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NEW DEVELOPMENTS IN O.D. TECHNOLOGY:
PROGRAMMED TEAM DEVELOPMENT

by

Mark Plovnick, Ronald Fry, and Irwin Rubin

July, 1974 WP #721-74

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INTRODUCTION - Rationale for Programmed O.D. Technology

Some of the more fundamental propositions shared by practitioners and theorists of organization development concern the importance of viewing the change agent as a critical part of any system he is intervening in. Much of the O.D. literature focuses on consultant strategy and behavior and its likely impact on a client organization.

This is not to say that Organization Development is without its own knowledge and technology base. The applied behavioral science literature is indeed abundant, and various well-known practitioners have written much around O.D. technology. However, within the field there is a commonly shared view that the interpersonal competence, charisma, personality, etc. of the individual O.D. practitioner is paramount in successful O.D. interventions. Argyris, in describing certain applications of O.D. technology, specifically the "Confrontation Meeting," notes:

"...the interventionist is crucial if openness is to be achieved in a short time period. Beckhard presents an excellent example of an interventionist who is able to behave in ways that temporarily unfreeze clients and reduce the potential threat."^2

This emphasis upon the interventionist in O.D. has a parallel in the historical emphasis upon the leader or manager in organization theory. Extensive research has been done on the characteristics of effective vs. ineffective managers. Development programs proliferate to translate these research findings (inconclusive as they often are) into training to change

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^1 For example, the Addison-Wesley Series on O.D., Reading, Mass., 1969; and Argyris, C., Intervention Theory and Method, Reading, Mass., Addison-Wesley, 1970.

^2 Argyris, C., ibid, page 53.
the manager's style. The emphasis in both this research and training has been the person -- the manager.

Within organization theory we are witnessing a broadening of, if not a shift from, this focus upon the person. While management training still is, and probably should be, an important activity, increasing emphasis is being placed upon the role of technology and structure in our efforts to understand and improve organizational functioning. The often quoted maxim, "It is easier to change the structure of an organization than it is to change personalities," is moving out of the realm of mere lip service.

Within the field of O.D., however, this shift has not yet become predominant. The focus still seems to be upon the interventionist versus the intervention. There has not been, for example, extensive research on the effects of different O.D. technologies (interventions) independent of the interventionist. Many O.D. interventions still have the quality of mysterious black boxes -- something goes in and something comes out, but we have little concrete understanding of "what goes on inside" and with what differential effects.

The importance attributed to individual competence is in many cases appropriate. Many interventions cannot be programmed. Many situations do require highly skilled and experienced interventionists. However, this attitude can in some instances inhibit the consideration by "less experienced" practitioners of certain types of interventions or change programs that could

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be highly effective. Many types of interventions and O.D. technologies can be programmed and packaged in such a way as to enable many practitioners to implement them effectively in a client system. The assumption here is that the technology itself, in addition to the consultant's personal competence, contributes greatly to a program's effectiveness. As Argyris further notes on the "Confrontation Meeting":

"In addition to his personal charisma and competence, Beckhard uses structural arrangements to enhance openness."¹

It is these "structural arrangements: -- the data collection tools (e.g., Force Field Analysis), the work group structures (e.g., mixed vs. homogeneous subgroups), the problem-solving models, etc. which are "programmable."

While many structural interventions are often designed organically, in response to the needs of the situation at the moment, it is possible to anticipate many of these choice points and preprogram them. In fact, we would argue that many of these choices are already "preprogrammed" by consultants. Consultants approach consulting situations with a set of assumptions or theories about what is important to look for and how to intervene. These predispositions limit the nature and extent of the choices the consultant makes on-line, organically. These theories can be made more explicit and are consequently also programmable.⁵

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¹ Argyris, C., op.cit. page 53.

Over the past two years, we have been involved in the design and testing of "programmed" team development interventions. Our own strategy in designing such programs has been to develop materials that can be utilized by a client system either (a) without any consulting resources, or (b) with either internal or external O.D. resources serving as facilitators. When a consultant is used, the programmed materials enable the consultant to contribute his skills in whatever ways he feels comfortable to enhance the effectiveness of the change program.

In the remainder of this paper, we will articulate our own theories which we have tried to program and describe the design issues involved in developing and implementing such a programmed package for Team Development.6

Conceptual Models Behind a Team Development Program

A well thought out intervention program requires consideration of the theoretical and practical issues concerning (1) program objectives and (2) program procedures. Team development seems to mean different things to different people with respect to both objectives and procedures. For example, sensitivity training with a work group represents team development at one level, while skill training programs such as "New Emergency Procedures for the Cardiac Intensive Care Unit" have been labeled team development in other places.

