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CHAPTER 11

COMPARING PSYCHOTHERAPISTS' AND CHANGE AGENTS' APPROACHES TO CHANGE:

Reflections on Changing People and Changing Organizations[1]

Léon de Caluwé, Frans Que and Hans Vermaak

Management consultants and psychotherapists have traditionally worked in separate arenas, crossing each other's paths only infrequently. Occasional meetings between the two, however, can turn into lively conversations that result from a recognition of each other's ideas and activities. This is especially the case when the consultants are specialists in change management and when the therapists stay clear of a medical model. As meetings between these professionals and their professions begin to increase, the overlap of their interests also becomes increasingly clear. Few would dispute that organizations can make people sick and that people, in turn, can damage an organization's health. Psychotherapists are spreading their wings beyond the health care system and are offering their services to organizations, while management consultants are attempting to change therapeutic institutions. Given this context, what can change agents and therapists learn from one another?

ORGANIZATIONAL CHANGE AND PSYCHOTHERAPY

There are several similarities between organizational change and psychotherapy:

- Both try to *affect change*. Both perspectives use and develop

theories that try to explain and predict processes of change. The basic premise is "if you do this or that, some specific outcome will result or at least become more likely." There is a search for causality, a hope of prediction. The contrast between changing people and changing organizations suggests more similarities than differences: changes within organizations take place by and for people, while people change in the context of their (organizational) environment.

- Both try to *further professionalism*. Based on theories in their respective fields, each approach acts methodically. Bodies of knowledge have been established that describe and categorize approaches, processes and instruments. Both groups also accept that a professional presence is important, which further stimulates professional and personal development through training, supervision, codes of conduct, and so forth.
- Despite this professionalism, both groups wrestle with the *limits of their profession*, especially in terms of causality and influence. Planned or intentional change fails more than it succeeds, and most organizational changes that do take place are unplanned, unintentional and spontaneous (Van de Ven, 2000).Where changes are planned, in both disciplines it is not always clear what actually causes things to happen. In many instances, contextual factors (like attention, patience, trust) seem to be more influential than the specific intervention per se (see, for example, Karasu, 1986; Mayo, 1933; Roethlisberger,

1941).

- Assessing the *effectiveness of their approaches* is a sensitive issue in both disciplines. It is difficult to measure effects, let alone prove that they can be attributed to a specific method of change. Change can be regarded as an observed or observable difference of some kind of trait or aspect of someone or something (a person, an interaction, an organization, a city) over a specific period of time. Any assessment involves so many choices (in terms of what are considered viable criteria, target groups, instruments, etc.) that demanding objectivity or cross-method comparison is often futile. This is especially the case when change focuses on less tangible matters. How do you measure that someone is happier, that cooperation has improved, that learning has deepened, or that an organization's culture has shifted? Beauty is in the eye of the beholder.

There are, of course, many differences between these professions as well. Therapists generally focus their attention on an individual or a small group (e.g., a family), whereas the object of attention for change agents is an organization or at least a substantial part of it. Organizational change intervention may involve hundreds of people. Remuneration also works very differently. Therapists' fees are often covered by health insurance, while clients pay the bill for organizational change efforts out of their own coffers. Therapists' fees are often also lower than those of consultants. Therapy can last a long time (sometimes years), while change agents generally have a shorter period to try to affect change. You have to be "in need" to get treatment by a therapist in the

health care system, whereas change agents will also work with you when you are healthy and strong.[2] Finally, therapists appear to be more cautious than consultants. They often terminate the therapeutic process, rather than the client, by stating "This is enough; you are ready." In organizational change, in contrast, the client typically terminates the contract.

Despite these apparent differences, the chapter explores some of the main similarities between the two professions. We initially look at how therapists and change agents have worked together and have learned from each other. The discussion then turns to an underlying obstacle in these interactions (as well as in writing the chapter) – the difference in language between the disciplines. Drawing on the dominant paradigms and perspectives of organizational change and psychotherapy, the chapter concludes with our thoughts about the two professions and how they might further benefit from each other.

Early Interactions Between The Professions

[Note: "Professions" rather than "Disciplines"? While therapy might be considered a discipline, organizational change is much more of a "field" than a discipline per se. OK?]

The backgrounds of both professions could hardly be more different. The world of therapy has a century old tradition of theorizing about and reflection on clinical practice. The works of Freud and Breuer (see Freud, 1895), for example, mark the beginning of a tradition with strong Germanic roots. Its growth takes place mostly in the arena of (mental) healthcare where its practitioners are well trained (e.g. as a psychiatrist or clinical psychologist) in specific tools and methods.

Our knowledge about organizational change, in contrast, has emerged from managers' and consultants' practical experiences. Its history of theorizing and teaching is, at best, half as

long as the history of psychotherapy. The contributions of Lewin (1951), Benne (19xx), Bradford and Lippitt can be regarded as the starting point of a tradition with strong Anglo-Saxon roots. Compared to therapy, its growth has largely taken place in the world of the "healthy." Change agents have rarely been specifically trained and have backgrounds ranging from forestry and photography to economics and information technology – as illustrated by the Dutch consultancy sector that was started by accountants, engineers and psychologists (Hellema en Marsman, 1997).

[re: green highlight above for Benne, Bradford and Lippitt – add reference]

Crossing over

It was a matter of course that psychotherapists would eventually begin working as consultants. As a natural evolution, they began to apply their therapeutic expertise to organizations, and quite a few have written about how therapeutic concepts can be used in the context of management consultancy. Psychoanalytic theories and concepts on group dynamics, as evidenced by the work of Kets de Vries (1984), Gabriel (1999), Kernberg (1984, 1998) and the Tavistock Institute, are the most frequently utilized.

[Much of the material that follows was too long for a chapter in the volume -- I cut it back, reworking it to focus on the main points. Please read it over carefully to ensure that I did not change the meaning of your arguments – and that the changes are OK.]

The general focus of this work was an attempt to reveal the hidden psychological processes in organizations. Kets de Vries (1984), for example, stressed how the neurotic, irrational behavior of a leader influences an organization's functioning in many subtle ways. His work traces how such neuroses can nourish irrational, and generally unproductive, organizational processes, thus magnifying the manager's neurosis to company levels. Similarly, Gabriel (1999) uses the psychoanalytic literature (e.g. Freud's postulations on libidinal and aggressive drives) to probe organizations, focusing

on the interrelationships between individuals' characters, the organization's culture, and the dynamics of leadership. Exploring topics like (primitive) fears, regression and control loss, Kernberg (1998) proposed a model that integrates the (psycho) dynamics of individuals, groups and organizations. As early as the 1940s, the staff of the Tavistock Institute developed learning interventions that were based on the same principles as group psychotherapy, and their interventions can be considered one of the roots of the Organizational Development (OD) tradition.

Working together

Although management consultants never really crossed over into therapeutic territory, there is a history of cooperation between both professions – most prominently in the area of coaching. While executive coaching has become a booming profession over the last decade, its background is much older. During the middle of the last century, different psychotherapeutic perspectives emerged that placed the individual's subjective experience above the therapist's interpretation. These schools later became known as humanistic psychology, and include Rogers (1942), the founder of client- centered therapy, Perls (1976) who started Gestalt Therapy, and Maslow's (1954) well known work on motivation.

