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## FROM PROCESS CONSULTATION TO A CLINICAL MODEL OF DEVELOPMENT PRACTICE

**BILL COOKE**

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Further details: Institute for Development Policy and Management
University of Manchester
Published by: External Affairs Office
Harold Hankins Building, Precinct Centre,
Oxford Road, Manchester M13 9QH, UK
Tel: +44-161 275 2814
Email: idpm@manchester.ac.uk Web: www.manchester.ac.uk/idpm

# FROM PROCESS CONSULTATION TO A CLINICAL MODEL OF DEVELOPMENT PRACTICE

## ABSTRACT

*This paper argues that two related concepts, process consultation and, in particular, the clinical perspective, developed by the organisational psychologist Edgar Schein, can improve the understanding, teaching and conduct of development practice. Process consultation - which is more than just the application of so called process approaches - and the clinical perspective are described, and the case for them is put, in relation to contrasts with ethnography and action research and in the light of contemporary debates about development studies and practice. Five particular aspects of the clinical model - the primacy of the" helpful intervention", the subservience of science to helping, its client centredness, it recognition of interventionists' financial and political status, and its overt normativeness are seen as particularly relevant to development practice. In conclusion, the clinical model is seen to pose four challenges for development studies - the creation of development's own theory of practice, the establishment of rigorous practitioner training programmes, the consequent institutional change, and an acknowledgement of the implications of development studies' disciplinary biases*

*we cannot understand the world fully unless we are involved in some way with the processes that change it*

M Edwards (1989) *The Irrelevance of Development Studies*, p125

*one cannot understand a human system without trying to change it*

E H Schein (1987) *The Clinical Perspective in Fieldwork*, p29

## INTRODUCTION - A GENERAL THEORY OF HELPING ?

The similarity of Edwards' and Schein's claims about the relationship between understanding and change provided the initial impetus for this article. Its purpose is to argue that Schein's[1] conceptions of the clinical perspective and process consultation provides a model for development practice, and the training of development practitioners

Support for this case is provided by Edwards' recent statement (1996:19), after Uphoff (1992) that there is a new paradigm of reflexive, post newtonian development practice emerging. Process consultation and the clinical perspective are presented as long-standing, relatively sophisticated, and institutionally established examples of that reflective post-newtonian practice. Like the work of Bennis, which Uphoff cites, the clinical perspective and process consultation have been developed within the management field of Organisation Development (OD). However, while much development activity has an organisational focus, eg in institutional development and capacity building (Fowler 1992, Moore et al 1995), process consultation and the clinical perspective are seen here as more generally applicable.

Process consultation is more than the application of what in development are called "process approaches". Together the clinical perspective and process consultation provide a general theory of practice; Schein talks of the assumptions of process consultation

underlying any "*general theory of 'helping'* regardless of the context." (1987a:21). In this theory, every social researcher is assumed through his or her action, whatever the intent, to make a difference to, to *intervene* in, that being researched. If a clinical practitioner - for example a social worker, a therapist, a process consultant - the interventionist is assumed to have a helpful intent towards the human system in which she or he is intervening, to know how to help, and conversely how not to harm. A clinician is a practitioner first, for whom knowledge about how to research is but a sub-set of this knowledge of how to help.

It will not be argued that the clinical approach is perfect. As Blunt (1995) points out, it emerges from a eurocentric tradition.There are justifiable critiques, it needs enhancement, and it complements, not replaces the work of others. Nor is it suggested that the approach should completely replace what currently takes place in development studies. The principles behind Hulme's argument (1994) in response to Edwards, that development research has informed, and transformed development practice are acknowledged as crucial. The grounding of practice in macro level understandings provided by development research compensates for an acknowledged weakness in OD, and by implication of the clinical approach, namely its emphasis on the management of change to the exclusion of analyses of the context of change (Wilson 1992).

