Process Consultation, Action Research, and Clinical Inquiry: Are They the Same?[1]

by

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Working Paper 3833 July 1995

[1] Paper prepared for special journal issue on organization development by David Coghlan.

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This short essay is an attempt to clarify what I see to be a confusion in the field of consultation and organizational development between formal research and data driven inquiry on the one hand, and clinical research and client driven inquiry on the other hand. I do not want to review in this analysis all of the issues of organization development and consultation that are today confounding our efforts to think clearly about how to manage change and help organizations. Rather I want to focus on just one issue on which there is specific confusion and ambiguity, and "unpack" it in some detail, because I believe it underlies much of the broader confusion and may explain why so many planned change efforts do not fulfill their promise.

We start with the concept of "action research." This term has been used in some instances as an extension of formal research in advocating that the client system should become involved both in the gathering and analysis of the data pertaining to the change problem, thereby making the client more of a researcher. Action research has also been used as an extension of clinical

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work where the client in the process of seeking help begins to engage in inquiry and research processes with the help of the consultant clinician, thereby making the clinician more of a researcher. On the surface these models may seem to be the same, but my argument is that they are drastically different in terms of their underlying assumptions and their implications for consultation practice.

The fundamental difference derives from a consideration of whose needs are ultimately driving the inquiry and helping process. When Lewin first formulated action research it was clearly a case of the researchers wanting to figure out how to be more successful in implementing some changes that the researcher desired. He found that by involving the targeted population and getting them involved in the research process, they became more amenable and committed to the desired change. But the initial drive came from the change agent, and it was the change agent's goals that were driving the process. In this model, action research involves the client system in the researcher's agenda, even though the client system might ultimately be the beneficiary. But the client did not initiate the process and it was not the client's needs that drove the process. It was the researcher's choice to involve the client.

When I first formulated the concept of process consultation and contrasted it with being an "expert" or a "doctor" in a helping relationship, I was trying to argue that a model which I am now calling a "clinical" model starts instead with the needs of the client, is client driven and involves the researcher in the client's issues rather than involving the client in the researcher's issues. The word clinical is deliberately introduced here in order to highlight that some

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perceived pathology is usually involved and that the helper takes on the obligations that are associated with being in the helping professions, i.e. the interests and the welfare of the client must be protected at all times, and all of the helper's actions, whether diagnostic or not, are de facto interventions and must be evaluated as interventions before they are undertaken. This clinical model is often also lumped into "action research" but is fundamentally different in that the initiative remains at all times with the client.

The difference between the models must be sharpened because most models of consultation and action research that are promulgated today muddy the waters by postulating at the outset of a project a "diagnostic period" or a stage of "data gathering" that is represented as occurring prior to a postulated stage of "intervention." Lip service is paid to the fact that "of course, data gathering is also an intervention," but in my view the potential for real damage through clinically inappropriate data gathering is sufficient to argue that lip service is not enough.

To put it more bluntly, if we take a clinical perspective, we must assume that the way in which we enter a diagnostic relationship with a client is in itself a major intervention that must be evaluated as an intervention not just as a method of gathering information. Or, to put it more concretely, we start intervening when we first pick up the phone and answer an inquiry from a potential client.

An example will make clear what I mean. In management consulting one model goes as follows: 1) The CEO invites the consultant to help him or her build a better team among his or her subordinates. 2) The consultant takes on

the job and recommends that "as part of the diagnosis," he or she should interview and/or give psychological tests to the team members "in order to find out what is really going on." 3) Based on those interviews and tests the consultant promises to "make a recommendation" to the client (the CEO) on what to do next, i.e. what kind of "intervention" to plan. The consultant will, of course, make him or herself available to help in this planning and with the implementation of whatever intervention is agreed upon. However, no mention is made in the proposal of the fact that a major set of interventions will have already occurred through the interview and testing process. Subordinates of the CEO will have had no choice in whether or not to expose themselves to the consultant and, if psychological tests are used, will have had no choice about how much of their personality will be revealed to the consultant without their knowledge. Heavy interventions, indeed, for something that is labelled as "just diagnosis."

