_____
_____
(School or University)

Year awarded DSW/Ph.D_____
_____
(School or University)

Year you became licensed_____

Number of post-degree years of experience as a therapist_____

Which of the following best describes your primary job affiliation? (please check (X) one)

hospital: psychiatric_____ medical_____
outpatient clinic_____
family service agency_____
private practice (full time)_____(part-time)_____
community mental health center_____
other (specify)_____

Which of the following most closely approximates your major theoretical orientation: (please check only <u>one</u> category)

behavioral_____ humanistic/existential_____
psychoanalytic/psychodynamic_____
other (please specify)_____

How often do you use consultation?
_____ on a regular basis
_____ only when I have a specific problem

For the particular consultation we'll be discussing how many times did you and the consultant meet? _____

Please rank your use of the following learning methods (1=most frequent use 6=least frequent use)

_____ books/journals
_____ supervision
_____ seminars/conferences
_____ consultation
_____ university courses
_____ other (please specify)_____

Consultant's approximate age _____ Consultant's gender_____

Fee (per session) _____ Length of session_____

APPENDIX E

INTERVIEW GUIDE

Learning and growing for the clinical social worker does not cease after one's formal education has ended. There are many avenues to pursue in order to continue one's personal and professional growth and development. I'm interested in how you used the consultation process to meet your learning needs.

Motivation

1. Why are you seeking consultation at this time?
2. What were the circumstances that lead you to seek this particular consultation?
3. Are there any other reasons you sought consultation? (probe guide)
   ...was there a special case you had in mind to present to the consultant?
   ...what was the difficulty you were having with the case?

Selection

4. How did you choose the consultant?
   (probe guide)
   ...what led you to this particular consultant?
5. Why did you select a social work consultant?

Expectations

6. What expectations did you have prior to the consultation? (probe guide)
   ...what expectations did you have of the consultant?
   ...what expectations did you have of yourself?
7. What were your goals for the consultation?

Attributes

8. What do you think are some of the most important attributes a consultant should possess?
   (probe guide)
   ...what are the significant skills?
   ...what are the important traits?
   ...what are the significant attitudes?
   ...what type of knowledge should the consultant possess?
   ...how do you identify expertise in a consultant?
   ...in your opinion, what makes a consultant an expert?

Consultant Role

9. What kind of role did the consultant play in the consultation?
   (probe guide)
   ...what did the consultant do?
10. Did the role change during the consultation? If so, how?

Consultant Activity and Methods

11. How did the consultant demonstrate an understanding of what your learning need was?
   (probe guide)
   ...specifically, how were your learning need(s) clarified?
12. What happened in the consultation process that helped you to meet your learning need?
13. In describing what happened during your consultation, what methods did the consultant use to assist you in dealing with the problem you presented?
   (probe guide)
   ...what did the consultant do that gave you a better understanding of your patient?
   ...what did the consultant do that gave you a better understanding of yourself?
   ...what did the consultant do that gave you more objectivity in evaluating problems or proceeding with treatment?
   ...what did the consultant do that encouraged you to feel more autonomous?
   ...increased you self confidence?
   ...enhanced your self esteem?
   ...encouraged you to make your own decisions?
   ...helped you feel less guilty?
14. How do you differentiate between personal and professional growth?

Consulting Relationship

15. Would you describe the consulting relationship?
   (probe guide)
   ...what was it like?
   ...what are/were its significant components?
   ...how would you describe the learning alliance?
16. Was this consulting relationship typical of your educational and training experience? If not, how was it different?

Content

17. As you think about it now, what was it you wanted or needed to learn?
18. How did you become aware of that?
19. What was it that you actually learned?

Outcome

20. Can you tell me what you liked and found most helpful about the consultation?
21. Can you tell me what you didn't like or found confusing, frustrating or disappointing?

22. What effect did the consultation have on you?
    (probe guide)
    ...how did the consultation personally affect you?
    ...how did it professionally affect you?
23. Was the consultant's approach to your problem one that you have been able to use in your practice?
24. What do you think it is about consultation that makes it an important avenue for continued learning and growth?