While these theorists were all well acquainted with the then dominant schools of psychotherapy – Freudian psychoanalysis and behavior therapy – they were not satisfied with either. They disapproved of the power differences between therapist and client, especially the therapist prescribing expert solutions. According to them, therapists should base their work on real personal contact rather than relying strictly on methodology. Since psychoanalysis and behavior therapy used models based on a deep distrust of human nature, with all its primitive urges and dark impulses, these therapies

ultimately tried to control and regulate human nature. Maslow (1954), for example, argued that Freud supplied the “sick half” of psychology, while the humanists would rather focus on the “healthy half.” This way of thinking, thus, challenged prevailing practice. They did not consider an expert diagnosis and treatment plan as necessary, since therapists should trust the client’s lead. They placed more emphasis on the personal growth of the client (and the therapist) than on special training or special techniques. Rogers (1951) even distanced himself from the label “therapy” and introduced “counseling” to stress that his approach could also be used outside of the established mental health arena.

While some research backed their views, showing that laymen with the right attitude and a real interest in clients could achieve more success than trained professionals (e.g., see …) [provide a reference or two here]), these arguments deeply troubled the establishment. In the years that followed, however, many people from outside the therapeutic establishment became counselors, and up to the present both the humanistic perspective and the practice of counseling maintain their popularity. Therapy was no longer the exclusive treatment of clients with extraordinary sicknesses, but a way of providing support to ordinary people trying to come to grips with existential dilemmas central to life itself (e.g., life vs. death, free choice vs. destiny). Further influenced by the human potential movement in the 1960s, “therapy” ventured into the realm of self-actualization.

Although there are myriad labels for the process of supporting individual change, their methodological roots are harder to distinguish. Many therapists, for example, are eclectic, making use of Rogers’ ideas just as easily as counselors or coaches, while counselors and coaches are generally well aware of such psychodynamic concepts as transference and counter transference. It could even be argued that the main value in

using the labels of coaching/counseling versus therapy is in market positioning. Coaching is the label of choice for consultants to introduce methods from the therapeutic realm as a commercial service in their clients' organizations. It is also the label under which therapists expand their activities beyond the mental healthcare system. For our purposes, *therapy* will be used as a generic term for all the activities aimed at individual change, without regard to the label under which it might be positioned in the market.

Language Complications

Due to their separate histories, therapists and change agents developed different subcultures, each with its own language, making cross communication a complicated process: 1) change agents and therapists use different words for the same concept; 2) even when they do use the same word, they often have quite different meanings; and 3) both "steal" language from the other for metaphoric use in their own arenas. Where the first two could be regarded as problems, the third complication serves to enrich the two perspectives.

Same concept, different words

Both professions use similar concepts with regard to what triggers change. They both assume that for change to happen those involved must somehow: 1) be motivated to change, i.e., feel a need or desire to change, 2) perceive that the change is for the better, and 3) have the capabilities to make the change come about. Change agents and therapists both assess early on if these requirements are met. If not, their professional judgment will ["should"instead?? stop them from initiating a change effort. With respect to the above, change agents use the words *importance* and *urgency*. They check what interests can best be served and look for a sense of urgency. They begin their job when

enough of either is present and the organization has the "abilities" or "competencies" to make it a success (Blanken, 1994). Therapists, in contrast, use terms like *burden* and *load* to refer to the seriousness of the situation or the need for change. If the burden approximates or exceeds people's vitality or bearing capacity, then people suffer and experience distress. When such distress becomes semi-permanent, they speak of disease or illness.

Another similar but differently worded concept in both disciplines concerns the need to shed a different light on a client's problem right from the start. Dominant views, norms or values can be part of the problem and frustrate a change initiative. Change agents traditionally refer to this need as *unfreezing*, a "reduction in the strength of old values, attitudes or behaviors" (see, for example, Cummings & Worley, 1993). Therapists refer to it in terms of *pre-therapy* or *pre-contemplation*, a phase meant to raise a person's awareness that they have a problem and how the problem is actually affecting them. The clients' predicament is not that they cannot see solutions, but that they often cannot see their problems. Once they do, of course, they might still downplay the need to change, potentially feeling that "these are problems I can live with." The *contemplation* phase that follows is meant to encourage clients to move from a hope for change to a commitment to change and, in that sense, completes the reframing exercise. The client is now ready for treatment.

A last example concerns the term *counter transference*. In psychotherapy, the term describes the phenomenon that therapists may "project" their own unresolved and usually unconscious emotional conflicts and associated ideas, values and feelings onto their client. In doing so, therapists could potentially confuse their own problems with the problems of the client. This closely resembles "pigeon holing," as consultants categorize and place what they observe into "pigeon holes" because it reduces uncertainty and saves

the time required to treat each case as unique (Perrow, 1970). In doing so, they often define cases in terms of what they feel themselves qualified to handle. Consultants then offer their preferred solutions to clients, without properly recognizing the individuality of each client.

Same words, different concepts

An opposite type of language confusion concerns the idea of a *systems approach*. In change management, this approach refers to rather rational and analytic methods used for gaining insight into complexity by taking feedback mechanisms into account. To find such mechanisms, contributing factors are mapped and their causal interrelationships charted, which can lead to graphical representations, mathematical modeling, and simulations. In psychotherapy, a systems approach refers to the relations between the client and his or her significant others, in essence the social system in which he or she lives. If this social system has great influence on the functioning of the client, then improvement can only be expected when significant others, for instance a father or partner, participate in therapy sessions, becoming, in effect, a subject of therapy as well. For psychotherapists, the systems approach provides a viewpoint that informs their treatment decisions rather than an analytical endeavor employed to chart complex problems.

Intervention is another term used differently in the two disciplines. Therapists regard it as a single purposeful action. It can range from a remark or a question to a request or invitation. It is a very small part of a treatment plan outlining the approach and steps to be taken during the course of therapy. While change agents may also use the word intervention for something small, they generally reserve the word for a more comprehensive set of actions grounded in methodology (e.g., strategy analysis, culture

change initiatives).

A last example is the word *structure*. Therapists use it in relation to an individual's personality. It refers to the underlying characteristics and predispositions, usually rather stable, that lead to more or less fixed psychic or behavior patterns. These are normally hidden aspects that exert a great deal of influence over the individual. In change management, structure refers almost to the opposite. It concerns the most visible aspect of an organization – the formal division of tasks, responsibilities and authority. It is often the first thing people show you when asked what the organization looks like. It, too, is rather static, but it is relatively easy to change and is rarely believed to be the most influential aspect of an organization.

Use of metaphors

Images, words and language of one discipline can be used as metaphors in the other. A change agent, for example, may refer to an organization as a typical "borderline" organization. A "dip" in a group's development may be labeled as a "depression" and an organization's culture can be characterized as "schizophrenic" or a management style as "neurotic. It seems that therapists are much less inclined to borrow language or images from change agents, maybe because the academic status of their profession is not boosted by such verbiage. Therapists do, however, employ metaphors from other disciplines and share these with consultants. Good examples are machine and computer related metaphors. Therapists and consultants frequently use a computer metaphor, for instance, describing the ways that people and organizations deal with information.

Crafting Language

The three language problems discussed above can make comparisons between the disciplines more difficult. To complicate matters, the language within each discipline can be rather ambiguous as well. Elsewhere we have written that change management concepts are often misused or used to camouflage ideas that might be the exact opposite (Caluwé, 1997). As result, the professional language can become alienated from its underlying concepts. Similar conclusions have been drawn in relation to the therapeutic world (e.g., Kuiper, 1984). The challenge lies in re-analyzing underlying concepts and re-describing in ways that allow change agents and therapists to regain a language that allows for clearer and more meaningful communication with clients and with each other.

In this chapter, we use the term (management) consultant and change agent interchangeably, intended to include facilitators, process consultants, organization development practitioners, management experts, and so forth. Similarly, the term (psycho)therapist refers to the broad collection of psychiatrists, clinical psychologists, counselors, psychoanalysts and the like. *Change* refers to the key activity in both disciplines, only with a different primary client system: for therapists the client system is an individual (sometimes together with significant others); the client system for change agents is (parts of) an organization. *Client* is synonymous with patients, client system, persons or people as objects of the professionals' attention. In reference to their activities, change agents "do" interventions and therapists "do" therapy.