The article explains and puts the case for the clinical perspective and process consultation in the light of the debate about the purpose of development studies, of contemporary practice issues to be found in the literature, and of the distinctions Schein makes from ethnography and from forms of action research. It will, in passing, provide a contrasting view to those who imply that process consultation (eg Blunt 1995) or OD (eg Bailey et al 1993) in development are *necessarily* a vehicle for western managerialist hegemony, but as more than a defensive response. Rather, the intention is to suggest that while adaptation is required, as is the position of Kiggundu (1986) and Srinivas (1995) in relation to cultural biases in OD, the clinical model positively improves the way we think of, teach and conduct development practice. This is not because it provides direct answers to immediate practice problems, but because it forces a reflexive openness and honesty about how they are addressed.

In the next section the article will review process consultation, alluding to work carried out applying the concept in development, and outlining the relationship between process consultation and the clinical perspective. The section following that will illustrate the contrast between the clinical perspective and ethnography, and between the clinical perspective and action research. The application of the clinical perspective in development is then reviewed in the light of five key characteristics. The conclusion then outlines four challenges which the clinical perspective and process consultation pose to development studies.

## REVIEWING PROCESS CONSULTATION

### Process consultation and development

Despite, at an anecdotal level, there appearing to be a number of people working in development claiming to be process consultants, there are few documented accounts of process consultation, in Schein's sense, for development. Mbise and Shirima (1993) identify process consultation as a more appropriate than a "consultant engineering" mode of operation within the Eastern and Southern African Management Institute (ESAMI), but do not go into depth. The UNDP's Management Development Programme has produced a substantial process consultation based approach to the systematic improvement of the public sector (Joy and Bennett, undated) but while their approach has many overt parallels with Schein's model of process consultation, it does not explicitly draw on it. Murrell (1994) provides the most detailed consideration of Schein's approach to process consultation in a development context, presenting a description of its application in his work with the UNDP. He does not, however, set out to explore the relationship between the clinical perspective and process consultation, nor link the two together to general development practice. This article tries to provide that complementary understanding, examining the relationship, and making the link, rather than just reiterate Murrell's work.

Coghlan (1988) points out that the term process consultation as defined by Schein does not merely describe interventions addressing group dynamic processes, despite this implication in some OD texts. Hence the earlier point, that using what are called

"process approaches" in development would not by itself make one a process consultant either. Process consultation describes a particular mode of practice, its major distinction being in the way the relationship with the client is structured by the consultant (Schein 1987a:29).

The use of the word "client" may be problematic for those approaching it from a development perspective, for whom there may be associations with the creation of dependency. It should therefore be stressed that its clinical perspective/process consultation use is intended to convey a different, more honest message about the relationship between the consultant/researcher and the client. That relationship is explored below; but as a starting point it should be noted that the creation of dependency is the very opposite of the intention of process consultation. Other attractions are that, first, it is an avowedly "*more developmental"* (Schein 1987a:9) approach, seeking to empower people to solve their own problems. Second, it seeks to achieve sustainable change; and third, paralleling Hamdi's (1996:7) same point with respect to development practice, it respects the depth of indigenous (emic) client knowledge, and the profound limitations of the outsider consultant's (etic) knowledge (Schein 1987a:9)

Process consultation recognises three principles. First, clients know more about their own situation than the consultant ever will. Second, a consultancy process needs to engender psychological ownership of the activities which result from it on the part of the client. Third, the consultant should seek to develop clients' capabilities to solve their own problems. Process consultation is thus defined by Schein (1987a:34) as:

> *"...a set of activities on the part of the consultant that help the client to perceive, understand and act upon the process events that occur in the clients environment"*.

Its focus is human processes, including face to face relationships, communication, group and inter-group processes, and broader organisational issues such as values, culture and norms. As a matter of course it takes on Edwards' point regarding development practice (1989:121) about the role of emotion in understanding problems (Schein 1987a:7). For

example Schein analyses the anxiety, frustration, and tension when groups meet for the first time (1987a:41).

**Process consultation as an embodiment of the clinical perspective**

Schein's description of the relationship between the clinical perspective and process consultation is that they are "*essentially the same*" (1995:19). However, in its most thorough descriptions, (ie in Schein 1987a and 1988) process consultation is described in terms of intra-organisational interventions. From the point of view of development practice taking place in extra-organisational contexts it is more helpful to use Schein's description of process consultation as an "*embodiment*" of the clinical perspective, and his distinction between the clinical perspective as the conceptual underpinning and process consultation as the "*day to day routine*" of clinical work (1995:18).