Our own notion of Team Development objectives and procedures is based upon (a) our functional definition of "team," and (b) our interpretation

6These activities were sponsored in part by the Robert Wood Johnson Foundation as part of an overall effort to transfer applied behavioral science technology to the health care world. Other papers on this subject include, Rubin, Plovnick, and Fry, "Initiating Planned Change in Health Care Systems," Journal of Applied Behavioral Science, 1974, 10-(1), pages 107-124; and Wise, H., et al Making Health Teams Work, Ballenger Publishing Company, Cambridge, MA., 1974.
of Argyris' criteria for effective intervention: valid data and free choice in interactions with and between clients.

Definition of Team - Implications for Team Development

Our definition of "team" is a functional definition drawing upon the work of organization structure theorists such as Lawrence and Lorsch,7 Galbraith,8 and Thompson.9 We define "team" as that combination of people whose coordinated inputs are necessary to accomplish a given task or set of tasks. For example, the top team of a corporation, consisting of the vice presidents of finance, production, marketing, etc. and the corporate president are a team because all of their inputs are necessary to develop and implement an effective coordinated policy for their company. They are not a team just because they meet once per week -- they meet once per week because they have to -- because they are interdependent around a particular task.

The team then is a mechanism for integrating the efforts of several people/functions to accomplish some task. Different tasks will require different combinations of people and different levels of interaction and interdependence. An intervention strategy for a given team then must focus on defining the appropriate level and type of interdependence and interaction for that team. To do this the strategy must focus on defining the task that the team exists to perform. In this sense, the team's task, or mission becomes the starting point and focus for all subsequent decisions with regard to how

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the team should be organized and managed.

This has important implications for consultant-designer behavior. It requires the consultant or designer to consider the relationship between the task and the various factors that comprise the team (i.e., roles, relationships, procedures, etc.) in determining what is important, what data to collect, and what interventions to make.

This may sound obvious and trivial, yet it is often overlooked. Many practitioners approach all client systems with the same normative prescription for how that system should operate. Often this takes the form of an objective of "increasing the level of interpersonal warmth, openness, trust, etc." or "encouraging participative management," or "developing skills at group process." While all of these objectives seem worthwhile they are often not the best starting point or even at all appropriate for some teams. Only a careful analysis of the team's mission can lead to subsequent decisions about appropriate roles, procedures, processes, norms, etc.

This "task-oriented" approach to team development is similar to a model described by Beckhard. Beckhard has identified four main areas of concern, one of which is usually being discussed whenever a team is meeting:

1. to set goals and/or priorities;
2. to analyze or allocate the way work is performed;
3. to examine the way a group is working its processes such as norms, decision-making, communications;
4. to examine the relationships among the people doing the work.

Beckhard notes that a team development intervention must focus on one of these areas at a time. Implicit in his list, from our point of view, is a

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hierarchy, or order of importance. That is, (1) the task -- goals and priorities -- needs to be defined first. The team, by our definition, exists to do a task. If that task is unclear, it cannot be a well-functioning team. Only then can (2) appropriate roles be identified to accomplish that task. Once the roles are clarified it becomes important to (3) examine procedures/processes -- the way the group is working together. Finally, (4) interpersonal issues that may still be impeding the group should be worked on. Each successive issue should only be resolved with respect to its preceding levels in the hierarchy. A lower level issue is only dealt with if it is blocking the solution of a higher level concern. For example, the team may have to define some procedures to manage its process in order to resolve the question of its goals and priorities, or an interpersonal issue may be blocking the solution of a procedural problem.

Beckhard also acknowledges the tendency of consultants to define inappropriate starting points in the hierarchy. He notes that these strategies are based on preconceived notions of where a team "should be" which among O.D. consultants typically emphasizes interpersonal issues.\(^{11}\)

Not only is it often inappropriate to start with lower level issues, given our hierarchical theory, but it is usually more difficult. As Harrison notes, interventions at the task level, rather than at the interpersonal level, usually involve less threat to the client and have more immediate acceptance and payoff.\(^{12}\) In addition, we have found that many lower level issues,

\(^{11}\)A part of this bias, in our experience, comes from the perceptions -- held by both the client and the consultant -- that goals and role issues are less "jazzy." The seemingly mystical power of the consultant is most needed around the "gutsy" issues. Both clients and consultants experience fewer thrills in plodding through difficult but important goal conflicts.

particularly interpersonal issues are actually only symptoms of higher order problems (e.g., goal conflicts) and can only be resolved or managed by dealing with that higher order problem.

Valid Data and Free Choice

In addition to our theory of teams our program design has been influenced by Argyris' criteria for effective intervention — that is, valid data and free choice, in client interactions. We interpret these criteria to mean that an intervention, to be effective, must:

1. Maximize the completeness and authenticity of information clients are using to make decisions. This means that our inputs, as expert resources on the technology, process, or structure of meetings, decisions, etc. must be shared and clarified. While the objective of most of our procedures is to facilitate the communication of valid information among members of the client team, we also, feel compelled to provide normative solutions or models to clients where we feel those models are appropriate (e.g., Vroom's model of effective organizational decision-making). This is the valid data we bring to the situation. Thus, we combine both the Process Model of consulting and the Expert, or Medical Model.

