13. Seeking mutuality and confronting power: an 'upstairs' scenario.

Introduction

While working with the 'downstairs' staff in developing 'good practice' frameworks, I was simultaneously working with the other senior staff 'upstairs' in finding new markets for the department's services. This activity surfaced issues of power and difference which took precedence over clinical work. Although the marketing process led to a more elaborated 'map' of the patient journey from point of referral outside the district, this was overshadowed by tensions within the group. It is these tensions and my dealings with them which I wish to present in this chapter. I will report one particular meeting as being the point at which I recognised the need to take a more active role in the team, and to develop a different relationship with William. This relationship leads to the need for me to re-conceptualise power.

In reporting these events I move away from a direct focus on complex cases to the issues of seeking mutuality in a relationship with a male colleague and the personal learnings this leads to. Although I retained an active interest in developing 'good practice guidelines for complex cases', and although the events reported in this chapter helped towards their elaboration, I am now departing from this as a focus for the research. I retained the notion of the Hermeneutic Dialectic Process as a macro-map for gaining constructions from different groups and, within this map, spent time with the administrative team devising a parallel administrative protocol for supporting the clinical process for 'complex cases'. The 'management of complex cases' eventually became a recognised part of our service which was successfully marketed and contributes to our income generation. However, I am not reporting these later developments as they became peripheral to the developments reported below in relation to my research interests and purposes.

Marketing: tensions and possibilities.

The group of people who came together to develop a marketing strategy comprised the Core Group, Ann the ward manager, and three senior nurses who had previously held regional roles before the health reforms. Gerry, the most senior clinical nurse, was among them. These 'regional' nurses continued to do work with cases referred in from other districts, but their roles required re-defining in the light of the changes. This group contained all the people that we considered as having roles extending beyond the delivery of the service to our local health authority. Looking at this another way, we were the individuals at risk if we were unable to find new purchasers. Therefore, we were the individuals who needed to be involved in developing a marketing strategy to secure these new purchasers.

As a large group we had not worked together in any sustained way before. Within this group however there were sub-groupings of individuals with a history of working together, and who brought the patterns of relationship which had evolved from that history. There was the core group, with our history of several years of meeting and inquiring together within the limits of our professional roles and personal motivations. There was the group of regional nurses who often felt the 'meat in the sandwich' between the respective views of our service and those they liaised with around the region. And there was Ann and I with our history with the nursing team and the day care team.

In addition, we had two marketing consultants coming in from 'outside' as experts. This added another dimension to the dynamics of the group, with a range of responses from willing acceptance of outside expertise on the part of Jan and myself to barely veiled scepticism on the part of Stewart.

We were united as a group in our perception of the need to make changes, but we were varied in our views about how that should be done. Once underway with the process, three main options began to emerge as strategic developments suggesting further inquiry. The first was to consolidate our existing contracts. All but the two medical consultants felt there was considerable opportunity to secure our contract with existing purchasers over the longer term by improving the quality of the existing services.

The second was to develop a short term rehabilitation service of six weeks duration for people requiring medical, psychological and social interventions following detox from drugs and/or alcohol. This was to be a highly planned intervention aimed at individuals with specified problems whose needs would be carefully assessed prior to admission to the programme. Such a service could be achieved by reorganising existing resources. In marketing terms it was 'new product for existing customers'. William the clinical director was particularly keen on this. The third option was the development of a completely new venture, a convalescence service providing psycho-social support for people recovering from episodes of major physical illness. Stewart was particularly keen on this but supported by William. This would be a 'new service for new customers' and would take us outside existing patterns of service delivery, requiring the Trust executive group to provide bridging finance. It was a high risk option which did not take into account the existing skills and career pathways of the majority of the staff.

The provision of a service for 'complex cases' was an invisible fourth strand. It was implicitly known by Jan, myself and Ann that we were developing expertise in doing this work, but as yet it was not explicitly recognised by the two consultants. In this setting there was little chance of introducing the concept and having it accepted by the two consultants who would not perceive themselves as being the major 'stakeholders' and would therefore 'squash it'. This fourth strand required painstaking and 'hard' work whereas the two consultants had made it clear that they were not interested in new developments which were not "fun and life-enhancing" for them.

Over the course of six months, many members of this group had put in long hours and hard work doing market research, using the structures and procedures provided by the marketing consultants. In doing so we had learned to look at our department through the eyes of others. To some it was a revelation, realising how "ethnocentric" we had previously been. For me it further strengthened the idea that we had something unique to offer in 'management of complex cases'.

As this first phase of the marketing was drawing to a close and decisions had to be made, issues of power moved from the realm of the implicit to the explicit in a very public way. This was revealed in a half day meeting between the group and the two marketing consultants who were going to take us through a complex decision-making process to arrive at key objectives and priorities.

The personal significance of this meeting was that it awakened in me the realisation that I had to find a way of directly involving the doctors in what I was trying to achieve. It was no longer possible to 'skirt round' them and hope that my work would succeed. However, at this stage I did not wish to view the relationships in terms of power. Firstly, I will tell the story of that meeting as I wrote it shortly after the event, reconstructed from my reflective diary on the day and from field notes made in the meeting. Then I will reflect on its implications.

An Awakening.

Marketing meeting: Present were Jan, William, Stewart, Gerry, Luke, Paul (three senior nurses) myself, and Steve and Bob the two marketing consultants. Ann (Ward manager) was not present.

