

The Role of the Consultant: Content Expert or Process Facilitator?

One of the persistent dilemmas that faces any consultant, helper, therapist, or manager is how to be helpful in a situation in which there is a choice between telling others what to do, being a content expert, or facilitating through various interventions a better problem-solving process that permits those same others to solve the problem for themselves (Schein 1969). In this article, I would like to spell out in greater detail some of the assumptions that underlie different models of consultation, and indicate the kinds of interventions that are most suitable in the process model.

The expert model of consultation has basically two versions: (a) *purchase* of specific information or expertise as in the case of hiring a consultant to do a market survey, or (b) *doctor-patient* as in the case of hiring a consultant to come into an organization to do a diagnosis and suggest various remedies for whatever ailments are found. The difference between these two models is in the degree to which the client retains control

and wants only specific solutions or information. The consultant is hired because of specific skills in eliciting that information or specific knowledge to solve a given problem. The client decides what to do with the information, if anything. In the doctor-patient model the client abdicates some degree of control by admitting that he or she does not know what is wrong, giving the consultant broad powers to come into the organization to do a diagnosis (often the client does not even realize that some of the diagnostic techniques themselves may disturb or change the organization), and implicitly commits himself or herself to accepting some kind of prescription or remedial course of action.

The process consultation model also has two versions: (a) *catalyst* model where the consultant does not know the solution but has skills in helping a client to figure out his or her own solution, and (b) *facilitator* model where the consultant may have ideas and possible solutions of his or her own but for various reasons

decides that a better solution and better implementation of that solution will result if he or she withholds his or her own content suggestions and, instead, consciously concentrates on helping the group or client system to solve their own problem. This last version of process consultation frequently applies in managerial situations where the manager decides to "help" a subordinate or group to achieve their own solution by creating a good decision-making process rather than making the decision personally. Occasionally managers also find themselves playing the catalyst role in complex problem solving situations because they genuinely do not know the solutions yet are accountable for reaching some solutions within a given period of time.

Content vs. Process

Any human problem solving activity can be analyzed both at the level of con-



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tent and process. If we are to understand clearly the role of the consultant vis-a-vis content or process, we must first have a clear idea of what we really mean by these two underlying concepts. At its simplest, content refers to the actual task to be performed or problem to be solved, while process refers to the way in which the problem is attacked, defined, worked on, and ultimately solved. Content is what the typical secretary of a group would keep records on during the meeting—the agenda, the ideas that were presented, the solutions that were offered, the decisions that were reached, and the future agendas that were settled on. In contrast, if one were to observe the process of this same meeting, one might record the communication patterns (who spoke to whom, who spoke how often, who interrupted, who shouted, who asked questions, who made assertions) quite independent of the actual content of what each person said. Similarly, one might track leadership behavior in terms of initiating activity, pushing toward consensus, summarizing, and testing feelings. Or one might catalogue all of the decisions made in the group in terms of whether they were reached autocratically, by some means of minority rule, by majority rule, by consensus, or by unanimous agreement. Process observations can be made, regardless of what the group is talking about, because they focus on the problem-solving activity per se rather than the intellectual content of the problem.

If we think of the analogous distinction in counseling, the counselor can listen to the words of the client, or can listen to the tone of voice, the feeling that accompanies what is said, whether or not it is put in the form of a question or assertion, how the client related to the counselor through cues such as body position and communication style, how the client responds emotionally to inputs from the counselor (e.g., a question is always followed by a silence, or an interpretation is always followed by a defensive denial).