**Process consultation versus expert and doctor -patient consultancy**

Process consultation is described through contrasts with expert and doctor-patient modes of consultancy. As an expert the consultant is paid by the client to use his or her expertise to fix a particular problem. For expert consultancy to work there is a requirement that the client initially diagnoses the root cause of the problem correctly, selects the right consultant, communicates needs to the consultant accurately, and accept the expert's subsequent diagnosis and prescription (or recommendations).

The doctor - patient mode involves some consultant - client interchange in arriving at a diagnosis. The consultant will collect data from the client, and thus to some extent involve the client organisation in arriving at a solution. However the power and responsibility of diagnosis and of prescribing remedies rest with the consultant. In an organisational context, successful doctor - patient consultancy still relies on the client's ability to select the right doctor, the consultant's ability to arrive at a full and thorough understanding of the organisation and its problems, sufficient to decide what is best in terms of management action. Moreover, there is still the issue of acceptance of consultancy findings.

Eliding these two approaches to strengthen the contrast with process consultation, Murrell provides a useful translation into the development context, where the expert/doctor becomes "*the engineer, the economist or the management consultant...*", too frequently with no locally relevant expertise, insensitive to indigenous culture and ignorant of existing institutional and managerial capacity (1994:3). This contrasted with a process consultation approach which does not assume that the development expert, or development agency, knows the conditions and needs of any given country well enough to describe a project or programme (1994:2).

## INTRODUCING THE CLINICAL PERSPECTIVE

### The clinical perspective versus ethnography

In 'The Clinical Perspective in Fieldwork' (1987b), Schein uses another contrast as a heuristic device, this time between clinical and ethnographic perspectives. In so doing he recognises that exaggerated archetypes are being used, that both are more complex than the analysis allows, so much so that the clinical and the ethnographic often blend into one another.

Yet at the same time Schein believes (1987b:12), and tries to, show that the distinction between clinical and ethnographic is more profound than that between quantitative and qualitative inquiry. This is notwithstanding a recognition of the importance of the latter, which in a development setting Moris and Copestake have illustrated quite thoroughly with respect to rural development (1993). Nonetheless, it is stressed that it is crucial for the fieldworker to be clear throughout whether she or he is working in the *general role* of a clinician in a relationship with the client or a *general role* of an ethnographer in relation to the subject.

This role clarity is required, for example, with respect to choices to be made about what is best for the client/subject, and what is best for the inquirer or researcher. The client/subject is typically unaware of such choices, so they must be made by the clinician/ethnographer applying ethical professional standards which protect various organisational constituencies (1987b:20)[2]. Such standards are seen as ultimately being

about client vulnerability, a distinction being seen between how this is perceived and acted upon clinically and ethnographically. Hence the significance of the general role adopted.

The clinician, through formal training, learns to think in terms of client protection, that is the avoidance of interventions which are "*unscrupulous, wasteful or harmful..*" and of the to create an environment enabling the elucidation of *"whatever information is needed to make a good diagnosis on the basis of which to give a valid and helpful prescription"* (1987b:21) Such an approach would not preclude operation in the doctor-patient mode however; so it is also made clear that process consultation further enjoins the consultant to avoid dependency and enhance the client's own problem solving capacity.

The ethnographer's clients are seen ultimately as academics (1987b:20), the ethnographer's primary goal is to obtain valid data for "science", not usually to change or help the system being studied. Indeed the ethnographer often seeks to obtain information with the overt intention of not changing, influencing, or disturbing the subject. Even when there is an intention to help, this is subservient to by the need for scientific rigour. Both roles demand that no harm comes to the subject/client as a result of the clinician/researchers presence. But otherwise they are quite different.

An illustration of the difference between the clinical and the qualitative (if not purely ethnographic) research ethos is provided by considering the constraints to the applications of qualitative enquiry in rural development identified by Moris and Copestake (1993:87-92). These include the use of language accessible to non-specialists in conducting qualitative enquiry, practitioner and senior management ignorance of, and consequent adversity to qualitative enquiry, and bureaucratic and institutional constraints. The clinical practitioner does not have "real work" constrained by problems like this; addressing problems like this is the clinician's real work. A clinician citing bureaucratic obstruction of an intervention in a case conference might be asked, inter alia, to reflect on whether he or she is blaming the client, whether there had been a failure to diagnose the readiness for change, and whether the intervention had caused harm by raising expectations for some which could not have been met in the overall client context.

