SWP 48/91 "ORGANISATIONAL CONSULTANCY AND CLINICAL PSYCHOLOGY - THE MEETING OF TWO WORLDS"

DR YOCHANAN ALTMAN
Human Resources Group
Cranfield School of Management
Cranfield Institute of Technology
Cranfield
Bedford MK43 OAL

(Tel: 0234 751122)

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ORGANISATIONAL CONSULTANCY AND CLINICAL PSYCHOLOGY - THE MEETING OF TWO WORLDS

Dr Yochanan Altman

The last decade saw an increased interest for organisational concerns among clinical psychologists in the UK. The sweeping changes in the National Health Service and the pressures these generated for professional staff, line managers and patients, have been major contributing factors.

While there is a natural common ground of shared values, concerns and methods, there are also some major differences, between the two practices.

The aim of this paper is to chart out these points of contact.

I The Past

The first thing that comes to mind is the enormous impact Clinical Psychology had on the formation of Organisation Theory and the practice of Organisational Consulting.

In the UK, the work of the Tavistock Institute of Human Relations, which developed out of the Tavistock Clinic is most noted. Probably all key figures: Bion, Rice, Miller, Bridger, to mention a few of the founding fathers, come from a clinical (psychoanalytic) background.

In the US, two main figures immediately come to mind. Abraham Maslow, who laid the foundations to motivation theory 'started life' and always considered himself a clinical psychologist . The other is Fred Herzberg, the author of probably the most influential paper on motivation in organisations.[1] He started his career as a Clinical Psychologist, working with the mentally ill and specialising in electro- shock therapy.[2] Both Maslow and Herzberg have another thing in common - their differentiation between health and pathology is fundamental to their thinking. Both distinguish between healthy and unhealthy individuals and, by implication, healthy and non-healthy or pathological organisations. The clinical underpining is self-evident.

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[1] 'One more time: How Do You Motivate Your Employees' Harvard Business Review, Jan-Feb 1968, sold 1.3 million copies. Management Newsletter, Vol 4, No 3, May 1991.

[2] Op cit.

The next thing which comes to my mind are recruitment and job selection tests which are the biggest hit ever to hit occupational psychology (more occupational psychologists make more money out of job selection tests than anything else). These tests are often used to gain insights into organisations and as a starting point for organisational consulting. Personality tests are a key element in these. Probably the most widely used test in industry, Cattel's 16 PF has originated as a clinical tool and presently the most popular managerial test in the US as well as in the UK is probably the Myers-Briggs Type Indicator which is based on Jungian typology.

Lastly, one cannot but wonder where organisational theory and organisational consulting would have been today without the contribution of Kurt Lewin. Lewin, one of the founding fathers of modern organisational theory and organisational consulting, creator of the T Group, was also the formulator of an important personality theory. Among the topics he engaged in were child behaviour and the mentally handicapped. He saw his work in organisations a natural continuation to his clinical individual concerns.

II The Present

Coming closer to the present, one of the major contributors to organisational psychology and organisational consulting, Edgar Schein, the author of Process Consultation[3], is conversant with clinical approaches, as evident from his writings and work. Schein's initial training was in Clinical Psychology.[4] Yet, while Lewin, Maslow, Herzberg would have felt as comfortable in the psychologist (psychoanalyst) armchair conducting individual therapy, as much as providing organisational consultancy to a commercial firm, - I doubt that Schein would consider himself a therapist. And in that respect he is representative to his generation.

Perhaps it's a natural process. Clinical Psychology was the base discipline and organisational psychology and organisational consulting had to branch out of it. With time and growth, differentiation has taken place. It is not very practical, and in any case quite difficult, to specialise in clinical psychology as well as in organisational psychology and organisational consulting. As I will show, the practices differ dramatically on a number of key issues, which would make it rather difficult for one person to be an active practitioner in both.

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[3]Process Consultation, Addison-Wesley, 1969,1988

[4]Conversation with Edgar H Schien, Organisational Dynamics, 1988, Fall, p70

This does not, however, imply that clinical psychology and organisational consulting have to travel different routes. Not at all. I can mention at least one model of successful cooperation between two related disciplines and a number of current successful 'good practice' examples.

