KETS DE VRIES INSTITUTE

THE CLINICAL PARADIGM

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From: The Path to Individual and Organizational Transformation: Confronting the Elephant in the Room

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Change is difficult, and unlearning habitual patterns can be especially painful, but remaining stuck is often worse. In Path to Individual and Organizational Transformation, Manfred Kets de Vries offers a practical and hopeful approach to organizational change. He argues that effective organizations depend on human action: what people do, how they do it, and why they do it.

This synthesized chapter excerpt introduces the clinical paradigm as a way of reading leadership and organizational life beneath the surface. Instead of treating behavior as purely rational, structural, or economic, the clinical lens asks what hidden motives, formative experiences, emotional patterns, group pressures, and systemic relationships may be shaping what people do. It is a practical, management-facing application of psychodynamic and systemic thinking: leaders learn to become more observant of themselves, more curious about others, and more skilled at diagnosing the repeating patterns that block change.

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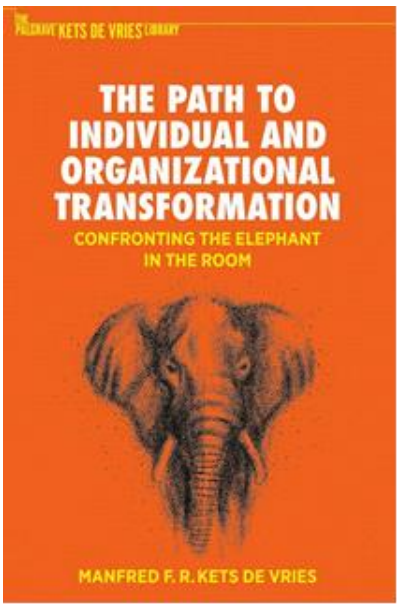


The last of sights, the last of days; and no man's life account as gain Ere the full tale be finished and the darkness find him without pain.
—Sophocles

The physician must be able to tell the antecedents, know the present, and foretell the future—must mediate these things, and have two special objects in view with regard to disease, namely, to do good or to do no harm.
—Hippocrates

Illness is the doctor to whom we pay most heed; to kindness, to knowledge, we make promises only; pain we obey.
—Marcel Proust

The Nobleman, the Monk, and the Price of Seeing

A nobleman visited a Zen master and told him that he wished to be enlightened. The Zen master asked him if he was willing to undergo all the challenges that come with enlightenment, to which the nobleman answered affirmatively. Immediately afterwards, the Zen master asked the nobleman what he was good at and he replied that he was an excellent chess player. With this knowledge, the Zen master arranged a game between the nobleman and a monk who was a beginner at chess. He explained to the nobleman that the rule of the game was that whoever lost would be beheaded.

Inevitably the nobleman was much better at the game, but all the while he was winning, he struggled with his conscience: on the one hand he wanted to become enlightened, but in the process, he might cause the poor monk's death. With this predicament in mind the nobleman began to play badly. Yet, whereas playing well came easily to him, playing badly without being obvious was a surprisingly difficult task, requiring considerable ingenuity. The nobleman played on at the edge of his nerves, sweating profusely, until the Zen master eventually stopped the game and said to him: "Your first lesson is over. You have learned a number of things today: empathy, compassion, concentration, and resilience. Express your gratefulness to your chess opponent for making it possible."

This story opens the clinical paradigm because it reveals a problem familiar in executive life. Leaders often arrive with impressive technical repertoires, decisive habits, and a strong sense of performance. Yet the real challenge may not be whether they can win. It may be whether they can notice what winning costs, whom their competence endangers, and what inner motives are driving the moves they make. A clinical approach begins at that moment of complication. It asks leaders to look not only at strategy and structure, but also at conscience, fear, rivalry, dependency, ambition, shame, and the repeated patterns that shape their choices.

Being at the "Bedside"

To call an approach clinical is not to imply that organizations are hospitals or that leaders are patients. It is to suggest a disciplined stance of observation, inquiry, and care. A clinician does not stop at symptoms. The

fever matters, but so does the history of the fever. The presenting problem matters, but so do the conditions that maintain it. In organizational life, the symptoms may be stalled change initiatives, destructive conflict, executive derailment, avoidance, chronic mistrust, passive resistance, burnout, grandiosity, or the puzzling collapse of a plan that appeared entirely rational on paper.

The clinical paradigm invites the coach, consultant, or leader to sit at the bedside of organizational life. From that position, the work is to listen for what is said and what remains unsaid, what is visible and what is hidden, what is rationalized and what is felt. It is a way of entering the messy territory where cognition, emotion, behavior, and relationship become inseparable. Plans fail not only because incentives are misaligned or structures are poorly designed. They also fail because people carry histories, defenses, hopes, fears, and unexamined expectations into the room.