**The clinical perspective versus action research?**

The clinical perspective is explicitly developed from the action research tradition of Kurt Lewin, and clinical practitioners archetypally use an action research model (Schein 1987b:29). However, the distinction between clinical approaches and some, but not all, approaches to action research is important. Only action research is that is client initiated can be considered as clinical inquiry, and not that where a researcher or change agent decides the problem to research and/or the goals of the inquiry. Action research which the client is involved in or participates in the researchers' agenda, even if ultimately the beneficiary as is the case in some development interventions is not clinical inquiry, nor process consultation (Schein 1995). Again, this principle parallels Edwards' initial call for participatory research not as an efficacy improving technique but "*as a means for facilitating people's own development efforts"* (1989:129)

## THE CLINICAL PERSPECTIVE IN DEVELOPMENT

Rather than precis Schein's text, the clinical perspective is examined in the light of five features which underline its relevance to development practice. Explaining that relevance means, however, that some of the detail of the clinical model is lost[3].

### (1) The foundation construct is the helpful intervention

The clinical-process model calls for a reconfiguration of the meaning that is attached to "research". That new meaning is provided by understanding research through the foundation construct of the clinical-process model, which is that of *helpful intervention*. The clinical perspective requires research as part of the requirement to help, carried out as part of what is often called a "diagnosis". The mechanisms by which this is done are prescribed by the need to avoid entering into expert or doctor-patient modes. As we have already noted, all research activity is seen as an intervention; but not all interventions are assumed to be helpful. The very presence of a consultant, and even mere data gathering changes things for the client/subject, and/or their stakeholders. For Schein this cannot be stressed too strongly. Although the fact that data collection is an intervention has lip service paid to it, the real damage that inappropriate data collection can cause has to be seriously acknowledged and reflected in practice. From the very first interaction

everything the consultant does is an intervention (Schein 1995:18) The clinical perspective therefore requires researchers to predict the possible positive and negative consequence of all of their actions. Researchers must also be able to defend such actions as helpful, which in turn requires the recognition, discussed below, that such defences arise from the practitioners normative assumptions, about what is and is not helpful.

Morss (1984) provides an illustration of the damage caused by the very existence of interventionists in Malawi, Lesotho and Zambia, with the number of donor projects causing institutional destruction through their consumption of the resources of indigenous organisations and distortion of their objectives. More, from the clinical perspective, it is unequivocally clear that certain forms of development practice are interventions before they are research. The most obvious of these is Participatory Rural Appraisal. Clinically speaking the description of PRA as research, or even as combination of research and communication techniques (Cresswell 1996:17) is misleading and unacceptable, lending a false cloak of legitimacy, objectivity and neutrality, to a process which is about effecting change.

But the obviousness of the PRA parallel itself misleads. If any form of development assistance whatsoever is provided, an intervention is made. From this position, the response to Blunt's (1995) claims of cultural limitations of process consultation in development assistance is to accept, first that process consultation is culturally biased; but second to ask what, other than its overt acknowledgement of this bias, makes process consultation different in this respect to any other form of development assistance or intervention. But more than this, if all research is seen to be an intervention, it is not just development assistance, but most of the activity carried out in the name of development studies which has to be reexamined in terms of the difference it makes for its "subjects".

**(2) Science is subservient to helping**

The clinical practitioner has a responsibility to be clear about the consequences of the research approaches used. Scientific validity does not legitimise the practitioners activity, its helpfulness does. If not used carefully, science will not help, but harm. Adherence to an allegedly scientific model can relieve the consultant from feeling a need to predict the consequences of, for example, a research process for the client system as whole. Intentionally or not, an espoused need for scientific purity can cause client and consultant to collude in creating a dependency on the scientist, ie expert, consultant.