ORGANIZATIONAL CHANGE PARADIGMS

A range of meanings are given to the concept of *change* by managers and consultants alike, supported by a steady stream of experience, research and publications.

In previous publications, we stressed the need to distinguish these meanings and their associated theories (see Caluwé & Vermaak, 1999, 2002b). As a way of integrating these myriad perspectives, we suggested a model characterizing five families of change theories, each labeled by a color.

Yellow Print Thinking

This view is based on socio-political concepts about organizations, in which interests, conflicts and power play important roles (see, among others, Greiner & Schein, 1988; Hanson, 1996; Morgan, 1986; Pfeffer, 1981). Yellow-print thinking assumes that change only succeeds if the powers that be (including formal positions and informal opinion leaders) are committed to backing it up. This view assumes that actors change only if their own interests are taken into account, or when it is possible to compel them to accept certain ideas. Resistance and failure are seen as inevitable if a change effort does not have all, or at least most of, the key players on board. Combining ideas or points of view and forming coalitions or power blocks are favored methods in this type of change process.

Change is thus considered a negotiation exercise aimed at achieving feasible solutions based on consensus. This way of thinking fits smoothly with change processes where complex goals or effects must be achieved and in which more people or parties are involved in mutually interdependent ways. The color yellow can thought of as the color of *power* (e.g., symbols like the sun and fire) and of the type of process (e.g., coalition formation around a “log fire”) needed to bring about change.

Blue-Print Thinking

Blue-print thinking is characterized by a preference for the rational design and

implementation of change (see, among others, Hammer & Champy, 1993; Kluytmans, 1994). Project-oriented work reflects this approach (e.g., Wijnen, 1988; Wijnen & Kor, 2000), while Scientific Management is the most classic example (Taylor, 1913). In blue-print thinking it is assumed that people or things change when a clearly specified result is laid out beforehand. Each step is planned down to the last detail, and control over the result, as well as the path taken, is a managerial prerogative. Rational arguments rather than stakeholder interests are seen as the most important. Failure is thought to be inevitable unless all relevant facts and figures are taken into account.

Change agents, therefore, are inclined to select proven methodologies with reproducible results. Transparency, objectivity and efficiency are greatly valued. This way of thinking works well when change is focused on the "hard" aspects of an organization, such as organizational structure, systems or infrastructure. The color blue represents the type of *blueprint* (architectural) design that is drawn up beforehand and is "guaranteed" to represent the actual outcome.

Red-print Thinking

Red-print thinking has its roots in the classic Hawthorne experiments (see Mayo, 1933; Roethlisberger, 1941). This view assumes that people and organizations will embrace change when it is made attractive to them. In this way of thinking, it is important to stimulate and to inspire people, in essence seducing them into acting in accordance with desired goals. Care and personal attention, however, are also important. In recent years, the idea of Human Resources Management (HRM) and its related practices are representative of red-print thinking (cf. Fruytier & Paauwe, 1996; Paauwe, 1995; Schoemaker, 1994).

The main assumption is that people change in anticipation and response to formal

and informal rewards (e.g., salary, promotion, bonus, acceptance) or sanctions (e.g., demotion, rejection). An underlying concept is barter. If you give people a bonus, they will work harder. If you promote an individual, he or she will become more responsible. When you show care or interest in people, they will flourish and perform better. The aim is to have a good “fit” between what individuals want and the organization needs. The change effort often focuses on “soft” aspects of an organization, including management style, employee talent, and organizational competencies. Communication is a highly valued way to manage expectations and “sell” visions. The color chosen here refers to the color of blood, as people must be influenced, tempted and stimulated for change to succeed.

[Note: given the reference to the Hawthorne Studies I added the notion of formal and informal rewards and deleted performance evaluation in favor of “acceptance” and “rejection.” This seems to fit the social network aspect of the Hawthorne Studies more fully – change OK??]

Green-print Thinking

With its roots in action-learning theories (e.g., Argyris & Schön, 1978; Kolb, Rubbin, & Osland, 1991), green-print thinking came into its own with the emergence of Organizational Development in the 1950s (e.g., French & Bell, 1999) and has been further expanded in the more recent thinking on “learning organizations” (Senge, 1990; Swieringa & Wierdsma, 1990). In green-print thinking, the idea of “change” and “learning” have very similar meanings. People change when they learn. People are motivated to discover the limits of their competences and to involve themselves in learning situations. Learning is thought to be particularly effective in collective settings, as it allows people to give and receive feedback and to experiment with more effective

ways of acting.

The aim is to strengthen the learning abilities of the individual as well as the organization. Change happens when people and the organization learn. [Reversed this – OK??] Instead of prescribing top down outcomes for the change process, learning is viewed as most effective when people work toward their own learning goals and when they take ownership of their learning. This approach fits well with changes that focus on the developing people's competences, especially (semi) autonomous professionals. The color green was chosen because the objective is to get peoples' ideas to work, giving them the "green light." It also refers to the idea of "growth," as in nature.

White-print Thinking

The fifth view on change arose in reaction to Cartesian and Newtonian philosophies which can be characterized as deterministic, mechanistic and linear. Change is nourished by chaos, network and complexity theory (e.g., Checkland & Scholes, 1990). These perspectives strive to understand organizations as complex living systems whose behavior is life seeking with limited predictability (e.g., Bateson, 1984; Capra, 1996). Self-organization is a core concept. In white-print thinking, the dominant image is that everything changes autonomously on its own accord, that everything is in motion as captured by Morgan's (1986) "flux" metaphor. The time for change is when and where there is energy. White-print thinking assumes that failure results when we think we can change everything we want. It is assumed that it is more important to understand the areas of vitality in an organization, where such energy is inclined to flow, and to find means to support this dynamic so change will then take care of itself.

Complexity is thus viewed as an enriching, rather than disruptive, aspect of organizational life. Diagnosing the complex dynamics of a system and then creating

“room” for change is a favorite approach. Sense-making plays an important role in this approach as does removing obstacles for change, explicitly relying on the strength and character of people. External stimuli are deemed of lesser importance. The color white reflects the association with openness and spaciousness in that white-print thinking encourages self-organization and evolution. The outcome, being rather unpredictable, is often an adventure.

[You need to add a brief summary/transition paragraph here, drawing out the implications of these very different views of change.]

PSYCHOTHERAPEUTIC PERSPECTIVES

Since the beginning of the last century many different forms of psychotherapy have arisen, each with its own body of theory and frames of reference. Moursund (1993), for example, stated that in the United States more than 150 different forms of psychotherapy existed in the 1990’s. In the Netherlands, in contrast, a restricted number of psychotherapeutic schools are semi-officially recognized: psychoanalysis, analytic psychotherapy, cognitive (behavior) therapy, client centered therapy, group psychotherapy, and family or system therapy. Many authors have proposed other classifications for the range of psychotherapies (e.g., Van Kalmthout, 1991). For our purposes, we will draw on a classification based on Millon’s (1996) work on personality disorders.

In his classification, Millon (1996) distinguishes two *domains*, the functional and structural domains, a distinction borrowed from biological psychiatry. Millon (1996: xxx)states that people experience an inner world and an outer world, and claims that many *processes* are needed “to manage, adjust, transform, coordinate, balance,

discharge and control the give and take of inner and outer life." [Please add a page reference for this quote.] These processes, which he calls the *functional domain*, are connected with people's physiology and result in "expressive modes of regulatory action." There are four expressive modes within this domain: expressive behaviors, social conduct, cognitive processes and unconscious regulatory mechanisms. These processes take place in the present.