The "clinical" approach draws on ideas from psychoanalysis (in particular, object relations theory), dynamic psychotherapy, developmental psychology, family systems theory, paradoxical intervention, motivational interviewing, neuroscience, evolutionary psychology, group dynamics, and cognitive theories. The umbrella term "clinical paradigm" has been taken to summarize the practical application of many of these theories within an organizational setting.

The point is not to turn the leader into a therapist. The point is to give leaders and change agents a richer map. When an organization is stuck, a purely mechanical explanation may be insufficient. Something is being protected, repeated, avoided, projected, split off, or enacted. The clinician's task is to ask: what purpose does the symptom serve?

Freudian Origins

The clinical paradigm has psychoanalytic roots. Freud's enduring contribution was not a complete and final theory of human life, but a radical insistence that the surface of behavior is not the whole story. Human beings are moved by motives they do not fully know, shaped by memories they do not simply remember, and influenced by emotional patterns that can be reactivated in new settings. Workplaces may look modern, rational, and data driven, but the people who inhabit them are never only rational actors.

In leadership, this insight is decisive. A leader's early experiences of authority, recognition, abandonment, rivalry, dependence, trust, or humiliation may echo in present-day relationships. A chief executive who cannot tolerate disagreement may be defending against an old sense of being challenged or exposed. A talented manager who repeatedly chooses impossible assignments may be trying to prove worth to an internal audience that can never be satisfied. A team that polarizes around heroes and villains may be enacting primitive emotional patterns rather than evaluating reality with balance.

The clinical paradigm is based on a number of premises:

1. **What you see isn't necessarily what you get**. The world around us is much more complex than a superficial view suggests. Much of what happens is beyond conscious awareness.

2. **We are not always rational human beings**. Paradoxically, irrationality is grounded in rationality. Irrational behavior is commonplace in organizational life, but it nearly always has a rationale to it. This rationale is critical in understanding a person's inner theater—the core themes that affect an individual's personality and their subsequent leadership style. Well-intentioned and well-thought-out plans are derailed daily in offices around the world as a result of psychological dynamics and forces that are beyond consciousness. Finding this rationale is rarely easy, however in our approach we foster the Sherlock Holmes of corporate life—the organizational detective adept at teasing out what's really going on beneath an executive's quirky behavior or an employee's questionable attitudes.

3. **We are subjected to various motivational need systems.** These determine our character and create the tightly interlocked triangle of our mental life (the three points of which are cognition, emotions, and behavior). In order to influence behavioral patterns, both cognition and emotions need to be taken into consideration. Emotions determine many of our actions and an understanding of them plays a vital role in effective leadership; put simply, emotional intelligence is a necessity.

4. **We all have a dark side**. However much leaders may be depicted as paragons of virtue with all the glowing attributes their role demands, all leaders—and indeed all people—have a darker side. Many leaders are derailed by the blind spots in their personality that they (or we) have failed to recognize.

5. **We are a product of our past**. As the saying goes, the hand that rocks the cradle rules the world. Ultimately, the way we behave is the result not just of our genetic endowment but also the developmental circumstances of our early years. We tend to repeat, replicate, and respond to certain behavioral patterns that, like it or not, demonstrate a continuity between past and present.

From the Individual to the System

Although psychoanalytic thought gives the clinical paradigm depth, systems theory gives it breadth. The individual is never the whole story. People live in networks of relationship. Teams and organizations have patterns, feedback loops, roles, boundaries, myths, rituals, and shared anxieties. A problem that appears to belong to one individual may be maintained by the system around that person.

A difficult executive, for example, may be carrying aggression that no one else in the team wants to own. A passive department may be responding logically to a history in which initiative was punished. A burned-out leader may be the visible symptom of an organization that rewards heroic over functioning. A conflict between two people may express a broader split between innovation and control, headquarters and field, founders and professional managers, or past success and future adaptation.

The systemic perspective changes the intervention. Instead of asking only, how do we fix this person, the clinician asks, how does the system invite, reward, punish, or require this behavior? What role does the symptom play? What would the group have to face if the symptom disappeared? Which relationships reinforce the pattern? Where are the feedback loops? Where is the anxiety located? This is not to remove personal responsibility. It is to locate responsibility more accurately.

In practice, systems thinking helps leaders notice how people position themselves in relation to one another. Who speaks first? Who translates for whom? Who is protected? Who is scapegoated? Who carries bad news? Who is treated as the parent, the child, the rebel, the expert, the outsider, or the conscience of the group? These roles may seem natural because they have been repeated so often, but they are constructions. Once visible, they can be renegotiated.

A Pluralistic Toolkit

In our pursuit to gain a better understanding of people and organizations, we appreciate the value of moving seamlessly from an individual to a systemic orientation. Our effectiveness as "organizational clinicians," however, has been enriched by familiarity with other models of individual and organizational change.