2. Maximize the client's control over the decisions he must make. We interpret this to mean that we will leave ultimate decisions in the hands of the client but we will be clear about our own preferences when we have them. Where we think alternatives are appropriate we discuss our perceptions of the implications of one over another — in the interests of valid data.

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Again all of this sounds obvious and trivial, yet we and others have noted the tendency of O.D. consultants to be overly non-directive in their efforts to meet the Argyris criteria. While much of the data required to make effective decisions does reside with the client, a significant source of expertise also resides with the consultant and he is obligated to share it.

Program Description

These two theories have lead us to our programmed package in team development. Using the task-oriented definition of team development and our interpretation of Argyris' criteria of effective intervention we will discuss the objectives and procedures of this program and their implications.

Program Objectives

1. Our top priority objective is to help the team to work on its actual goals, roles, and procedures during the program — that is, to improve the performance of its task.

2. Our secondary objective is educational — to build in "know how" for continuing development.

The implications of this hierarchy of program objectives are twofold. First, conceptual and theoretical material is kept to a bare minimum. The emphasis is instead upon describing the recommended model's procedure and its rationale and not the theoretical or empirical foundation upon which it rests.

Second, program activities always focus upon the team's own data and their own problems. Our approach is not to use educational simulations and then to help the team make the connection to their real world. The program focus is their real world. To the extent that a particular model does help to solve a real problem, it will, we assume, become internalized and used in the future. Education or learning will, therefore, have taken place.
Program Structure

In designing the program, we chose to utilize a format built around a half-day weekly team development meeting over an eight-week period. The more "traditional" intensive model of a long weekend seemed undesirable for several reasons.

The more intensive model often results in significant re-entry problems. A more spread out approach helps to meet the need to integrate team development activities into the everyday work routine of the group. The period between development sessions provides an opportunity for (a) reflection time for individuals to integrate their own thinking and learning and (b) gives individuals the opportunity to test new skills and procedures immediately on the job.

Our own experience with intensive weekend sessions points to the strain associated with solving difficult work problems all at once. They are exhausting. Our own program is also demanding -- people do get tired -- but a very different norm is developed. It is a norm which says: "Development is a part of our everyday work. It is not solely left to special time slots."

Another problem with the weekend model is directly tied to the interpersonal bias held by many O.D. people and clients. The implicit scenario goes something like this. "We need a long weekend because it takes time to develop the trust and openness necessary to work on the difficult interpersonal issues which are hanging up this team." If and when interpersonal problems are the significant blocks to effectiveness, the weekend model may be appropriate. Given our hierarchical theory, however, we assume that interpersonal issues are more often than not symptoms of other problems (goals, roles, processes), not the causes themselves.
In the process of designing the program, we have had to come to grips with questions and concerns in four areas: the notion of a fixed sequence of interventions; managing client dependence; handling significant interpersonal issues; and the role of a consultant with programmed materials. We turn now to a discussion of these issues.

Fixed Sequence

As noted earlier, both consultants and clients' diagnosis of the kind of team intervention required (goals, interpersonal, etc.) is often based on symptoms rather than causes. Our own view is that many of the interpersonal or procedural issues identified in diagnostic activities are often symptoms of higher order problems, such as unclear goals. For an example, on a production team the quality control supervisor and the production foremen may define their problem as low trust, or a "personality clash." In fact each has different objectives or goals built into his job. Unless the team can clarify the conflict between goals of quality and quantity with specific performance indicators that everyone agrees to, the "personality conflict" can never be resolved. Once there is a shared, clear "team" goal, both men can collaborate towards achieving it.

Because of the tendency to define symptoms as problems, rather than seeking the higher order causes, we have not provided client systems with an option about where to start the program. After an initial start-up meeting in which the team diagnosis their present level of team functioning, the core of the program works through seven modules each addressing themselves to successive stages in the (1) goals, (2) roles, (3) processes, model.

There is the risk in a fixed sequence that a team may be forced
(assuming they chose to follow the recommended sequence) to work on a module which does not represent a problem or issue for that team. For example, a team may be very clear about its goals and priorities but find itself re-addressing them as a result of the imposed sequencing. However, the likely outcome here is that the team quickly finishes the module having reinforced its understanding of its goals. This potential dysfunction is more than offset by the assurance that at no point can a great deal of time and energy be inefficiently spent working on unresolvable symptoms instead of causal problems.