1. A model for imitation?

Let us consider a contemporary successful model. Organisations are people and systems. While people make organisations, to reiterate a point made recently by Schneider[5]; it is equally true that organisations make people. Organisations are powerful entities that impact people, direct their life and influence their well being. The Tavistock Institute of Human Relations were the pioneers suggesting a paradigm they coined **socio-technical systems**, advocating a close link between a systems view and people's concerns.[6] The model has long since been taken up by the Scandinavians, who have developed it to form a key paradigm in their work organisations: Volvo is a frequently quoted example. In a typical socio-technical (design/consultancy) team, a system person, probably an engineer, will work along a behavioural (human) scientist, possibly a psychologist. Both inform each other. Both recognise their inter-dependency. Could this be a model for cooperation between clinical psychologists and organisational consultants? One of the strengths of the socio-technical approach is that both partners have a clear and distinct professional identity and they recognise the differing bases of knowledge, methodology, and worldview from which they come. Perhaps the fact that they come indeed from very different backgrounds facilitates cooperation, since no partner can claim expertise in the other's domain.

2. Domain for Cooperation

Health, in its various manifestations, has been in the foreground of organisational concerns for some time now. In the 1970s it was the quality of working life (QWL). In the 1980s it was executive stress. With 1992 at the door and federative Europe on the horizon, I will be surprised if culture-related health issues (culture shock? relocation anxiety?) will not become the hallmarks of the 1990s. This seems an obvious domain for cooperation between clinical psychologists and organisational consultants.

5B Schneider, The People Make the Place Personnel Psychology 40, pages 437 - 457, 1987

6E L Trist & K W Bamforth Some Social and Psychological Consequences of the Long-wall Method of Coal-Getting Human Relations 4, pp 3 - 38, 1951

The notion of the 'healthy' versus the 'pathological' organisation has only been scratched at its surface. The various manifestations of organisational life: physical, spatial, command structure, communications, decision making procedures, organisational climate and culture, informal relations, organisational norms and myths - all can be usefully viewed within a framework of 'healthy' versus 'pathological'. All have profound impact on the well being of individuals (is workaholism a disease?) and the success of organisations.

3. Examples of 'good practice'

Examples of 'good practice' of cooperation between clinical psychology and organisational consultancy, may be called for. Two consultancies come to mind: one is based in London and the other in Boston. The first, the Grubb Institute, who emanated from the Tavistock Clinic and the Tavistock Institute have developed tools in organisational consultancy drawing heavily on clinical experience. For instance, their Organisational Role Analysis, which is a method of one to one consultation events between manager and consultant.

The other example are the McBer consultancy in Boston, formed by David McClelland and his disciples. McBer have been in the forefront of organisationally applied psychology for the past thirty years, in such areas as motivation (McClelland), Learning Styles (Kolb), Organisational Climate (Litwin), Power (Winter) Managerial Competencies (Boyatzis), blending clinical (analytical) with a behavioural experimental approach, and applying them to organisational concerns.

Some other 'good practice' examples are the recent application of cognitive-behavioural theory to organisations[7] and Kelly's personal construct theory which is gaining momentum among management researchers and practitioners.[8]

III Organisational Consulting and Clinical Counselling -the differences?

The above 'good practice' examples are however the exception, not the rule. The great majority of contemporary organisational consultants, though some may well have a degree in psychology and belong to a pertinent professional body such as the

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[7]Bandura A. Organisational Applications of Social Cognitive Theory Australian Journal of Management 13, 2, December 1988, pp275-299

[8]Vyakarnam, S. Introduction ot Personal Construct Theory for Application in Management Graudate Management Research, Summer 1989, pp 7 - 19

British Psychological Society, operate in a context far removed from the Weltanschaung of clincial psychology.

1. The Consulting Frame

To start with, while both clinical psychologists and organisational consultants are 'experts', they work out from very different expert power bases.