A similar scenario occurs when senior management requests a survey of an organizational unit to see what morale is, or what issues that unit perceives. The surveyor consultant agrees and the implicit contract is that once the data are gathered, the consultant will report them to senior management, will help to interpret them, and will help management decide what kind of "intervention" to do next. Typically, this planning will involve a careful thinking through of how to feed back the data into the organization, and a complete ignoring of the issues surrounding the data gathering itself.

In both cases the consultant invokes criteria of scientific validity and promises to make the best possible diagnosis so that the intervention will be valid in terms of the data uncovered. To make the situation palatable the CEO

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will typically let the subordinates know that he or she has undertaken the project on their mutual behalf and hopes that they will cooperate in the data gathering. It may never occur to senior management that they are already intervening and the consultant may not raise the issue because often the consultant is also caught in the mental model that this stage is "just" data gathering.

Now, from a clinical or process consultation point of view, what is wrong with this scenario? It sounds OK because it invokes good diagnosis, valid data, not leaping into action before knowing what is going on. What is wrong is that the data gathering process as a management mandated intervention prevents the participants from having a genuine choice about whether or not to reveal themselves and becomes a non-negotiable intervention in their lives with unknown consequences. It reinforces the hierarchy in assuming that the CEO has the right to ask his subordinates to participate in this kind of inquiry and, in that process, may actually distort the diagnostic process because the actual problem between the CEO and the subordinates may lie in that very relationship, i.e. that they may feel powerless in the face of his or her decision to launch the interviews or survey.

If they acquiesce they simply reinforce the very pathology that may need to be addressed, or worse they may damage themselves by revealing data to a superior who may take advantage of it. On the other hand, if they refuse or participate only in a token fashion, they may either distort the data or create a revolt that the CEO may not have anticipated and may not know how to deal with. In both cases what is wrong is that the consultant did not operate from a clinical model which would have forced him or her to consider what the clinical consequences would be of gathering data in a certain fashion.

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It is my contention that a clinical process must a priori consider all of these possibilities and must involve the initial client in an up front process of jointly figuring out each next step. The consultant must raise the question of what would be the consequence of interviewing the subordinates or doing the survey, of how the data would be fed back and what kinds of confidentiality would be guaranteed. Of greatest importance at this stage is also to share with the contact client the possible outcomes, especially the possibility that the data will reveal a problem in the relationship of the client to the people who will be interviewed or surveyed. In other words, what if a lot of negative data come out about the boss who is launching the project? Is he or she ready for it? How will they handle the feedback?

In working with the initial client on what to do next and examining such questions, data will be revealed that make it clear to the clinician/process consultant where the pitfalls are, so that the next intervention will take full advantage of the data that have already been revealed. For example, when the CEO asks the consultant to do the survey, the consultant could and should raise the question immediately of what kind of data might be revealed, who would and should see the data, what if the data were rather negative on the CEO, etc. and observe closely the degree of acceptance on the part of the CEO of the various scenarios. If the CEO acts defensively, the consultant might advocate not doing the survey at all, but proceeding with more individual work with the CEO or working with the entire team simultaneously or moving toward a lower key educational intervention.

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If and when a senior management working with the process consultant have fully thought through the various consequences of a survey and have jointly decided that such an intervention is appropriate, that the data feedback process is congruent with the intentions of the overall project, that no harm will befall people as a result of participating, then the question of how to gather the data validly, how to involve people appropriately in designing questions and in planning feedback becomes appropriate. At that point the more traditional indexes of validity and reliability can be invoked. But in my experience too many consultants sell the data gathering on validity and reliability criteria in the first place and give virtually no attention to the clinical issues of whether, when and how to do a survey at all. They encourage a level of dependence on the part of the client that actually subverts a clinical process of examining the consequences of doing the survey. It is as if the consultant is saying "trust me, I'll get you reliable and valid data, and then I'll even analyze it for you, advise you on what it means, and tell you what you then could and should do about it."

