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COMPETENCE, IMPERMANENCE, AND TRANSITIONAL MAPPING
A Model for Systems Consultation

JUDITH LANDAU-STANTON
University of Rochester School of Medicine and Dentistry
Rochester, New York

The model for consultation presented here has evolved from engagement in this kind of work since 1963. It is oriented toward prevention, having developed from a community and social-medicine perspective (Caplan, 1965; Kark & Mainemer, 1977; Kark & Steuart, 1962). It was developed in concert with my approach to family therapy (Landau, 1981, 1982; Landau-Stanton, 1985, in press), and in many ways the two are operationally inseparable. This model has been used in consulting in such diverse contexts as community, self-help, business, educational, medical, religious, and legal groups.

The view that one takes of the families one treats is inescapably reflected in the approach assumed when undertaking systems-oriented consultation. The two are isomorphic. There are at least three features of the present model that warrant emphasis: *competence*, *impermanence*, and the use of *transitional mapping* to guide the intervention.

COMPETENCE AND IMPERMANENCE

A major contribution of most current family therapy approaches has been their recognition of a family's inherent competence and integrity—the realization that the family does not need a permanent guardian functioning in the role of therapist. Like many brief therapies, and unlike some individual approaches, these family therapists hold that, if one believes the family is competent, one does not enter its domain with the idea of long-term residence. Instead, one supports family members, restructures, builds on strengths, and attempts to leave them with the tools to continue, unaided, into the future. Likewise, one should enter a consultative relationship with the belief that the system at hand is intrinsically sound and possesses the

competence to right itself, perhaps with only a little help from a friend. Thus, the consultant serves more as an agent of growth, and works under a time-limited contract. If consultants are effective, they succeed in obliterating their function and their position in the system.

I generally find it useful to start a consultation with parables and metaphors drawn from the area of competence of the person or people consulting me. This is then translated into a potential action within that area (a procedure that is very empowering), and then generalized to the subject or system about which consultation is requested. I encourage the consultees to design a course of action in their own way, even if it is not the way I would have done it. This design is then transferred to the system in question. Such approaches (1) take advantage of both the consultees' general knowledge and knowledge of the system, (2) reduce resistance because the adopted plan is primarily their own, and (3) allow them to accept primary credit for any beneficial change that does result.

There certainly are ways *not* to empower that will make the consultation a failure. For instance, the student learning to provide consultation frequently makes the classical error of attempting to enter as an "expert," saying, "The only way to handle this particular problem is my way, and you've made catastrophic mistakes so far." A related error is for the family-oriented consultant to believe that only he or she has the answer and, for example, to assert: "This is a specific family problem that only family therapists can resolve. Whenever you hit this particular problem, you will have to come to me because I'm the family consultant." A better approach would be to say, "You must see these problems over and over again. I'm sure you've learned an awful lot about how to deal with them. What are the things you've managed to do and what are the problems you've run into?" This approach immediately removes blame and relabels the problem as generic rather than specific. The more generic it gets and the more one identifies the consultees' particular areas of expertise, the more one empowers them, and the more able one is to exit rapidly.

The position taken thus far is different from what some family therapists consider to be "consultation." However, this may simply be a matter of terminology. Some forms of "consultation" may be more aptly termed "liaison." *The American College Dictionary* (1953) defines liaison as "a connection or relation *to be maintained* between . . . units, bodies, etc. [italics added]" (p. 702). In a liaison relationship, the specialist becomes a permanent part of the system, providing it with input from his or her own special area of expertise—like the neurologist who provides ongoing case advice to a cardiopulmonary unit. While a legitimate and often essential activity, liaison is obviously different from a consultation model aimed at getting in and out with the least amount of effort over the briefest period of time.

