PROCESS CONSULTATION AS A GENERAL PHILOSOPHY OF HELPING

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I would like to review with you today some observations that I have made over the last 30 years about the process of helping human systems. I say human systems rather than individuals or small groups because much of what I have been working on as a consultant is inter-group and organizational level problems. Individuals are always centrally involved, but the definition of who precisely is the client can get very complicated indeed.

In fact the "systemic" approach implies that one think simultaneously in terms of three clients: 1) immediate or contact clients with whom one is interacting in the "here and now," 2) primary clients who are the real targets of change, and who pay for the change efforts, and 3) ultimate clients who are the stakeholders that have to be considered even though one might not ever interact with them directly.

I make this point at the outset because process consultation has been stereotyped in the organization development literature as something one does primarily with small groups. My own experience is that one is working on a daily basis with indi-
individuals, small groups, or large groups, but one's concerns are always "systemic" in the sense that one is considering one's immediate interventions in terms of their consequences for other parts of the system. For example, one might choose not to help a manager to become more autocratic even if that was the manager's wish, if one thought that such behavior on his part would be dysfunctional for the department and/or harmful to his subordinates.

I have three points that I wish to develop in this talk:

1) Helping is a general human process that applies to parents, friends, teachers, and managers, not just to consultants or therapists whose central role is to help.

2) To be helpful to human systems involves choices that the helper has to make, and those choices rest on key assumptions that have to be examined continuously during the helping process. Those choices are primarily the on-line real time decisions on when to be in the role of expert, doctor, or process consultant. The contrast between these roles will be explored in some detail below.

3) One of the central concerns of consultants should be to improve the ability of clients themselves, especially managers, to become more helpful in their dealing with superiors, subordinates, peers, customers, suppliers, and other stakeholders. In other words, the helping role is a critical one in all human affairs, hence more people should be taught how to be effective helpers. It is an especially important role in hierarchical organizations, and, therefore, needs to be taught especi-
ally to managers and leaders.

Some Historical Footnotes

I have come to the philosophy that underlies these conclusions over a period of time, and base it on a variety of experiences as a teacher, researcher, and consultant. My background was in social and clinical psychology, and I had a chance to see these roles in operation while working from 1952 to 1956 in the Neuropsychiatry Division of the Walter Reed Army Institute of Research under David Rioch. I came to MIT in 1956 and was encouraged by Douglas McGregor to get involved with the activities of the National Training Laboratories for Group Development where for 15 years I served as a trainer in various kinds of human relations, leadership, and other workshops, especially ones focused on managers (Schein & Bennis, 1965).

I learned a lot about how an effective group should operate, and also learned that to make a group more effective one could not simply advise it, but had to find a way to make the data visible in such a way that the group could learn from its own experience. The essential skill of the trainer was to make observations in such a way that the group could learn from them, a model not unlike the psychoanalytic group model being proposed by Bion (1959) at the time, and utilized by the A. K. Rice Institute in their workshops today.

Given this background, I approached my first organizational consulting with models of effective interpersonal relations and group behavior in mind, and with an armamentarium of observational and intervention skills in my tool bag. I was for-
 fortunate in 1965 to be given an opportunity to work with the top management team of a young high tech company, with the explicit mandate to "help the group with communication and to make them more effective as an executive team." I was to join the group at their weekly staff meeting, observe them at work, and intervene as appropriate.

There was more than enough to observe. The managers in this group were very confrontive, constantly interrupted each other, often shouted at each other, revealed information of a negative sort about each other at the meeting, blamed each other, and in other ways behaved ineffectively. I shared my observations as I felt it to be appropriate and when I could get a word in edgewise, and suggested that the group examine the consequences of the behavior I was observing. Their response was always one of interest. Members were grateful to have their behavior pointed out and they expressed regret and some shame at what they themselves could easily see as "bad." They complimented me on my identifying these issues, and then went on doing just what they had been doing all along. In other words, nothing changed.

