TOWARDS THE RE-CONSTRUCTION OF A CLINICAL PSYCHOLOGIST AND A REFLEXIVE BODY OF PRACTICE.

7. Preparation for Action Inquiry

Introduction

Having set aside the idea of a Cooperative Inquiry group for the time being, I immersed myself in practice. By now there had been many developments in the department and I was working across a number of different teams, supporting the changes. I was still keeping a 'noticing eye' on my practice, capturing experiences in notes and journals as I went. However I was feeling rather dispirited as a researcher, wondering how I would ever get started. I was doing increasing amounts of work around 'difficult' or 'complex cases' but I still felt wary about having explicit conversations about what I was doing and what I was trying to achieve. Nonetheless, in preparation for 'the real research' I began considering how I might test out in practice the relevance of some of the concepts from Torbert's Action Science.

By way of providing a background for this 'testing out' I want to develop two strands in this chapter. The first is to describe changes in the department in terms of the services provided, the roles played by different members, and the relationships between them. This 'thick description' will provide a set of context's for construction of meaning about the events I wish to describe in subsequent chapters. In terms of Cronen and Pearce's (1986) set of embedded levels of contexts for construing meaning, I will be describing some of the patterns at the level of *relationship* and at the level of *cultural beliefs* (including professional and organisational) which I discerned to be operating at the time.

The second strand in this chapter is my further reading of Torbert's model of an Action Inquiry. He uses the terms Action Inquiry, Living Inquiry, Community of Inquiry, and Collaborative Inquiry, in a somewhat interchangeable way across his writings, according to his particular focus. I will stay with Action Inquiry as a broad term to cover his work will present several aspects which seemed to offer potential rigour to an inquiry into my own practice.

As a narrative comment, these two strands are contiguous not only in terms of framing the next stage of my research journey, but also because they signal the emergence of power as an issue in relationships. In the account which follows, based on diaries and records written at the time, I describe how I saw power as operating in practice. At that time I was standing outside these descriptions, unaware of my own implicit framings and unaware that I was seeing power in terms of an attribute which individuals possess. From my reading at that time of Torbert's (1991) model of power at the heart of his Action Inquiry, I saw myself as having only limited forms of power and hence 'side-stepped' it as having only limited potential relevance.

I will revisit power much later in this thesis, describing how, toward the end of the research journey, I developed a more multi-dimensional view which was more thoroughly grounded in personal experience. It was only at this later stage I came to realise more consciously that I was seeing the consultants as 'having' power and myself as being 'power-less' in relation to them. In the meantime, this chapter contains the seeds of that later awareness.

This chapter has two parts;

- an account of further developments in the work setting;
- further readings from Torbert's Action Inquiry model.

Further developments in the work setting.

By this time, the department had reorganised into a completely different format from when I had first arrived. This had been based on a department-wide consultative and planning process which Jan had led shortly after her arrival. We had broadened our remit to include all forms of addictive behaviours,

although substance misuse of one form or another was still the main presenting problem. We now had a community team, coordinated by the most senior clinical nurse, which comprised community psychiatric nurses and counsellors who worked in different localities alongside other community services. This was backed up by a range of hospital based services, including in-patient assessment, inpatient detoxification, and various day-time psychological treatment and support activities. Augmenting both community and in-patient services was an outpatient service (providing assessment, consultation and follow-up treatments) delivered from the hospital site and provided by doctors, nurses, psychologists, occupational therapists and social workers. The most senior and experienced staff were based in this setting because it was both a local service to the health district as well as a regional and national specialist service.

I saw the patterns of working together across the department and between the disciplines as being strongly influenced by the interests of, the roles played by, and the relationship between the two consultants. At that time I felt that any initiatives I took would have to be in relation to the consultants as they expected to take lead roles in determining the direction and nature of services delivered. I saw the issue for me as finding a relationship with each respectively in which there was mutual recognition and support, therefore I needed to understand how they worked, what they hoped to achieve, and where they were 'coming from'. These were the lenses through which I observed relationships in the department at that time.

Working together - cooperation and conflict..

By now all staff were conversant with working with both alcohol and drug problems, apart from the two consultant psychiatrists who retained their separate interests. Stewart had a strong interest in illicit drug misuse and had obtained public health funding to do HIV/AIDS prevention work. This occurred mainly through the provision of legal prescribing of substitute opiates to minimise risk and reduce harm associated with the injection of illicit drugs and the chaotic and criminal lifestyle which surrounded their use. Stewart took on consultant psychiatrist responsibility for those clients seen by the community team and those admitted to hospital requiring drug detoxification and management of drug problems.