The *structural domain* is conceived as "substrates and action dispositions of quasi-permanent nature" connected with people's anatomy. ["substates" ??; also, please add a page reference for the quote] The important things that one experiences or encounters in life are somehow stored in one's brain. These memories, affects, attitudes, needs, fears, conflicts and so forth stem from the past, but they also shape, transform and sometimes distort the way people experience their life in the present. They even influence the way people are inclined to lead and experience their lives in the future. The structural domain contains predispositions to think, act and experience. While people are often unaware of the content of this structural domain, they sense its influence. Millon's (1996) work separates four structural elements: self-image, object representations, morphologic organization and mood/temperament.

Insert Table 11-1 About Here

Millon's distinctions are a useful means to classify psychotherapies. As illustrated in Table 11-1, each structural element, as well as each expressive mode, can be related to certain therapeutic perspectives. Classic behavior therapy, for instance, can be regarded as a form of psychotherapy focusing on expressive acts. The only exception is made on the intra-psychic level: psychoanalysis works both in the functional and the structural

domain.

[What about the Phenomenological level? The Table suggests that the functional and structural domains are appropriate for both?? Please clarify.]

The chapter focuses on six conversation-based psychotherapeutic strategies, since they have the most interesting parallels with organizational change strategies. Biological psychiatry, therefore, is not addressed in this chapter. These strategies, however, constitute a reasonable map of the field of psychotherapy. [Changes OK??]

Behavior Therapies

These therapies are rooted in behaviorism and in (single-loop) learning theories (e.g., Bandura, xxxx; Eysenck, xxxx; Lazarus, xxxx; Pavlov, 1897; Skinner, 1953). Strict adherents of the therapeutic tradition only accept objective observable behavior and events as a starting point and focus for therapy. According to this perspective, all behavioral patterns are "taught" through the use of past rewards and punishments, that is, through *conditioning*, regardless of whether it has come about by chance or by design.

Behavioral therapists are trained in analyzing how undesirable behavior has been stimulated in the past, for instance by situational incentives. They also understand the ways in which changing a set of incentives can lessen unwanted behavior and encourage some alternative pattern of acting. To accomplish such change, they design a program using interventions that have been subject to extensive empirical research. Behavior therapists are generally attached to the empirical basis of their practice and often stress their use of proven technology, typically staying in close touch with the academic arena and keeping up with scientific research as a way of updating their practice. Critics argue that behavior therapists focus too much on observable symptoms at the expense of less tangible causes.

Both the results and the therapeutic process are usually well defined, as protocols are followed and methods are carefully prescribed. Interventions are based on *exposure* (i.e., clients are exposed to feared stimuli in the safety of the therapeutic setting), *response prevention* (the therapist prevents the usual dysfunctional behavioral response, e.g., by calming the client down), and *positive reinforcement* of the desired behavior. The combination of exposure and response prevention can take different forms. One confrontational approach is *flooding*, where clients are brought to face their anxiety head on and not allowed to leave, as when people with fear of heights are taken to the top of a skyscraper. In *systematic desensitization*, clients are confronted in steps with situations that are increasingly anxiety provoking. Each successful step is positively reinforced by a small reward. Treatment of arachnophobia, for example, might start with some sessions in which clients are taught relaxation exercises. Gradually, clients are confronted with real spiders, first simply looking at them followed by touching and perhaps even allowing the spider to walk on the client's arm or hand.

Interaction-oriented Therapies

The basic tenet of this approach is that sources of crucial problems do not reside within people but result from what happens between people (cf. Kiesler, 1983; Leary, 1957; Sullivan, 1953). The quality of recurrent interactions with other people, especially those who have been or are still close to us, are import determinants of how we develop and experience ourselves. It is assumed that each person has a specific set of preferred behavioral patterns. Because of this behavioral set, a person "forces" others to behave in complementary ways. As such, they not only restrict others' actions but also evoke reactions that confirm the way they think about themselves and about the world. While there is typically sufficient flexibility within these patterns that we can function

adequately in daily life, at times these interactions can turn into rigid patterns.

Clients are often not aware that they are trapped in counterproductive interaction patterns. To raise their awareness and explore alternatives, they must be trained by a therapist in meta-communication (communication about the way they are communicating) preferably without repeating the same problematic interactions. Since therapists are typically well trained in recognizing these interaction patterns, the fact that persistent patterns are bound to emerge in the therapeutic relation itself makes them easier to spot. The therapists' awareness of their own thoughts, feelings, associations and reflexes serves to help them to identify the client's interaction patterns and the likely effects they will have on other people.

The therapeutic setting can vary. It can be a one-to-one setting, working with the client and his or her family, or with a group of clients (together with another therapist). The advantage of a larger setting is that it allows for more interaction patterns with which to work. Also in family therapy one might work very closely with the actual roots of the interaction patterns, improving one's ability to address them. In group psychotherapy, interaction patterns also tend to repeat themselves between the client and individual group members.

Cognitive Therapies

Cognitive therapies are based on concepts and theories connected to different modes of learning (cf. Beck & Beck, 1990, 1995; Beck & Freeman, 1990; Ellis, 1962). The basic assumption is that the way people think has enormous influence on how they live and experience their lives. According to cognitive therapists, recurrent problems arise from dysfunctional convictions rooted in dysfunctional thought patterns, ranging from selective abstraction, thinking in dichotomies, arbitrary deduction and over-

generalization to catastrophic thinking. People can experience a distorted sense of reality as a consequence of such patterns, escalating relatively minor incidents into far more significant, potentially life challenging situations. A simple thought literally snowballs toward an avalanche of more distorted and pervasive ideas. Because people base their action, at least in part, on their perception of reality, their actions often perpetuate their beliefs.

Cognitive therapists assume that different ways of thinking can create a different experience of reality. This different experience, in turn, can lead to new behavior, transforming a vicious circle into a learning one. They analyze the problems their client brings to a session, chart thought patterns and attempt to uncover the convictions that accompany both. Cognitive therapists are usually quite active and will ask many questions to get to the underlying convictions that spur the dysfunctional ideas. After analyzing and categorizing the dysfunctional cognitions, they challenge their credibility, a process that can be quite confronting and often meets with resistance. Positive experiences gained in such interactions, however, help ground new viewpoints and anchor the changes that are undertaken.

Client-centered Therapies

The two main approaches within this humanistic perspective are Rogers' (1942) client-centered approach and Perls' (1976) Gestalt therapy. In both approaches, the concept of self image is very important. It is assumed that the notion of oneself – the notion of "I" and "me" – gives people a sense of stability in an ever changing world. These therapists also assume that each person has both an inherent potential and a natural tendency to grow. Instability or a lack of development is caused when natural learning processes are blocked, which over time results in a disturbed self image.

Because people posses an inclination for growth, it is not necessary to restore this disturbed self image through harsh invasive methods. Instead, it is thought that the answers to an individual's questions lie within that person. The most important thing therapists need to do is create a setting that allows clients to reestablish contact with who they are. Clients are then stimulated to explore their experiences, specifically those that puzzle them. By focusing on their experiences and reevaluating them, clients can recommence learning. Feelings and thoughts do come up, but their content is not essential. The underlying keys are the extent to which clients can focus on their own experiences and have trust in their own spontaneous development.

Client-centered therapists have only one mission – to ensure that the therapeutic relationship establishes optimal conditions for growth. No brilliant analyses, no strict protocols, no shocking reframing of viewpoints. The client already possesses all the brilliance, stamina and vitality needed. Growth emerges from the quality and character of the therapeutic relationship. For this, the attitude of the therapists is more crucial than specific interventions. Important process conditions are respect, genuineness, unconditional positive regard, accurate emphatic understanding and a commitment to the clients' development. The relationship is non-hierarchical. Therapists are not the experts; the client is considered the expert of their own lives.