In fact, we would go as far as to say that something of our success as change agents owes much to the eclectic use of a number of conceptual frameworks, and a willingness to adapt them to the diverse situations that are presented to us. Therefore, in addition to the more psychodynamic-systemic orientation, we regularly refer to a number of other conceptual schemes to help leverage meaningful change.

An example of this would be the application of ideas derived from **short-term dynamic psychotherapy**. In this form of intervention, we try to solve problematic issues within the shortest possible timeframe. Short-term dynamic psychotherapy involves looking at the most essential patterns in interpersonal dynamics under the lens of various mental triangles that influence human behavior. Features that are characteristic of this kind of intervention method include a focus on affect and emotional expression, self-experience and relatedness, maladaptive relationship patterns, the exploration of unconscious motives and fantasies, and the relating of current experiences to influential past experiences. Much of this approach is influenced by psychoanalytic concepts, however the "dynamic" aspect refers to the exploration of the unconscious as fundamental to the internal struggles people experience in the present.

Developmental psychology helps connect present behavior with earlier adaptations. A significant proportion of theories within this discipline focus on childhood development as the period of an individual's lifespan that the greatest changes occur, and where one achieves many significant physical, emotional, and social milestones. Early formation experiences in turn shape the cognitive, social, intellectual, perceptual, personality, and emotional responses as adults.

Evolutionary psychology reminds us that many emotional reactions have deep survival roots. This approach looks at human cognition, emotions, and behavior that are the effects of long-term human evolution. This assumes that certain internal mechanisms are the adaptations and products of natural selection which have helped our ancestors to travel, survive, and reproduce to a greater extent than other species.

Additional insights can be derived from **neuroscience,** which point to the embodied and biochemical dimensions of social experience. Neuroscience seeks to demonstrate how a social setting can affect our brain circuitry and biochemistry, which are also influenced by genetic controls. In turn, these neurobiological mechanisms will affect behavior, and the proponents of neuroscience hypothesize such brain mechanisms will eventually and exhaustively explain the mind and, in time, human nature itself.

Existential psychology adds another layer: the question of meaning. Leaders are not only bundles of motives and defenses. They are also human beings trying to construct lives that feel purposeful. Toxic behavior patterns may need to be reduced, but the deeper coaching question is often what kind of life, leadership, and contribution the person wants to create. The clinical paradigm is concerned with being and becoming: with who the person is now, and with the self the person is capable of becoming through more authentic choices.

At the same time, we recognize that humans continually re-create themselves as a way of adapting to the constantly changing nature of life. Our work is intended to foster each client's pursuit of self-fulfilment by helping them to make authentic, meaningful, and self-directed choices. Thus, our interventions are also aligned towards the necessity for free will, self-determination, and the search for meaning.

Encouraging self-determination is one of the intentions behind our use of **motivational interviewing**. Its central wisdom is that people are more likely to change when they voice their own reasons for changing. Mandatory change often produces compliance, resentment, or concealment. A directive, confrontational approach may intensify resistance because the client begins arguing for the status quo. Motivational interviewing reverses this dynamic. It invites the client to articulate ambivalence, examine consequences, and strengthen self-determined commitment.

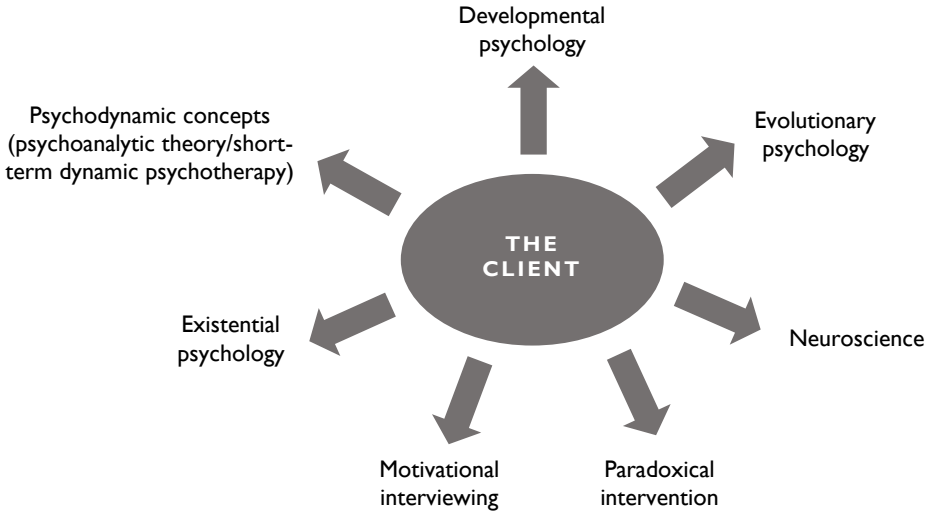
In leadership coaching, this matters because executives are often surrounded by advice. They may be told what they should do by boards, peers, consultants, spouses, employees, or coaches. Advice can be correct and still fail. The more important question is whether the leader has internalized the need for change. *What does the leader stand to gain? What does the leader fear losing? What values are being violated by the current pattern? What future does the leader want strongly enough to endure discomfort now?* Motivational interviewing works like resistance judo. It does not collide with resistance head-on. It studies the resistance, respects its function, and helps the client redirect energy toward a chosen goal. The coach remains nonjudgmental and non-adversarial while still being purposeful. The client is not shamed into change; the client is helped to recognize the gap between present behavior and desired identity.