A major and unfortunately all too common error that a consultant can make is to imply that "I'm the only one who deals with this kind of problem, and you're going to need me forever." When I hear somebody imply that he or she expects always to be the consultant to a given service, or state that "I have been their consultant for 10 years," I think, "Why are you still there?" Optimally, one should be able to say, "I *was* a consultant to that group. They may, rarely, call me at intervals only when they get stuck with something new, and I say, 'Oh, this is a new problem. Let's see what you've done in the past and what we can add now.'" In other words, the error is in taking on long-term consultative commitments and presuming that one will be needed again and again. In fact, after a truly successful consultation—one in which the consultee has been provided with all the tools necessary to resolve new situations—the consultant should hope and expect never to be called again.

There is a parallel here with the sort of cradle-to-grave commitment that some therapies seem to espouse. If the consultant attempts to assume the decision making or the executive functions of an organization, that consultant has exchanged his or her original role for the role of executive or therapist. The concept of consultation implies a time-limited, temporary engagement, in which one enters and then departs. If one remains permanently inside, one has abused or abandoned the consultant role. A good therapist does not do that. One's first therapy session should begin with something like "Let's talk about the problems and how you see them, and how I see them. Let's see whether we want to work together, whether we're going to like each other. You are the experts on your own family. I'm a relatively uninformed stranger. Because I came from outside, I may have some ideas that you can use. But the strengths and ideas for change lie within your family." A tack such as this is easily transposed to a consultation relationship.

An important advantage of this type of consultation should be noted. If a consultant "consults" with an agency or system over an extended span of months or years, his or her capacity to affect and influence positively more than a very few agencies or systems is limited. A brief, impermanent approach, on the other hand, allows the consultant the time and freedom to help a considerably larger number of systems, thereby having a much more widespread impact on the society within which he or she works.

TRANSITIONAL MAPPING

Along with the presumption of system competence, it is usually helpful to recognize that the system to which one consults has a history, a future, and a legitimate raison d'être. While such notions are perhaps self-evident, hold-

ing them in mind can help one begin to determine what the system is having to contend with at present, where it is heading, and, therefore, how it may be most effectively helped. It is always legitimate to ask why the group, agency, or system is requesting consultation at this time. Why not 6 months ago, or 2 years hence? Where did it, or they, get off track? What changes have occurred to make things different? Are there subsystems in conflict and, if so, in what different directions are they moving? As answers to these questions materialize, the consultant can begin to implement a plan to get the system back on track—to mobilize its resources so it can continue at a more efficient level of functioning and in a direction of its own choosing.

It was in response to questions such as the above that I began to develop the approach of *transitional mapping* (Landau, 1982; Landau, Griffiths, & Mason, 1981; Landau-Stanton, 1985). Transitional mapping is a generic technique for both diagnosing a system and suggesting where the key point(s) of intervention might be; it is applicable to both therapy and consultation and is based on what I have called "transitional theory" (Landau-Stanton, 1985, in press), which concerns the intrasystem change from one status or state to another. A sociological example is the change from an agrarian to an urban society, with families moving from an extended to a nuclear form. This can happen instantly in some situations—either as a result of precipitous change or natural evolution—and it can happen slowly in others. When there are disparate rates of change among subsystems, with resulting asynchrony, dysfunction often results. Disparities develop between elements, that is, between individuals or subsystems, in which certain elements are not changing as fast as others. Thus we may get disparity between the individual and the family, or between the family and the context or culture.

Transitional theory is readily applicable to organizational consultation. For instance, if new managers come into a business system with a whole set of their own ideas and fail to look very carefully at the system (in a sense, fail to map it and work out who relates to whom, what the projected trends in the business are, what the level of financial return might be), they will be asking for trouble. If they do not clearly discern these processes, attending instead only to goals of their own that are totally different from those of others, they are going to get acting out, a possible breakdown of the system, and loss of profit. On the other hand, if they go in and analyze exactly how the system components are interrelated, assessing where the system is coming from and where it is going along all possible significant trajectories, they have a chance of success. Unless one knows the transitional pathway and the actual directional trend, "stuckness" will result. One needs to allow the system, or certain of its elements, to move backward a bit, and then perhaps forward, connecting both extremes simultaneously, because all movement

in natural systems is in both, or many, directions. When one gets tremendous asynchrony, one gets huge pendulum swings from one polar extreme to the other, rather than natural growth. In a way it is like the stage of leaving home in the family life cycle (Haley, 1980) in which the parent pulls back and the young person desperately rushes out and fails. The movement is extreme and oscillatory, rather than gradual and recalibratory.