An important off-shoot of the humanistic school is existential therapy. The main subjects addressed in existential therapy are the universal dilemmas of human existence: life and death, fate and free choice, the meaning or meaninglessness of life, independency and isolation, and so forth. [Is this needed? You don't really delve into this and it could easily be cut. I don't think it adds anything. – cut it out??]

Analytic Psychotherapies

The basic view of this school is that every person is a product of his or her life's experiences. According to psychoanalytic theories, persistent problems are caused by unconscious inner conflicts that are rooted in childhood experiences. While analytic psychotherapy makes use of these theories, it emerged as a separate approach much after Freud's time. In this approach, therapists look at "object relations," i.e., important relationships in one's past (with the associated events, situations, people, feelings and so on), that still heavily influence the way the individual looks at, thinks about and experiences the present. Intimate relationships during childhood are seen as especially important. These early impressions, sometimes called object representations, can distort people's perceptions of present day life and lead to repetitive behavior, both by clients and, as a result, also by their counterparts. This dynamic can thus lead to clients recreating the same types of relations over and over.

In contrast to classical Freudian thinking, these therapists do not regard adult psychopathology as a mere repetition of childhood conflicts. They think that experiences later in life can have great influence as well. As a result, they try to rework important and conflicting themes in the present. They do not go as far as interaction oriented therapists, however, who try to directly influence present day relations. Instead they first attempt to understand how present day relationships (including the one with the psychotherapist) can be understood in light of the client's past relational anxieties and conflicts with significant others. For this reason a client's biography becomes very important for charting object relations. Therapists try to make clients aware of object relations and their unwanted influence, and try to free them from unrealistic perceptions and feelings associated with their present relationships.

Therapists are very active in this approach. They ask questions, give feed back,

confront the client and give interpretations. This is not to say they lack confidence in the client's ability to develop and heal, but in contrast to Rogers' client-centered approach they do not believe that such growth happens spontaneously. They believe that expert guidance and interpretation are required. If therapy succeeds, then clients will be free (or at least freer) from re-experiencing their past and be more open to new experiences. They generally will feel an increased sense of reality. Since successful treatment often releases the energy required to shield things from one's unconscious, clients generally feel more vibrant and more self control.

Psychoanalysis

Similar to analytic therapists, psychoanalysts also focus on internal unconscious conflicts originating in a client's past. Such object relations, however, are not sufficient to explain or treat such conflicts. For psychoanalysts, problematic perceptions, thoughts and interactions are shallow manifestations of hidden, defended and unconscious feelings. Psychoanalysis assumes that problems stem from a person's past inability to deal with strong emotional pain. In order to cope, people develop defense mechanisms to limit their awareness, allowing feelings to stay hidden. A great diversity of defense mechanisms exist, ranging from … to … [note 2-3 defense mechanisms that you think appropriate] (see Freud, 1966; Kuiper, 1984), and they are engrained over time and become part of an individual's personality structure.

Consequently, treatment is not easy and is generally quite lengthy. Psychoanalysts postulate that if a client's personality can be "reconstructed," these defense mechanisms will loose their reason for being and clients can let go of them without negative consequences. While reconstruction requires the source of painful emotions to be uncovered and fully worked through, only then can clients begin to live

in emotional freedom. Because clients are not aware or conscious of these painful emotions, special techniques are needed to search for them, such as free association and dream analysis. Once anxieties and defense mechanisms are brought into the open, they can be analyzed, understood and addressed. As a result, the client's mystical world becomes a more familiar place. The pace at which this happens is determined by how much a client is able to bear emotionally.

ORGANIZATIONAL CHANGE AND THERAPY: POINTS OF DEPARTURE

Drawing on the two preceding sections, the chapter turns to an exploration of the similarities and differences between the various approaches to organizational change and therapy. We are well aware that such an endeavor is not to be taken lightly and our analysis is not intended as either comprehensive or exact. Instead, the effort should be regarded as a first venture, meant to encourage further and more substantial dialogue. To facilitate comparison, we will draw on a series of tables that summarize the basic characteristics of the different approaches to organizational change and psychotherapy.

Insert Tables 11-2 and 11-3 about here

As suggested by a comparison of Tables 11-2 and 11-3, there are several similarities in the assumptions underlying the different paradigms. For example, the blue-print world of thought – with its tendency to work according to plan, to focus on observable aspects of reality, to work with analytical schemes and to rely on experts – has considerable overlap with behavior therapy, analytical psychotherapy and psychoanalysis. The red-print emphasis on relationships, emotional well being, barter, and interaction corresponds to interaction-oriented therapy and client-centered therapy.

Green-print essentials – like the use of feedback, tight coupling between thought and action, creating safe environments and working with mental models – are also found in interaction-oriented therapy and cognitive therapy. Spontaneous development, removing obstacles, building on self-confidence and authenticity are aspects of white-print thinking, which are also imbedded in client-centered therapy. While there do not seem to be many yellow-print characteristics in therapeutic approaches, this approach might be relevant when dealing with conflicting aspects in an individual's personality structure (psychoanalysis). Yellow-print thinking may also have some applicability in systems therapy and group therapy, where several people are involved. Finally, it might also be useful in delineating who should be part of the client system (a decision to be made by the therapist at the beginning of treatment) and in drawing up (psychological) contracts between the client (system) and therapist.

A comparison of Tables 11-4 and 11-5 also reveals a number of similarities in types of interventions. Blue-pint approaches tend to be rational, analytical, strongly planned and procedural, often focusing on visible behavior – with strong overlaps with behavior therapy. Analytical psychotherapy and psychoanalysis also reflect blue-print thinking, although they focus on non-visible behavior. Red-print aspects like an emphasis on feelings, interactions, communication and empathy can be found in both interaction-oriented therapy and client-centered therapy. Green-print characteristics, including questioning, expressing, giving feedback, reframing, are part of cognitive therapy and client-centered therapy. Client-centered therapy's emphasis on specific process conditions also has many similarities with white-print change. Once again, similarities between yellow-print thinking and the different therapeutic approaches seem to be limited.

Insert Tables 11-4 & 11-5 about here

The role of the rational, procedural and analyzing expert in behavior therapy and psycho-analysis suggest commonalities with blue-print change agents. Interaction-oriented therapy and client-centered therapy focus on interactions within the therapeutic relationship and the experience of the client – essentially red-print characteristics. Being a role model, a fellow inquirer, and someone who mirrors and co-explores reflect green-print aspects of cognitive and interaction-oriented therapy, while trust, authenticity and acceptance are key white-print features of a therapist in a client-centered approach. [Nothing about yellow-print thinking? You should add some brief comparative statement here.]

Tables 11-6 and 11-7 also reveal outcome-related similarities. Blue-print notions about predictability, efficiency, and controllability are also found in behavior therapy. In contrast to the underlying assumptions and processes noted above, overlaps between the intended outcomes of blue-print thinking and analytical psychotherapy and psychoanalysis are limited because of … [brief summary statement here.]. White-print change and client-centered therapy are similar in their inability to either pre-define results or predict how they will come about. Red-print and green-print approaches can be somewhat pre-defined and predictable and, in that respect, occupy the middle ground in organizational change, as do interaction-oriented therapy and cognitive therapy in therapeutic change.