Schein illustrates with an example of an survey of organisational morale, where the surveyor gathers scientifically valid data from the workforce at the behest of senior managers, to whom results are reported, and on the basis of which an intervention is designed. This approach is wrong from a clinical perspective. It assumes that senior managers have the right to ask subordinates to participate in this form kind of inquiry, reinforcing a hierarchy and feeling of powerlessness that may be the root cause of the problem, potentially distorting the diagnosis, by generating a token response, or by creating an unanticipated and damaging (for all parties) revolt. Fundamentally this data gathering collection is an intervention mandated by the powerful - in this case management - where there is no genuine choice for the non-powerful about whether or not to participate and reveal themselves, in "*what becomes a non-negotiable intervention their lives with unknown consequences"* (1995:15). Bell's discussion of "*the tyranny of methodology"* (1994:317) provides an articulation of the development parallel to this position in relation to the transfer of knowledge and technologies relating to farming systems research. He critiques the "*western scientific mindset"*, and questions the value of PRA/RRA as being only untyrannical or locally sympathetic as the practitioner allows.

Despite the subservience of science to helping, clinical research is rigorous, and clinical data is valid. But clinical perspective produces a different kind of knowledge, the true knowledge, as our introductory quotations argue, arising from change. Schein shares Edwards' (1989:122) concern for the nature of the truths field research reveals, and argues that clinical experience reveals richer truths than those found through traditional

academic research and disseminated by publication. Unlike Edwards, though, this richness is seen to derive in part from the access the consultant has to the powerful, discussed below in the section on politics and interventions. Generally, the data from which these truths are developed result from the very visibility of the interventionist, in direct contrast to the unobtrusive ethnographer. That is, most is learned about the client system through witnessing and analysing how it interacts with the interventionist.

For the clinician the key test of validity is whether the results of a given intervention be accurately predicted, and whether there is improvement. If unpredicted outcomes occur - be it failure to improve or different improvements to those expected - the clinician is expected to reflect - to conduct post mortems in case conferences - on and to modify models of client system pathology and wellbeing. This often the only form of validation there is available to clinicians, and it is accepted that:

> *"simply imposing the traditional scientific criteria will always find clinical data wanting. Yet given the amount of faith we apparently put in data obtained first hand in this manner, there must be a way to legitimise such data....the ability to predict the outcomes of interventions is the best direction to pursue."* (Schein 1987b:54)

**(3) The clinician meets client defined needs**

The clinical intervention is client driven. It is the client who decides that there is a problem that needs addressing, it is the client for whom the consultant works, it is the client who ultimately decides whether or not whether the intervention is successful. The client always has the initiative. More, as we have already noted, the clinician is required, unlike the ethnographer, not only to do no harm; rather he or she has to actually make things better for the client, from the clients perspective.

Data is therefore generated from client, not researcher needs. It is always kept in confidence, and seen as belonging to the client, and the consultant is expected to make the meeting of his or her needs subservient to meeting those of the client. Creswell (1996:17) makes exactly the same point in relation to the practice of PRA. For the

clinical practitioner who is also an academic there are three hurdles to be crossed before data generated from an intervention, or even accounts of interventions enter the public domain of journal articles. First, the client has to provide freely given informed consent. Second, the clinician has to be absolutely sure that no harmful consequences arise, informed consent or not. Third, the clinician is obliged to reflect on whether the whole intervention has consciously or otherwise been distorted by the desire to get into print.

An illustration is presented in response to Bailey et al's critique of modernism, OD, and western development hegemony, which draws on a daily log of interviews, observations, and "*inspired learnings"* from a "*visit to Ghana"*, to provide a contrasting account of the work of "Dr Imani" ("*although Dr Imani's intentions were noble...it became readily apparent he was operating from the tacit assumptions of the modernist development paradigm"*) and "Dr Katche" ("*the oasis of postmodern thinking and action in Ghana"* (1993:43-4)). The clinical view would start from a belief in the profound limitations of what could be known about those with whom one is working over any timescale, let alone a visit. Client wise, it would ask whose needs an article published in an expensive western journal met. It would question whether confidentiality had truly been maintained, perhaps in contrast with Murrell's (1994) refusal to identify even the country where his case activity was conducted. Other issues would include the researchers' assumptions about who information about the doctors belonged to, whether the doctors were shown the accounts of them that were in the article, and had freely consented to their appearance, irrespective of any real or imagined need to keep donors and other stakeholders happy.