William, on the other hand, took consultant psychiatrist responsibility for the hospital based services and for those clients across the service who had alcohol and related problems. However, the way in which they had divided their work created tensions for themselves and others, most of which remained implicit. For example, although William had consultant responsibility for patients in the hospital based services, Stewart exercised complete autonomy over services to drug patients. Gradually, the available resources became increasingly used to meet the needs of drug users and William appeared to allow this to happen. Also, although the community team saw individuals with alcohol problems, it was Stewart who provided medical consultation to them on this area. Team members commented privately that Stewart seemed less interested in these problems and as a result they took second place in team case reviews.

The implications of this were that when there were conflicts of interest arising out of meeting the needs of drug versus alcohol patients, in both the hospital and the community settings, resolution was difficult to achieve because of the unacknowledged differences between the two consultants.

My reading of this was that there were two factors at work. Firstly, the professional socialisation of doctors deeply ingrained a belief that a consultant could practice with complete autonomy, no one had the right to tell him or her what to do (It was widely held within health circles that the central government reforms of the 1980s were intended to interrupt this state of affairs). Secondly, Stewart was a strong advocate for the role of substitute prescribing as a means of changing patterns of drug misuse. He believed that drug use was endemic in our society and that many of the accompanying problems were caused by its illicit nature, placing the selling of drugs into the hands of international crime with the subsequent exploitation of drug users, forcing them to use adulterated substances with risk to health and forcing them into crime to pay exorbitantly inflated prices.

On the other hand, William was deeply against prescribing on moral grounds and was adamant that he did not want to prescribe "free drugs". Nor did he wish to enter into the sort of co-dependence with drug users which came with prescribing, often for years on end. However, he accepted that it was

reasonable for this sort of service to be provided because of its ability to prevent spread of HIV. This difference was not discussed in public by the two, but I knew that if William were to challenge Stewart about his transgressing the boundaries, Stewart would challenge back about William taking on some of the prescribing load. The two retained a cooperative working relationship by joining together around mutual interests as consultants, such as pay and working conditions, teaching of medical students and junior doctors, and their responsibilities for doing the after hours 'on-call' rota for responding to emergencies within the wider Trust. Complaining about central management by the Trust executive group was an additional 'shared reality'.

However, over time I came to see their relationship in a slightly different light, in relation to more subtle issues arising out of the widely accepted 'medical world view'. This world view afforded both power and vulnerability. Each consultant had their basis of professional authority and identity within medicine. Neither consultant wished to work in mainstream psychiatry for a variety of reasons, but both had an interest in psychological treatments and so working in addictive behaviours provided a solution to this dilemma. However, they had received only a limited training in psychological methods and had only limited expertise in psychological treatments. So they drew their power and authority from within medicine with its emphasis on the primacy of the doctor's medico-legal responsibilities, on diagnosis, and on treatments which clearly and logically followed from this diagnosis. However, this 'medical model' does not map easily onto the complexity of problems with mental health and illness. Diagnoses do not provide a neat description of the aetiology and course of the 'illness', and nor do they provide accurate predictions about treatments or prognoses. Nonetheless, the model still holds primacy, both within health circles and by the public at large.

If the consultants were to step out of this territory, then they would lose a substantial amount of their influence when working alongside other professionals who were at least as skilled, if not more so, in the various competencies required to deal with mental health and illness problems. They each required the other for affirmation and support in their roles as doctors, and therefore would turn to the other for this in times of uncertainty, risk or conflict. This provided a position which afforded safety and certainty and maintained their power, but it was also a position which did not support change and transformation as it kept them firmly within a positivist world view. It also located them in continued reliance on Argyris and Schön's (1974) Mystery-Mastery strategy. The reliance on this strategy is not unique to doctors and is one I observed from time to time within psychology, although with a different texture due to a different power base.

A further factor establishing doctor's centrality in mental healthcare is their statutory role to sanction admissions and discharges from hospitals, to detain patients under the Mental Health Act, and to prescribe medical interventions such as medications and some physical therapies such as electro-convulsive therapy. Nurses similarly are required by law to provide healthcare to patients in hospital setting. By contrast, Psychologists and other 'Professions Allied to Medicine' have no such statutory roles and mental health services are not under a statutory obligation to employ them, although it is recognised in codes of practice that services should be multi-disciplinary.

This was my understanding at the time of the roles the two consultants played in the department and of how I saw these roles being maintained by both power and vulnerability. I located myself outside such an analysis. Implicit in it is a construction of them as 'having' considerable power to set the agendas and determine the pattern of service delivery, and of myself being relatively 'power-less'. This was a construction which was to 'shadow' me for some time to come,

I have already alluded to the introduction of substitute prescribing as having considerable influence on patterns of service delivery and relationships among the 'actors', but I would like to elaborate on the nature of this influence because it is a significant fulcrum around which differences in viewpoint, and hence conflict, occurred.