In this approach, one constructs a clear structural and directional map of the group with whom one is consulting, not just in terms of the families or groups that form the units of the system, but in terms of how those families or groups relate to each other, how they fit into the larger system, what the hierarchies are, and what the trends are. Whether it is a closed community, a surgical ward, a transplant system, a school system, a state service, or whatever, one maps it in terms of its transitional trends. How did that particular system originate and where is it heading in terms of service, of growth, of philosophy, of ideals? This model shares elements with some of the approaches used in sociology and anthropology. It asks: What are the basic modes of relating and the basic ideals, philosophies, and motivations of the group? What are the trends of change, and how did the group originate? Where are the ideals likely to take it? How much is this group influenced by its larger context? Is the cultural context pushing it in a particular direction? Is it a question of a new group evolving in a larger system? Where is the larger system going? How does the direction of the larger system affect this particular group?

The transitional map should encompass the whole organization as to subsystems, power structure, history, development, and culture. Both intended and potential directions for change are also indicated. Rigid or conservative and progressive or pioneering elements are included—these usually denote who is ready to change, who is in the transition between change–no change along the various trajectories, and so on. While there is not space here for a full explanation of transitional mapping (the reader is referred to the aforementioned references), a simplified example will be given in the section on "countering insularity."

APPLYING THE METHOD

INITIATING THE PROCESS

My general approach is not to seek consultation, or to reach out for it, but rather to wait for the system to make the first move. When I am contacted, there is often discomfort on the part of the requester, as if he or she feels

embarrassed at not being able to solve the problem alone. My inclination at that point is to put the person at ease, assuring him or her: "This is a really tough situation that you couldn't be expected to deal with . . ." or "It's not surprising that you feel this way given how unreasonable the expectations are . . ." Essentially, I want to eliminate any notions the person may have that he or she is stupid or incompetent. I want him or her to feel supported and empowered because then he or she is more liable to take a chance on doing something different, if that is appropriate.

There are times when I break my rule about not reaching out. This usually occurs when I get a number of similar referrals from a particular person, agency, or neighborhood. In the first and second cases, this may indicate a dysfunction within the treatment system. The third case may be indicative of a problem in a community, neighborhood, or school system. In such instances I may contact the people running the system and bring the pattern I have observed to their attention. This must be done tactfully, and in a joining way, so that it can be perceived as helpful rather than critical. An example of such a situation with a mastectomy group is given later in this chapter.

INCLUSIVENESS

While there is often a natural tendency for the consultant to deal primarily with the person requesting consultation, the systems consultant should be aware of the myopia that can occur with this approach. Frequently the person with the "complaint" is at the nexus of competing, counterpulling subsystems within the overall system and has become immobilized. Dealing with this person exclusively is analogous to trying to treat a severely symptomatic member of a family alone—progress is difficult or impossible to make and is, at best, very slow. This person is not empowered by the system and is unable to empower others, remaining stuck and impotent to effect change. For this reason, I find it more efficacious to expand the system immediately, bringing in as many of the cast of characters as possible, in network fashion (Speck & Attneave, 1973). All are then included in the mapping process and the problem solving. Consulting with a group or a team in this way gives much more valuable information, allows a wider range of interventions, and introduces flexibility in terms of the kinds of change that may be possible. In particular, the consultant should beware of being exclusively linked to a "system pariah" who is unfavorably situated within the overall organization, because any moves the consultant makes from that position will invite the same reaction incurred by the pariah.