At first I attributed my lack of influence to my lack of skill in making the consequences of the group's behavior sufficiently visible. But as this scenario repeated itself over many months, and as my own frustration grew, I began to realize that I was making some assumptions about helping that were inappropriate and that needed revision. I realized that the helper has some real choices about how to help, and that I was making incorrect choices.
Specifically, I was assuming that I knew better how a group should operate than the group I was working with. I was importing a model of effective group action from my training experience into a work setting. I was also imposing a set of humanistic values pertaining to how people should communicate, how they should not publicly embarrass each other, and how they should reach consensus on decisions.

In letting those assumptions guide me, I was missing a crucial point---the group had a task and an agenda that was more important than all of the above considerations, and that agenda was driving and stabilizing their group process. Specifically, this agenda was to resolve some very critical strategic issues around choices of technology and products, in an industry where no one really knew what would and would not work, and where the academic tradition prevailed that ideas had to be fought out in order to be tested and validated. I was busy trying to civilize the group to some model I had, while the group was searching for truth in a life and death struggle against its competitors in its industry. I was imposing my expertise about groups on a group that was trying to solve a problem that was far more important than how to be an effective group.

Of course, I could point out to myself that I was doing my best to respond to the very request the group had made of me. They had asked me to help them to be more effective as a group. But I eventually realized that they themselves did not know exactly what they had in mind. They only knew that "something" was wrong and were counting on me to help fix it. They sincerely
tried to help me by paying attention to what I was pointing out, but they, like I, found that some other agenda was driving their behavior.

In retrospect, the essence of what I came to think of later as "process consultation" as a philosophy was derived out of the insight that I could not be helpful until I gave up my own notion of what the group should be, and began to pay attention to what the group was actually trying to do. I had to abandon a lot of theory about how individuals, groups, and organizations should function, and learn to be a much better observer of what was actually going on.

My learning process was aided by the fact that this executive group violated most of my preconceptions, yet was enormously successful in running their business. Their track record in decision making was extremely good, and the company was growing very rapidly. Obviously, something was lacking in my own theories of effective individual, group, and organizational behavior.

As I began to get in tune with what the group was trying to do, and as I allowed my curiosity to override my need to be helpful, I, in fact, became more helpful. Instead of focusing on the dysfunctional aspects of interrupting, I began to focus on the idea that was being cut off and occasionally restated the idea. As the group suffered information overload, I went to the flipchart and wrote down for all to see some of the ideas that might be getting lost. As I observed destructive conflict between two members of the group, I asked them to elaborate what
they were trying to say instead of pointing out to them that they had interrupted. I began to intervene in the "real" process of the group, its task process and only allowed myself to get preoccupied with interpersonal issues when there was time, a clear need to deal with them, and a readiness on the part of the group to do so. Needless to say, the feedback from the group was that "now I was really helping."

I knew I was on to something, but the clearer articulation of what lay behind these insights was only later forced upon me by a colleague who perceived management consulting to be a waste of time. Why teach elementary psychology to a bunch of managers or counsel them on their hang-ups when one could be doing important research? I was angered by this challenge because I felt I was learning more in my training and consulting experiences than in the research laboratory. But I also realized that the essence of what was going on with my clients was invisible and misunderstood by my colleagues. This led me in 1969 to write about the three models of consultation that I now understood more clearly (Schein, 1969), and to elaborate the process consultation philosophy in the recent revision and addition (Schein, 1987, 1988).

Three Models of Helping

The essence of process consultation as a philosophy of helping can best be articulated by contrasting it to two other models of helping that seem to me to be substantively quite different. The helper has to make on line choices as to which model to be operating from moment to moment.
Model 1: Providing expert information

Clearly there are times when it is most helpful to give information that is relevant to some problem that the client has. The client wants to know how the workers in a given plant feel about something and requests the consultant to do a survey to find out. A subordinate asks the boss: "how do I deal with this problem employee in my group?" and the boss tells her how. A child asks a parent "how do I do this math problem on my homework?" and the parent shows him how to do it.

This seems straightforward enough, but notice that the model has behind it several assumptions that often cannot be met. It assumes 1) that the client knows what the problem is, 2) that the client has communicated the real problem, 3) that the helper has the correct information that the client needs, and 4) that the client has correctly thought through the consequences of asking the question and receiving the answer.

It may be that doing the survey will raise issues and expectations that the manager is not prepared to deal with, it may be that the subordinate or child is learning how to be dependent on the boss or parent at a time when it might be more important for them to learn how to dig out the information themselves. It is also possible that the boss or parent is wrong and the information will not be helpful.