Substitute prescribing - a 'double-edged sword'.

Most of the original drugs team (Nurses and Counsellors) welcomed the arrival of substitute prescribing with Stewart because they felt they had not been able to attract drug users to the service without it. On the other hand it was an activity which had come to take centre stage in most of the

interactions between staff and clients, and between those staff who worked in this part of the service and Stewart.

Stewart saw prescribing as the "lever for change" with drug using clients, using it to attract them to the service then using it to both meet their immediate needs while at the same time requesting change in behaviour and attitude in return for its continuation. In the early days he described it as a "bargaining tool". However, there was a 'flip-side' to this which meant the health worker was now tied to the client in responsibility for maintaining the supply of a powerfully addictive substance. Many drug using clients frequently presented in crisis, unable to adjust to the routine and limitations introduced into their lives by being on a script - for example, regularly collecting it from the pharmacist, attending weekly appointments for counselling and review sessions, and so on. When the client was in crisis because they had prematurely used their script, or lost it, or for many other reasons were not coping, then there was a high degree of urgency for the worker to respond. Drug using clients could place severe pressure on services to respond immediately with complaints, threats of violence and actual violence. This placed all in a tightly bound relationship with its many frustrations.

By initiating this service, Stewart had unfolded a far bigger pocket of hidden need among the population than anyone, including himself, had imagined. He could not see everyone and had insisted that every client on a script had a drugs counsellor (a role played by a range of staff) who had to take responsibility for assessing and meeting their needs This included the week-by-week negotiations for any changes or reductions in scripts as they supported the clients in reducing their drug use and in making changes in their lives. This could work well or badly according to the stage of motivation the client had for really making change. This arrangement placed Stewart or his junior doctors in a particular hierarchical situation in relation to both client and other staff and he had not organised this in a way which made it easy to manage. The onus was on the drugs counsellor to find Stewart or one of his junior doctors and provide them with all the relevant details. This lead to much frustration and stress for all.

It had been agreed at the outset of my job that I would provide some support to Stewart in developing the drugs side of the service. I did this through being part of an assessment team seeing drug clients for the initial assessment and making decisions about how their needs could best be met within the resources across our services, including being placed on substitute prescriptions. I had not worked in a service which offered prescribing for drug users before and was interested to learn what the issues were.

However, having done this for some time, I had decided by now it was not the best use of my skills to spend time with clients who, for the most part, did not particularly want to learn alternative ways of managing psychological stress or distress at this stage of their drug using careers. This did not discount their need for such a service, it was more that my skills were better placed at other contact points. In addition, I did not enjoy being placed in such a powerless position, trying to meet client needs by pursuing doctors across busy timetables for scripts. It was gradually becoming clear to me that I would be more effective if I only took on directly those cases where there was an agreed need for specialist psychological interventions.

I had tentatively tried to raise these issues for discussion but did not feel my immediate nursing colleagues at that time wanted to confront the issue. It seemed they saw their power base as coming from the interdependent and delegated role relationships with a doctor. I had one or two confrontations with Stewart but these did not lead to any meaningful discussions where there was mutual listening. I needed Stewart's support if I was to work effectively with drug users, and he needed me because ultimately, as he often put it, "despite all the pharmacology involved, at the end of the day it is all about psychology" However, we had different ideas about the nature of that psychology.

It was clear to me that the roles the doctors played were a major factor influencing the degree of flexibility required for adaptation and change. I saw myself as having to negotiate my way between and around the implicit and explicit differences and conflicts of interest, while at the same time maintaining my sense of personal authenticity and hopes for an open, relevant and alive service. I felt that I needed to develop a more collaborative relationship with them in those areas of my work where there was a necessary interdependence. I saw possibilities for this within my relationship with William but was unsure of how to achieve this with Stewart. In the next chapter I describe my practice with two

'complex cases' in which I attempt different ways of working in relation to Stewart around the focus of casework. But before moving on, I wish to give a more expanded description of the roles I had developed within the department and of the network of relationships of which I was a part. Again, this is with the intent of creating a backdrop for understanding developments in the research.

My roles within the department.

I was responsible for the small psychology budget and had now employed a junior psychologist to support the community team and together we had two-tenths of a secretary. My job was to provide specialist psychological treatments to the department within these resources and to provide teaching and supervision to psychologists in training. While I was seen by others as taking the lead in the psychological treatment area, I did not want to do so in the traditional way which would have placed me outside other arenas. I ran the risk of giving up a degree of formal power over psychological treatments for wider and less easily understood roles because they afforded the opportunity for participating in wider change in how services were given.