Clinical psychologists work within the all-powerful medical establishment, which is enshrined by law, with a wide public legitimacy - note the current dispute between the British Medical Association and the Government, about who is to determine the means and procedures by which the NHS should operate.[1]

It is symbolically significant that the client, - that is the *patient* - **comes to the clinic/practice** for consultations, to be given expert *help*. Here is a traditional patient/doctor model of relationship. Significantly the transactions take place in the practitioner's professional realm, employing the practitioner's conceptual models and language.

The organisational consultant on the other hand, while working out an expert role from a professional base, does not however operate within an expert system. The organisational consultant is providing *professional services*, within the client's universe. Significantly and symbolically, the organisational consultant's work takes place **on the client's premises** or on 'neutral' grounds (hotel, conference centre). The transaction language employed is mostly taken from the client's universe and the consultant is expected to be conversant with it. The client always retains his/her independence viz a viz the consultant. It's up to the client to accept or reject the consultant's advice.

2. The psychological contract

The client who seeks the clinical psychologist's advice is soliciting help from a well informed expert who knows 'the right answer'. The client threfore subjects himself/herself to this superior knowledge and enters the role of *patient*. Within the NHS the patient will have limited choice as to the identity of the clinical

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[1]The BMA's early 1991 public campaign included one poster/advertisement which read "what do you call a man who ignores medical advice?" - Mr Clarke (the name of the then Secretary of State for Health).

psychologist whose help s/he will get. Even if private help is solicited, the particular identity ('personality') of the practitioner is of lesser consequence than his/her professional credentials, that is - one's standing in the professional community.

Incumbent upon the role of patient, the definition of problem, needs and possible remedies are subject to formulation by the helper. Fees would be fairly standard and rarely negotiable.

The psychological contract is essentially a professional contract within the wide band of the medical practice, between a patient and a professional expert helper. It is comprehensive, open ended and non-negotiable.

Not so in organisational consulting. The identity of the consultant is of primary importance, less so his/her professional credentials. A major consideration is given to the consultant's familiarity with the contextual world of the client. Secondly, his/her interpersonal skills ('chemistry') viz a viz the company. Professional credentials come last. In fact, I found that having a PhD may be sometimes counter-productive, as clients would interpret academic qualifications (that is credentials in the professional world) as going against 'praxis' (credentials in the client's universe).[10]

There is a good reason for that. The definition of problem, terms of reference, requirements and even possible solutions, are determined by the client. The client projects his/her universe upon the consultant and the consulting process. The essence of management, particularly at higher levels, is less about the application of knowledge and more about negotiating transactions, manipulating information and effecting decisions.[11] The client expects that the consultant will assist him/her in these processes, rather than acting as an external expert supremo.[12]

The psychological contract is essentially a private contract between a client and a service provision agent. It is specific, well defined and negotiable.[13]

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[10]A recent publication by the Employment Agency, as part of its 'TEC' (Training Enterprise Councils) programme on Organisational Process Consulting does not mention professional credentials among its recommendations for choosing a consultant. The publication was prepared by Price Waterhouse - one of the largest consultancies in the UK. (Choosing and Using a Consultant - A Guide for Managers and Directors, Employment Department, 1991).

[11]Kakabadse, A The Politics of Management Gower, 1983

[12]Kakabadse, A Politics of a Process Consultant in Kakabadse, A and Parker, C Power, Politics and Organisations John Wiley & Sons, 1984

[13]The Employment Department Guide for Managers and Directors - Choosing and Using A Consultant recommends the following: "a clear contract between you and the consultant is essential to avoid

The differences cannot be attributed to differing client knowledge of the respective disciplines.

An average manager, in the UK in particular,[14] would know no more, and probably less, about organisation theory and organisational consulting then the average layman would know about personality theory and clinical consulting.

Their *perceived* knowledge, however, would differ because of the differences in contract.

3. The contractual milieu: what the client believes s/he is buying and what the consultant think s/he is selling

The clinical psychologist is perceived by the client to be a healer in the mould of the medical professions. The organisational consultant is perceived by the client to be delivering services.

The clinical psychologist is operating within a meritocratic[15] framework, subjected to prescribed routines of professional practice and a developed ethical code.

Criteria of success are considered to be an inherently professional matter. Of course the patient's opinion matters, but it is not critical; the healer decides when the patient is cured.

