Legitimating Clinical Research in the Study of Organizational Culture*

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I would like to discuss in this paper some of my feelings about the state of research in organizational psychology, especially as it pertains to that difficult concept--organizational culture. I will begin with two stories. At a recent symposium on telecommunications I was sitting next to the President of one of the major providers of such services. A professor was analyzing the market penetration of different companies in different parts of the world and made several references to my neighbor's company. He was getting increasingly agitated and finally said to me: "Its wonderful what these professors can make up in the way of a story on company data that happen to be completely wrong."

The second story was told to me by a colleague who had been part of a research team to study how a large British

corporation had managed some of its major changes over the last decade. The research program called for "accurate data" hence all interviews with members of the company were to be tape recorded. My colleague reported a particular instance where the manager whom he was about to interview said: "Do you want to hear the official story or do you want me to tell you what really happened?" My colleague replied that he of course wanted to know what really happened. The manager then said: "In that case you better turn that tape recorder off." My colleague was there with a teammate, and reported that the peer pressure was such that he said: "I'm afraid we'll have to leave the tape on and just hear the official story." The taped data were then fed into a larger data pool from which a book was written about this case. I believe these two stories set the proper tone for what I want to say.

In the first part of this paper I would like to make some observations about how we learn in this field and how I believe we should do research. I will argue that we have largely adopted a traditional research paradigm that has not worked very well, a paradigm that has produced very reliable results about very unimportant things, and sometimes possibly invalid results altogether. In that process I believe we have lost touch with some of the important phenomena that go on in organizations, or have ignored them simply because they were too difficult to study by the traditional methods available. All too often we are not willing to turn off the tape recorder.

I. The Clinical Research Paradigm

In place of the traditional research paradigm based on quantitative measurement and statistical significance, I would like to propose that we learn to gather data in natural situations and particularly in "clinical" situations where we are asked in one way or another to help an organization (Schein, 1987a). We not only need to learn to gather data in these settings by basic inquiry methods, but we also need to train ourselves to become more helpful and, thereby, get access to organizational situations where clients want something of us. And then, and this is perhaps the most difficult challenge of all, we need to be able to report such data, to learn from them, and to treat them as legitimate scientific data in organizational research. So what I am calling "clinical research" is the observation, elicitation, and reporting of data that are available when we are actively engaged in helping organizations.

We must not confuse clinical research with qualitative research or ethnographic research. What is broadly labelled qualitative or ethnographic or participant observer based research still operates from the traditional scientific model. In this model the investigator at her own initiative requests entry or infiltrates the research site and makes observations without disturbing the situation. In some models of research, the less you influence the research site, the better a researcher you are.

In the classical Hawthorne studies, you will remember, we made a fetish out of the fact that the observer could be shown to have no effect on the members of the Bank Wiring Room. Only later did we realize the power of the Hawthorne effect, that actively observing workers and paying attention to them had more impact on their morale and productivity than any of the variables manipulated in the formal study.

The person who understood this best was Kurt Lewin, and I still believe he had it right when he noted that one cannot understand a human system without trying to change it. It is in the attempt to change the system that some of the most important characteristics of the system reveal themselves, phenomena that even the most talented ethnographer would not discover unless he happened to be present when someone else was trying to produce some change.

Clinical research, then, is an extension of the concept of action research as articulated by Lewin and his followers, but it differs from action research in a very important respect. The essence of clinical research is that someone in the organization has requested some form of help and that the researcher comes into the situation in response to the needs of the client, not her own needs to gather data. Some action research fits this model, but there is nothing in the concept of action research per se that focuses on client needs as a necessary condition for relevant data to surface.

So not only does clinical research result from helping activities that are client driven, but the clinician is paid

for his services and enters a psychological contract that obligates him to be helpful. This implies that the clinician gives higher priority to the helping process than the research process, and that the researcher has helping skills, not only research skills, or she might not be given access in the first place. But once the helping relationship exists, the possibilities for learning what really goes on in organizations are enormous if we learn to take advantage of them and if we learn to be good and reliable observers of what is going on.