This was another 'double-edged sword' as I saw it. Claiming sovereignty over psychological treatments, as had other psychologist colleagues in the Trust, would place me in an overt position of being in charge of a certain range of activities. On the other hand it would also place me into conflict over territory, particularly with the two consultants who saw themselves as having the expertise to assess for and prescribe a range of treatments, including psychological. Rather than remaining located purely within the role of providing formal 'psychological treatments', I chose instead to occupy a range of roles which allowed me to work more flexibly in supporting others in developing their psychological skills and knowledge, and at the same time facilitate the delivery of quality health care.

I was happy for others to take up psychological treatment roles and to support them in this, even if they did not closely follow prescribed methods. I was careful to ensure they operated within their competencies, skills and responsibilities, and sought to complement what they were doing rather than prescribe how things should be done. I would take on cases only after consultation and being sure that my skills were needed. Accordingly, I only took those cases which were complex or required a degree of specialist skill or expertise not able to be provided by other team members. Carrying a caseload myself and supporting others in carrying theirs was my base within the department.

Taking on a range of roles enabled me to understand the organisation from a number of vantage points. As a member of the Core group I developed an understanding of the strategic development issues we faced. These spanned service agreements with Health Authorities across the region, relationships with other departments in the Mental Health Unit and with other agencies in the district, and the internal administrative procedures and resources required to support staff in fulfilling their roles. The Core group was not so much a forum in which decisions were made, rather it was a place in which ideas, stresses and tensions were aired in various forms.

I had also taken particular responsibility for ensuring the smooth running of outpatient clinics so learned first hand about the views of secretarial and administrative staff and how the department appeared through their 'eyes'. I learned that the conflicts and difficulties which arose from time to time mirrored the differences between the consultants. This had to be worked around to ensure the clinics functioned effectively.

Through my clinical work, I was developing a closer working relationship with several nurses as well as the Ward Manager on the inpatient ward. This enabled me to understand what their day to day work was like and what the issues were that they faced. The Ward Manager saw me as someone who could support her and had asked me to work with the nurses as a group on several occasions in helping them audit aspects of their work, and in dealing with clinical problems. Two of the nursing team had started consulting me about their case work.

Through providing supervision to the junior psychologist and several community team members, I had access to their experiences in both providing community based services and in referring in their clients for hospital based care and treatment. I was able to provide for them the alternative view of what the hospital-based services were trying to achieve and what the overall direction was which we as a

department were trying to take. Several members of the community team had worked for many years in the old hospital based service and tended to construct a 'them and us' view and I found myself providing a mediating viewpoint and on occasions a very challenging viewpoint when I felt some of their criticisms of the service were demeaning of the efforts others were making. Within the department, my roles 'bridged' many different sub-systems and I was later to realise how this afforded my much influence in facilitating change.

For the time being I did not see this as a form of power, in fact I often felt isolated by occupying this multiplicity of roles because few were able to understand what it was I was trying to achieve. Fortunately, I was able to find a small network of people in the wider health care system who had similar ideas. Within the department, Jan and I had a partnership in ideas as well as being a couple and were able to work together in supporting each other and I will weave this as a strand into the research from time to time.

Relationships between the department and the 'wider world'.

Finally, as part of a wider mental health organisation we were going through the phase of developing service agreements with the health authority and preparing for Trust status. This meant that we were to become a "self-managed" legal entity as a healthcare provider which would enter into contractual agreements with purchasing Health Authorities. It was becoming clear that we were not going to generate enough income from our existing purchasers (which include several other surrounding health districts) and we were about to develop a marketing strategy. In preparation for this Jan, in her role as Directorate Business Manager, had found funding to extend and refurbish our buildings, increasing our bed numbers and giving us more options for developing services.

The process of developing a marketing strategy was to eventually change the way our department worked with outlying districts who referred in to us, highlighting differences in attitudes within the department and giving rise to more explicit conflict. This creates a setting in which I revisit the issue of power later in the research.

In the meantime this is the backdrop against which I focused more on practice, setting aside for the moment the idea of Cooperative Inquiry, and instead exploring alternative possibilities from within Action Inquiry. In preparation for reporting this in the next chapter I will now present those aspects of Action Inquiry which seemed most salient to my practice at the time.

Further readings from Action Inquiry.

Although Torbert (1981) warned that Collaborative Inquiry was an experiential process, occurring in a more or less distorted and incomplete fashion at any given moment, I was still unable to fully appreciate its relevance to me at this point. I was unaware of how much I was in the grip of certain old paradigm notions of research, most particularly, 'once you have chosen your focus and your method, stay with it despite inconvenient interruptions'.