Instead, from a process consultation perspective, all interventions should be jointly owned by the consultant and the client who is involved at that stage. If the client either does not understand the intervention and its possible consequences or is uncomfortable with it, there is created de facto a dependency on the consultant as the expert or doctor which not only lets the client off the hook as a learner but allows the client to "blame" the consultant if things don't work out. The client and consultant have, in this instance, colluded in creating a safe but probably ineffective scenario for fixing the problem.

To get back to the survey example, when large groups are involved, the method of feedback that is typically advocated by the traditional action research

model is to "cascade" the feedback down the organization, with the CEO seeing all the results first, then each organizational level seeing its data and being obliged to feed back to their subordinates their results, and so on down the organization. This is alleged to be good practice in that eventually even the lowest level employees learns the results for at least his or her own unit and is therefore officially "involved" in the process. With such feedback usually comes the mandate for supervisors to also report what they are doing about the various problems that employees have identified in the survey. Sounds very reasonable. Again the question, what is wrong with this process?

Several things, from the clinical process consulting point of view. First, it automatically reinforces the dependence of the employee on the hierarchy and communicates that it is the hierarchy that is responsible for fixing the problems that the employees identified. But in my experience lots of the problems identified can, in fact, be fixed by the employees at their level once they recognize them as shared problems. Second, it builds up employee expectations that management will now deal with and fix all the problems that they have identified. This expectation also is implicitly based on the assumption that "once we have told them, it is their job to fix it." If management ignores some grievances morale can go down as a result of the survey, just the opposite of what management wants. Third, it puts supervisors in a very difficult position of saying to their people "here is what you have complained about and here is what I am doing about it." For many supervisors such a conversation would be so incongruent that they would probably avoid the feedback altogether or subvert it in some manner.

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If one takes an interventionist client centered perspective, a very different scenario can be proposed. The assumption in this model is that the contact client wants the survey in the first place not just to identify problems but to fix them. Many of the problems that will be revealed can only be fixed by higher management, but many others can typically be tackled by the very people who are initially reporting them. If the client is not interested in fixing the problems, the question arises of whether just data gathering will be helpful or not and if the client even wants help. But, assuming that the client does want help, the clinician process consultant should propose an entirely different feedback process.

Step one would be to go back to each work unit at the lowest level surveyed and share with them just their own data with two questions for them to answer: 1) Here is what you have said. Have I understood your concerns or do you want to correct or elaborate them? 2) Now that we have clarified what the concerns are, please sort them into those which should be fed up to higher levels in the organization and those which you can begin to tackle at your own level. At this point, psychologically, the group has been genuinely empowered and reminded that they still own the data. The group must take some responsibility for what it is saying and what it will do about what it is saying. If management does not want to empower groups in this way, we should again question why the survey is being done in the first place. If they do want to empower groups in this way, this method is essential because the group knows that at this point in the process they are, in fact, the only ones who have the data. They have to take the next step responsibly. The irony is that when one does this, many groups report that this working with their own data is the very

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first time that they have ever been asked to participate in something meaningful and have been asked to take some real responsibility.

If this process is carried out with each group in an upward cascading process, each level only gets the data that pertain to that level or higher levels, and each level must take responsibility for what they will own and work on, and what they will feed up the line. The very process of feeding back thus builds involvement and commitment and signals that management wants the problems solved. Higher levels want to know only those things that are uniquely theirs to deal with.

When I propose such a process I typically get the argument that the client paying for the survey will never agree to seeing only the limited data that this process will reveal at his or her level. However, in my experience this need to see all the data is premised on the client's perception that he or she will have to do all the feedback and remedial work. Once the client understands that the upward cascading process actually gets problem solving started at the time of feedback, he or she is typically much more attracted to it. It takes longer for the data to get to the top level, but it is a much quicker way to get problem solving started in the organization. If that is not what the client wants, then the survey probably should not have been done in the first place. Just gathering the information so that management can make an assessment of whether or not there are problems stands a good chance of creating problems among employees where there were none before. The survey gets them thinking about issues that they may not have thought about and gets them talking to each other about areas where they did not realize they had shared views. Once several employees discover from talking about the survey that they share a concern, it

becomes more of an issue than it may have been when each thought they were alone in their view. The survey then becomes, unwittingly a tool stimulating "revolution" rather than problem solving.