Why do I think the possibilities are enormous? There are several reasons. First, if we examine the psychological contract in the traditional research situation and the clinical situation, we will discover an important difference. In the traditional situation the researcher has to develop a site, gain entry, and establish himself as someone who will not be too great a pain to have around. The deal is that the researcher will be allowed to hang around, interview people, maybe even administer questionnaires, provided she does not do too much harm to the organization and provided that whoever approved the entry feels that he is going to get some benefit from seeing the research results. But notice that there is nothing in the situation that would motivate a member of the organization to put much time or effort into helping the researcher, and there is certainly nothing in the situation that would motivate her to reveal some of her deeper observations or attitudes.

The ethnographer might argue that if he hangs around enough, important things will reveal themselves, but I doubt that this will be true unless the ethnographer has come to be seen as helpful to have around and has, therefore, migrated into a clinical relationship with his "subjects." A striking example of this kind of migration occurred some years ago in an effort of one our graduate students to become a participant observer in an engineering group of a local high tech company. He felt himself to be on the periphery of things for many weeks until one day at lunch time an informal soccer game took place and he scored the winning goal for his group. Suddenly he had a role, albeit a non-work related role, and from that day on he was accepted as a member of the group and people began to share with him how they really felt about things. Significantly, a central part of this role became "clinical" in that he was increasingly asked by various members of the group for advice on how to handle certain situations. It was his ability to help that gained him real entry into the group, not his research skills. And the more he helped, the more the members of the group felt obligated and anxious to help him by spending time with him explaining how things really worked and sharing their feelings about about what was going on.

If you stop to think about it, the traditional research situation, by its very nature, will only produce superficial data unless you use unobtrusive methods or manipulate the situation experimentally, both of which are hard to do and

often unethical in organizational situations. Once the situation has been defined as clinical, however, where the group members want help from the outsider, the psychological contract shifts dramatically. We now have a reverse psychological flow. In the traditional situation the researcher wanted something from reluctant organization members, and had relatively little to offer in return. In the clinical situation, clients want something from the helper, are willing to pay for it, and, most important, lay themselves open to being questioned by the clinician on matters that may be regarded under other circumstances as private or secret, or "dirty linen."

If I am a traditional researcher, and ask: "How do you get along with your boss?" the respondent may evade giving an answer because it may be viewed as being none of my business. If I ask the same question as part of a process of helping the client to solve some problem, it is much more likely that I will get a meaningful answer because the client is seeking help and paying for it. The very fact that the client has initiated the process, licenses the clinician researcher to ask questions that would under other circumstances be viewed as invasions of privacy or be evaded in order to maintain an image. And, of course, because the client is paying for the help, he obligates himself to give answers in order to "get his money's worth."

An effective ethnographer or interviewer operating from the traditional model will argue that her skill in

establishing a relationship with the "subjects" or "natives" will elicit trust and, therefore, equivalently deep data. But I would argue that when that happens, it happens because the relationship has, in fact, gradually come to be redefined as a helping relationship from the client's point of view. And this can happen even if the researcher has no helping skills or intentions, which creates the awkward possibility that the client's trust is, in fact, misplaced. The researcher may be quite unable or unwilling to help, and is likely to disappear as soon as he has enough data. If the researcher is able to be helpful, a healthy, productive, mutually beneficial relationship results. In the ideal situation, then, both the researcher role and helper role are needed, and often can be found in the same person.

In either case, what the researcher is told or what she observes is not automatically deeper or more valid. There is still the problem of psychological defenses and the need to give socially desirable responses. The client will still have reasons to evade, avoid, idealize, deny, project, and in other ways distort what is going on, but the defenses now become data about the organization rather than being simply a product of the researcher/subject relationship. If the person refuses the traditional researcher with "its none of your business," little has been learned and the researcher has no legitimate right to pursue the matter with follow-up questions.

In the clinical relationship the same evasive response or a response like "I get along fine with my boss" said in a tone that conveys that something else may, in fact, be going on, suggests hypotheses about the climate in the organization that can be legitimately followed up. For example, the person might be afraid of his boss, or the person might be protective of his boss, which are hypotheses now about a state of affairs in the organization that can be pursued with further inquiry questions. The point is that in the clinical relationship the clinician is permitted and expected to continue the conversation by asking for further information, or probing for what might be behind the response. If the person adamantly refuses, one can legitimately ask what might be going on that would cause such a refusal and pursue the inquiry.