25. Would you care to elaborate on any of the questions we've already discussed? Is there anything important we've not covered that you want to add? Are there any comments or questions that you have about the interview itself?

26. Would you be interested in the results of the study?

REFERENCES

Abramovitz, A. (1958). Methods and techniques of consultation. American Journal of Orthopsychiatry 28 126-133.

Addams, J. (1930). The second twenty years at Hull House. New York: Macmillan Co.

Aiken, D. (1957). Psychiatric consultation in the family agency. Unpublished doctoral dissertation. University of Chicago, Chicago, Illinois.

Alpert, J., Ballantyne, D., & Griffiths, D. (1981). Characteristics of consultants and consultees and success in mental health consultation. Journal of School Psychology 19 312-322.

Amacher, K. (1976). Exploration into the dynamics of learning in field work. Smith Colledge Studies in Social Work 46 163-217.

Argyris, C. (1961). Explorations in consulting-client relationships. Human Organization 20 121-133.

Babbie, E. (1973). Survey research methods. Belmont: Wadsworth Publishing Co.

Babbie, E. (1979). The practice of social research. Belmont, California: Wadsworth Publishing.

Babcock, C. (1949). Some observations on consultative experience. Social Service Review 23 347-358.

Bandler, B. (1963). Ego centered teaching. In H. Parad and R. Miller (Eds.), Ego-centered casework, problems, and perspectives. New York: FSAA.

Bartlett, H. (1961). Social work practice in the health field. New York: NASW.

Beisser, A. & Green, R. (1972). Mental health consultation and education. Palo Alto, California: National Press Books.

Berlin, I. (1960). The theme in mental health consultation sessions. American Journal of Orthopsychiatry 30 827-828.

Berlin, I. (1964). Learning mental health consultation: History and problems. Mental Hygeine 48 256-266.

Berlin, I. (1969). Mental health consultation for school social workers: A conceptual model. Community Mental Health Journal 5 280-288.

Bindman, A. (1959). Mental health consultation: Theory and practice. Journal of Consulting Psychology 23 473-482.

Bindman, A. (1964). Bibliography on consultation. Journal of Education 146 56-60.

Blake, R., & Mouton, J. S. (1976). Consultation. Menlo Park, California: Addison-Wesley Publishing Co.

Blaha, M. (1952). When and how a consultant can be used most effectively. Educational Leadership 10 96-100.

Blumberg, A. (1960). The consulting function of leadership. Adult Leadership 8 265-266.

Blumberg, A. (1959). The role of the consultant. Some papers on consultation. New York: National League for Nursing.

Boehm, W. (1956). The professional relationship between consultant and consultee. American Journal of Orthopsychiatry 26 241-248.

Bordin, E. Edward, S., McKeever, N., Tipton, J., Charters, W., and Kounin, J. (1955). Effective consultation. Adult Leadership 3 13-26.

Bro, R. (1980). An exploration of the role of mentor: A new clinical teaching concept for the education of advanced professionals. Unpublished doctoral dissertation. California Institute for Clinical Social Work, Berkeley, CA.

Brunner, E. (1959). An overview of adult education research. Washington, D.C. Adult Education Association.

Brunner, J. (1961). The act of discovery. Harvard Educational Review XXXI 21-32.

Charters, W. E. (1955). Stresses in consultation. Adult Leadership. 3 21-22.

Clemence, E. (1965). Dynamic use of ego psychology in casework education. Smith College Studies in Social Work XV.

Caplan, G. (1955). The role of the social worker in preventive psychiatry. Medical Social Work 4 144-159.

Caplan, G. (1959a). Mental health aspects of social work in public health. Washingon: U.S. Children's Bureau.

Caplan, G. (1959b). An approach to the education of community mental health specialists. Mental Hygiene 43 268-280.

Caplan, G. (1963). Types of mental health consultation. American Journal of Orthopsychiatry 33 470-481.

Caplan, G. (1964). Principles of preventive psychiatry. New York: Basic Books.

Caplan, G. (1970). Theory and practice of mental health consultation. New York: Basic Books.