The patient's 'quality assurance' is extracted from the codes of ethics and professional practice. The patient does not presume to have the know-how, skills or means to reach an independent assessment of the efficacy/progress in the course of treatment. If unsatisfied, the patient is more likely to complain to a professional authority, then to seek remedial action in the courts.

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misunderstandings.... The contract should state: exactly what is to be done; how long it will take and key stages; fees - precisely what is included in them; responsibility for and definition of expenses; how the work will be controlled and monitored; criteria for evaluating the results; basis on which the agreement can be terminated." (p11, Employment Dept., 1991)

[14]In comparison to his/her counterpart in Europe, the US and Japan - C. Handy et al, Making Managers, Pitman, 1989

[15]Mintzberg, H Power in and Around Organisations, Prentice Hall, 1983

The organisational consultant is operating within the service sector, selling services, without grounded professional guidelines and no binding code of practice/ethical code.

The ultimate criteria of success is sales turnover and every consultant is expected to contribute to it. Bonuses (which constitute a significant element in the consultant's pay) are almost entirely based on sales performance. This is true for any consultancy, including those in applied psychology, such as test agencies[16]

Equally, the client is the sole determiner of success. In this respect, 'the client is always right' and one of the measures of a consultant's success is repeat business.

From the client's point of view, 'quality assurance' is a matter of professional reputation of course[17], but mostly subject to routine commercial procedures. The client expects to monitor the progress/efficacy of the delivery and in case of dissatisfaction is likely to resort to the customary measures within a commercial contract - e.g. withholding of payments, legal action.

4. Some critical differences in the consulting practice

The different belief systems, held by both clients and consultants, fundamentally impact the type, process and results of the consulting practice.

The organisational consultant's framework drives the practice towards quantification and specificity.

Figures are an effective measure (at face value) allowing a client to monitor results. In the client's universe, where the organisational consultant is but one of several expert service providers (alongside the accountant, legal adviser, market researcher) **quantification** is a familiar and accepted concept.

The result? - *training*. A consultant finds that s/he is engaged in the delivery of training in all shapes and forms. Anything, from the introduction of a comprehensive change programme down to instructing the use of performance appraisal forms, will come in a training mode.

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[16] All major UK test agencies operate on this principle.

[17] Defined however not by a professional establishment criteria but by word of mouth and the visibility of consultant in the client's universe. (Most likely through a public relations drive).

Training is ideally suited to fit into the service provision mould as it incorporates the following desirable features:

- It can be defined in terms of inputs, throughputs and outputs. It can be quantified (number of delegates, length of delivery, meals consumed).

- It can be measured independently by the client, most commonly by means of the so-called 'happy sheets'[18] These are easily quantifiable. They allow the client to be in a position to comment about the delivery of the training and to intervene accordingly.

Luckily for organisational consultants these days, *participative management* is a trademark for 'good practice' in organisations, thereby allowing training to be available to a large number of employees.

Likewise **specificity**. The client buys a service (or even a product)[19]. It has to be clearly defined and indeed differentiated in the market place, i.e.: why is my service/product superior to the competition.

While the practice in organisational consulting drives towards closure, clinical psychology counselling emphasises an open contract.

The contract is open in two ways. First, the expected outcomes are not known and the time required for completion is equally unclear at the beginning of the contract (treatment). The underlying reason, sustaining this paradigm of relations is a derivative of the client's positioning as *patient*.

Compare this with the organisational consultant client, who not only pre-determines the desired result and times the contract; but expects also to control the consulting process itself.

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[18]Brief individualised assessments, commonly assessing for training contents and presentation, measured along a Likert type scale, delivered at end of session/day/training.

[19]Some of the consultancies term their provisions as 'products' rather than 'services'.

While both parties provide expert advice, the clinical psychologist clearly operates in the band of the professions while the organisational consultant operates within the band of the commercial world.

While the one is expected to provide counsel based on standard practice, the other - to provide services based on competitive advantage. One is driven by the power of a professional hansa, the other by the competition from next door. One expects the clients to court him (her), the other - is chasing them and doing 'cold selling'.[20]

IV East Meets West

Is it a case of East is East and West is West?