In actual practice one will find, of course, that there are subtle connections between the content of what is being worked on and the process by which the work is being done. Sometimes the process mirrors the content but more often the content is a subtle reflection of underlying feelings and thus mirrors the process. For example, in training groups it was a common experience to have the group choose as its "topic" something that was related to its underlying process, e.g., the group might choose to discuss

leadership as an agenda item when it was in fact hung up on a severe leadership struggle among several members. Process issues are usually reflections of underlying emotional currents in the person or group which reflect unconscious or denied assumptions, norms, and feelings. To help an individual or a group to confront process issues can be seen as a process of "surfacing," making something unspoken or unconscious available for examination, review, and analysis. Whether or not one chooses to confront such issues depends upon the consultant's diagnosis of how much the process issues are getting in the way of effective problem solving or goal attainment. I will deal with this question in greater detail later in the paper, but wish to point out for now that, though content and process are very different and can be observed totally independently of each other if one chooses to do so, they are in fact subtly interrelated and one of the consultant's toughest decisions is when and how to focus on that interaction.

Three Models of Consultation and Their Underlying Assumptions

The initiative for seeking help and involving a consultant is always with the client. Most clients are at the outset content centered. They cannot achieve some important goal, they cannot solve a particular problem, they cannot get a particular set of information, or they lack a necessary skill to fix something which does not work, so they turn to a helper.

Model 1: Purchase of Expertise. The core characteristic of this model is that the client has made up his or her mind on what the problem is, what kinds of help are needed, and to whom to go for this help. The client expects expert help and expects to pay for it but not to get involved in the process of consultation itself. The extreme pure model is the television repairman or auto mechanic. When something doesn't work, we want it fixed. Other examples might be the purchase of a market research survey, the hiring of a consultant to develop a computer program for a given problem, or the hiring of a lawyer to determine whether a given course of action will run into difficulty or not. The essence of the message from the client to the consultant is "here is the problem, bring me back an answer and tell me how much it will cost." Psychologically, the essence of this relationship is that the client gives away the problem temporarily to the helper, which permits the client to relax, secure

in the knowledge that an expert has taken it on and will come up with a solution. This model is, almost by definition, totally content oriented.

In order for this model to work successfully, the following assumptions have to be met, however,

1. *That the client has made a correct diagnosis of his or her own problem.* If I have misdiagnosed my problem the consultant will typically not feel obligated in this model to help me rediagnose to discover what is really the problem. That is not part of the consultant's contract unless I make it so, in which case I shift into one of the other two models to be presented below.

2. *That the client has correctly identified the consultant's capabilities to solve the problem.* If I go to the wrong expert and get a poor solution, that is my problem as the client. Furthermore, in my discussions with the consultant I have to be aware that the consultant is perfectly within his or her rights to attempt to "sell" me, and that I have no excuse if the service proves to be less expert than I expected. The burden is on the client to evaluate the expertise.

3. *That the client has correctly communicated the problem.* If I fail to make it clear to the consultant what problem I am really trying to solve, there is a good chance that I will end up paying for services or information that will not be relevant. The process often breaks down here because clients do not check whether consultants have "heard" correctly what the client's problem is before they charge off to solve it. Many market surveys end up being useless and many counseling sessions end up being nonhelpful because the client sought "advice" but did not fully and clearly get across what the problem really was, and the consultant in this model is under no obligation to check out whether the initial problem statement is in fact accurate or not.

4. *That the client has thought through and accepted the potential consequences of the help that will be received.* How often have we gone to a service repairman and then resented paying the bill when we are told that our equipment was beyond repair and should be replaced altogether? How ready are we to pay attention to the results of the market survey once we have launched it, or, more commonly, how ready are companies to deal with the results of opinion and attitude surveys that get into morale questions if the results do not fit their prior assumptions? Consultants who operate by the purchase of expertise models have learned over and over again

that clients become angry and disillusioned if the expert information they are given does not fit in with their prior expectations.

In summary, this model of consultation is appropriate when clients have diagnosed their needs correctly, have correctly identified consultant capabilities, have done a good job of communicating what problem they are actually trying to solve, and have thought through the consequences of the help they have sought. As can be seen, this model is "client intensive," in that it puts a tremendous load on the client to do things correctly if the problem is to be solved. If problems are complex and difficult to diagnose, it is highly likely that this model will not prove helpful.