Let me summarize. The clinical approach to action research, embodied most clearly in process consultation, rests on a number of assumptions and values:

1) Only the client ultimately knows what he or she can do, will do, and wants to do, hence the strategic goal of process consultation must be to develop a process that will build the consultant and client into a team that will own all the interventions.

2) It is the job of the consultant/helper to educate the client through the early interventions on the potential consequences of later interventions.

3) Everything the consultant does, from the earliest responses to the clients initial inquiries, is an intervention. The consultant must therefore be highly aware of the consequences of different "diagnostic" interventions.

If initial intervention are so critical, we need some concepts to differentiate the options that the process consultant has. Initial interventions can be categorized into four classes that have different degrees of impact on the client:

a) Pure inquiry: What is going on? Tell me more.

This intervention interferes minimally with the client's own efforts to get their story out in their own way.

b) Diagnostic inquiry: Why did that happen? Why did you do that? How did that make you feel?

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This intervention interferes with the client's thought process in that it attempts to get the client to think about reasons and causal linkages. The consultant is guiding the client's thought process and inquires further about feelings and reactions.

c) Action oriented inquiry: What did you do? What will you do about that?

This intervention also interferes with the client's thought process by forcing the client to think about prior, present, and future actions. The consultant is guiding the thought process toward action and toward the future.

d) Confrontive inquiry: Have you considered that this happened for the following reason? Could it be that you were.....? I wonder whether they did that because.....

This intervention is labeled "confrontive" because it forces the client to think about content that the client may never before have thought about. Whereas the other interventions interfere with the client's thought process, this intervention interferes with the content. The client must now consider some thoughts that the consultant is having. Suggestions, advice, and other more directive interventions are all in the category of "confrontive" by this same definition.

The reader will recognize that part of the skill of helping is to know how to move through these various kinds of interventions in such a way that the client is stimulated to tell his or her story with minimal disruption of either the process or the content. Why is it important to hear the client's full story? Because the client will typically not tell the helper what is really the problem until he or she

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trusts the helper to be helpful. One of the first tests of that is whether the helper is willing to listen without being too intrusive.

The major implication of this line of thinking is that in the training of consultants/helpers far more emphasis needs to be given to the clinical skills of "on-line" intervention. Right now the training is heavily biased toward the skills of data gathering and toward academic theories of large and small system interventions. In that process the consultant may learn all about how to gather information as a prelude to designing the grand intervention and, in that very process, lose the client or, worse, damage the client by thoughtless inquiry processes.

A second implication is that if clients are more likely to reveal what is really bothering them as they come to feel more like a team member in the inquiry process, more valid data will surface for a theory of what goes in organizations. One reason our organization theories are weak is that they are based on superficial data gathered from reluctant "subjects." A clinical inquiry model that stimulates real openness on the part of clients will reveal a set of variables and phenomena that will make it possible to build far better theories of organizational dynamics.

In conclusion, if we go back to the original question posed in the title, it should be clear to the reader that I view "Process Consultation" and "Clinical Inquiry" to be essentially the same, but that the concept of "Action Research" has come to mean two quite different things that should not be confused. Action research as defined by researchers involves the client in the data gathering but is driven by the researcher's agenda. Action research as defined by the

clinician involves the helper consultant in the client's inquiry process and the process is driven by the client's needs.

I have tried to argue that the clinical model is the more appropriate one for consultation and organizational development projects because its assumptions fit better the realities of organizational life and are more likely to reveal important organizational dynamics. It is time we took the clinical model of action research more seriously and trained consultants to implement it appropriately.

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