The planned purpose of the day-long meeting was to evaluate a range of options for new markets for our service which were to be part of a final marketing strategy. A paper had been circulated prior to the meeting with nine different options we had generated out of previous

meetings. I had not brought my copy with me and had not read it previously, so quickly read one belonging to someone else.

As the meeting started I was finding it difficult to concentrate on the business at hand, still being preoccupied with several pressing problems I had been presented with on arrival at work that morning for which I had hastily organised temporary solutions until lunch time. Behind that again was a tiredness and preoccupation with other things - preparing teaching sessions until midnight the previous night, trying to find time for research writing over the last two weeks, and feeling like I was not 'up with the pace' at work.

Steve the marketing consultant began with a lengthy explanation of the process for the day which would culminate with a data set he would then run through a computer program. I was not following this fully but assumed this was due to my preoccupation with other things. I remember saying to myself, "just listen carefully and it will eventually come clear, and anyway its nice to sit back and let someone else take charge. Steve often begins like this and eventually we manage as a group to get a workable process going."

Bob was unusually quiet and appeared withdrawn. His face was pale and gaunt and I assumed that he was in pain as I knew that his back problem had recurred recently. We had swapped 'bad back' stories.

After Steve had finished describing the process William summed up the goal for the day as "developing a shared understanding" of all the options we had generated so far then agreeing an order of priority. Stewart then declared that we should only consider the first three of the nine options. These were the ones concerning provision of new services only. The remaining six concerned developments of existing services. In the last meeting, at Steve's suggestion, we had grouped these options as requiring different strategies.

At that point Jan intervened and challenged Stewart by stating that we could only develop new services to the extent that we managed our existing ones well and held them alongside any consideration of proposed change. Steve supported Jan by affirming that our existing purchasers remained the most important. Stewart said yes he agreed but that it was not important for this exercise, we had to do that anyway and it could be left for some other occasion outside these meetings. Then followed an escalating interchange between Jan and Stewart which William quickly joined by declaring also that we should only consider the first three. At around this point Stewart personalised the argument by stating that he thought Jan was "wilfully misunderstanding" him. Jan replied to this by stating what she understood Stewart's views to be, how hers differed from his, and ended by observing that it seemed to her that they each shared different values about what was important.

At some point around here I intervened. I was feeling confused about the issue of whether there had been a previous agreement to only focus on certain options, not having read the paper beforehand and with both William and Stewart behaving as though this were the case. But I also felt that staying with what we were doing as an option had to be considered alongside any new options as anything new had to be strongly rooted in what we had achieved so far (even though we were losing contracts in spite of having performed well, leaving us all feeling rather helpless and discouraged). I could see that Jan was feeling stunned and bruised by the encounter and I was surprised that William had joined so strongly with Stewart. I was not surprised at Stewart's stance as he had made it clear at the beginning of the marketing project what his agenda was and had entered the process reluctantly. I had also seen the conflict before between Jan and Stewart in the Core Group over management issues, where Stewart would overtly belittle any efforts by others where he was not in control or which endeavoured to develop more interdependent relationships with other individuals or departments in the Trust.

I was feeling anxious at this stage that the process seemed to be getting out of hand. I saw that Jan was silent and sensed she was feeling wounded . I felt hurt for her and I was worried also that if this process continued we would end up down some road that I would not feel comfortable with and be able to work authentically with. I had entered the morning relying on

the process to help me gain a sense of focus about what we were trying to achieve for the day and I was beginning to see that this was unlikely to happen without some effort on my part.

I was wanting to get some balance back into the process, to bring my self out of my wooliness and to find some way of supporting Jan back in. I commented that I thought we had been invited to consider all the options and that as it was important to gain a 'shared understanding' we should start with getting this clear. William interrupted vehemently that "we have not been 'invited' to do anything, we are in charge of this and we will do what we want!".

There was silence. Steve was looking very tense and suggested we continue with the task, watching the two doctors carefully and not paying much attention to the rest of the group. I was feeling stunned at William's joining so heavily with Stewart. I had not seen him do that for a long time. I did not know what to say and felt we had been 'rail-roaded'. None of the others in the group (three men who were nurses) had spoken so far this morning but acquiesced with Steve continuing with the task as Stewart and William had defined it. Jan also acquiesced but was looking stunned, upset and vulnerable.

As we continued there was little participation apart from William and Stewart. Jan was completely silent. I could not concentrate on what was being said as I was engrossed in my thoughts, reflecting on what was happening and what could I do about it. I wrote down on my note pad:

> *"If we don't attend to existing purchasers and get a clear understanding of what is required we will not know what resources are available to pursue other options. A lot of management resources are invisibly used without people being fully aware of what goes on. There is no inquiry here. How do I inject inquiry? How should I have managed that?"*

I tried to think through what I could have done/could do. The thought 'there is no inquiry present' stayed in the forefront of my consciousness. I was aware of the following stream of thought:

> *" From my experience of Stewart, if I had inquired more of him he would have either retreated more into his determined position or collapsed and gone along with the alternative with bad grace, and that would still leave us being organised around his position. It would have been far better to have joined with Jan and supported her by inquiring more fully and helping her elaborate her views so that they were fully available for the group to consider. It is too late for that now, my fear is that it would look as though I was rescuing her and that would be demeaning of her. Also I do not want to put her on the spot again as she looks withdrawn and extremely vulnerable. I need to find a way of stating my own position, perhaps by declaring my own discomfort at the way the group process is going. That feels too risky as I don't think anyone but the doctors will respond and I won't be supported by the silent members. I feel too vulnerable to cope with that possibility at the moment. The two doctors have used the power of their position to push their own agenda. I am confused about what that agenda actually is at the moment but it feels as though its about keeping control of where we go. Steve and Bob have colluded with this. I wonder what they think is happening. Where is Bob? He usually comes in at the point of conflict to smooth things over.*
>
> *Perhaps I can put my own discomfort aside and go along with the direction the doctors have taken us. At some point we will have to come back to considering the other options. It is not possible to solely pursue their favoured direction of developing services independent of the Trust and its existing service agreements. They believe we are far more independent of the Trust than we actually are. We have explicitly tested this out over the*

course of the marketing but they do not wish to acknowledge this. This course feels the easiest but does not feel authentic. I do not know what to do."

By then I noticed that William did not look at all relaxed and the level of participation was still very low, with Steve doing an increasing amount of talking. Suddenly William declared that we should stop as "this is not working and some people are obviously unhappy". This was said in a slightly resentful and accusing tone.

Without thinking I quickly interjected, saying I was really glad he had brought this up as I was feeling the same way but had not known how to express this. I noticed that he visibly relaxed as I said this. I went on to say something about the process needing to be more inquiring and respectful of peoples' contributions, and that the marketing would only work to the extent that the outcome represented a consensus. I do not remember clearly what else I said because the next event captured all my attention. Stewart directed a critical remark to Jan, at which point Luke, who was sitting next to her, suddenly leaned forward in his chair and taking his glasses off confronted him by saying that he was "rail-roading people". Stewart retorted and Luke replied: "You are doing it again. You have been doing it a lot. You have a lot of really good ideas which I value hearing but you do not listen to anyone else. I have made a number of suggestions throughout these meetings which go completely unacknowledged by you or are put down by you , so I have given up saying anything!"

Stewart adopted a bodily posture as if prepared for fighting and said: "OK, if it is resentment time let's get all the resentments out . Come on let's hear them!" Luke refused the invitation, replying that he had said all he wanted to say.

William then intervened by offering to include the other options as "obviously some people consider them important". Again, this was said in a slightly resentful manner. Stewart turned away in his chair shaking his head while concurring with a gesture which said 'I will do this to humour you and keep the peace.' There were one or two murmured comments agreeing that we should move forward, including the other options.

Steve, who had retreated to the back of the room, stepped forward again to the flip chart and offered that he may have been the cause of confusion by suggesting the options be grouped separately. In reality, he said, they all needed careful consideration for the purposes of developing a marketing strategy. He was anxious that we move on as time was very limited.

At this point I was afraid Steve would focus back on the task without giving us an opportunity to deal with process. My instinct was not to focus on the conflict again at the interpersonal level but to address the issues at the group level. Despite the extensive work the nurses had done on this strategy, they had largely remained silent in the meetings while the doctors' views remained ascendant. The doctors had frequently doubted or challenged the methodologies and the marketing consultants had taken pains to bring them 'on board' but in so doing had increasingly moved toward a leader-centred style of running the meetings in an attempt to keep control of the process. Correspondingly, they tended to speak more to the doctors than anyone else. This was no longer working and Jan and Luke had finally challenged the doctors openly.

It seemed to me that if we could not create a process which affirmed the contributions of all then the whole venture would collapse. I strongly did not wish this to happen - the future of myself and others was at stake here.

I interrupted Steve, affirming what he and William had said, affirming his wish to keep us on task within a very tight timetable, but expressing my worry that the task would not be achieved if we did not pause for long enough to address the process. I observed that the interchanges so far had only involved half the group and said that I wished to create an opportunity now for the others to offer their views on the process and how they wished to proceed.

There was a brief silence, then Gerry spoke. He said something about other people's resentments, which I do not clearly recall, and then about how he had felt lacking in confidence in putting forward ideas and so had remained silent. I wanted to affirm his experience of feeling silenced and so amplified this by responding that I had felt the same at times and hoped we could support each other in contributing.

Paul followed by saying that he felt no need to say anything at this stage but would be happy to if any one wished. I responded that I would like to hear. He made no reference to conflict or personal discomfort, saying only that he was happy enough to proceed, including the other options in the decision making process. There was no further comment and I felt I had gone as far as I could in creating an opportunity for people to speak. William then took charge of the meeting by going to the flip chart and suggesting a way forward.

As the rest of the morning progressed I felt myself more fully present in the discussions and noticed that the level of participation was increasing. William and Stewart offered more acknowledgement of others' contributions, although making jocular comments to each other indicating their preference for some options and their dismissal of others. Jan gradually came back into the discussion but continued to look vulnerable and subdued.

I was interested to note that as we went through the sophisticated process provided by the marketing consultants , teasing out criteria for making judgements , gaining agreements on them then assigning personal and group weightings to them, the options the doctors had previously wanted to exclude increasingly 'gained weight'. I wondered if the strategy of 'going with it' I had considered earlier may have worked after all? But I concluded that living things only 'gain weight' when nourished.

Over the course of the following few days, I wrote about this meeting extensively in my reflective diary. Following are my reflections after the action as they occurred to me over those several days.

Reflections on action.