While this analysis emphasises the differences between the two practices, which are profound and real, one should not overlook the similarities: both clinical psychology and organisational consulting are helping practices, as well as income generating businesses. Both utilise commercial routines as well as established scientific procedures.

The ultimate question is: where are we going to? From East to West or vice versa? Are we evidencing a 'medicalisation' of organisational consultancy or 'commercialisation' of clinical psychology?

Two indicators may be instructive.

The first is the ever increasing costs of medical care, which strives Governments to bail themselves out of a national health service type arrangement - see the recent Australian experience and the contemporary British case. The way this is done, by introducing a market/commercial stride into the system, requesting quantification of inputs-throughputs-outputs, resembles key characteristics of the organisational consultancy paradigm.

Second, an equally universalistic trend towards the erosion of the powerbase of the medical paradigm. The critique is levelled against the unspecified, uncontrolled

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[20]A few attempt to have one foot in each camp. I like the following business statement by Psycom International - an organisational consultancy: "The nature of our approach to client problems is inherently flexible and allows for on-going adaptation to specific needs, while never compromising methodological rigour or ethical standards". This reads like an attempt to walk on water and Psycom reassure me that it is indeed so and that they can (just) do it.

power over people's bodies, well-being and life - against the form and methods of the medical practice. [21]. Fourcault points to undercurrent trends: the drive to free oneself from the power of the 'expert' by controlling the processes of interaction, i.e. by changing the nature of the psychological contract.

In our context, this means a pre-determination of desired results and monitoring of the transformation process - the consultation practice itself: essential ingredients in the organisational consultancy universe.

Are we, then, evidencing a full swing to commercialisation? Probably, but not entirely. A counter trend would be the recent drive by the British Institute of Management, the Training Agency and others, to introduce minimum standards - the so-called 'competencies' - into management practice. In the same mould is the current attempt to apply British Standard 5750 - an industry type standard - to education and training[22] and the British Pscyhological Society initative to introduce a Certificate of Competence in Occupational Testing for non-psychologists.[23] On the other side of the Atlantic, alarm bells have started to ring, over the more extreme forms of some current fads, the like of Outdoor Development, Neuro Linguistic Programming, Biofeedback, Sales and Motivation Training, calling for mandatory government regulation?[24]

The pendulum sways both ways, but we seem to be amidst a tide towards commercialisation.

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[21]M Fourcault, The Subject and Power in Mischel Fourcault, Beyond Structualism and Hermeneutics. H L Dreyfus and P R Rabinow, Harvester Whitsheaf, 1982.

[22]Times Higher Education Supplement 12 July 1991, p. 1 "Ministers Warned off 'Kite-mark' for colleges".

[23]The BPS advertisement points out that "the Certificate has the support of the IPM" - an industry based association.

[24]Lipton, M "New Age" Organisational Training: Tapping Employee Potential or Creating New Problems? The Human Resource Professional, Winter 1991, pp 72-76.

A Biographical Addendum

Interpreting cosmologies and world-views necessarily stems from one's own. It would only be fair to provide the reader with some signposts to my own universe.

I was born and grew up in Israel, where I also obtained my BA and MA in social-industrial psychology from Bar-Ilan University.

Israel was among the first in the West (Israelis prefer to define themselves as Westerners) to have a Psychologists Act (in 1977) which enshrined in law the charter of the profession. This proved to be of little help to organisational consultants steming from a psychological discipline. The market place wasn't over impressed with professional credentials and that was the first instance that drew my attention to the discrepancy between the two worlds.

In 1979/80 I spent a year with the Tavistock Institute of Human Relations, which exposed me to a British tradition in organisation consulting and subsequently I read for a PhD in Industrial Anthropology at Middlesex Polytechnic, adding a cultural perspective to my worldview.

I have been involved in organisational consultancy for the past 17 years, though mostly as an annex to my work in teaching, research and training.

Clinical psychology fascinated me ever since my first visit to an asylum as a young undergraduate. Over the years I have been informed by my wife, Michal, who moved gradually into the profession. Starting as an educational psychologist, she is now specialising in cognitive-behavioural therapy.