Insert Tables 11-6 and 11-7 about here

The idea that the future is in our hands and that we can construct and shape it is

reflective of both blue-print organizational change and behavior therapy. Satisfying relationships and a pleasurable life are red-print ideals of interaction-oriented therapy and cognitive therapy. Gaining more effective ways of thinking, rich insights, a new perspective of life, and freedom from limiting cognitions are typical green-print characteristics of cognitive therapy, analytic psychotherapy and psychoanalysis. The ideals of client-centered therapy overlap with white-print ideals: building (on) self-confidence, increasing vitality, and having a deep experience of one's own life. There are also parallels when it comes to limitations – for example, learning can be as marginal in behavior therapy as in blue-print changes, while meaningless "fiddling" and focusing too much on one's own experiences are pitfalls of white-print change and client-centered therapy. Finally, yellow-print thinking seems to be … [it is awkward to simply abandon yellow-print thinking without a least a brief explanation/note; can you add something?]

As this brief discussion suggests, there are a number of interesting connections between different approaches to organizational and therapeutic change. Most of the overlaps are constant throughout the Tables. Only the yellow-print approach is hard to match with therapeutic perspectives. To a much lesser degree, the same holds for matching analytical psychotherapy and psycho-analysis with approaches to organizational change.

Paradigm Shifts

Hunt (1991) suggests a continuum between objective and subjective perspectives on the nature of science. At one extreme is a mechanistic image of the world where science is considered a rational empirical endeavor and social reality is viewed as a concrete structure. At the other end of the spectrum is a transcendental concept, in which

reality is seen as a projection of human imagination, that reality takes place within people's minds. [Note: suggest dropping the Figure – it's not yours and it add a layer of complexity that isn't necessary beyond the objective-subjective distinction – OK??]

There are strong indications that there are slow paradigmatic shifts taking place along this continuum (Caluwé, 2001). The classic (objective) approach to change within organizations involved experts attacking problems rationally and coming up with detailed plans of action (solutions). This approach has been increasingly challenged by clients, especially those who wanted to contribute their own meaning to their problems, participate in change processes, and collectively create new realities. The trend in change management is moving away from thinking in concrete, coherent and consistent objective terms toward greater recognition of the (subjective) ambiguities, complexities, irrationalities and chaos in organizational life. Change agents appear to have over-relied for decades on blue-print and red-print change approaches. Green-print and white-print views are now getting more attention, if not always in actions then at least in words. [Anything about yellow-print thinking?]

Psychotherapy, partly under the influence of consumerism, has, over the years, also shifted away from its origins based on (objective) content-driven approaches and expert roles. Clients may come to therapy now with their own questions and issues, but also with their own (subjective) preferences on the method of treatment and therapeutic objectives. Recent trends suggest that some clients are even taking control of the healing process, using therapists as a resource rather than the other way around.

These shifts, of course, do not occur without resistance and counter actions. Among organizational change agents and their clients, for example, we still observe the desire for "instruction manuals," seemingly objective descriptions of indications and counter-indications of interventions, stating when and how they should be employed and

what their side effects might be. Among psychotherapists (and the insurance firms that pay for many therapeutic treatments) this preference is mirrored in the desire for treatment protocols and evidence-based approaches, which favor those therapies (and therapists) that focus on clear procedures and concrete behaviors. Similar debates can be traced back to ancient Greece and appear to be part of an ongoing pendulum-type movement between objective and subjective approaches (e.g., Kendell, 1975) that is likely to continue well into the foreseeable future.

Toward multi-conceptuality: Using contrasting viewpoints

Multi-conceptuality is a trait of the more subjective approaches. It is assumed that many different and contrasting ways exist that enable us to understand and describe the complexity of reality. Multi-conceptuality involves making use of several conceptual viewpoints, even if they conflict with each other (e.g., Millon, 1996). This is possible and even desired in diagnostic pursuits: looking through several "lenses" increases the richness of the diagnostic outcome. We have even postulated that change agents create "blind spots" and miss important pieces of the diagnostic puzzle when they fail to take all five color paradigms into account when looking at an organization (Caluwé & Vermaak, 2002a). In their intakes and pre-diagnoses, therapists and change agents both observe that applying multiple perspectives contribute to a richer insight. Sticking to one approach or school of thought, while possibly allowing for greater consistency, obstructs such insight. In line with postmodern perspectives, professionals appear increasingly to enrich their diagnosis by eclectically using different theories.

Trend towards integration: Applying meta-theoretical design

Integration across these different approaches also plays an important role,

especially in the therapeutic treatment of clients with complicated problems. The reflex to choose a treatment from one's own familiar school of thought, can, in those cases, be counter balanced by an awareness of its limits and the possibilities that other treatments may offer. In this respect, only multi-conceptual diagnosis provides sufficient information to allow for well-reasoned choice. Yet, while it might be possible to look beyond one's own preferred paradigms, it is far more difficult to operate in less familiar arenas. Therefore, the treatment design can best be executed with the involvement of different types of therapists. This can result in a consistent and well thought out treatment plan, which delineates the roles, tasks, actions, responsibilities and qualifications of the various therapists to be involved in the treatment process.

A similar development can be observed in the arena of organizational change. In an intervention plan, actions that are derived from different paradigms (colors) are often combined. Sometimes a project approach (blue-print) is used in one part of the organization, while in another the managers participate in a management development program (green-print). In another change effort, communication efforts might be used to prepare people for using a new IT system and motivate people to use it: a red- and blue-print approach might be used to support each other. Here too, the design of the intervention plan can best be undertaken together, with multiple change agents involved to assure the "colors" and their different approaches do not work against each other. As part pf the design, roles, phases, outcomes, responsibilities, and so forth are defined for later implementation by the various change agents.

The willingness to combine interventions (parallel or sequential) evokes the need for design criteria. As such, a meta-theory can be of help. De Haas (2000), for example, has developed a scheme for integrative therapy, in which he draws together insights and approaches of different therapy schools. He presents a model with four factors that

serves as a therapeutic meta-theory. The central tenet is that the dominant factor in the diagnosis implies the main method of treatment:

1. **Personality**: characteristics or features of a person, including drives and urges, motives and interests. Treatments of choice are psychoanalysis or analytical psychotherapy.
2. **Circumstances (that promote vulnerability)**: some situations invoke or produce problematic behavior. The preferred treatment is interaction oriented therapy.
3. **Embeddedness in society**: refers to participation in a larger network, such as the family, work groups, or friends. Does the individual have a stable working environment and career perspective? Embedded problems are often best addressed with a systems approach.
4. **Skills**: abilities required for daily life, but also social skills, societal skills and professional skills. The treatment of choice is behavior therapy.

There are interesting parallels between this therapy-based meta-theory and color-print thinking. It is increasingly assumed that, in order to survive in the long run, organizations need to have all the “colors” balanced, even though they have conflicting principles. This essentially means that a balanced or sound organization has to cope with the paradoxes that result from these conflicting principles. Thus, if a color is absent in an organization, there might be a need to include that perspective when planning the intervention. For instance, a firm of engineers with blue-print management tendencies

might not want to approach quality control in a standard blue-print way (e.g., ISO 9000 handbooks), especially if this has been applied many times before with decreasing success. Instead, some creative young managers (green-/white-print) might be requested to experiment with quality circles (green-print). Yet, while a transition to an unfamiliar "color"/approach for the engineering firm might contribute to more favorable outcomes, this type of mental shift also requires significant effort and adjustment.

Other parallels can be drawn between De Haas' (2000) integrative model and color-print thinking. Personality, for example, has similarities with action theory in which the motives and interests of individuals are highlighted (yellow-print). Circumstances and red print-thinking are related, in that people are seduced, tempted and punished. As a result, certain behaviors are evoked by changing people's circumstances. Societal embeddedness overlaps with blue-print thinking: careers, work and family are seen as hard and visible (structural) features of an individual's position and performance. Finally, skills develop through green-print learning initiatives. These parallels, of course, raise many questions and are by no means set in stone. A tendency toward this type of integration, however, seems increasingly evident and inevitable.