- I think this is 'Action Inquiry in action', that is, use of reflection-in-action, use of framing/ advocating/ illustrating/ inquiring in dialogue, seeking a focus for collaboration, and seeking to bridge incongruities across territories of experience. This felt more spontaneous and more authentic to me, and more resembled Torbert's (1991) term 'stumbling gait' which he uses to characterise the experience at any one time of engaging in more or less incomplete 'experiments-in-practice'. My interventions in the meeting were not pre-planned and smoothly executed, but rather arose in the 'heat of the moment', using the opportunity as it arose to address incongruities across differing domains of experience and to invite others to collaborate in addressing them, thus using the 'energy of the moment'.

- So, what did this 'experiment-in-practice' achieve, and what did I learn? The conflict in the group 'woke me up' in more ways than one. It literally challenged me out of my preoccupation with events outside the meeting to become more present in the meeting. It also alerted me to the realisation that I had to take a much more active role in the group if the marketing was to succeed - I had too easily accommodated to the process which had emerged over time. I could no longer afford to do so.

  The meeting revealed clearly how William finds himself caught between Stewart on the one hand and Jan, myself and the nurses on the other. Although I was stunned at his siding so openly with Stewart, eventually it was he who challenged the process and created the opening I was looking for but could not see a way of achieving myself. I have no way of knowing if the meeting would have progressed differently had I not also intervened at

that point. Clearly there was considerable tension 'simmering', which Jan and Luke made explicit. Whether the overt confrontation between Luke and Stewart would have occurred without my framing the need for all views to be respected and a consensus reached, I do not know. I needed to challenge the process in the group but in a way which moved us on beyond conflict to collaboration, and I needed to become active in the group at this point for my own sense of authenticity. I am interested, in retrospect, how the two doctors accommodated to the change in process. But on the other hand, I feel I had a hand in shifting the focus away from interpersonal disagreement to one of the need to work together for success - this was a frame with which no one could disagree, no matter what their private views were about how this would happen. The increasing levels of participation over the morning vindicated my intuition to intervene at the level of group process and goals rather than at the level of individual members.

- This meeting also 'woke me up' to the idea that I must work more closely with William in making explicit how I work with complex cases. Unless he understands this he will not be able to support what we do. Of the two consultants he is the one with more energy and interest, despite his declared interest in the 'convalescent' option.

- The meeting highlighted interesting patterns of relationship which resonate with the concepts of agency and communion. I saw unmitigated agency as creating a hostile environment for communion in that meeting. The two doctors preference for the 'new niches in the market' were characterised by metaphors of 'forging ahead', 'conquering new fields', 'ownership', having 'high visibility' in the health field, and imposing their views of what was needed on others. These are all characteristics of an agentic strategy, and if unmitigated by characteristics of communion can lead to isolation (of individuals from each other and of the department from other services) , silencing, and unaware damaging or ignorance of contextual patterns which ultimately are important for longer term survival (for example the willingness of other services to collaborate with us).

By contrast, outside the meetings, the activities of Jan, the nurses and myself were characterised more by communion. Jan had worked hard behind the scenes in facilitating the marketing process, linking the sub-groups together and ensuring they had the resources to do the job. Myself and the nurses had made new links with our existing purchasers and referrers, better understanding their requirements of us, and collaborating more effectively around communicating about referrals, providing more timely and relevant information to them, and acting on their requests as opposed to presuming we knew what they 'needed'. The process of the marketing had allowed us to become more aware of and sensitive to our wider environment, and this in turn had opened up possibilities for more interdependent and mutually respectful working relationships. These activities, and their outcomes, remained muted and unacknowledged in the marketing meetings in the face of the agentic style which held sway and overly-determined the interpersonal process. I felt I needed to exercise considerable agency momentarily in order to allow for more communion to be present in order to redress the balance.

- I feel uncomfortable in presenting Stewart in such a 'dark' way in my writing - although that is how I experienced him in the meeting. I feel the need to note the light side which is there at times, when we join together in friendly and interesting ways that allow us to work together. For example, sharing 'insider' appreciations of drug using culture from our youth, and sharing a scepticism about models of pathology and the degree to which contemporary

psychiatry and clinical psychology are based on these, offering false promises about many 'life difficulties'.

Implications of the Marketing.

I will now consider some implications which arose for me from the marketing and which are grounded in my experiences in the meeting as conveyed in the story above.

• 'Complex Cases'

Although this story about the marketing is not about 'complex cases' directly, there was a 'story behind the story'. The marketing process extended discussions with referrers from across the region which inevitably included 'complex cases'. Although we were envisaging a need for a short term rehabilitation service, it became increasingly apparent that there was also a need for the sort of work we were already doing with 'complex cases' which would not fit easily into the more pre-planned concept of short term rehabilitation. So inadvertently, I and the senior nurses developed a more detailed 'map' of the 'patient journey' from the point of referral and learned of referrers' requirements of us in supporting their own work with 'complex cases' as they perceived them to be. As they learned about our work, they became more interested in seeing what we had to offer. The senior nurses on several occasions arranged for referring teams to visit us and would ask me to meet with them and talk about 'complex cases' and how we worked with them. I used Rosemary's story as an exemplar.

In terms of my use of the Hermeneutic Dialectic Process, I had elaborated my 'map' of how 'upstairs' constructed 'complex cases' - the consultants were 'blind' to them, and the rest of us kept the work 'invisible'.

• Finding new markets and new relationships.