It is in this interactive process that the clinical relationship differs most from the traditional research relationship. The clinical researcher can formulate hypotheses about what is going on and test them "on line" by the kinds of interventions she makes. And, in observing the responses to interventions, the clinician is confirming or disconfirming hypotheses, and is constantly gathering more data for reformulating hypotheses. This interactive process is what I mean by learning about an organization in the process of trying to change it. Interventions in this context then become research tools and can be used to do mini "field experiments."

II. Process Consultation as a Form of Helping

The next issue to be addressed, then, is what should we mean by an "intervention." Organizations are, by definition, open dynamic systems. Therefore, anything I do as a clinician or researcher is an intervention that will produce some unknown amount of change. The illusion among some researchers or ethnographers that they can go into organizations without influencing them has been the source of a great deal of misunderstanding. Instead of attempting to maintain this fiction or to argue for minimal influence, why not acknowledge that any appearance of an outsider on the organization's doorstep is an intervention? The issue, then, is to decide what kinds of interventions are desirable.

Here we come to a central tenet of how I believe we can be most helpful and how I would distinguish my clinical approach from that of many others. Consultants and helpers must be able to be what I have called "process consultants" which means that the client is encouraged to become actively involved in diagnosing his own situation and helping to formulate interventions that will work in his culture (Schein, 1987b, 1988). What this means in practice is that as a helper I must make interventions whose primary function is to stimulate inquiry and diagnosis. I must ask genuine questions and develop a genuine curiosity about what is going on in the client's world so that the client comes to see me as a person who is helpful to have around.

It has been my experience that when I am in this kind of process consultant role, pursuing as best I can a process of pure inquiry, that I also learn most as a researcher because the client becomes more and more motivated to reveal to me what she believes is going on. A level of trust builds up that allows me then to ask very probing questions without feeling that I am treading on private turf. This level of trust also often results in being invited to attend meetings or to observe real work getting done, permitting me to check whether my developing image of what is going on has any validity.

If, on the other hand, I come in as an expert or a doctor with ready made diagnostic tools, tests, and prescriptions, I will learn less and will be less likely to be helpful because I will not know enough about the realities of the client's world to know what prescription would in fact be helpful. I will stimulate unknown amounts of dependence or counterdependence, either of which would undermine inquiry.

The process of inquiry as conducted by a process consultant is an attempt to meet the client wherever she is and to work with the reality as it is defined. If a formal diagnostic process such as psychological testing or employee surveying is to be done, the decision to do it must be owned fully by the initial client with full knowledge of the potential consequences. As a process consultant I have to make those consequences clear and to point out that such

diagnostic processes are typically major interventions into the organization. The consultant should never do just what the client requests or demands, but always insure that the client fully understands and accepts the potential consequences.

I reject out of hand the proposal by some managerial psychologist to routinely give tests, do assessments, or do surveys as an initial diagnostic process. Though these are labelled as "diagnostic" they are, in fact, major interventions with unknown consequences, and in the early stages of a relationship the client is simply not in a position to assess what those consequences might be.

Two examples will make this clear. In the use of surveys, the early administration of questionnaires for diagnostic purposes often raises employee expectations that management cannot meet, or creates an illusion of empowerment among employees that does not reflect reality. Because the survey is defined as "merely" diagnostic, insufficient attention is paid to the method by which feedback will be given to participants. If the feedback does not occur or is mishandled, the organizational situation will worsen substantially as a result of the survey administration.

On the use of psychological tests and assessments, I have recently read a book on psychological consulting to management in which the author outlines as his primary method the following steps. A CEO will call him in with a presenting problem. In order to help, the psychologist will

require that the CEO and his immediate subordinates undergo a psychological assessment, with the argument that unless he obtains such data he cannot really determine what might be going on in the organization. Unfortunately, nowhere does this same author spell out the possible consequences to the CEO and his team of all of them being subjected to a psychological assessment. Nothing is said about the process by which the CEO might get the consent of his subordinates, nor is any attention given to the possibility that some members of the team may not be psychologically ready for an assessment. As a process consultant the clinician must get full understanding and ownership from the immediate client of any such proposed diagnostic or other intervention if a healthy helping relationship is to be formed.