Coleman, J. (1947). Psychiatric consultation in casework agencies. American Journal of Orthopsychiatry 17 533-539.

Coleman, J. (1953). The contributions of the psychiatrist to the social worker and to the client. Mental Hygiene 37 249-258.

Coleman, J. (1968). Psychiatric consultation in perspectice. American Journal of Orthopsychiatry 38 364-365.

Collins, A, Panacoast, D., & Dunn, J. (1977). Consultation casebook. Portland: Portland State University School of Social Work.

Cook, M. (1970). Ten commandments of consultation. Journal of American Public Welfare Association 8 303-305,

Davenport, Judith (1985). An investigation of the relationship between a clinical supervisor's theoretical orientation and preferance for a model of supervision. Unpublished doctoral dissertation. California Institute for Clinical Social Work. Berkeley, CA.

Dewald, P. and Harle, M. (1953). Utilization of the psychiatric caseworker as consultant during the psychoanaltically oriented therapy of a patient. American Journal of Orthopsychiatry 23 785-794.

Dinkmeyer, D., & Carlson, J. (1973). Consulting: Facilitating human potential and change processes. New York: John Wiley & Sons.

Dinkmeyer, D., & Carlson, J. (1975). Consultation: A book of readings. New York: John Wiley & Sons.

Doehrman, M. (1976). Parallel process in supervision and psychotherapy. Bulletin of the Menninger Clinic 40 3-104.

Dworkin, A., Dworkin, E. (1975). A conceptual overview of selected consultation models. American Journal of Community Psychology 3 151-159.

Eisdorfer, C., & Batton, L. (1972). The mental health consultant as seen by his consultees. Community Mental Health Journal 8 171-177.

Ekstein, R., & Wallerstein, R. (1958). The teaching and learning of psychotherapy. New York: Basic Books.

Ekstein, R.; Motto, R.; Rosenfeld, H.; Heinecke, C; & Gilman, L. (1971). Issues in consultation: The mental health worker and educator. American Journal of Orthopsychiatry 41 312-314.

Farley, B. (1963). Individual mental health consultation with public health nurses. In L. Rapoport (Ed.): Consultation in Social Work Practice. New York: NASW, 99-116.

Feldman, F. (1968). The tripartite session: A new approach in psychiatric soscial work consultation. Psychiatric Quarterly 42 48-61.

Filstead, W. (1970). Qualitative methodology. Chicago: Markham Publishing Co.

Frankenhuis, J. (1977). How to get a good consultant. Harvard Business Review 55 133-139.

Gallessich, June. (1982). The profession and practice of consultation. San Francisco: Jossey-Bass.

Garfield, S., & Kurtz, R. (1976). Clinical psychologists in the 1970's. American Psychologist 37 1-9.

Garrett, A. Psychiatric consultation. (1956). American Journal of Orthopsychiatry 26 234-240.

Gaupp, P. S. (1966). Authority, influence and control in consultation. Community Mental Health Journal 2 205-210.

Gibb, J. (1959). The role of the consultant. Journal of Social Issues 15 1-4.

Gibb, J., & Lippitt, R. (1959). Consulting with groups and organizations. Journal of Social Issues 15 1-79.

Gilmore, M. (1963). Consultation as a social work activity. In L. Rapoport (Ed.): Consultation in social work practice. New York: National Association of Social Workers.

Glaser, B., Strauss, A. (1967). The discovery of grounded theory. New York: Aldine Publishing Co.

Glaser, B., & Strauss, A. (1970). Discovery of substantive theory: A basic strategy underlying qualitative research. In W. Filstead, (Ed.): Qualitative Methodology. Chicago: Markham Publishing Co.

Glidewell, L. (1959). The entry problem in consultation. Journal of Social Issues 15 51-59.

Golann, S. (1965). Mental health consultation, a bibliography. College Park, Maryland: Department of Psychology, University of Maryland.

Goldmeier, J. and Mannino, F. (1986). The role of social work in consultation. In F. Mannino, B. MacLennan, and M. Shore (Eds): The practice of mental health consultation. National Institute of Mental Health. Washington, D.C.: U.S. Government Printing Office.