As it became clearer that we could, in marketing terms, 'fill this niche in the market', it also became clearer to me that we needed William 'on board' to support the work as clinical director and as consultant psychiatrist. At that time the consultants were still seeing themselves as the 'experts' on what was needed and as having a right by appointment as regional consultants to 'gatekeep' and make decisions about the pattern of service provided to the other districts and about the types of referrals accepted. However, through the marketing the senior nurses and I had received almost unanimous feedback that referrers did not want our service to unilaterally 'gatekeep'. Instead they wished us to accept their judgement about when they were no longer able to meet the needs of their clients as they perceived them to be. They wished for a more collaborative relationship in which they felt their needs had been heard and validated and where the service provided was negotiated.

I did not wish the two consultants to cut across the relationships we had begun to form with the referring teams and undo the gains. As the two consultants were necessary to our service in terms of their medical expertise, and as they 'figure headed' the service as far as the wider environment was concerned, I felt that I had limited options as to how I could work around or through this dilemma. I could work 'around' the consultants, or work 'with' them as I saw it. There were limited degrees of freedom open to me in working around them as we were too tightly bound together as senior members of the department and as members of the Core Group. As such they were part of my immediate reference group for making the service effective. On the other hand, there were limited degrees of freedom open to me in working with them. Their main reference group, albeit it a seemingly unsatisfactory one as they portrayed it, was the consultant's group and the wider world of medicine. I was not part of that world and did not wish to be so. But on balance, I felt I needed to work 'with' them and I felt that I would be more able to do so with William.

Despite public appearances, William was privately interested in the marketing and was beginning to see the importance of understanding 'customer requirements' as an important underpinning for providing a 'quality service'. He had proved the more listening and affirming

of the two doctors and the one I most trusted. My past attempts of trying to mediate the effects of the unspoken differences between them was not going to be an effective strategy for supporting the changes I now saw as possible. The marketing meeting had shown me clearly that, in public, the two consultants would always ally with each other. I did not know what passed between them in private, and how much they explored or resolved differences. I could not join their sub-system as doctors, but I could invite William to join my sub-system as practitioners working with 'complex cases'.

If I could develop a closer working relationship with William clinically, and make more 'visible' my work with 'complex cases' in such a way that he could 'see' it, then I believed that the gains would be two-fold. Firstly he could then be more supportive of it, and secondly he might also be able to see in a different way how the department worked 'downstairs' and be a more effective Clinical Director through so doing. I felt it vital for the department that this should be achieved and I saw my making a stronger alliance with William as a potential key. I would be giving up a more neutral position in relation to the two consultants than I had previously adopted, carefully trying to weave between, but this seemed no longer to be an effective strategy.

On another level, I was also interested in developing a relationship with William in which we could value each other's contributions from a position of more in-depth mutual inquiry. I was looking for such a working relationship with a senior male colleague and so my purposes also had a more personal dimension.

• Power.

Curiously enough, at this time I saw power as only a peripheral issue and not as a useful frame for making sense of the patterns of relationship around managing change. Although I saw the consultants as using unilateral power in the meeting in directing the agenda, my analysis was based more on the differences in world views according to profession and gender. I carried this 'bracketing off' of power in relationships into my inquiry with William, and I turn to an account of this next with the consequences of having to re-view my thinking on power.

Developing a collaborative relationship with William.

From this point on I sought to work more closely with William around client/patient care. This seemed to be an 'inquiry niche' which offered most potential for collaboration together. This was a core aspect of both our roles, we had regular contact with each other around casework, and it was in this domain that I wanted him to have a richer appreciation of how I worked. Alternatively, it was a domain in which I believed he could extend his own skills and I wished to support this. I felt that if he could develop this area of his work it would give him a firmer base to work from and enable him to work more collaboratively with other clinicians.

I also wondered if we could together step outside the restraints of professional roles and world views and work together in a way which valued our respective strengths and values. He had an agentic 'crispness' to his approach to clinical work which I valued when feeling slightly muddled or overwhelmed with complexity of cases and periodically sought him out for consultation at such times. I wanted to show him more communal ways of working to complement this so that he could understand and support the 'downstairs' work with the nursing and day care teams. I also saw him as moving too rapidly into challenge and confrontation modes when faced with uncertainty, leaving him feeling isolated from his peers. This was also 'true' with clients/patients as I saw it.

I sought every available opportunity to do this informally at the start of this phase - over coffee, chatting at the top of the stairs outside our office, or when needing to involve him in a particular case. My work with Rosemary had progressed to an interesting phase and I told him stories about this. By now we had acquired additional residential property in preparation for our short term rehabilitation service which provided warden assisted night time accommodation for clients in order that they could attend for day treatments and care. I was offering this to Rosemary at times when she and her family were in crisis and she was requesting admission. She could come in provided she collaborated with us in developing her own care plan. We had discovered that if we supported her in this and did not 'push' treatment for her eating disorder then she increasingly was presenting this to us to work on. A key moment for me was when telling William about this, he burst out laughing and said "It's a 'do nothing' treatment". This captured his imagination and he used this term from then on. In turn he started admitting his own clients in this way. This was the beginning of a more explicit recognition that as a department we offered a service for 'complex cases'. Interestingly, it was mostly women who came to use the residential accommodation and William came to recognise the value in providing a space for women like Rosemary to review their lives and receive support in exploring new options in the face of complex family problems and social isolation.