THE LINK APPROACH

Even when one does deal primarily with the requesting person, it is not always necessary to deal with a large group or a team. If one gets a proper sense of the system, one can approach the consultation with an adaptation of the *link therapy* approach (Landau, 1981, 1982; Landau-Stanton, 1985, in press). In this approach with families, the system is mapped and a "transitional" member—one who has access to all the subsystems and power leaders but is not firmly planted in one camp—is selected with whom to work. This person is then coached as a therapist or agent of change to his or her family.[1] The link concept can also be used with an organization.

Coping with mastectomy: A case example. A surgeon specializing in cancer called me and said, "I'm worried about a woman who has had a mastectomy and doesn't seem to be coping." I asked to meet with him about the case and then proceeded with psychotherapy. Subsequently, however, two similar cases were referred and, although I also commenced treatment with them, my antennae had, by that time, shot up. I requested a meeting with the surgeon, at which time I told him the trends I was seeing. Identifying with him, I asked, "What are you up against in your practice? What are your colleagues dealing with? What are the other resources that you use? Could we meet with the cancer association and see what they're providing for mastectomy patients?"

The surgeon and I then met with the person conducting a mastectomy group and all the other surgeons in the city who were doing mastectomies. We invited the radiotherapist and the head nurse from each inpatient unit, and we all considered what action might be indicated with this particular group of people. What they had been doing up to that point was convening a mastectomy group where the women sat and moaned to each other once a week. We redesigned the whole system, moving it into a multifamily group mode. We looked at what could be done in terms of helping prevent emotional difficulties around mastectomies. We first had to make the service people competent because they believed that these women were a dead weight and that there was nothing to be done with them and their classical, postmastectomy reactions.

After careful consideration, I decided that the surgeon was in a transitional position within the larger body, agreeing with aspects of both extremes, refusing to be pushed into a rigid position, and relating well to all concerned. At a meeting of the professionals and paraprofessionals, it became evident that this surgeon would serve best as leader of the group. I coached him as I would a link therapist (Landau,

1. See Landau-Stanton (1985) for a discussion of the clear differences between this approach and that used by Bowen (1978).

1981), to work with a team of selected representatives from the professional and paraprofessional groups involved in the treatment of mastectomy patients. I did some coaching beforehand and some of it in the meeting, as I would in family therapy, encouraging the surgeon to take charge and slowly coaching him until he took over. I did not have to go to all meetings. I was already empowering him and his group and moving myself out so that they could continue without me. What he then did was to get the others to decide what they would feel most competent doing. How could they work with this group of patients and feel really good about it? What did he and each of them dread about this mastectomy group? What was the pain of the group? What were the problems that were draining them? Each problem was then positively reframed so that it became more obvious what both the professionals and the mastectomy patients could do to become more competent. For the patients this meant bringing in their families and making a contribution to other cancer patients. From the multifamily group, a whole community service evolved, oriented to other groups of patients with cancer, laryngectomies, ostomies, and so on. By the time this had happened, I was out of the picture.

RETROGRESSION AND PROGRESSION

In the application of transitional therapy with families (Landau, 1982; Landau-Stanton, 1985, in press), one option is to attempt to move the families ahead in a "progressive" way vis-à-vis the overall society or context, for example, to get them to accept more flexibility in curfew hours for their teenagers, to learn the language in a new culture, and so on. The other major option is to help such families reconnect with the "old" ways, for example, by adhering to the time-honored prescriptions of their culture for dealing with problems. This is the "retrogressive" approach. It is sometimes chosen by rigid families because they feel safer with it. Later on, they may rise up, shake themselves, and move forward, perhaps going forward and backward through several cycles. By reconnecting them with both their past and their possible future, one enables them to make a choice. Usually they end up going in the direction that is most "natural" to them. However, whatever direction is selected, in the end the family must make the choice. A synchronization of the subsystems must occur. If the therapist arbitrarily attempts to select the final direction, perhaps even imposing himself or herself at the head of the system, he or she will be extruded by the family and efforts to bring about change will be ignored.