Goode, W., & Hatt, P. (1952). Methods in social research. New York: McGraw-Hill.

Gorman, J. (1963). Some characteristics of consultation. In L. Rapoport (Ed.): Consultation in social work practice. New York: National Association of Social Workers 21-31.

Grady, M., Gibson, M., and Trickett, E. (1979). Mental health consultation, theory, practice, and research 1973-1978: An annotated reference guide. National Institute of Mental Health. Washington, D.C.: U.S. Government Printing Office.

Green, R. & Hammovitch, M. (1962). Education of social workers for mental health consultation. American Journal of Orthopsychiatry 32 225-226.

Green, R. (1965). The consultant and the consultation process. Child Welfare 44 425-430.

Green, R. R. (1983). Social work consultation to employee assistance program personnel: An exploratory study. Unpublished doctoral dissertation. California Institute for Clinical Social Work, Berkeley, CA.

Green, S. (1956). The use of the consultant: Workshop 1955. American Journal of Orthopsychiatry 26 234-252.

Group for the Advancement of Psychiatry. (1956). The consultant psychiatrist in a family service agency. Report #34. New York: GAP.

Hansen, A. (1964). The psychotherapist as a consultant. International Psychiatrty Clinics 1 475-482.

Havinghurst, R. & Orr, B. (1956). Adult education and adult needs. Chicago: The Center for the Study of Liberal Education for Adults.

Haylett, C. & Rapoport, L. (1964). Mental health consultation. In L. Rapoport (Ed.): Handbook of community psychiatry and community mental health. New York: Grune & Stratton.

Hilgard, E. & Bower, G. (1966) Theories of learning. New York: Appleton-Century-Crofts.

Hollister, W. & Edgerton, J. (1974). Teaching relationship building skills. American Journal of Public Health 64 41-53.

Houle, C. (1970). An exploratory study of the self educating person. Adult Education 8.

Houle, C. (1972). The design of education. San Francisco: Jossey-Bass.

Houle, C. (1980). Continuing learning in the professions. San Francisco: Jossey-Bass.

Isaac, S. & Michael, W. (1981). Handbook in research and evaluation. San Diego: Edits Publishers.

Iscoe, I., Pierce-Jones, J., Griedman, S. & McGehearty, L. (1967). Some strategies in mental health consultation: A brief description of a project and some preliminary results. In E. Cowen; E. Gardner; & M. Zax (Eds.): Emergent approaches to mental health problems. New York: Appleton-Century-Crofts. 307-330.

James, B., Kidder, M., Osberg, J. & Hunter, W. (1986). Traditional mental health consultation: The psychodynamic perspective in F. Mannino, B. MacLennan, and M. Shore (Eds): The Practice of Mental Health Consultation. National Institute of Mental Health. Washington, D.C.: U.S. Government Printing Office.

Jenkins, D. H. (1951). The `helping' relationship in education. School of Education Bulletin University of Michigan 22 5.

Kadushin, A. (1977). Consultation in social work. New York: Columbia University Press.

Kadushin, A., & Buckman, M. (1978). Practice of social work consultation: A survey. Social Work 23 372-379.

Kaslow, F. and Associates. (1977). Supervision, consultation and staff training in the helping professions. San Francisco: Jossey Bass.

Kaufman, I. (1956). The role of the psychiatric consultant. American Journal of Orthopsychiatry 26 223-234.

Kenney, K. (1986). Research in mental health consultation: Emerging trends, issues and problems. In F. Mannino; B. MacLennan; and M. Shore (Eds): The practice of mental health consultation. National Institute of Mental Health. Washington, D.C.: U.S. Government Printing Office.

Kerlinger, F. (1964). Foundations of behavioral research. New York: Holt, Rinehart, and Winston Inc.

Kidd, J. (1973). How adults learn. Chicago: Association Press.

Kline, M., & Cummings, R. (1955). A study of the learning characteristics of public health nurses in relation to mental health education and consultation. Journal of Social Psychology 42 43-60.

Knowles, M. (1970a). The modern practice of adult education, Andragogy versus Pedagogy. New York: Association Press.