This aspect of our relationship became more complex when William began asking me to help him directly with some of his casework by seeing families together with me conducting the interviews. I would discuss with him what his aims for the session were, give him my views about the necessary strategies and process needed to achieve this and then negotiate the roles we would respectively play. I clarified with him that he wished me to conduct the session and 'take charge' of the process. William would happily agree with this but then at the end of the session, after a break in which we would discuss what feedback we would give to the family, he would depart from our agreement and head off on his own tangent. This was usually diametrically opposed to what I felt was needed in order for the family to have a better grasp of dilemmas and difficulties and leave them feeling empowered to deal with them. William would move back into a directive mode by prescribing how they should do things.

On the first occasion this happened, I checked afterwards whether in fact he had not felt in agreement with the way I had conducted the session or with the formulation I had suggested to him. He remarked, "Oh no, I really enjoy the experience of working with someone who is more competent than me. It is not often I feel as though I can sit back and let someone else take charge".

Therefore I persisted with involving him in my work and responding to his invitations to join him in his. I tried different ways of sharing leadership in sessions - he leading with me observing, us sharing leadership conjointly, me leading with him observing. I could find no comfortable way in which I felt both styles could be harnessed in the best interests of the client without resorting to a more explicit supervisor/supervisee relationship. I was reluctant to do this yet.

So I suggested we support our work together by having weekly peer review meetings, thinking that if we had more time to reflect at leisure about our work we could address some higher order assumptions which could facilitate this working arrangement. But although he agreed we did not get to the point of regularly having them. He often had more pressing demands and seemed tentative when I questioned it. For my part I was not wishing to intrude too far, so together we allowed this to fall by the wayside. It was clear he preferred the implicit and the informal.

My beginning assumptions had been that I could offer an alternative set of frames for working with clients through coaching, modelling and dialogue. I did not believe that the formal supervisor/supervisee relationship was the only context for learning new skills - although it is an extremely important one, and one in which I have experienced much learning from both positions. So I was happy to proceed with an informal arrangement for the time being.

Yet I came to realise that this seeming preference for the informal learning arrangement we had together was in contradiction to a set of beliefs William held about the world of work. He looked for certainty, needed to see large changes occurring in the short term, and liked frameworks in which rules and hierarchical lines of authority were clear. He also expected a clear demonstration from clients of commitment to change This set of understandings emerged over time from conversations together where these issues were both explicitly and implicitly discussed. He once said "I am not a therapist, I do not have the skills. I am a doctor and a researcher."

I was unwilling to invite a relationship of supervisor and supervisee with its explicit hierarchy of expertise, partly because I did not think he would accept it and partly because of my own needs. For my part, I was partially aware of some of my own life scripts operating. I recognised a need to find a 'brotherly relationship' with another man and I sought this with William. We shared many life stories together and I came to know him more intimately. But correspondingly, I am not someone who takes risks with intimacy and when I sense vulnerability in others, particularly men, I tend to wait at a respectful distance, offering support but not challenge. In our discussions together, William took risks in allowing himself to show his vulnerability. I maintained a respectful distance, offering occasional gentle challenges, but usually 'backing off' and allowing what I saw as a 'saving of face'. I did not take risks by pursuing further inquiry or challenging some of the implicit assumptions I saw as lying behind the vulnerability. I found myself always trying to find a position in the relationship in which we maintained an equality of status as individuals independent of professional roles. I found myself always seeking a position which avoided William being 'one down'. In doing so I was often muting myself in relation to him to preserve the quality of equal valuing I was seeking. I was aware that I did this for both of us, but it took some time before I understood in more depth what unexamined assumptions I was carrying in the form of life scripts which informed this.

There were times when this arrangement gave rise to frustration on my part, mostly with myself. I would encourage him to take the lead in casework situations which then turned out badly from my point of view and I would be angry with myself for doing this, knowing the risk from the start and knowing that I expected much from him that he probably was not aware of. The times I became frustrated with William was when he behaved in an un-inquiring and 'shoot from the hip' style with colleagues outside the department. This would either put his own reputation at risk, or limit the extent to which others would be prepared to 'do business' with us. He would become either very wounded or dismissive on getting feedback that he was seen this way. If I inquired into this with him we would slip into our familiar pattern of him becoming increasingly vexed or wounded and me backing off.

On one occasion when he was feeling particularly vexed at his medical colleagues across the Trust I listened, inquired into his beliefs about what was happening, then asked him to consider some alternative explanations. He replied "But David, you are so psychologically healthy". This was not offered in an ironic tone, but it effectively silenced me as I heard the sub-text 'I cannot see the world your way so please do not pursue this'.

It was only when our department was required to work more collaboratively with other services external to the trust and with other departments within the Trust that this relationship began to change. It was in the context of working with William and others in developing an Intensive Care Unit for acutely distressed people that I discovered more about myself, my relationships with other men and power

Developing an Intensive Care Unit

I was very aware of how William was perceived by many of his colleagues from all disciplines - as sometimes arrogant, cavalier in his disregard for other's opinions, somewhat impulsive, and as challenging of their views when he disagreed. By some he was seen as ambitious, and hence were in competition with him for senior posts. By others he was seen as an enthusiastic supporter of the health 'reforms' and hence not to be trusted. Not all saw him this

way, and a few nurses who had worked more closely with him in clinical situations when he was a senior registrar valued him for always 'being there when there was trouble'.