Sometimes it is the helper, the consultant, manager, or parent, who must think about these assumptions and assess the hidden consequences of providing expert information. And sometimes, based on this assessment, the helper must choose not to
operate in that model even if requested to do so. Yet to recog-
nize that one may not be as expert as one assumed, or that the
client may not really benefit from one's knowledge is extremely
difficult to acknowledge.

Model 2-- Playing doctor

Clients often invite helpers to be, in effect, a doctor
who will investigate, interview, psychologically assess, run
tests, make a diagnosis, and offer a prescription or suggest a
cure for the problems identified. If consultants find model 1 to
be an ego trip, think how we respond to model 2. For example,
the organizational client wants us to investigate what is wrong
in a department and suggest a cure; the subordinate goes to the
boss with a broad request for diagnostic help in dealing with his
problem people; or the child comes to the parent with the lament
that she cannot do the math ever, and doesn't know what is wrong.
The temptation to put on our stethoscopes and to launch into a
diagnostic investigation is overwhelming. The popular notion of
the consultant as one who gives advice or makes recommendations
fits this model, and some models of psychological consulting to
management start with individual assessments of the key actors in
the situation as a basis for diagnosing the systemic problems
that may be operating.

Given our training and role as outside "experts" this
all sounds eminently logical and appropriate, but what does it,
in fact, imply at the level of assumptions? Several critical
assumptions undelie this model. First, the doctor model assumes
that the client has correctly identified the sick area. Second,
it assumes that the presumed "patient" will reveal the information necessary to make a good diagnosis. I have often had the experience that my data were invalid because either a grateful client exaggerated the problems or a resentful client denied them completely.

Third, a correlated assumption that applies especially to clinical psychologists in the consulting role is that they have the necessary expertise to arrive at a correct individual or group diagnosis. Are our assessment instruments good enough? Fourth, this model assumes that the client and/or patient will accept and believe the diagnosis arrived at. Fifth, it assumes that the client and/or patient will accept the prescription and do what the "doctor" recommends. And, finally, it assumes that the client/patient will be able to remain healthy after the doctor leaves.

I am sure that you all know from your own experience how frequently we are frustrated in our helping efforts by clients who do not accept our expertise, who file our reports instead of acting on them, who misunderstand and subvert our recommendations, or who revert to their disease the minute we leave. As an aside, I might comment that this last condition may not bother us as consultants inasmuch as it keeps us employed, but the fact of the matter is that if the patient becomes that dependent upon us as doctors we are no longer dealing with consultation or helping. We then become de facto managers wearing consultant hats.

If we become conscious of these assumptions, we recognize that the model often goes awry because one or more of the
assumptions cannot be met. It is a perfectly good model when it applies, but only when it applies. Incidentally, more and more physicians are themselves questioning this model as they observe their own patients resisting diagnoses or prescriptions, and as those prescriptions themselves become more complex.

Model 3--Process consultation

That brings us to the philosophy I have labelled process consultation and a set of assumptions that seem to me to fit better the kinds of human systems with which we typically deal:

First and foremost, I assume that clients, whether managers, subordinates, children, or friends often seek help when they do not know exactly what their problems are. They know "something" is wrong but the help they really need is in figuring out exactly what is wrong. Once that has been figured out, they often can figure out their own solution.

Second, I assume that most clients do not know what kinds of help are available and what kinds of help are relevant to their problems. They need help in figuring out who or what could best help them.

Third, I assume that many of the problems in human systems are such that clients not only need help in figuring out what those problems are, but that clients would benefit from participation in the process of making the diagnosis. This is especially so because of the likelihood that they are in some way part of the problem and need to be led to this insight.

Fourth, I assume that only clients know what form of remedial intervention will really work because only they know
what will fit their personalities and their group or organizational cultures.

Fifth, I assume that clients have "constructive intent" and will benefit from the process of learning how to solve problems, so that future problems can be more effectively dealt with. The implication here is that if the goals of the client are not acceptable to the consultant helper in terms of his or her values, they should not enter a helping relationship in the first place.