If the client recognizes that the diagnostic process itself is a problem, that something is not working but it is not clear what kind of help is needed, the client will adopt one of the next two models—doctor-patient or process consultant.

Model 2: Doctor-Patient. The core of this model is that the client experiences some symptoms that something is wrong but does not have a clue as to how to go about figuring out what is wrong or how to fix it. The diagnostic process itself is delegated completely to the consultant along with the obligation to come up with a remedy. The client becomes totally dependent upon the consultant until such time as the consultant makes a prescription, unless the consultant engages the client in becoming more active on his or her own behalf. As we will see, to the extent that the consultant does that, he or she is moving toward the process model. Several implicit assumptions are the key to whether or not the doctor-patient model will in fact provide help to the client.

1. *That the client has correctly interpreted the symptoms and the sick "area."* I cannot get help from an orthopedic surgeon if my pains are of hysterical origin. This is why it is often important to go first to a general practitioner who functions partially as a process consultant before engaging in a "pure" doctor-patient relationship. In the organizational area we see many examples where companies conclude that they are hurting in the financial area, bring in a financially oriented consulting firm, work up new financial strategies, and then find a year or so later that things are no better than they were. No one discovered that the problem did not lie in finance, or organization, or product strategy or sales promotion, or

whatever. It is very easy for clients and consultants to get caught up in a mutually reinforcing incorrect diagnosis if they move too rapidly into a doctor-patient mode of operating. Charlatans or just plain bad doctors are consultants who play on the client's dependence and purvey prescriptions that fit the doctor's area of expertise rather than the client's problem area.

2. *That the client can trust the diagnostic information that is provided by the consultant.* One of the biggest problems in this model is that the client has no way of evaluating whether or not the consultant's conclusions that the problem is X, is in fact a correct diagnosis. Often the consultant is deliberately obscure, technical, or otherwise esoteric in order to impress the client and to insure that further services will be purchased. There is nothing in the contract that obligates the "doctor" to worry about the client's degree of understanding of the diagnosis or its consequences except professional norms. In medicine these norms are reasonably clear and are enforced through collegial and professional associations. In the field of consulting such norms are much less clear and there are few practical ways of enforcing them because more of the client/consultant contact is hidden from view.

3. *That the "sick" person or group will reveal the correct information necessary to arrive at a diagnosis and cure, i.e., will trust the doctor enough to "level" with him or her.* In my own experience in working with groups there are two sources of distortion that make diagnosis difficult: (a) the person or group identified as "sick" or in need of help is resentful about that very identification and handles the resentment by denying or just plain "clamming up"; or (b) the person or group thus identified is so relieved to finally get some much-needed attention that they unburden themselves of all the accumulated grievances of the past, thus making it very difficult to put what is said into any kind of reasonable perspective. Consequently, when a client asks me to visit a group in which "there is a problem" I tend to resist that request until I have a much clearer idea of what is going on in that group from the initial client's perspective. The issue here, as in model 1, is whether or not the consultant is willing to take the problem on his or her own shoulders and allow the client to become even temporarily dependent. Such dependence, if allowed, may undermine the reaching of an accurate diagnosis.

4. *That the client has thought*

through the consequences, i.e., is willing to accept and implement whatever prescription is given. It is a comforting feeling to give away one's problem and to be dependent upon a helper, but it is not always comfortable to be told at a later time what one will have to do to "cure" the problem. The consultant comes in, makes the diagnosis, and then recommends a "reorganization." This solution may be entirely correct in the abstract but may not fit some prior assumptions that the client had made about the future or some values that are held by key managers, or may conflict with some other "facts" about the culture of the organization that may never have been revealed to the consultant. If the client is then upset about the prescription or having wasted money on something that he or she considers not implementable, the blame is on the client for having entered into the doctor-patient model without accepting all of its consequences. Of course, if the consultant cares about implementation, he or she will anticipate this problem and avoid getting into the pure doctor role in the first place.