Trend towards autonomy: Focused and authentic behavior

Diagnosis and design are intellectual, cognitive exercises. One might be able to "play" with a diversity of models and viewpoints during diagnosis and even design beyond one's own school of thought, but acting beyond one's own paradigm and schooling is an entirely different matter. In essence, integrative acting is not a possibility. Change agents and therapists are generally only capable of skillfully executing a limited part of the spectrum of all possible interventions or treatments. In fact, their role often becomes blurred and unclear when they try to accomplish too many

different things at the same time, damaging their credibility in the eyes of clients. A change agent can only “act” in one “color” at a time. So the fit between the intervention, the client system and the change agent is very important in the arena of organizational change – just as important as the fit between the treatment, the client and the therapist in personal change. It implies that therapists and change agents should be aware of the limits of their competences. What concepts and approaches are they capable of effectively working effectively work with? Respecting one’s limits contributes to a high degree of professionalism. It also corresponds with a common vision and practice in the therapeutic arena that designates diagnosis and treatment as two distinct phases. If an intake shows the client requires a treatment alien to the person doing the intake, then a switch to a different therapist for treatment makes sense and is best facilitated by the existence of separate phases. In organizational change, unfortunately, such separation is much less common.

WHERE DO WE GO FROM HERE?

Given the exploratory character of the chapter, although much ground has been covered and many parallels highlighted, we have only brushed the surface of the subject matter. Rather than trying to draw firm conclusions, we prefer to let the ideas mature, to be further explored at a later date. Some preliminary reflections, however, seem in order.

Although there have been significant rifts and rivalries between the different therapeutic schools, we are moving toward a greater inclination to make use of each others’ ideas, to combine different methods, and to even strive for an integrative approach. Change agents, too, have had their battles and debates between adherents of different approaches. Yet, within this field as well the idea is also taking ground that different perspectives should not be routinely discarded, especially since they could be

contributing to difficulties in trying to affect change. In both arenas, eclecticism appears to be taking firm root.

Such eclecticism raises interesting questions about professionalism. Does someone become a (top) professional only he or she can work across disciplines, knowing all the schools of thought and applying them when needed? We do not think so. While it appears to be desirable to know about each of the approaches and what each has to offer, it is neither necessary nor feasible to be able to effectively implement all of them oneself. Change agents and therapists not only have their personal preferences, but also different dispositions, different experiences and different abilities in terms of the different approaches. They can never be effective across the board. This suggests that true professionals are selective in accepting only clients that suit their ability and refer the rest to colleagues.

In comparing both disciplines, we find there are many similarities between the approaches of change agents and therapists. Their language and jargon may often be different, but the concepts and ideas conveyed by them are much more alike and applicable beyond each separate arena. This confirms what we know from experience – change agents and therapists have much to offer one another and much to learn from each other.

There seems to be a growing convergence between both types of practitioners. While changes agents have always borrowed ideas from the therapeutic arena, such borrowing appears to be on the increase (e.g. Kets de Vries, 1984; Gabriel, 1999), possibly due to the growing interest in green-, red- and white-print approaches to change. In these approaches, the human psyche plays a dominant role. It has only been in recent years that therapists have begun to seek inspiration from the arena of organizational change. The more academic tradition and status of the therapeutic world

may have discouraged taking knowledge about organizational change all too seriously.

Convergence can also go one step further beyond borrowing ideas to actually working together with clients. This assumes that the disciplines might well compliment each other. Organizational change might be more effective if therapists addressed personal development or resistance. Similarly, therapy might be more effective if an individual's environment also received "treatment," extending a systems approach from including family members to incorporating a complete work environment. Such cooperation between the two disciplines is visibly present when it comes to executive coaching: professionals using therapeutic methods in a workplace along side and in concert with other change efforts.

Such inter-profession cooperation could easily include many other possibilities. Some words of caution, however, are in order. This kind of cooperation can only develop if there is complete transparency and full agreement with the client (system). Employees should not be forced into therapy in the workplace nor should therapeutic clients be confronted with parallel change efforts targeting their surroundings. It might be tempting for professionals to explore each others domains and apply each others methods, but this can also pose new problems. As much as eclecticism within each arena has its limits, given personal dispositions and abilities, eclecticism between disciplines is even trickier. Therapists should not relinquish their caring and loyalty to an individual client in favor of focusing on functional criteria that would, perhaps, better serve the organization. Change agents, in turn, should not put individual interests above collective interests: they are obliged to have the system's interest at heart rather than any one individual (like the CEO). Respect for each other's skills, concepts and experience, as well as associated roles and professional codes is a precondition for any further convergence and learning between both practices.

NOTES

1. An earlier version of this paper was presented as part of the Management Consulting Division program at the Academy of Management meeting in Seattle, Washington, August, 2003. The chapter is developed from the supposition of the three authors (two are consultants with some experience in coaching; one is a psychiatrist/ psychotherapist with some experience in consulting) that there are many parallels between organizational change and psychotherapy. We invited colleagues from both professional arenas to explore this idea further in group conversations spread out over a year. One of the participants, Ernst Marx, has recently deceased. We dedicate this chapter to him in remembrance of his great personality and his many contributions to our professions.
2. Executive coaches, who might be thought of as "therapist change agents," work in between these arenas – a point that will be explored more fully in the chapter. [Note: I moved this as a footnote and added the "therapist change agents" – OK??]

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	Functional Domain	**Structural Domain**
Behavioral level	• Expressive acts: Behavior therapies • Interpersonal conduct: Interaction oriented therapies (system psycho-therapies)	
Phenomenological level	• Cognitive style: Cognitive therapies	• Self-image: Client centered therapies • Object representation: Analytic psychotherapies
Intrapsychic level	• Regulatory mechanisms: Psychoanalysis	• Monophological organization: Psychoanalysis
Biological-Physiological level		• Mood/Temperament: Biological psychiatry

Table 11-1 Millon's Functional and Structural Domains

Types of Change	*Things/people will change if you ...*
Yellow-print	• can unite the interests of the important players. • can compel people to accept (common) points of view/opinions. • can create win-win situations/can form coalitions. • demonstrate the advantages of certain ideas (in terms of power, status, influence). • get everyone on the same wavelength. • can bring people into a negotiating process.
Blue-print	• formulate a clear result/goal beforehand. • lay down a concrete plan with clear steps from "A" to "B." • monitor the steps well and adjust accordingly. • keep everything as stable and controlled as possible. • can reduce complexity as much as possible.
Red-print	• stimulate people in the right way, for example, by inducements (or penalties). • employ advanced HRM tools for rewards, motivation, promotions, status. • give people something in return for what they give the organization (barter). • manage expectations and create a good atmosphere. • make things attractive for people.
Green-print	• make people aware of new insights/own shortcomings. • are able to motivate people to see new things/to learn/to be capable of. • are able to create suitable (collective) learning situations. • allow the learning process to be owned by the people involved and geared toward their own learning goals.
White-print	• start from drives, strengths and the 'natural inclinations' of people. • add meaning to what people are going through. • are able to diagnose complexity and understand its dynamics. • give free reign to people's energy and remove possible obstacles. • Make use of symbols and rituals.