What all of this means from the point of view of a philosophy of helping is that the helper must 1) suspend most of his or her own biases initially, and must 2) create a mutual inquiry process that will not only create a shared sense of responsibility for figuring out what is wrong and how to fix it, but will also enable the helper to pass on some of his or her own diagnostic and intervention skills. The helper must help the client to learn how to learn.

Another way of putting this point is to note that in the expert or doctor model, the consultant/helper allows and even encourages the client to pass her presumed problem on to the consultant. Once the helper has accepted the problem and the responsibility to do something, the client can relax and wait for the helper to come back with answers or recommendations. The client is then in an ideal position to distance herself from whatever the consultant may have come up with if it does not suit her.

From the point of view of a philosophy of helping on
human systems problems, if we allow the client to distance himself, we have already lost the war, because it is, after all, the client's problem we are dealing with. From the point of view of process consultation it is essential to create a situation in which clients continue to own their own problems, and the consultant becomes a partner or a helper in diagnosing and dealing with those problems. But they will never be the consultant's problems, and we should not allow clients to feel that we can take their problems off their shoulders onto our own.

As the relationship between the consultant and the organization evolves, the concept of who is the client comes gradually to be broadened so that the consultant may be working with individuals, groups, and organizational units at different times. But the basic assumptions of how to work with these various client systems remain the same.

The Three Models in Practice

Having articulated for you the three models of helping and some of the assumptions that underlie them, let me now be practical and discuss how they really work out in my own experience. I find that I am continually moving from one model to another as the situation dictates, and that my greatest problem is to know when to be operating from which model. I have learned two guidelines that reflect the process consultation philosophy and would like to outline these for you:

1) **Always start in the process consultation mode.**

When a client, manager, friend, child, subordinate, or boss comes to you with a request for some sort of help or a
question that invites you to give an answer or advice, start with the assumption that you may not know exactly what you are being asked for and should, therefore, begin with a spirit of inquiry rather than in an expert or doctor mode.

I assume that whatever I say will be an intervention, so the process of helping begins with my first response to the inquiry. I therefore need to define for myself a category of interventions that I label "exploratory interventions" whose strategic goal is simultaneously to:

1) provide help,
2) provide some diagnostic insight, and
3) insure that the client will continue to own her problem and begin to feel that we are a team working on it.

The initial interventions are, from my point of view, the most important ones because they communicate my strategic intent and create the right kind of psychological contract between me and the client. The client is typically overtrained to expect me to take an expert or doctor role, especially if I am being paid for the help, so I have to simultaneously start to be helpful and correct the stereotype. I may later realize that I should be the expert or doctor, but I have no way of knowing that until I have thoroughly explored the initial situation.

So I say things like "go on," "tell me a bit more," "can you describe the situation," "what do you have in mind," before I leap in with answers and advice. The key is to allow myself to be genuinely curious and to communicate that I feel no obligation to take the problem on to my own shoulders. But I do want the
client to feel that I am being helpful.

I also want to communicate my genuine ignorance of the deeper psychological and cultural issues that may lie behind what I am told. Even with my diagnostic tools and experience, the reality is that in any new situation I know very little about what is going on, and, in fact, this ignorance on my part is one of my most important assets because it permits me to ask all sorts of dumb questions that might offend if I really understood my contact client's situation better.

As the conversation develops, my focus gradually shifts to what I call "diagnostic interventions," but I am still operating in the process consultation mode because these interventions invite diagnostic thinking from the client, not from me. Examples of such interventions might be "Why do you feel this is an issue or a problem?" "Why do you think this is happening?" or "Why did you come to me with this question?" Where the focus of exploratory questions is on the "What," the focus of the diagnostic questions is on the "Why."

These questions may, of course, be perceived by the client as stalling and arouse impatience on the part of the client. If I begin to irritate the client I am not being helpful. The choice of intervention, therefore, has to be guided all along by the strategic intent to be helpful, and that may require moving more rapidly to what I call "action alternative interventions." Here the focus shifts from why something might be happening to what the client has done or is intending to do about what is happening. So I might ask "What have you tried to do?" or
"What do you plan to do?" or "What alternatives have you considered?"

The common characteristic of these three categories of intervention that define them in my mind as being in the process consultation model is that they each keep the client actively solving his own problem without having to deal with advice or new items of information that come from the helper. The helper is steering the process but is not adding any new content.