However, an espoused client centredness still begs the question of who is the client. Schein identifies contact clients, who make the initial approach to the consultant, intermediate clients who contribute to the planning, the primary client whose budget the fee comes from and with whom the consultant primarily works, and the ultimate client, that is the broader stakeholder whose interests are to be protected (which from an OD point of view is the whole organisation) and at a higher level the community and society (1987a:125). The consultant has to apply professional criteria and his or her own values in deciding who the primary client is and how to balance the requirements of different clients, who in development are more extensive in number and have more complex

relationships. It also has to be recognised that client centredness does mean that the practitioner is taking the client's side, and that there are implications with respect to power, as the next section shows.

**(4) Interventionists are paid and political**

The clinical perspective openly accepts that money conditions the relationship between the change agent and the client. At a practice level this requires the consultant to recognise the dynamics which could lead to a trading off of what should be done with what the paying client expects to be done. A common issue is that of divulging information gained by to the consultant in confidence from within the client system. The competent clinician should make clear from the start that no such information will be revealed; and give up the job rather than divulge. The other frequent expectation is that the consultant will act in an expert, scientist mode which although initially more familiar and more comfortable for the client, and making for easier marketing for the consultant, is ultimately less helpful and potentially more damaging.

This openness about fees also demonstrates the difference in assumed power relationships in clinical as opposed to ethnographic practice. The clinician clearly works *for* the fee payer, who has control over the clinical practitioner's economic well being, and the expectation that the practitioner will be working for him or her. This implies that the practitioner has to accept that the decision to hire him or her is the reflection of, and requires a willingness to engage, but not collude, with the realpolitik of the client system. Critiques of Organisation Development (eg Dunphy and Stace 1988), and by implication of process consultation, argue that in practice it embodies the unitarist assumptions that there is a commonality of interest throughout the system as a whole. An alternative view is that there may be, or inevitably are, differences of interest within any system - between managers and workers, men and women, ethnic groups and so on, and that only the powerful amongst these who have the resources to hire the consultant and permit ongoing access. The consultant will, willingly or not, consciously or not, perpetuate the interests of these powerful, and would not be hired otherwise. Moreover the in his or her day to day activity implicitly political choices are being made, in who is given credence, who is asked to express a view, in whose experience and reality is seen as mattering.

Schein does at the very least acknowledge this issue, in his warnings about top down action research processes, and when he states:

> *"...any time we help someone we are in effect allying ourselves with the goals and values they represent. We cannot later abdicate responsibility for the help we may have provided if that help turns out to have had bad effects...on other groups"* (1987a:127)

However, the criticism that there is not within OD generally (except notably in McClean et al 1982), or in Schein's work in particular a detailed examination of the political choices the consultant makes in choosing a client, and from day to day is accepted. Chamber's call for a new professionalism which "*puts people first and poor people first of all"* (1993:1) provides a particularly relevant starting position from development as to the side the clinical practitioner should take. But to get into a position to take this side, and to act in its interests usually requires the practitioner to be sanctioned by and engage with the powerful, not least with donors and with governments. Moreover, there are still the day to day practice issues. Mosse (1994) suggests that the way that knowledge is generated and constructed even by PRA is influenced strongly by existing social power relationships, citing cases where women's participation is consequently limited. Nonetheless, the argument here is that although understandings of the politics of intervention practice need to be developed to a more sophisticated level, this does not in itself justify the complete rejection of all the clinical model has to offer, not least because it allows the articulation of the issue, and provides a framework where the consideration of political practice issues can be addressed.

**(5) Interventions and interventionists are avowedly normative**

The helpful, or problem solving orientation of the clinical perspective, and the use of the words "diagnosis", "pathology" and "health", despite the eschewal of the doctor patient mode, all point to the existence of normative assumptions on the part of the practitioner. However, these assumptions are not hidden behind claims of scientific rigour (although the clinical practitioner must be so rigorous). Rather, clinical practice requires an honest

and open admission, to oneself as a practitioner and to one's clients, of its normative nature, which can be seen at three levels.