The decision to foster retrogression or progression—whether initially or at later stages in treatment—usually requires an understanding of the system in its broadest terms. Otherwise, the therapist can slip into a miscalculation. For example, sometimes in applying a structural intervention, the

restructuring on its own may look absolutely perfect, and yet it does not take effect. In isolation, the intervention may appear appropriate, but it may not have been applied at the right point and in the right direction. This is particularly likely to happen if the family is not permitted to participate in the choice. When one constructs a larger map that includes more of the multiple systems involved, as well as details of where they have come from and where they may be going, that particular restructuring may be against the overall direction of change or contrary to the history and future of the transitional pathway. Thus the restructuring does not work. The same holds for consultation. Where the person most directly related to the potential change is not properly empowered, one tends to get many people, each feeling responsible for change, working at cross-purposes and creating a transitional conflict in which they actually heighten the asynchrony in the system. Without a proper overview, the consultant may err toward precipitating exactly the sort of symptomatology that one sees in a dysfunctional family system.

It is my experience that, in contrast to working with families, consultation with communities and large groups does not result in the selection of a retrogressive option. While they certainly have elements and subsystems that prefer retrogression, and such an option may be explicitly proposed by the consultant, progression finally wins out. This may be because, in consultations of this sort, I have endeavored to use the whole system, while specifically avoiding consultation with a particular individual. Where everyone is included, perhaps progression is the inevitable choice when the survival and well-being of the total system is at stake.

Death and dying: A case example. In 1967, I was asked to consult with a diverse group of clergy about death and dying. They had been feeling very hopeless as to what they could achieve. In the first meeting, I talked with them about the way they were handling this in their communities. They were still at the stage where death was handled as an isolated thing, where the minister counseled the family separately from the patient. As the discussion continued, it became more and more clear that the context of that particular community made an enormous difference in these clergymen's readiness to carry out a more systemic kind of consultational counseling around issues of death and dying.

I decided to map each aspect of the context separately with them—the historical development of the religious group, the way that they saw their role in society, the extent to which they had formed an isolated group, the direction they were moving, and so on. (At that time, the ecumenical movement had become infused with new vigor, and whether certain individuals were seeing themselves as moving more in an ecumenical direction made a tremendous difference, being reflected in the way that they were prepared to treat the individuals within a family.) As the process

unfolded, the clergymen became enthusiastic and, by the end of the session, they had coalesced and decided to continue together as a group. They gained strength by understanding each other's philosophies. They became able to provide hope more easily and to define family goals that could be meaningful to the people they were counseling.

Interestingly, those people within the group who were moving toward an ecumenical bias were more amenable to working systemically in their own counseling systems.[2] The less ecumenical and more traditional members observed with interest what the others were doing, but shifted only slightly, generally holding to their previous position. Being able to observe without feeling judged themselves, however, allowed them to open up a bit and to understand what the others, whom they regarded as very radical, were doing.

As the meetings continued, several members initiated multifamily groups on death and dying. In response, the more traditional members tended to exclaim, "This is not for me. It's ridiculous. It's taking away all my power. You can't do this. It's like a circus. Dying is something between man and God." But they were still prepared to work with multifamily groups instead of dealing with members separately. This was preferable to feeling scared and incompetent. They did not shift as much as the more ecumenical group, but they did shift to including family members and persons from the community. Rigidity often results from a feeling of incompetence. If the helping leaders do not feel competent, they take on far more responsibility than is necessary. They almost become family members. However, once they see their own position in a broader context and in a context of change, rather than "this is where I'm stuck and I'm going to be stuck for a long time," they are able to move into a broader helping mode in which they use community resources and require less detailed control. Broadening and empowering them allows for change.

COUNTERING INSULARITY: SOME EXAMPLES WITH SELF-HELP GROUPS

In consulting with self-help groups in such areas as learning disabilities, postoperative cancer, inherited disorders, substance abuse, and mothers of twins, certain features stand out. One of these is the insularity that can develop. This can reach such extremes that dissolution of the group, or a major change in its charge, may be the most healthy result. Let us take the Mothers of Twins Association as a somewhat amusing example.