Although I could see their perspective, I also felt that I had another view of him from working closely with him and always offered that to people if asked about my relationship with him. I wished them to be able to see his strengths (his humour and concern for others which lay behind the public persona) and to appreciate how much he was prepared to take risks in allowing others autonomy if he understood what they were doing. I was unaware of the extent to which I was seen as a 'stabilising influence' until a pivotal meeting about the development of a new service within the Trust.

By this time we had our marketing strategy underway. Short term rehabilitation and a service for 'complex cases' were now earning us substantial new income. However, we were still struggling to cover our costs each year and William was still keen on the department solving this by providing some sort of service to private patients. He was reluctant to find a solution which relied on any closer relationship with other departments in the Trust.

At this stage, Jan had just left the department to take up an executive director's position on the Trust. She had been working with nurses across the Trust for several years to develop a proposal for a nursing led Intensive Care Unit which would provide a service to all departments. This proposal had been accepted by the Trust Executive and now it was a matter of finding a 'home' for it within a department which could provide the managerial and administrative structures as well as a multi-disciplinary support. The Trust Executive group (now including Jan) offered us this role. In so doing it sought to solve two problems - our financial short-fall, and the impasse it was experiencing with the large Adult Mental Health Department which insisted it was the logical home but which could never take the necessary organisational steps to implement it.

William was very apprehensive because he doubted the degree of support he would receive from the other doctors in the Trust. He expected to be undermined by them. As Stewart was not interested himself in expanding his clinical role, and was only reluctantly accepting of the need for our department to take this step, William felt he was going to be on his own as a doctor. On the other hand it offered a career step for him and it solved an anxiety-provoking financial burden. After much discussion between our Core Group and the Executive Group we agreed in principle to take it on. A large meeting was organised on Christmas Eve of senior members of all departments to discuss the proposal and see if there was sufficient agreement. The Chief Executive felt he was undertaking something of a gamble in making this proposal and needed to see what degree of support it would gain before making a final decision.

I attended the meeting with a clear strategy in mind. I saw many opportunities in this proposal to 'unlock many log-jams' across the Trust with regard to how acutely disturbed patients were cared for, and with regard to opening up communication between departments. I had prior knowledge that several consultants in adult mental health would see this proposal as 'stealing their territory' and would overtly or covertly oppose it. I needed to speak strongly from a position of confidence that we could do the job, but also strongly from a position of offering collaboration and support rather than competition.

In the meeting all had an opportunity to speak. There was a growing agreement for the proposal until it came to the doctors to speak. The lead consultant from the Adult Mental Health Department openly confronted William - "We do not think you have the skills to do the job". We were all momentarily stunned, we had never seen consultants break ranks in public like this before. However, William held his own and the meeting ended with the doctors agreeing to continue meeting to sort out how they could work together.

The executive group decided to go ahead with the venture. I learned later that my speaking in the meeting had increased the confidence of the Chief Executive that we could develop the service. He saw me as an "expert case manager" and felt that my involvement would stabilise and support William.

Confrontation.

Following this time, my relationship with William deteriorated. Jan's leaving the department had left a big hole for many people. William no longer had someone to support him managerially and although I was willing to work more closely with him to help him make the transition, this proved to be impossible. He began isolating himself, became inconsistent and increasingly made unilateral decisions without consultation. I became worried for him and worked harder to try to help but could not 'get it right' for him. I understood that he might have felt abandoned by Jan, that he was feeling wounded by his medical colleagues and sought to overlook the frustrations of trying to work with him. I tried to hold things together when his decisions caused chaos and confusion. I became miserable and unhappy, then increasingly angry as I saw all the things the department had worked hard for at risk of slipping away. I sat on this for a while until 'one event too far'. He had made a decision involving me but without consultation or consideration for my feelings. I was insulted. I had to say something to him before a department meeting in which the particular issue would arise, but could not get to meet him so I wrote a long letter. I was concerned for him, I cared about him, and I regretted very much having to write rather than say this face to face, but I was very angry and wanted him to understand clearly the consequences of his management style which I saw as alienating of myself and others. I could only support him and work with him if he was prepared to be more open and collaborative.

William responded immediately. He caught me before an early morning meeting the next day, asking to talk. I did not wish to miss the meeting but he was clearly very distressed and I deferred. I do not wish to reveal the content of our meeting but the significance for me was that it was the beginning of me breaking the previous pattern I had seen as operating between us. I did nothing to soften the confrontation, although I did this with care. He offered to stand down as Clinical Director and for me to take his place. I refused as I saw this as constructing the situation as an 'either/or' struggle for control over territory. I did not see it this way. I replied by saying "I do not wish the job. But if I thought you genuinely believed I would be the better director, then I would consider it. I think you should sleep on that one for a while then let me know". This was never mentioned again.

Our relationship became more open for a while and so I risked disagreeing with him more openly, which on one occasion led to an argument in which we both lost our tempers and swore at each other. I felt then that he was not going to let me work more closely with him and it was clear that I could not replace the role Jan had played in supporting him. For many months our relationship became more distant again as William retreated into isolation.

Towards a realisation about power and vulnerability.

Over the course of the next year I took the lead in working with clinical teams from across the whole Trust in developing a consensus about the 'Patient Journey' from the point of referral through the ICU and back to the referring team again. This was in preparation for the opening of the service and was both challenging and productive. In that context William and I could work together, although he was very apprehensive about being challenged by consultant colleagues. After one meeting, a senior nurse from the acute psychiatry department commented that she had never sat in a multidisciplinary meeting which had been so open and such fun.