Knowles, M. (1970b). Andragogy, not pedagogy! Adult Leadership 16 350-356.

Knowles, M. (1972). Innovations in teaching styles and approaches based upon adult learning. Journal of Social Work Education. 8 32-39.

Knowles, M. (1975). Self-directed learning. New York: Association Press.

Knowles, M. (1978). The adult learner: A neglected species. Houston, Texas: Gulf Publishing Co.

Knowles, M. (1980). The modern practice of adult education. Chicago: Association Press.

Knox, A. (1977). Adult development and learning. San Francisco: Jossey-Bass.

Kohut, H. (1971). The analysis of the self. New York: International Universities Press.

Kohut, H. (1977). The restoration of the self. New York: International Universities Press.

Kohut, H. (1979). The two analyses of Mr. Z. International Journal of Psychoanalysis 60 3-27.

Kohut, H. & Wolf, E. (1978). The disorders of the self and their treatment: An outline. International Journal of Psychoanalysis 59 413-425.

Kutzik, A. (1977). The social work field. In F.Kaslow (Ed.), Supervision, consultation and staff training in the helping professions. 25-60.

Leader, A. (1957). Social work consultation to psychiatry. Social Casework 38 22-28.

Levinson, D. (1978). The seasons of a man's life. New York: Alfred A. Knopf.

Lincoln, Y, & Guba, E. (1985). Naturalistic inquiry. Beverly Hills: Sage Publications.

Lindeman, E. (1936). Adult education for social change. Bloomington: New Republic, Inc.

Lindeman, E. (1962). The meaning of adult education. Montreal: Harvest House.

Lippitt, R. & Watson, W. (1958). The dynamics of planned change. New York: Harcourt, Brace and Co.

Lippitt, G. (1959). A study of the consultation process. Journal of Social Issues 15 43-50.

Lippitt, R. (1959). Dimensions of the consultant's job. Journal of Social Issues 15 5-12.

Lippitt, R. & Lippitt, G. (1975). The consulting process in action. Training and Development Journal 29 38-41.

Lippitt, R., & Lippitt, G. (1978). The consultation process in action. La Jolla, California: University Associates.

Loflond, J. (1971). Analyzing social settings. Belmont, CA: Wadsworth.

Macarov, D., Akbar, A., Kulkarni, P. & Wertheimer, M. (1967). Consultants and consultee: The view from within. Social Service Review 41 283-297.

Maddux, J. (1950). Psychiatric consultation in a public welfare agency. American Journal of Orthopsychiatry 20 754-764.

Madge, J. (1965). The tools of social science. New York: Doubleday Anchor.

Mannino, F. (1969a). Consultation in mental health and related fields: A reference guide. National Institute of Mental Health (PHS Pub. No. 1920). Washington D.C.: U.S. Government Printing Office.

Mannino, F. (1969b). An experience in consultation as perceived by consultants and consultees. Mental Health Study Center, NIMH, Adelphi, Md.

Mannino, F. & Shore, M. (1969). Evaluation of consultation: problems and prospects. In Mental health consultations in community settings. A. Rogawski, (Ed.): San Francisco: Jossey-Bass Inc.

Mannino, F. & Shore, M. (1971). Consultation research in mental health and related fields--A critical review of the literature. Public Health Publication No. 2122. Washington, D.C.: U.S. Government Printing Office.

Mannino, F. & Shore, M. (1975). The effects of consultation. American Journal of Community Psychology 3 1-21.

Mannino F. & Robinson, S. (1975). A reference guide to the consultation literature. In F. Mannino, B. MacLennan, and M. Shore (Eds.) The practice of mental health consultation. National Institute of Mental Health. Washington, D.C.: U.S. Government Printing Office.

Mannino, F., McLennon, F, & Shore, M. (1975). The pracitice of mental health consultation. National Institute of Mental Health. Washington, D.C.: U.S. Government Printing Office.

Mannino, F. & Shore, M. (1986). History and development of mntal health consultation In F. Mannino, E. Trickett, M. Shore, M. Kidder, & G. Levin, (Eds.). Handbook of mental health consultation. U.S. Department of Health and Human Services, NIMH.