2. In the ecumenical movement, diverse churches share community activities, educational programs, clergy, and interdenominational fellowship. Frequently their efforts are directed toward overall social change.

Mothers of Twins: A case example. I attended the inaugural gathering of one of these groups as their guest of honor, being privileged to have twins myself. I found they were regarding themselves as some sort of rare, unique group. The feeling I had, in fact, was very similar to what I had experienced at the initial meeting of the Inherited Disorders Association—a semiprivileged, semipunished group. What struck me about both of these, and subsequently about a lot of other self-help groups, was their self-perception both of being a particularly prized piece of the community and also of being damned. In both ways, they felt isolated from the community. Being prized or being damned made them different, something of which they felt both scared and very proud. Such groups often start similarly. Commonly, one or two people feel that they are not coping. Hence they get together and make themselves special in order to compensate. Generally, though, they do not feel so special that they truly believe they are coping.

I never became a member of any of these groups. I remained a consultant. With the Mothers of Twins group, I was very careful not to join, but rather to say, "I have twins, but I don't feel the need to belong to a special group, because twins are also children," which was a small beginning toward moving them back into the community. These mothers had been emphasizing their differences and ignoring their similarities. In consulting with them, the thrust was toward first getting the people who had originally formed the group, the ones who were feeling (as with any other group) both empowered and incompetent, to become truly competent. These mothers could then aid the other members to be competent and reassimilate with the community. Up to that time, they had been involved in activities such as getting together and having their twins play with other twins, very much like the muscular dystrophy groups sometimes get their kids to play with other children with muscular dystrophy. My tack was to encourage them to come out of the isolation to which they had let their uniqueness carry them. The transitional choice these families were making was whether to continue the pathway toward dysfunction or to select a different direction. Consequently, I got them to question why had they come there, and to map out where they had come from and what some other alternatives might be in terms of a transitional pathway. Should they be making an impact on the community by asserting, "Look, we have twins. We therefore are unique and must be helped"? Or should they be working toward dispersion of their group and mobilization of larger parts of the community, which would both provide a service to others and fulfill their own needs? More specifically, to help the Mothers of Twins become aware that they had a choice of direction, and did not have to continue blindly along one route, I primarily used mapping, drawing a huge map on the board, and asking: Who are the people in this group who started the organization? Why did you do it? What were you hoping to gain from it? What were you scared of losing if you didn't have it? What are your fears and hopes? How do your parents and grandparents feel about it? What do you think your great-grandchildren are going to experience?

Where do you want it to lead? I did a lot of restructuring and reframing around the possible trend, drawing out the trajectory they were on and asking: What does this mean? Were the people who started the group specifically people who had felt they had a mission because they were producing twins like great-grandmother's twins? In some ways, this intervention amounted to a form of graphic consciousness-raising, forcing the whole group to come to grips with where they came from, why, and where they might (or should) go.

Mapping a Leader's System

For simplicity, rather than mapping the entire system of the Mothers of Twins (MOT) group, I will concentrate on the founder and show how her family's transitional conflict affected the group and its evolution. Because the map I arrived at illustrated some personal conclusions about the founder, this was generally not what I drew for the group, but rather the map I constructed for my own use in order to understand the system.

The group was essentially started by a clergyman's wife, who, it was later determined, had been using the group to maintain balance within a system that included her family and her husband's family, as well as the larger church community which he served. The stated goals of the group were fellowship, support, education, and making a contribution to future mothers of twins. The hidden agenda was to share the feeling of "specialness" and also to find an accepting peer group in other parents who struggle similarly. The clergyman's wife's personal agenda included creating an "elite" society in order to find acceptance outside of the congregation (her husband's) that had rejected her.

The stated purpose for the consultation was to teach the members how to raise twins, for example, by lectures and through being available to advise on child-raising decisions. The hidden purpose was for the group to have access to a professional who had already "coped" with raising twins. It was also anticipated that the consultant would fulfill the role of mother/grandmother to the group, and provide them with a stamp of understanding approval for their "not quite coping."