Another commented on my seeming hesitancy in opening another meeting in which I anticipated much difference of agreement and potential conflict. He said "you are a powerful person, why were you so tentative in opening the meeting." On inquiry he was referring to my inviting possible disagreement after framing the purpose of the meeting and the objectives we needed to reach, allowing a long enough pause for reply. I knew that there were different positions held by members of the meeting on the existence and the nature of the ICU, and I wished to test out whether they would be voiced and to create a space at the outset for that to happen. I wished to avoid the possibility that they would be voiced outside the meeting and thus lead to less robust decisions. I explained this to him, but he remained mystified as to why

I needed to do that. He saw it that I had enough "power to take people with you confidently". I in my turn did not see the issue in terms of power.

While this was happening, we were gradually losing direction within the department. In Jan's absence, Ann the ward manager had taken up a part time role as business manager and Gerry the senior clinical nurse had taken over the nursing lead. They both became members of the core group but were struggling in their new roles and did not have the confidence of the staff groups they were meant to be leading. Furthermore, the process within the core group left them feeling mystified and silenced. The process I described in the marketing meeting came to the fore again. I spent much time with both Ann and Gerry discussing our respective views of the processes operating in the department, hoping I could 'help them up to speed' in their new roles. However, this proved to be slow work, and neither seemed to be developing the confidence or skills which were required. I also spent time with William and Stewart, trying to support them in dealing with the problems which cropped up in the day to day services for which they had responsibility.

Although Stewart had agreed with the department taking on the ICU, he now thought it was a bad idea as it became clear about how much time it would take from senior staff to support it. William, who was continually anxious about the degree of cooperation he would get from other doctors, swung wildly from one extreme to another and in the face of Stewart's pessimism he himself became pessimistic. Within the core group meetings he joined with Stewart by engaging in negative and blaming dialogue about the way other departments were run and about the way the Trust was managed. Although I understood by now that this was William's way of dealing with the unacknowledged conflict between the two over control of the resources within the department, and as a reflection of his anxiety about his relationship with consultants in other departments, I nonetheless felt this as unproductive and silencing of others. By joining together in blaming 'outsiders' the two consultants seemed to be preserving the status quo.

Stewart was finding the drugs work tedious and overwhelming and was looking for ways of moving more resources from within the department into this area. This caused conflict among staff at many levels. Although William privately disagreed with Stewart's strategy, he would not confront the issue openly and explicitly as clinical director. He felt restrained by the assumptions within their shared professional world that no one consultant could tell another what to do, and restrained by his own assumptions about his role as clinical director that he needed formal authority from the Chief Executive to do so. The fact that the Chief Executive was also a part-time consultant rendered this as unlikely in William's view. Therefore he saw himself as being without authority to challenge openly the way in which Stewart organised his work and in which he covertly used a disproportionate amount of limited resources.

I alternated between two extremes. On the one hand trying to hold the core group together by supporting individuals outside the weekly meetings, on the other 'sitting back and letting it happen' within the meetings, feeling impotent to do anything effective. I became increasingly 'swamped', feeling as though I was losing my identity within the department and as though I was forever doing 'damage limitation'. It seemed that the more I moved forward in developing the ICU work, the more unstable things became in the department. I felt caught between the two extremes.

I also felt strongly that I was wasting my time being in the core group, that I should withdraw from it and get on with my own work. It seemed clear that the only rational alternative to the current chaos was to work with like-minded people in developing the ICU and to redraw the boundaries around clear psychological treatment roles within the department and work with people who were interested. I needed to take charge of my area of responsibility and put a boundary around that so that I could protect myself and the other psychologist from the chaos. My style of seeking to support communion had lead me into feeling flooded and overwhelmed and 'out of control'.

But equally strongly, I felt a reluctance which gave rise to many questions. What was my 'own work' within the department? I had repeatedly declined to 'take control of psychological

treatments' in an agentic and high profile way. What was it that I could now retreat to given that my purpose had been to diffuse 'psychological treatments' into the fabric of the department and not make it a discrete entity? If I decided to put a boundary around 'psychological treatments' where would this be? But most importantly why had I not done this before? If I had, I would not now be in the situation of feeling that all I had worked for was in a precarious position. Although I could understand that the department was going through a process of adaptation and change in taking on yet another venture which required a re-negotiation of relationships, that explanation alone did not help.

Although the frame of gender and agency and communion partially helped me understand these dilemmas, although I could see the need for exercising more agency to protect the modality of communion in my work, and although I could see a strategy for doing so, I could not understand my reluctance. I wrote at length about the dilemmas but could not find a way through. I felt in an emotional turmoil and discussions with Jan about this often led to conflict She would highlight or point out alternatives with which I could rationally agree but to which emotionally I felt enormous resistance and to which I would reply "yes, but...". As I wrote further in my reflective diaries, I realised that the theme of power and powerlessness connected all my feelings and frustrations. I realised that I needed to confront this. I had been ignoring power as a 'reality' and it was now presenting itself to me in a way I could not ignore. In the following chapter I explore the literature on power and find some conceptions which fit with my values. I also discover some 'life scripts' which have been implicitly informing my relations with power and men. These discoveries allow me to 'move on'.