To summarize thus far, the essence of the clinical research relationship is 1) that the client wants help and is therefore more likely to reveal important data and 2) that the clinician researcher is expected to intervene which allows new data about the client system to be surfaced. The data thus revealed will allow the researcher to get a deeper insight particularly into 1) the psychological defenses operating in the organization, 2) the cultural assumptions that are driving the organization, and 3) the interpersonal and group dynamics that are operating, and 4) how power and authority operates in the organization. In building the helping relationship it is important to function in a process and inquiry mode so that the client can participate in

diagnostic activities and learn to own the consequences of whatever further interventions are made.

III. The Clinical Approach to the Study of Organizational Culture

How does this point of view impact the study of organizational cultures? As you well know, there are in our field now many definitions of culture and a number of so called culture surveys that purport to tell an organization, based on a set of individual interview or questionnaire responses what the important elements of its culture are. The development of these technologies is a direct reflection of our traditional research paradigms and clearly leads to superficial data, possibly even invalid data. The reason is that in order to develop a questionnaire, one has to understand in depth the phenomenon one is surveying, and I do not see how that deeper knowledge of culture is going to come about using instruments that are based on organization theories that never considered culture as an issue to be dealt with in the first place.

For example, I have encountered the argument that Likert's Systems One to Four are, in effect, cultures, so some version of the Survey of Organizations can supposedly be used to measure organizational culture. From the clinical perspective the main problem is that such instruments may measure the wrong dimensions at the wrong level of depth. Where I have been asked to help an organization decipher its culture, what I typically discover is that the important

dimensions of culture may have nothing whatever to do with how people are handled, yet that is what the Survey of Organizations and other such surveys are primarily concerned with. For example, in terms of basic shared underlying assumptions, which is how I define elements of culture, the most important shared assumptions in a company are often assumption about product type and quality, its basic image of what business it is in, how one brings products to market, what customers are like, whether the right way to function is to be customer driven or product driven, whether one should go into debt or always be self-sustaining, whether to go public or remain private. I have found that companies build strong shared assumptions around such issues, and those assumptions dominate decision making and strategy. How will I discover these dimensions if I go in with a prepared questionnaire or interview schedule, based on someone's oversimplified typology of organizations?

What is my clinical alternative as a process consultant? First of all I do not agree to help an organization decipher its culture unless it has some problem it is trying to solve. To do a full analysis of a culture would require years of ethnographic work and would still leave one wondering whether the description had utility or not. On the other hand, when some senior managers want help in figuring out whether or not their culture aids or hinders their efforts to pursue a new strategy or to make some organizational changes, then we have a basis for moving forward.

I define culture as the sum total of what a given group has learned as a group, and this learning is usually embodied in a set of shared, basic underlying assumptions that are no longer conscious but are taken for granted as the way the world is (Schein, 1985). The visible, hearable, and feelable artifacts of an organization are a manifestation of those underlying assumptions, as are the articulated and espoused values that often get written down as the company's philosophy.

Given that the essence of the culture is the shared underlying assumptions, the next step is to get the group that wants to solve a problem to come together as a group to learn to decipher its own culture. The composition of the group should depend on the nature of the problem the company is trying to solve, and this will typically be worked out by the process consultant working directly with the client to determine the pros and cons of various alternative groupings. In one recent case the problem was to identify in a culturally diverse company that had grown up by a series of acquisitions how to identify areas where common policies and practices were needed as the company moved forward into an uncertain future. In effect, the company wanted to know what components of its various sub-cultures should be a common culture. It was agreed that all the senior corporate managers and division general managers had to be present for this analysis.

In another case, a company was running a senior management development program which focused in part on a new strategy that the company was implementing. In this case they decided simply to insert one full day session on organizational culture to examine how the strategy would be impacted by the culture. I have had as few as five and as many as 100 in a room engaging in this type of activity.

The first diagnostic intervention with the group is to spend 30 minutes outlining how I view culture as a learned set of shared basic assumptions that become unconscious but manifest themselves as various artifacts and espoused values (See Chart 1). I point out that culture can be analyzed at the level of artifacts, the level of values, and the level of shared underlying assumptions.