When resistance is severe, **paradoxical intervention** can be used to create some leverage. A paradoxical intervention uses surprise to disrupt a self-maintaining pattern. Instead of fighting the symptom directly, the practitioner may prescribe, exaggerate, or reframe it in a way that reveals its mechanics. The client is forced to experience the pattern from a new angle.

For example, a leader who complains about being indispensable may be asked to deliberately make himself even more indispensable for a short period and to observe the consequences. A perfectionist team may be asked to design the perfect process for never reaching a decision. A conflict-avoidant executive may be invited to schedule a meeting devoted solely to naming the conflicts everyone is already managing indirectly. Such interventions must be used with care, judgment, and respect. Their purpose is not cleverness. Their purpose is to interrupt the loop that keeps the symptom alive.

The power of paradox is that it exposes choice where the client previously experienced compulsion. When a person can observe himself producing the very pattern he wants to escape, a new frame becomes possible. The symptom becomes less mysterious. The person can ask: what am I doing, what does it accomplish, what does it cost, and what else might I do? This is often the beginning of a tipping point.

Conceptual Models Facilitating Individual & Organizational Change



A Psychodynamic-Systemic Focus

The chapter ultimately returns to a psychodynamic-systemic focus as its governing approach. Psychodynamic thinking helps explain the inner life of leaders: motives, fears, defenses, fantasies, identity, and the historical roots of behavior. Systemic thinking helps explain how those patterns are amplified, contained, rewarded, or challenged by relationships and organizational structures. Together, these lenses provide an alternative to purely rational or structural explanations of organizational life.

The goal is practical awareness. Leaders need to understand why they do what they do and why others respond as they do. They need to see how their emotional patterns become team dynamics, how team dynamics become culture, and how culture influences strategy and execution. They need to recognize when a behavior that was once useful has become counterproductive. They need to become reflective practitioners who can pause, observe, interpret, and act with greater freedom.

When clients internalize this lens, they become their own organizational detectives. They begin to notice nonrational patterns without being frightened by them. They can ask better questions: What is being repeated here? What is the emotional tone? What role am I being invited to play? What anxiety is the group trying to manage? What history is entering the room? What conversation is being avoided? What change would become possible if we named the pattern?

This kind of awareness is consciousness raising in the deepest sense. It increases self-understanding, deepens understanding of others, and links individual behavior to the wider social field. It also creates a pathway to healthier organizations. When unconscious patterns become discussable, teams can stop acting them out. When leaders understand the link between past and present, they can revise old scripts. When systems see the function of their symptoms, they can design new patterns. The clinical paradigm is therefore not merely a theory of diagnosis. It is a disciplined practice of making meaning so that change becomes possible.

A Closing Reflection: The Leader as Clinician

The clinical paradigm asks leaders to cultivate a rare combination of capacities. They need the rigor of analysts, the compassion of healers, the curiosity of detectives, the patience of teachers, and the courage of people willing to examine their own participation in the problems they wish to solve. They must be able to look beneath the surface without becoming cynical, to name dysfunction without humiliating people, and to pursue change without imagining that force alone will create commitment.

At its best, the clinical lens humanizes organizational life. It reminds us that behind every chart, structure, process, and strategic plan are people with histories, needs, longings, defenses, and hopes. It also reminds us that organizations themselves develop character. They remember, repeat, protect, deny, aspire, and resist. To work clinically is to respect this complexity and to intervene with care.

The nobleman at the chessboard discovered that enlightenment was not a possession to be acquired. It was a way of seeing under pressure. The leader's version of that lesson is similar. To lead clinically is to see the move, the motive, the person, the relationship, the system, and the consequence. It is to ask not only, how do we win, but what are we becoming as we try to win?

Reader reflection questions

- What early lessons about success, failure, authority, conflict, or belonging still influence me?
- What role did I learn to play in my family or early environment: achiever, caretaker, rebel, peacemaker, invisible one, performer, rescuer?
- What patterns repeat across different teams or relationships in my life?
- What feedback do I repeatedly receive but still resist?
- Under pressure, do I become controlling, avoidant, pleasing, critical, withdrawn, competitive, or defensive?
- What would I discover if I asked, "What problem is this behavior trying to solve?"