The first is in the practitioners model of what healthiness or well-being on the clients' part is. The language of the clinical perspective, including the very word clinical, points to the predominance of Morgan's (1986) organismic metaphor, that is of theories which use an analogy between social organisation and biological organisms. Organisationally, socio-technical, or systems theory is most influential. Systems theory is powerful in the comprehensiveness of the analysis which it allows, enabling understandings (or diagnoses) which integrate organisational culture, the technology of work, organisational structure, leadership styles, motivation, and the relationship between all of these and the external environment.

Where such analyses are recognised as being weak (Morgan 1986:71) is in their failure to encompass the distribution of power, in their diagnosis of conflict as pathologically problematic, and their simplistic analysis of organisation - environment relationships. Kiggundu (1986) has also found their success on the evidence of 25 cases in developing countries to be limited, and argues that this results from the short termism of the western change agents involved (ie poor clinical practice) and the incompatibility of the general environment to socio-technical systems approaches. However, use of organismic models is not compulsory. Other models can be and are used in clinical consultation, including those which draw on psycho-analytical, psychodynamic, social psychological, political, feminist and anthropological concepts. There is no reason why others applicable to, or arising from development theories and practice cannot be used.

The second level of normativeness is in the prescription of the process to be used in interventions. The very advocacy of process consultation above doctor-patient and expert consultancy is normative, and accepted as such. For Schein, the normativeness of the clinical perspective is evident in prescription of client driven action research. From an OD and a clinical perspective, then, the distinction between "process" and "blueprint" approaches is not only non-existent, but deceiving. Recommending a process approach per se, and/or a particular process to follow are both stipulating blueprints, or to use the clinical term, prescriptive. There are debates about the level of prescriptiveness, and

Schein is one who has distanced himself from the methodology and technique specific approaches which were popular in the 1970's (Coghlan 1988:30).

Nonetheless, for Bailey et al (1993:54):

> *"The prescriptive character of OD is Western expert imperialism as it is outside in and anti-dialogical in nature. Because it is a 'normative discipline' OD imposes its values about 'planned change' for 'improvement'...."*

Written from Ohio, USA, in an article about Ghana and Ghanaians this anti-imperialist view is based on the quotation of French and Bell's standard definition of OD, which incorporates an explicit acknowledgement of its normativeness and prescriptiveness in undertaking planned change for organisational improvement. The clinical response is to argue that there are no forms of engagement that are not interventions, which are not to some extent "outside-in", and which do not reflect interventionist norms and values about making things better, not least the very in the very choice to act in one arena and not another, and to pretend otherwise is dishonest. OD is being attacked for its honest admission that this is so for itself, from a position where Bailey et al's own prescriptiveness, of "inter-being", and normativeness is hidden by an assumed but unacknowledged universality of post-modernism.

The third level of normativeness is evident in the so called "OD values" which are articulated in organisational terms of concerns for the empowerment of individuals, for democratic and participative managerial processes, and the mutually reinforcing nature of individual and organisational development. Blunt (1995) sees these values as the source of process consultation's cultural limitations, citing China as an example of a country with contrary values where process consultation is inapplicable. An out and out rebuttal of this view is not justified. It is supported within OD (French and Bell 1984:4); moreover, there is also evidence that the use of participative processes, and an espoused democracy can be used for concealed or unacknowledged ideological ends, not least in Schein's own early work on China. The clinical practitioner therefore has to continually examine his or work activity for manipulative behaviour; and reflect on whether he or

she should work in situations where the perspective is inapplicable, that is where it is at variance with these values.

Again, though, the argument is that the value specific nature of the clinical perspective and process consultation is not in itself sufficient to reject the whole concept. The commitment to empowerment and participation is after all in common with that found in areas of development practice, and the commitment to espoused values no more than that that already happens in development, eg according to Edwards (1994:283), in relation to NGOs in respect to their alleged "cultural imperialism".

## CONCLUSION - FOUR CHALLENGES FOR DEVELOPMENT STUDIES

Amongst the intervention strategies open to clinical practitioner is that of confrontive inquiry (Schein 1987a: 1987b:58). This involves the clinician confronting the client with data which might be seen as challenging, and lead to a change in self perceptions. Clinically, it is ultimately for the client to make sense of this data, and translate it into an articulation of the challenges being faced. This conclusion is in the confrontive spirit, but moves into prescriptive mode, specifying four challenges for development studies posed by this discussion of the clinical-process approach. All four arise from the clinical perspective's position that practitioners do not just emerge; they have to undergo thorough training first.