McMillen, W. (1952). Statistical methods for social workers. Chicago: The University of Chicago Press.

Medway, F. (1979). How effective is school consultation?: A review of recent research. Journal of School Psychology 17 275-282.

Mendel, W. (1966). The education of the consultant. In W. Mendel and P. Solomon, (Eds.). The psychiatric consultation. New York: Grune and Stratton Inc. 49-58.

Mendel, W. & Solomon, P. (1968). The psychiatric consultation. New York: Grune & Stratton Inc.

Merton, R. and Kendall, P. (1946). The focused interview. American Journal of Sociology 51 541-557.

McGreevy, C. (1978). Training consultants: Issues and approaches. Personnel and Guidance Journal 56 432-435.

McKeever, N. (1955). How to use a consultant. Adult Leadership 3 14-16.

Miller, R. (1977). Clues from the past about clinical learning. Clinical Social Work Journal 5 4.

Newfield, N. (1972). An evaluation of mental health consultation for public health nurses. Unpublished doctoral dissertation. Rochester: The University of Rochester.

Noy, P., De-Nour, A. & Moses, R. (1966). Discrepancy between expectations and service in psychiatry consultation. Archives of General Psychiatry 14 651-657.

O'Keefe, D. (1958). The psychiatric social worker as team member and consultant. In: Proceedings, The Annual Social Work Conference on Psychiatric Social Work. Baton Rouge: Lousisiana State University, School of Social Work.

Parker, B. (1962). Some observations on psychiatric consultation with nursery school teachers. Mental Hygiene 46 559-566.

Phillips, B. (1966). Social research strategy and tactics. New York: The Macmillian Co.

Plog, S. & Ahmed, P. (1977). Principles and techniques of mental health consultation. New York: Plenum Publishing.

Polansky, N. (1966). Social work research. Chicago: The University of Chicago Press.

Polkinghorne, D. (1983). Methodology for the human sciences. Albany: State University of New York Press.

Rapoport, L. (1963). Consultation: An overview. In L. Rapoport (Ed.): Consultation in social work practice. New York: National Association of Social Workers.

Rapoport, L. (1963). Consultation in social work practice. New York: National Assocication of Social Workers.

Rapoport, L. Consultation. (1977). In H. L. Lurie (Ed.): Encyclopedia of Social Work. 214-219. Washington D.C.: National Association of Social Workers.

Reynolds, B. (1942). Learning and teaching in the practice of social work. New York: Rinehart & Co. Inc.

Reynolds, B. (1951). Social work and social living. New York: Citadel Press.

Richmond, M. (1930). The long view. New York: Russell Sage Foundation.

Rieman, D. (1963). Group Mental Health Consultation with Public Nurses. In L. Rapoport, (Ed.): Consultation in Social Work Practice. 85-97. New York: NASW.

Robbins, R. & Spencer, E. (1968). A study of the consultation process. Psychiatry 31 362-368.

Robbins, R. & Spencer, E. (1969). A casebook of consultations. Berkeley, California: Calfiornia State Department of Public Health.

Robbins, R., Spencer,E. & Frank, D. (1970). Some factors influencing the outcome of consultation. American Journal of Public Health 60 524-534.

Rogers, C. (1969). Freedom to Learn. Columbus: Chas. E. Merrill Publishing Co.

Rosenthal, M.& Sullivan, M. (1959). Psychiatric consultation in a public child welfare agency. U.S. Dept. of Health, Education and Welfare.

Schein, E. (1978). The role of the consultant: Content expert or process facilitator? Personnel and Guidance Journal 56 339-343.

Schmuck, R. (1968). Helping teachers improve clsassroom group processes. Journal of Applied Behavior Science 4 401-435.

School of Social Service Administration (1951). The workshop on the consultation process. Chicago: University of Chicago.

Selltiz, C., Wrightsman, L. and Cook, S. (1976). Research Methods in Social Relations. New York: Holt, Rinehart and Winston.

Siegel, D. (1955). Consultation: Some guiding principles in administration, supervision and consultation. New York: Family Service Association.