I projected several possible future directions (some of which were shared with the group):

1. Continuation of current direction: Group stays together forever. Clergyman is free to adapt to his own congregation with wife occupied elsewhere and not competing with him. Clergyman's wife helps him move into other sectors while she has her own area where she is both in authority and accepted. Consultant stays on forever as new members join and old members remain.

2. New direction by the wife: (a) Clergyman's wife is ordered by hus-

band to devote more time to their own community and she leaves the group, which collapses without her leadership. (b) Clergyman's wife drops out, but another strong leader with equal needs emerges and takes over—leading to a status quo situation of the group.

3. New group direction: Clergyman's wife and the rest of the group review their agenda, map out where they came from (how the group arose) and where they may be heading. This may lead to: (a) occasional lectures on educational topics; (b) occasional consultations on immediate problems; (c) moving the twins and their mothers back into the larger community; and (d) taking responsibility for helping new mothers of twins fit into the larger community so they no longer need an isolated group or regular consultations.

In obtaining a historical overview of the group and its primary leader, it was learned that the clergyman had moved from another country where he had been schooled by the traditional, patriarchal "Mother Church." When he arrived in this new environment, it was unclear whether he fit into the culture, what his place was within the church hierarchy because of his youth and inexperience, and how his philosophy meshed with or differed from that of his congregation. In addition, he and his wife had met and married soon after his migration. The congregation refused to accept the wife, who dressed in a very old-fashioned way with covered head and long-sleeved, high-collared garments. Her attempts to fit into the congregation also failed because she was seen, ironically, as too self-willed and modern in behavior. When their twins were born, the clergyman, feeling deprived of his wife's attention and unsure of the congregation's acceptance, diverted his energies to a new ecumenical movement. This left the wife feeling even more isolated, and she embraced the MOT movement wholeheartedly.

Thus, both the clergyman and his wife were caught in the transitional conflict between, on the one hand, rigid clerical traditions upheld by a conservative board of trustees, and, on the other hand, their youth and desire to become part of the ecumenical movement by dropping many of the traditions and becoming less insular and more modern. In addition, the clergyman's wife felt dissatisfied with her role as a patriarchal wife and wanted to join pioneering groups for women's rights. In her attempt to be accepted by her own community, she covered her head, hid her body, and appeared to be very religious; at the same time, she resisted her husband's authority and made a move to join a more open society. Thus, she oscillated between the extremes. The twins were both a burden and special, and they also provided a link to an admired great-grandmother who had had twins. They gave her the perfect justification for moving out toward a different group.

Regarding the MOT group, the members of the group, each with her

own agenda, may have been seeking group support, forgiveness, and acceptance for producing a relatively unusual phenomenon. In some ways this is similar to people with a particular illness who band together against the world. The consultant should be careful not to encourage this. Instead, it is better to help the group create natural support networks within their extended families and communities—to mobilize the natural support system rather than create a permanent, artificial one, with its attendant consultant.

By mapping the trajectories of sociocultural change (e.g., movement toward matriarchy or parental equality in a traditionally patriarchal culture) as well as the trajectories of the clergyman's family, it became apparent that there were three possible outcomes: (1) more of the same, (2) retrogression for the clergyman's wife, with either more of the same or dissolution of the group, or (3) a shift by the clergyman's wife and family and by the group toward normalization and greater community contribution. These possibilities were presented to the group. The group, not the consultant, made a choice, opting for the third possibility. (As with most groups, and families, once the map is clarified, the third option is generally selected.) In this particular case, I subsequently learned, the clergyman and his wife moved still further along the transitional pathway and are now in partnership in business together. The group continues to meet occasionally for educational purposes.