The first challenge is for development to create its own "theories of practice" to be used in training. The clinical practitioner is trained in "theories that focus on models of pathology and health, effectiveness, coping, dynamics, and intervention" (Schein, 1987b:56). These are typically drawn from psychiatry, clinical psychology, applied psychology, sociology, anthropology, OD and social work. These must all be added to, and then subsumed within development's own existing, and it has to recognised, valuable, knowledge of practice. The managerial classics provide a starting point in terms of the provision of ideas, and in the methodologies they use to construct theoretical models. Argyris (1970) synthesized from a range of behavioural science theories. Lippitt and Lippitt (1978), like Schein, merged existing theory with reflection from their

own practice. Lippitt, Watson and Westley (1958) conducted an extensive literature based review of the work of change agents at individual, group, organisational and societal levels to construct a general approach to planned change and change agent practice. This is but a sample of the standard, some would say modernist, fare; but the literature is extensive, and continues to reflect broader theoretical debates, as our coverage of Bailey et al (1992) has shown.

The second challenge for development studies is for it to incorporate existing and new theories of practice into its training activities. McAuley's (1983) discussion of hermeneutics as a practical research methodology for students of OD at Masters level brings out three points. First, that the clinical practitioner does just not learn about theories in the abstract, but how to apply and adapt them. Second that that learning has to start with the acquisition and maintenance of a reflexive self awareness; and third that this must, and can be done within the rigour of a formal academic award programme. Clinical training for Schein should be at Masters or PhD level, and should incorporate "internships", some form of residency, or supervised practice. There should be some form of credentialing process by the institution and the wider community which leads to a "license" to practice (1987b:58). There is therefore a requirement to change development studies curricula not just in terms of content, so that the learning of development practice is more than the teaching of "skills", but also in terms of programme design, approaches to learning, and assessment methodologies.

This bring us to the third challenge, which is for the departments in which development studies is taught to be prepared to undergo the institutional change that these changes in programme content and design require. First there is the need for faculty who are able and willing to bring about these changes. Second, there is the need for institutional commitment to the research required to develop theories of development practice. Third, there is need to set up the new approaches to training that will allow supervised and reflective practice to be incorporated into formal award programmes without loss of rigour. Mann (1995, 1996a, 1996b) provides an example of how this has been achieved in an graduate OD programme with South African NGOs, but argues universities have problems in adapting away from traditional methods of teaching and assessment. At the same time, however, many universities, including those where development studies

departments are located, have long-standing programmes that have addressed the creation of reflexive practitioners while maintaining academic rigour, in medicine, social work, clinical psychology, education and of course in change management and OD. The problem belongs to development studies, not to universities as a whole.

This brings us to the fourth challenge. We have seen that, outside development studies, there are long-standing, institutionally established, academically rigorous practitioner development programmes. But these are sometimes being conducted within yards of development studies departments, sharing the same libraries, with academic staff sharing the same common rooms. We have seen that there is an extensive literature of general theories of intervention. Schein himself is not an obscure academic. More, what Edwards talks about as a new paradigm of reflective practice is not new; in fact it is at least as old as development itself (see Cooke 1996). From 1945 onwards clients in the north have increasingly had the clinical benefits of these institutions, this training, this literature. It appears that these benefits have failed to be shared with the rest of the world. The final challenge, then, is for development studies to reflect upon what this failure tells it about itself, and about the costs its own disciplinary biases have imposed upon those it would claim to help.

**NOTES**

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1. Now Professor Emeritus at the Sloan School of Management at MIT, Schein is also author of classic texts on organisational psychology (1980) and an on organisational culture and leadership (1990). He has already been the subject of two retrospective journal articles (Sashkin 1979, Coghlan 1988).

2. The principle of informed consent is seen as an illusion in this context; early on client/subjects do not know enough to make an informed consent choice. The researcher/consultant has to apply professional standards unilaterally, and make the client aware as quickly as possible of what they have committed themselves to.

3. It should be noted that Schein's own precis identifies fifteen components (1987b:68).