Sigh, R. (1971). Community mental health consultation and crisis intervention. Berkeley: Book People.

Signell, K. (1974). An interacton method of teaching consultation. Community Mental Health Journal 10 205-215.

Signell, K. & Scott, P. (1971). Mental health consultation: An interaction model. Community Mental Health Journal 7 288-302.

Smith, J. (1975). Social work consultation: Implications for social work education. Doctoral disseratation, University of Utah.

Sommers, B. (1979). New frontiers for the clinical educator: A study of the role of the animateur in the colloquim. Unpublished doctoral dissertation. California Institute for Clinical Social Work, Berkeley, CA.

Spradley, J. (1979). The Ethnographic Interview. New York: Holt-Reinhart.

Sussman, S. (1984). The study of structures. Unpublished manuscript.

Teitelbaum, D. (1961). An evaluation of an experimental program of assistance for newly appointed teachers in certain elementary schools of New York City. Unpublished doctoral dissertation. New York: New York University.

Tetreault, J. (1968). Informal consultation: social work activity with the elementary school teacher. Smith College Studies in Social Work 39 85-86.

Theimer, W. (1972). Utilization of consultants in inservice training. Paper presented at the American Educational Research Association, Chicago, Illinois.

This, L. & Lippitt, G. (1968). Learning theories and training. Training and Developmental Journal 20

Tipton, J. (1955). Consulting under fire. Adult Leadership 3 17-20.

Tough, A. (1967). Learning without a teacher. Toronto: Ontario Institute for Studies in Education.

Tough, A. (1971). The adult's learning projects. Toronto: Ontario Institute for Studies in Education.

Towle, C. (1950). The consultation process. University of North Carolina Workshop.

Towle, C. (1951). Consultation: Frame of reference for group discussion and application in specific situations. Chicago: School of Social Service, University of Chicago.

Towle, C. (1953). Common human needs. New York: American Association of Social Workers.

Towle, C. (1954). The learner in education for the professions. Illinois: University of Chicago Press.

Towle, C. (1970). Source materials--The consultation process. Social Service Review 44 205-214.

Tripodi, T. & Epstein, I. (1980). Research techniques for clinical social workers. New York: Columbia University Press.

Valenstein, A. (1955). Some principles of psychiatric consultation. Social Casework 36 253-256.

Van Ophuijsen, J. (1949). The psychiatric consultation. American Journal of Orthopsychiatry 19 397-403.

Warriner, A. (1949). The psychiatric social worker as consultant. Public Health Nursing 41 392-397.

Warwick, D. and Lininger, C. (1975). The sample survey: theory and practice. New York: Mc-Graw Hill.

Whitehead, A. (1929). The aims of education and other essays. New York: Macmillian Co.

Winnicott, D. (1958). Collected Papers: through paediatrics to psycho-analysis. London: Basic Books.

Winnicott, D. (1965). The maturational process and the facilitating environment. London: Hogarth Press.

Winnicott, D. (1970). The mother-infant experience of mutuality. In Anthony and Benedek (Eds.): Parenthood: Its psychology and psychopathology. Boston: Little, Brown, and Co.

Winnicott, D. (1971). Playing and reality. London: Tavistock

Wolf, E. (1976). Recent advances in the psychology of the self: An outline of basic concepts. Comprehensive Psychiatry 17 37-46.

Wolf, E. (1980). On the developmental line of selfobject relations. In: A. Goldberg (Ed.) Advances in Self Psychology. 117-135.

Wolf, E. (1983). Aspects of neutrality. Psychoanalytic Inquiry 3 675-689.

Wolf, E. (1984). The inevitability of interaction. Psychoanalytic Inquiry 4 413-423.

Wolfe, H. (1966). Consultation: Role, function and process. Mental Hygiene 50 132-134.

Zussman, J. & Davidson, D. (1972). Practical aspects of mental health consultation. Springfield: Chas. C. Thomas.

Zwibelman, B. (1971). Patterns of expectations for the consultant role. Unpublished doctoral dissertation, University of Missouri, Columbia.