If new content is clearly called for, if the client signals that she really wants new information or ideas or advice, the helper can, of course, provide them. But we are then dealing with what I call "confrontive interventions" because they have the effect of forcing the client to think about new facts, ideas, or alternatives that she might not have considered before.

If I want to be confrontive and yet stay consistent with the assumptions of process consultation, I have to couch these interventions in a way that does not make me an expert or doctor, yet that gets across my hypotheses about what may be going on. The easiest way to do that is to provide the new information or ideas in the form of alternatives, options, considerations, hypotheses, or possibilities. "Have you considered the following items of information?" "Have you thought about options A or B?" "Maybe you are having one of the following feelings-- you are anxious or maybe angry?"

By stating alternatives and by stating them in question form, the client is forced to stay in the active problem solving mode, and the helper once again signals that he will not take
over the problem. The helper should maintain the realistic posture that she does not really know what is going on, but has begun herself to consider some alternatives that can be stated to the client in hypothesis form.

The difference between stating alternatives in question form versus giving advice or making a recommendation may seem stylistically trivial, but is philosophically crucial. Clients operating from their stereotype of the consultant as doctor sometimes try to make the consultant feel like a coward or a copout if she does not offer a single recommendation, so the consultant must be able to argue for her style on the logical grounds that she cannot possibly get inside the client's system and culture to a sufficient degree to recommend a single course of action.

In my own experience I have been surprised how rarely it is necessary to be confrontive, and how much can be accomplished early in the relationship with an inquiry, diagnostic, and action alternative mode. Let us now turn to how things develop, which brings us to the second guideline.

2. Do not withhold your expertise if it is really needed by the client.

Just as it is not helpful to leap in with pre-mature advice, so it is also not helpful to withhold advice if the helper realizes that the client is about to make an error. If the initial inquiry process reveals enough about the problem to enable the helper to be an expert or doctor, and if this seems necessary and appropriate, then, of course, the helper should shift to either of those roles.
For example, in the high tech company group meetings previously referred to, once I realized what the group was trying to do, I found myself in an expert role with respect to two crucial issues: 1) I was more expert at listening than many of the group members and thus was able to restate or write down what members were saying as a way of making this information available to the whole group, and 2) as the group began to redesign their own meeting format, I realized I was more expert at meeting design and, therefore, was able to make recommendations on how future meetings should be run.

The key to moving into and out of these roles appropriately is to know enough about what is going on and to know what one's own areas of expertise really are. It is when I have not spent enough time in the process consultation mode to figure out what the problem really is, or when I develop the illusion that I really do know what the members of the client system should do that I get into trouble. My recent inquiries into organizational culture have shown over and over again how idiosyncratic organizations really are, and how difficult it is, therefore, to prescribe to managers what they should do (Schein, 1985).

A comment on individual assessment and employee surveys

To further illustrate the contrast between the consultation models I would like to comment on two kinds of interventions that are most typical of psychologically oriented management or organizational consultants-- 1) individual diagnostic profiles based on testing, interviewing, or assessment centers, and 2) opinion or morale surveys of employees in organizations.
In my view, neither of these interventions is appropriate as a way of initially finding out what the problems in the system might be because they immediately cast the consultant into the expert or doctor role and stimulate the kind of dependency on the part of the client that will undermine later joint problem solving. The consultant, by virtue of her special secret knowledge based on special tools of the trade, now has to take on the responsibility for diagnosing the situation and making prescriptive recommendations.

Does this mean that we should never use individual assessments or surveys? Not at all. What it does mean is that we should use these techniques only when the primary client has decided jointly with the consultant that such an intervention would be helpful, and when that client accepts the responsibility for the consequences of the intervention. A good test is whether or not the client is willing to explain to others who may get involved what the intervention will be and why it is being used. What this usually means is that a good deal of diagnostic problem solving has gone on before a decision is made to use such a major intervention.

Another point to note is that the three consulting models imply quite different ways of handling the intervention itself. In the expert or doctor model the consultant uses proven tools that the client is not professionally trained to administer or interpret. The consultant therefore has to interpret the results and make recommendations. The client is dependent on verbal or written assessments of individuals based on validated
tests and interviews, or, in the case of surveys, is given tables with statistical interpretations of their meaning and implications.