The next step is to ask the group to describe its own major artifacts and to record all of these on a set of flipcharts which are hung around the room . It is important to start with concrete artifacts so that we have plenty of data to look at when we later try to infer underlying assumptions. By the way, a good way to start this discussion is to ask the people with the lowest seniority to start by telling what it was like to enter this organization. Working in a group is essential because members stimulate each others' thinking and we are, after all, seeking data about a construct that is by definition shared. Shared things are easier to locate in a group than to infer from individual interviews.

Filling up the walls with flipcharts listing artifacts almost always leads into a discussion of the values, some explicit and espoused, some more taken for granted and in need of surfacing. By the time we have spent two hours doing this, some of the underlying assumptions become quite obvious and, more importantly, the domains in which important assumptions are held become obvious. As the consultant I try to emphasize through filling up the flipcharts that culture is both extensive and intensive, and that not everything in a culture is relevant to a problem one is trying to solve. So identifying the relevant domains becomes an important part of the exercise.

In trying to articulate assumptions, historical reconstruction becomes very useful. Identifying the values and attitudes of founders, early leaders, and current powerful figures in the organization makes concrete what members often feel only as vague abstractions. Asking the group about major events, crises or otherwise, focuses on how assumptions influence what was perceived and learned at those times.

An important point that surfaces from this way of doing things is the essential neutrality of culture. Group members soon realize that their cherished way of doing things is not the only way, and that there is no such thing as a good culture or a bad culture. Only by referencing the problem they are trying to solve is it possible to decide whether any given cultural assumption will aid in solving the problem,

will hinder the solution, or is irrelevant. To make this determination becomes the next part of the task for the groups. Either as a total group or in sub-groups, the participants now continue to identify shared assumptions and sort them into those that will aid and those that will hinder. What is often surprising to participants at this stage is to view cultural assumptions as something that can aid them. We have come to think of culture too much in terms of negatives and constraints instead of positive forces to be nurtured. If constraining assumptions are identified, one can now shift the discussion to the possible mechanisms by which those aspects of the culture might be modified, neutralized, or reframed in terms of even higher order assumptions.

The role of the consultant in this process is to stage manage the activity, to provide the theoretical framework within which to discuss culture, to remind the group of the organizational problem it is trying to solve (why we are doing this), and to ask provocative questions to elicit deeper levels of data than the participants might have come up with on their own. As more data are out, the consultant can certainly begin to reveal her own hypotheses about some of the deeper assumptions that may be shared, but she must keep her clinical hat on at all times to insure that whatever confrontive interpretations are made, they will be seen as helpful and will elicit more data.

Let me give some examples of how this works. Some years ago a group of managers from a large insurance company met to discuss the need for their company to become more innovative and flexible. They had a new CEO who had mandated various kinds of programs that should stimulate innovation but nothing had happened for a year or more. During the morning of this meeting the total group of 75 articulated various of their artifacts-- dress codes, office layout, pay systems, working hours, etc. The results seemed to reflect a fairly traditional kind of organization reflecting values that they cared about their customers, that they were good to their employees in a paternalistic way, and that morale was generally high. But innovative behavior was non-existent.

The participants then were sent off in groups of 10 to spend two hours after lunch to analyze the various assumptions they had begun to articulate, specifically from the point of view of aiding of hindering innovation. In the reports back a dramatic discovery was reported by every group. They had realized that over the 75 year history of this company two central assumptions about people and work had dominated: 1) The assumption that people work best when you given them rules to cover all contingencies, so the company had procedure manuals that covered everything; and 2) they also had been living with the assumption that the only way you can keep people focused on the rules is to immediately punish any deviation from the rules. In other words, they had been operating from a theory of human nature

that had built a powerful control system which, in turn, guaranteed that no-one would take any risks and innovate.

This insight produced a dilemma that management then had to grapple with. Should one try to change an assumptions that had been operating for decades, realizing that this might itself take a number of years, or could one reframe the problem to actually take advantage of the rule bound culture by, for example, making a new rule that every employee must contribute at least one new idea a week, or mandating that each company practice had to be reviewed each year. Taking advantage of the existing culture is always an easier change strategy than to try to change deeply held cultural assumptions.