Table 11-2 Assumptions behind different paradigms of organizational change

	Something Will Change If You ...
Behavior therapies	• take the observable behavior of people as a starting point. • analyze the incentives for desired and unwanted behavior. • reward desired, functional behavior in a conditioning process. • use scientifically proven protocols.
Interaction oriented psychotherapies	• make the patient aware of dysfunctional patters of interaction. • show how these interaction patterns repeat themselves in the here and now. • use the micro-cosmos of the therapeutic relationship as an arena for learning. • practice new interaction patterns in a safe environment. • (when necessary) surface and discharge underlying emotional tensions.
Cognitive therapies	• track and identify recurrent problems. • analyze fixed dysfunctional thought patterns, that produce these problems. • help people think differently by exploring alternative frameworks during therapy. • help people experience the effects and consequences of these different ways of thinking and support them in choosing an empowering perspective.
Client centered therapies	• believe in the people's potential for spontaneous and limitless growth. • explore and accept the clients' feelings and experiences. • trace what blocks people's development and help them to overcome these. • stimulate self confidence towards a healthy and robust self image. • have an authentic, honest and respectful relationship with both the client and oneself.
Analytic psychotherapies	• are able to trace unconscious inner conflicts. • chart how these conflicts have developed over time in the client's relations with significant others. • stimulate the client's awareness that his world view might fit the past, but distorts the present. • have clients re-experience and realize their entrapment. • bring clients to detach themselves from what scares them and to choose freedom instead.
Psychoanalysis	• track internal conflicts that cause severs anxiety. • identify the mechanisms with which the patient locks these conflict in their unconsciousness. • can characterize the client's personality structure based on these insights. • make the patient aware of these unconscious conflicts and avoidance mechanisms and work through them. • help the patient reconstruct his personality structure once old traits have lost their function.

Table 11-3 Assumptions behind different psychotherapeutic perspectives

	Illustrative Interventions	Role and Focus of the Professional
Yellow-print	• forming strategic alliances • conclave methods • arbitration, mediation, negotiation • top restructuring, policy making • protégé constructions, outplacement	• facilitator who guards his own power base and uses it when necessary • change agent focuses on positions and context
Blue-print	• rational planning and control, management by objectives, auditing • project management, business process redesign • strategic analysis, benchmarking • decision procedures, time management	• expert who takes full responsibility for the implementation and monitoring of progress, if mandated to do so • change agent focuses on expertise and results
Red-print	• HRM systems, like reward systems • planning of diversity, mobility and careers • social activities, management by speech • job enrichment, job enlargement • situational leadership, team roles	• a procedure expert, who elicits involvement and sometimes advocates particular solutions too • change agent focuses on procedures and atmosphere
Green-print	• giving feedback, mirroring • quality circles, open systems planning • coaching, inter-vision • gaming, clinics • teambuilding, training	• facilitator/coach, who supports people to solve their own problems, who is empathic and knows didactics • change agent focuses on setting and communication
White-print	• recognition of “hidden” patterns, “feedforward” • challenging status quo, sense making • self-steering teams, T-groups • search conferences, open space meetings • personal growth, networking	• personality, who tries to catalyze forces and uses himself as an instrument • change agent focuses on patterns and persons

Table 11-4 Processes related to different paradigms of organizational change

	Interventions such as ...	**Role and Focus of Professional**
Behavior therapies	• exposure and response prevention • flooding, relaxation exercises • systematic desensitization • aversion treatment • positive and negative reinforcement	• procedure-expert (analyzing, instructing, guarding and reinforcing) • the therapist focuses on client behavior and situational stimuli
Interaction oriented psychotherapies	• express how ones own interaction patterns relates to the client's interaction patterns • make schemes of the various interaction patterns • disturb and frustrate interaction patterns in the therapeutic relation and introduce new ones	• co-investigator and role model in terms of his interactions (analyzing, exploring, mirroring) • the therapist focuses on the interaction in the therapeutic relation
Cognitive therapies	• ask questions (Socratic method), analyze and categorize thought patterns and beliefs • feed back people's though patterns and deconstruct ways of thinking • reframe reality, explore alternative view points and assist a patient to experience these	• analyzing expert (asking questions, categorizing, reframing) who is also role model in terms of flexibility of viewpoints • the therapist focuses on cognitions and their consequences
Client centered therapies	• creating a therapeutic setting that communicates trust in the client's innate abilities • horizontal communication and active listening • having people explore their experiences focusing • empathy and self disclosure	• partner in therapeutic conversations (accepting and nondirective) and a role model in authenticity and self-confidence • the therapist focuses on the patient's experience of self and on his human potential
Analytic psychotherapies	• using the people's life history to clarify their 'object representations', how they themselves in the world • making people aware how their object representations disturb reality, including the reality of the therapeutic relationship • making people aware and work through underlying conflicts	• analyzing expert (supporting, questioning, giving feed back, confronting) • the therapist focuses on how the patients worldview is distorted
Psychoanalysis	• free association, dream interpretation • interpretations and confrontations • reconstruction of the personality structure • analysis of defense mechanisms, transference and counter transference	• analyzing expert (sounding board, interpreter, confronter) • the therapist focuses on fantasies, the patient's magical realm

Table 11-5 Processes related to different psychotherapeutic perspectives

Types of Change	Tangibility of Results	Ideals	Pitfalls
Yellow-print	• result is largely unknown and adjusts along the way • process id difficult to predict	• focusing on common interests and achieving common ground • establishing win-win solutions and feasible deals	• building castles in the air • destructive power struggles
Blue-print	• result is defined beforehand and guaranteed from the start • process (path) is predictable	• the future is in our hand and we can construct it • establishing the best solution (especially for 'hard' organization aspects)	• steamroller over people and their feelings • ignore irrational and external aspects
Red-print	• result is pre-mediated, but cannot be guaranteed • process is reasonably predictable	• optimal fit between individual aspirations and organizations goals • a motivating, pleasant solution especially for 'soft' organization aspects	• sparing the rod, … • avoiding conflicts, ignoring power games • smothering extraordinary individuals
Green-print	• result is pre-mediated but cannot be guaranteed • process is difficult to predict and co-produced along the way	• learning organization: learning with everybody, about everything, always • solutions that people develop themselves and that are owned by them	• ignoring the fact that not everybody is willing of capable of learning • lack of priorities and decisiveness, excess of empathy and introspection
White-print	• result is not defined in advance • process is unpredictable (The purpose resides in the process itself)	• spontaneous evolution, going with the flow, "lucky" coincidences • 0ptimal conflict level and making use of crisis	• ??????? detail here ???

Table 11-6 Outcomes related to different paradigms of organizational change

	Tangibility of Results	**Ideals**	**Pitfalls**
Behavior therapies	• results are pre-defined and observable • process is usually predictable • results are reached quickly (5-10) sessions	• all behavior can be taught and untaught • ones own behavior can be controlled, regardless one's past	- little self awareness - symptom relief and fire fighting
Interaction-oriented psychotherapies	- results can be pre-defined and observed reasonably well - process is difficult to predict - results can be reached in limited time (15-25 sessions)	- fulfilling and satisfying relationships - ability to be present with others in the hers and now	- over-analyzing interaction patterns - fretting about interaction details
Cognitive therapies	- results are reasonably pre-defined - process can be reasonably predicted - results can be reached in limited time (15-20 sessions)	- effective and realistic ways of thinking - empowering viewpoints - ability to reframe limiting cognitions	- struggling with conflicting beliefs - constructing a make-believe world
Client-centered therapies	- it is difficult to pre-define results - process is difficult to predict - results take considerable time (60-90 sessions)	- energy and self-confidence - rich emotional experience - ongoing and conscious sense making	- lethargy, a warm bath of limitless uncritical empathy - wallowing in one's own experiences
Analytic psychotherapies	- results are reasonably pre-defined - process can be reasonably predicted - it will take considerable time (30-90 sessions)	- having a grounded and realistic position in the world - experiencing life as non reparative, not governed by one's past	- understanding everything while changing nothing - using comprehension and labeling to avoid real experience
Psychoanalysis	- results are reasonably pre-defined - process is difficult to predict - results take a long time - (600-2000 sessions)	- gaining a rich and complex insight in oneself and the world around us	- Woody Allen like behavior - addiction to the daily session on the coach - using comprehension as an excuse

Table 11-7 Outcomes related to different psychotherapeutic perspectives