5. *That the patient/client will be able to remain healthy after the doctor/consultant leaves.* If this model of consultation is to be useful, it must be applied in those areas where one can reasonably assume problem-solving capacity on the part of the client. If the problem is likely to recur because the client has not really learned how to solve problems of this sort, the dependency on the doctor/consultant simply remains and the client then must decide whether or not such continued dependency is or is not appropriate. But there is nothing in the model itself that insures increased problem-solving skills on the part of the client.

In summary, the doctor-patient model of consultation highlights the dependence of the client on the consultant both for diagnosis and prescription and thus puts a great burden on the client to correctly identify sick areas, accurately communicate symptoms, and think through the consequences of being given a prescription. Contrary to medicine, the field of consultation does not provide the client with the same safeguards against charlatans, and hence puts a greater burden on the client to protect himself or herself from unnecessary or inappropriate help.

If the consultant or helper is dedicated to producing change, to implementing solutions, and to increasing the overall "health" of the client through improving the client's own problem-

solving skills, some version of the process consultation model must be applied.

Model 3: Process consultation. The core of this model is the assumption that for many kinds of problems that clients face, the *only* way to locate a workable solution, one that the client will accept and implement, is to involve the client in the diagnosis of the problem and the generating of that solution. The focus shifts from the content of the problem to the process by which problems are solved, and the consultant offers "process expertise" in how to help and how to solve problems, not expertise on the particular content of the client's problem. The consultant does not take the problem onto his or her own shoulders in this model. The "monkey always remains on the client's back," but the consultant offers to become jointly involved with the client in figuring out what is the problem, why it is a problem, why it is a problem right now, and what might be done about it. This consulting model is not a panacea appropriate to all problems and all situations. It also rests on some specific assumptions that have to be met if the model is to be viewed as the appropriate way to work with a client.

1. *That the nature of the problem is such that the client not only needs help in making an initial diagnosis but would benefit from participation in the process of making that diagnosis.* In my experience most problems that are nontechnical, that involve one or more other persons, that have group or organizational components, that involve values, attitudes, assumptions, and cultural elements, and which involve the client's own feelings fall into this category. Behind this assumption lies the further assumption that the information that is relevant to the diagnosis is fairly deeply imbedded in the client system and would not be easily elicited by an outsider functioning in a consulting role, but might be accessible if the client and consultant are working together both to elicit and interpret the information. Equally important is the assumption that the client would improve his or her problem solving *capacity* for future problem solving by learning through involvement with the consultant how to think about diagnosis, how to gather information, how to interpret it and how to draw conclusions about possible remedies. The consultant's skill lies in the process of helping—knowing what questions to ask, what to look for, how to stimulate alternate ways of thinking about prob-

lems, how to separate facts from feelings, how to involve others in thinking things through for themselves. All of these are skills that the client should improve.

2. *That the client has constructive intent and some problem-solving ability.* If the client is determined to be dependent or destructive, or if the client totally lacks problem-solving skills, this model obviously is inapplicable, as indeed might be any form of consultation. But the process model is clearly more vulnerable to the manipulative or destructive client, and hence the consultant must determine early in the relationship how much constructive intent is present and be prepared to terminate the relationship if it is not present.

3. *That the client is ultimately the only one who knows what form of solution or intervention will work in his or her situation.* Because of the degree to which the relevant information about values, assumptions, and attitudes is likely to be hidden in the client system it is essential to let the client generate the solution. Nine times out of ten when I have given "advice" I have been immediately told some new fact that made that solution irrelevant or unworkable. Instead of being angry with the client for resisting the advice, consultants should recognize that advice may have been inappropriate in the first place and that the client should have been helped to solve the problem. One way of doing this is to offer alternatives instead of advice and encourage the client to generate additional alternatives.