In the conglomerate group previously mentioned, small heterogeneous teams were sent off to identify what elements of their cultures should be blended to create a stronger common culture eventually. As they analyzed their assumptions in a historical context, quite a different insight emerged. They realized that they had all developed under strong founders and when they had been acquired it had been the policy to let each division continue to operate in a very autonomous fashion. In most cases these founders had been strong paternalistic father figures but they had all died or retired by the time this meeting was held. In recent years they had begun to miss these strong leaders and longed to recapture a sense of strong central leadership. What they really wanted was strong father figures not a common culture.

In fact, they realized that a strong common culture would interfere with the autonomous ways of operating that they had all become used to.

They were able to reframe and redefine their problem as follows: 1) How to identify areas of their business where they needed higher levels of coordination and common practices; and 2) How to develop strong leaders in each of their separate divisions. They realized that they neither needed nor wanted strong corporate leadership because in fact their various businesses were quite different from each other and their cultural diversity was a real competitive advantage. A few common policies would be helpful, but they did not need a "common culture."

Solving problems through reframing parts of the culture is a common organizational change process. For example, this kind of reframing can be seen in companies that committed themselves to policies of no layoffs, based on the assumption that their people would always be a valuable asset, only to find that technological changes and economic cirsumstances forced them into layoffs. One way that this has been handled is to invoke an even higher order assumption like "we always treat our people fairly or well," and then to create various kinds of transition programs which get people out but with generous buyouts, extensive outplacement, career counseling, and other services.

This clinical process of dealing with culture does not produce for the researcher a complete publishable account of

that organization's culture, but it provides a much better picture of culture dynamics than would have been elicited from interviews or questionnaires, and, possibly, even participant observation. Most important, it identifies fairly rapidly, often within one day, those cultural assumptions that are salient and relevant to a particular organizational problem. That is far more helpful to organizations than months of interviewing and surveying, and important new data are revealed as the clinician/consultant watches the organization deal with its own cultural realities.

IV. Clinically Revealed Data: An Illustrative Example

How then does this method help the research process, what new insights do we get from this kind of clinical consulting work? The most obvious gains are in the opportunities such data provide to observe dynamic forces that would ordinarily be concealed, especially regarding the operation of power and influence across organizational boundaries. In the culture analysis area I have tried to show what kinds of insights emerge from the actitivity itself. By way of a further answer, let me give another case illustration. In a bank that was trying to introduce an effective new technology for handling various financial transactions, it was only when the actual installation of the new multi-product workstations was begun, that it became evident that the bank had a powerful unbreakable norm that it would not lay anybody off and that it would not be able to

relocate the many persons who would be displaced by the new technology. The existence of the norm was well known, but no one had any idea of how powerfully held it was until the technological change was attempted. The new technology was at this point abandoned as impractical.

In the traditional research model the existence of this norm would be a sufficient explanation of the observed phenomena. But what I learned as a consultant to the head of this unit "deepens" our understanding considerably. Once we discovered that the no layoffs norm was operating, I began inquiries about the source of the norm and learned that it was strongly associated with my client's boss for whom "no layoffs" was a central management principle that he had made into a sacred cow. Though I had assumed from prior knowledge of social psychology that norms are upheld by group members themselves, I found in this situation that it was the boss's fanaticism that was really the driving force, and this was confirmed three years later when he retired. All the attitudes about layoffs changed rapidly, but, surprisingly, the new technology still was not introduced.

By the way, as a traditional researcher I would not have been able to hang around for so long, so I would not even have discovered that the constraint on the new technology was something other than the no layoffs norm. To explain further what was happening I had to draw on some other knowledge I had gained as a member of the design team for the initial change. I remembered that the group had had great difficulty

in visualizing what the role of the new operator of such a terminal would be and what the role of that person's boss would be. The group could not visualize the career path of such an operator and could not imagine a kind of professional organization where such operators would be essentially on their own. I asked a number of people about the new technology and confirmed that people did not see how it could work, given the kinds of people who were hired into the bank and given the whole career and authority structure of the bank.

So what was really in the way of introducing the innovation was not only the norm of no layoffs, but some deeper conceptual problems with the entire socio-technical system, specifically an inability to visualize a less hierarchical system in which bosses might play more of a consultant role to highly paid professional operators who, like airline pilots, might spend their whole career in some version of this new role. In fact, the no layoff norm might have been a convenient rationalization to avoid having to change deeper cultural assumptions about the nature of work and hierarchy in this bank.