In the process consultation model, if individual assessment seems relevant, the primary client has to help specify what areas need to be assessed. To avoid using possibly invalid tests, one would probably also move toward an assessment center concept using members of the client system to do the assessing. The main role of the consultant would be to teach members of the client system how to set up and operate an effective individual assessment process.

If outside professional assessment was desired, the process consultant would probably refer the client to the appropriate professional resource and help the client to develop an appropriate internal process for feeding back and utilizing the assessment information. The emphasis would be on providing such information only to the individual being assessed, and giving the choice of whether or not to pass such information upward in the organization to each assessee.

In the use of employee surveys the contrast between the models is equally sharp. In the expert or doctor model the consultant uses a proven, reliable, and valid questionnaire, tells the client how to administer it for maximum participation, collects the data, analyzes it, and then feeds it back to the top of the organization with appropriate advice and training on how to interpret and feed back the data to other levels in the organization. This is usually a "cascading down" process with each
level being given its own data with the mandate to work on it
with the participants before it goes down to the next level.
The consultant would typically train supervisors at each level on
how to handle the feedback session in order to motivate the
appropriate response from the employees.

In the process consultation model one would proceed
quite differently. Top management in the client role would
decide jointly with the consultant that a survey would help to
identify problems in such a way that the level in the organiza-
tion that "owned" those problems could get to work on them. The
real goal from the outset is not to gather data but to solve
problems.

The questions to be asked would be based on individual
and group interviews of diagonal slices of the organization, and
all employees would be consulted on what should ultimately go
into the questionnaire. The intent is to get diagnostic thinking
and involvement from the whole organization from the outset.
Such involvement typically results in a higher response rate to
the survey and a feeling of ownership of the data throughout.

Once the data are gathered, they are aggregated by group
from the bottom up, and each lowest level stratum group in the
hierarchy is given its own results (without the presence of the
supervisor) in order to do two things: 1) correct the data or
enhance it; and 2) sort the results into those problems identi-
ified that the group can do something about and those that need to
be passed upward for higher level attention. All of this happens
before anyone higher up has seen aggregated data.
The effect of such a bottoms up process is quite dramatic in that it clearly establishes in the employees' minds their ownership of the data and of some of the problems identified. The group meeting itself is a clear signal of management's expectation that employees are motivated to diagnose and fix their own problems. They cannot abdicate and become dependent by feeling that once they have told management about the problems, they are off the hook.

As this process works its way up the organization, problems get identified, sorted out, and worked on by those who have the resources and the responsibility. There may, in fact, never be a summary aggregate report. Top management may never see any statistics on different departments, but what they will see is a highly motivated organization working out solutions.

One may well ask why top management would pay for a survey if they never saw the results. Paradoxically, once top managers become clear that the bottoms up method is a way of starting to solve problems more effectively, they come to realize that in their own goal system it is more important to get solutions than long lists of problems. The process consultant must spell out for the company president the issue of whether he would rather see fancy tables and statistics that would leave him in the position of then having to motivate the "problem departments" to fix their problems, or would rather initiate a process that would identify problems locally in such a way that they would immediately get worked on. Most managers I have worked with clearly prefer the second alternative once they understand
its potential.

Summary and conclusions

Let me now restate what I have tried to present here. We all find ourselves periodically in the role of a helper. If we are to play that role effectively, we must be conscious of the choices we make in that role between being a process consultant, an information expert, or a doctor. I have argued that each of these major models rests on a set of assumptions that have to be examined, and that with human systems it is the assumptions that underlie the process consultation model that are most likely to be the correct ones.

I have further argued that in almost all human helping situations the initial interventions have to be guided by an inquiry mode to establish an appropriate helping relationship and that the process consultation model is the most appropriate way to do that. Finally, I have argued that as we get some insight into what is going on, we must shift into and out of the expert and doctor roles according to the realistic needs of the client and a realistic assessment of our own expertise.

It is my sincere belief that helping relationships are a basic category of all human relationships and that we must not only be better at managing such relationships when we are in the formal roles of helpers and consultants, but that we must teach effective helping to parents, managers, and all others who are involved with other people.
References