4. *That if the client selects and implements his or her own solution, the client's problem-solving skills for future problems will increase.* As was said at the outset of this section, one of the crucial elements of this model is the assumption that the goal of the consultation process is improved overall problem-solving skill on the part of the client, not only immediate problem solution. If there is no prospect of such skill improvement, the doctor-patient or expert models may be appropriate and less expensive.

A theoretical principle that underlies this model is that all human systems, whether individuals, groups, or organizations, are imperfect, have strengths and weaknesses, and can perpetually improve and grow. If this assumption or principle is accepted, it follows that any human system will benefit from increased capacity to diagnose and improve itself. It then becomes the ultimate function of the process consultant to help the client to perceive, understand, and act upon the process and content

events that occur in his or her environment in order to improve the functioning of that client.

The philosophy of improvement does not imply that the consultant imposes his or her model of health on the client, but rather, accepts the goals and targets of that client system. If the consultant feels that those goals and targets are inappropriate, the consultant must be prepared to confront the issue, negotiate, and, if necessary, terminate the relationship. But the process consultant cannot at any time take over the client's problems, specify the client's goals, or in any other way allow client dependence. It is essential in this model for the client to perceive himself or herself as owning the problem and being in charge of finding the solution, with the consultant's help. And help is here defined as focusing on the process of problem solving rather than the content of the problem itself.

Task Process vs. Interpersonal Process

How does the consultant implement the process consultation model? The basic principle is to get into the client's world and see it initially from the client's perspective. This usually means paying attention to the "task process"—how the problem is defined, how the agenda is set, how information is gathered, how decisions are made, all the activities that make up the "problem-solving process." The consultant may observe interpersonal conflicts, leadership struggles, communication breakdowns, emotional outbursts, and other *interpersonal* process events. Unless the client has stated as a goal the observation and analysis of such events, however, the consultant should stay focused on task process because it is likely to be in that area where initially most of the help can be given—by clarifying goals, restating or clarifying the agenda, insuring that all information relevant to the problem is brought out, helping the client to select an appropriate mechanism for making a decision, etc.

Interpersonal process events should only be dealt with if and when the client indicates a genuine readiness to deal with them and if there is *clear* evidence that the interpersonal events are getting in the way of effective problem solving. It is not helpful to a client to be pushed into interpersonal and emotional issues before there is an emotional readiness to deal with them. The consultant must take great care here not to start "playing doctor" and making all kinds of possibly

erroneous assumptions about the client's readiness.

Facilitative Intervention

Because it is the goal of the process consultant to pass on his or her problem-solving skills as well as to provide help on the immediate problem, it is essential that interventions set a good example of how to facilitate problem solution. The consultant should at all times act congruently with these values and should behave only in ways that the client might adopt as his or her own behavior at some future time. Psychological interpretations, clever observations, deep analyses, penetrating questions, confrontive challenges and other kinds of interventions that might be appropriate in training groups or therapeutic environments are totally inappropriate if the process consultant is trying to be a role model for the client. More appropriate would be well-timed clarifications, summarizing, genuine questions about observed incongruities in the problem-solving process, suggestion for how to move forward, and other interventions that show the client that the consultant is concerned about task accomplishment. If the observations on which the intervention rests have been sound and if the consultant's timing is good, the intervention will not only facilitate problem solving but will help to surface hidden assumptions or values that may interfere with good problem solving and thus aid the client's efforts to obtain insight into his or her own process environment.

Conclusion

My purpose has been briefly to spell out three different models of consultation, to identify the assumptions upon which each model rests, and to argue for the relevance of the process consultation model in all situations that involve personal, group, or organizational components, feelings, values, and cultural elements. Any given consultant inevitably ends up using all three models at different times and with different clients. The important conclusion for the consultant, therefore, is to obtain enough insight into his or her own behavior to know which model he or she is using at any given time and to assess the appropriateness of that model to the situation. The ideal consultant would be flexible enough to move across the three models.

Reference

Schein, E. H. *Process consultation*. Reading, Mass.: Addison-Wesley, 1969.



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