So what the clinical process revealed was that the phenomenon was overdetermined, multiply caused, and deeply embedded in a set of cultural assumptions about work, authority, and career development. We were dealing with a complex system of forces, and once this system was understood as a system, it became obvious why the bank did not introduce

the new technology. Attributing it to the boss with his norms of no layoffs would have been a misdiagnosis even though all the surface data indicated that this was a sufficient explanation.

V. How Valid is Clinically Obtained Data?

Hanging around organizations in a clinical consultant role reveals a lot, but, one can argue, this is shaky knowledge. How do clinician researchers know when they know something? I think the most basic answer to this question is that if one is observing dynamic processes, one confirms or disconfirms one's hypotheses continuously. As a matter of training, one should operate with self-insight and a healthy skepticism so that one does not misperceive what is out there to make it fit our preconceptions. But if we are reasonably careful about our own hypothesis formulation and well trained in observing what is going on, we should be able to generate valid knowledge of organizational and cultural dynamics throughout any period of interaction with an organization.

For me the problem with clinical data is not that it lacks validity, but that it is often not relevant to what I might like to study. The psychological contract with my client entitles me to go deeper, but not really to change the subject and broaden it to some research concerns I might have. On the other hand, we know so little of organizational dynamics, especially at the power centers, that I am glad to be allowed a glimpse of any part of this dynamic process in

order to inform me on what I should in the future be studying.

VI. Implications for Education and Training

If we take this point of view seriously, what does it say about our graduate education and training. I would not wish to abandon the teaching of research as a logical process of thinking, nor do I want to abandon empiricism. In fact, my view of clinical research in that it deals with immediately observed organization phenomena is more empirical than much research that basically massages second and third order data. What is needed then is better training in how to be helpful and how to be a genuinely observant, inquiring person.

Some suggestions come to mind. Why dont we send all our graduate students off into organizations to help them with something. Would it be that hard to locate organizations that would take interns for six months to a year not to subject themselves to research but have an intelligent energetic extra hand to work on some immediate problems? The more immediate and practical the problems the better. Students would learn helping and inquiry skills fairly fast if they knew they would need them during their internship.

Why dont we teach our students basic interviewing and observational skills? Instead of learning how to analyze tests or surveys, students might spend more time analyzing the everyday reality they encounter in a real organization.

Why dont we use more clinical materials in our graduate programs such as the recent books by Hirschhorn (1988, 1991), Kets de Vries (1984a; 1984b), Levinson (1972) and others who try to lay out more systematically some of the dynamic processes they have observed?

Why dont we put much more emphasis on self-insight so that future clinician researchers can get in touch with their biases early in their career as a way of clarifying their vision?

VII. Conclusion

The bottom line to all this, then, is that we need clinical skills for generating relevant data, for obtaining insights into what is really going on, and for helping managers to be more effective. We need more journals and outlets for clinical research, for case studies that are real cases, not demonstration cases to make a teaching point. We need to legitimate clinical research as a valid part of our field and start to train people in helping skills as well as in research skills. And we need more insight into our own cultural assumptions to determine how much they bias our perceptions and interpretations of what is going on. Our whole field needs to recapture the spirit of inquiry that Warren Bennis so aptly described back in 1970's as the hallmark of organization development.

Now, am I preaching to the choir or am I a voice in the wilderness? My feeling when I look at journals and at meeting programs and at tenure review processes that I am a

voice in the wilderness, but am slowly gathering some support. I think the traditional positivistic research paradigm has shown itself too often to be an emperor with no clothes, so it is time to try something new. And that something new is to go back to good oldfashioned observation and genuine inquiry in situations where we are trying to be helpful. The ultimate challenge for the researcher is to find roles for herself in which she can be helpful, and the ultimate challenge for graduate education in our field is to train our doctoral and masters students in how to be helpful. Certainly our organizations need help. Isnt it more important to try to help them and learn in the process than to make a sacred cow out of a research paradigm that produces neither valid knowledge nor help. I think I am asking many of you to re-examine your own assumptions and to reframe your own thinking in a major way. Are you brave enough to try it?

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