As another example, I recently consulted to a group of service providers in substance-abuse programs in Holland who were undergoing a consolidation of state and city services. There was confusion and anxiety as to who was going to provide the services and how the two systems were to mesh. Eventually, the situation became so complicated that there had been talk of discontinuing the service altogether. We proceeded by mapping first the major system, then the people within it and their directions of transition, and finally by looking at how one could help them reach synchrony before the merger. We determined that when they merged, people should fit into a matrix rather than continuing the dysfunctional behavior that had led them to consider a merger in the first place. I later received a letter from the group informing me that they had managed to get the plan adopted and that it has been working.

In family treatment, once the family has made a transition and moved on, there is usually little reason to continue the therapy. Consulting with self-help groups is very similar. In contrast, the self-help group itself usually needs to implement a membership recruitment process with built-in continuity. Otherwise, the group will continue primarily to serve its original members, which would eventually lead to decline and dissolution.

INTERVENING AND EMPOWERING

Once one has derived a transitional map, one can design a specific kind of intervention aimed at the point of transitional conflict—the locus where the transitional conflict patterns keep repeating. This intervention must, of course, be tailored to the system and be the sort that less sophisticated leaders in the system can apply. As an example, the aforementioned cancer group was a collection of women who were feeling unloved, unwanted, and mutilated, and, therefore, not able to provide mothering and loving for their families. A simple strategic intervention here might be to assert to them that they themselves needed to be cared for before they could provide caring to others and that, therefore, their families, their community members, and their health workers should take extensive care of them. One "compresses" (Stanton, 1984) the "caring" to the point where they can say, "Hey, this is enough. I'm not a baby. I don't need to be an infant. I'm going to start providing for myself and others." Meanwhile, one has mapped out how the leaders (in this case the professionals) can help the consultees to minister to the community. The map gives one an overall perspective and aids in the choice of the point of intervention.

Regarding one's posture vis-à-vis the organization, it is strategically wise not to be seen as a "member." Better that the consultant remain an outsider so as not to be easily pre-empted or co-opted. In fact, the consultant would be well-advised to refer to himself or herself as a "stranger" rather than an "outsider," because the former term more readily connotes a need to learn.[3] Too often, consultants enter an organization to teach. I believe that *one can consult more effectively if one enters to learn.* For instance, in consulting with organizations such as the Catholic and Mormon churches, I immediately phone the appropriate bishop or archbishop as soon as a case is referred. My purpose is to ask for help and direction: What does he think is going on with this family? What should be done? These requests elevate this key person and establish his authority clearly. After all, he is going to have to deal with this and similar instances after I am gone. While I might make suggestions about what I think might work, I leave the decision up to him.

Making sex education infectious: A case example. I was consulted by the director of health for a large region. He had been asked to redesign for the schools the sex

3. The senior editor has told me that he and his wife developed a reputation for being skilled and understanding in dealing with black families primarily because from the beginning they emphasized their lack of knowledge and their need to learn (L. C. Wynne, personal communication, April 1984).

education and family-life curricula, topics that lay well outside of his areas of expertise. He had become director of that system because his particular field was infectious diseases. In such instances, one has to recognize that by the time somebody approaches one for consultation he or she is often feeling incompetent enough to request a consultation. However, like all of us, he or she is often very reluctant to admit incompetence. Similarly, it is not uncommon for students, when they are starting to consult, to compete with, rather than to empower, those with whom they consult.

In this particular case, I asked the director, "If you were having to set up a system for teaching in schools, or developing an education system around infectious diseases, how would you do it? Who are the people you would bring in to teach? Which of your staff would you use? Would you use the parents? How much of the community would you use? Would you use the kids and ask what their perceptions are?" I thus encouraged him to do his initial mapping in an area in which he was competent. This gave him confidence and he was able to transfer the vast knowledge that he already possessed to this new arena. From there, his final plan only needed a bit of fine tuning before the implementation process began.

This example readily illustrates the principles of competence, impermanence, and transitional mapping. The end result is that the consultee, and the system, are empowered. To empower or not to empower is never the question. For successful consultation, one must always empower. No system needs a permanent consultant. It primarily needs *itself*. The consultant who knows this can both eliminate and prevent dysfunction.

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