Client Dependence

Developing a programmed Team Development intervention (whether or not a consultant is also present) does not eliminate the problem of client dependence. Indeed, in the programmed approach, the problem may be greater -- the team becomes dependent upon the materials -- particularly given our priority for task (doing) over education (learning).

To deal with this issue the program design includes a systematically decreasing amount of structure over time. Early modules, in other words, are very highly structured in terms of instructions, steps, time estimates, and the relative absence of options which would require team choices or decisions. Over time, this structure is relaxed and more options are provided. In the later modules, objectives and outcomes are specified while the team is increasingly left on its own to organize to meet these objectives. Decreasing program structure requires increasing team responsibility and team control over the programmed activities.\(^\text{14}\)

\(^\text{14}\)In the audio tape recordings we have compiled of teams using the program without any consultant help, we have seen clear examples of the "rebellion against authority" the consultant often experiences when he is present. Programmed materials do not eliminate, fortunately, normal group development.
Interpersonal Issues

The effective management and resolution of interpersonal issues are among the most difficult to pre-program in packaged form. It is here that a consultant can provide valuable inputs to complement a programmed package. He can clarify the existence of interpersonal issues and separate them from issues of goals, roles, or processes. With his skill, he can help to resolve interpersonal issues if and when they do arise to block movement.

The penultimate module (given our hierarchical theory) in our program is designed to explicitly help people deal with how they feel about each other. Its focus is on interpersonal issues. The wide majority of teams which have used the program to date have reported that this particular module was one of the least relevant in the program. It was perceived to be redundant -- many of those issues had been resolved in the earlier modules. Given our theory, such negative feedback was encouraging.

Consultant Role

Assume for the moment that, for whatever reasons (team decision and/or organizational decisions), the program will not be used in a self-instructional way -- a facilitator will be present.

We have already talked, above, about one way in which a consultant or facilitator can productively work with programmed materials. The materials become the intervention and his role is to facilitate this intervention.

It is our expectation that well-designed materials can significantly enhance a facilitator's skill and availability. He no longer needs to worry about "coming up with a design." The materials provide that. All of his energies and process skills can be directed at helping the team to get the most out of the design.
The highly skilled O.D. practitioner is a scarce resource in most organizations, and in general. A programmed package provides an internal O.D. person, for example, with an opportunity to gain significant multipliers on his time and resources. In one organization in which we have worked, for example, a cadre of team building facilitators have been trained by the internal O.D. staff to work with the programmed materials. These cadre members are line people who spend 80 percent of their time doing the same kind of work as do the teams with whom they work. They are not meant to be full time O.D. staff but they can be trained, by the more experienced internal O.D. staff to work with specific programs. They have the added advantage of being accepted by, and able to understand the language of, the teams with whom they work.

Any team building intervention is also, by definition, a large system intervention. The manner in which significant entry issues—selection of potential client systems, gaining top management commitment, introducing the program, etc. are handled can have a significant influence on the ultimate success of the program. These issues can be facilitated and managed by experienced consultants.

We have also seen a significant need for more consultant help after the completion of the team development program. Developed teams, have a way of becoming, appropriately, more demanding of autonomy and responsibility. They are more willing to constructively question top management decisions, procedures, policies, etc. Managing these kinds of larger system issues does require the more sophisticated intervention skills of a consultant.

In other words, programmed materials do not eliminate the need for the experienced consultant. Quite the contrary. Rather, they can provide the
consultant with an opportunity to use his unique skills and experience in the most efficient and effective way possible and thereby maximize his total impact.

Preliminary Results of Field Tests

The Team Development Program has been field tested in a variety of situations -- twelve teams in health care settings and six teams in three different industrial settings. With respect to the industrial settings (an insurance company, a metals processing plant, and a consumer goods manufacturing company), the teams involved represented diverse levels in terms of education and position in the management hierarchy (e.g., first-line foreman to a division manager and his staff). Some used facilitators while others did not.

The data available from health care settings\(^\text{15}\) is much more complete at this point than that from the industrial settings. The general trend in both groups is, however, clearly positive.\(^\text{16}\) The teams report clearer understanding of their goals, roles, and procedures. As a result, they also report improved coordination on the job, less dysfunctional conflict, greater use of team member resources, and increased team cohesiveness and member satisfaction. In several settings, these changes have been corroborated by others outside the team -- other managers and support groups.


\(\text{16 Evaluation strategies included: (a) Observations of program being used in several settings in its entirety; (b) audio tapes of critique sessions at the end of each module; (c) periodic questionnaires in teams not under observation; (d) taped evaluation sessions four to eight weeks after completion of the program.}\)
The presence or absence of a facilitator does not appear to be a significant variable. Similar results have been noted under both conditions.

More extensive field testing is presently underway. However, based on observations of the teams which have already used the program, it appears as though programmed team building interventions are possible — and practical.