However, I had been reading more of him and Jan had introduced his work 'Power of Balance' (Torbert, 1991) to William, the clinical director. The three of us from time to time referred to some of his ideas. At this point more of his ideas were seeping from the background to the foreground of my awareness as usefully informing my practice. The ones I will present here are:

- his operationalising of the interpenetrating attention span at the level of interpersonal dialogue;
- his development of various concepts of power to form a liberating and transformative 'Power of Balance';
- the associated developmental model of leadership which is required in order to exercise a power of balance.

An interpenetrating attention span.

Torbert (1992) operationalises the concept of an interpenetrating attention span (embracing the four territories of experience of purpose, strategy, behaviour and outcomes), for use in dialogue at the level of individual practice. Purpose, strategy, behaviour and outcome are translated into the terms 'framing, advocating, illustrating and inquiring' respectively. His premise is that if even one, two or three individuals in an organisation practice quality improvement with regard to their own actions, the organisations effectiveness can improve. "If the organisation's leaders are sufficiently artful devils, widespread, committed, inquiring participation may be the eventual outcome but it is scarcely the starting point" (p5).

- *Framing* refers to the speaker explicitly stating what the purpose is for the present occasion, what the speaker thinks the dilemma is which requires resolving, and what assumptions the speaker thinks are shared or not shared. The speaker can either suggest a frame for resolving a dilemma, or invite a surfacing of frames which others are bringing into the situation in order to minimise confusion of purposes. The aim here is to increase one's own and others' awareness of a shared question, vision, or mission.

- *Advocating* refers to explicitly asserting an opinion, perception, feeling or proposal for action. Torbert maintains that typically such assertions are expressed in terms of action but seldom in terms of feeling. Alternatively, he proposes an early and "vulnerable description" of feeling to minimise defensiveness and to invite openness from others. The aim is to increase mutuality and internal commitment among the actors or participants.

- *Illustrating* involves telling a concrete story to "put meat on the bones" of advocacy with the intention of orienting and motivating others. It also gives clear implications for action, or directionality, which advocacy alone may not give. The aim is to highlight incongruities or lack of alignment between individual, group and corporate objectives, actions and effects.

- *Inquiring* involves questioning others in order to learn from them about their perceptions of what has been framed, advocated and illustrated. The aim is to engage in a verbal form of action experiment which seeks to realign objectives, actions and effects across individual, group and corporate levels.

Torbert characterises this interpersonal strategy through dialogue as 'gently assertive inquiry' in which the actors pay more explicit attention to the dialogical nature of experience. The achievement of a balanced integration of these four kinds of speaking is not oriented toward attaining preconceived outcomes, but rather toward increasingly high quality awareness and genuinely informed action at individual, group and corporate levels. It is through this process that he believes effective outcomes become more likely. I was not sure about how smoothly this would translate into practice, but it would be one way of moving towards more explicit inquiry and hence address in part the concerns I had about authenticity as a researcher.

The particular appeal which the concept of an interpenetrating attention span held for me was its systemic quality of linking 'internal' elements of experience of the individual with outcomes or feedback from the 'external' world. It also offered a map for making sense of feedback loops between self and groups, and between groups and larger organisations. It held some analogic connections to Bateson's (1979) concept of mind as 'the pattern which connects'. Bateson conceptualised 'mind' as extending beyond the level of intrapersonal cognition and awareness to include all the elements within the field of awareness and the information feedback loops connecting all the elements. In the example of an individual chopping firewood, Bateson poses the idea that mind includes the person in action, the axe and the wood - the person swings the axe at a different angle according to the changing shape of the cut, and the cut changes shape in accordance with each swing of the axe. This set of information loops occurs in a wider context of information loops, all potentially connected in a non-linear fashion, according to whichever 'punctuation' the observer makes.

In Bateson's concept of mind he poses the conundrum of whether purpose exists, in the sense that no one element of a system has control over the others or in any way is causal. Any event, in a cybernetic

model of events, is both cause and effect. The concept of purpose implies a sense of 'causality', as if a chain of events emanates from some purpose. Torbert's main framing of the interpenetrating attention span can all too easily suggest a punctuation whereby 'purpose' has a particular power as a causal factor. I was grappling with this at an experiential level. Purpose often seemed to occur at multiple levels across time, frequently unravelling the more I questioned it, and often seeming to emerge out of action. To illustrate, I will recount an experience at a conference.

> During an experiential stream between workshops, a group of us went through a series of Tai Chi exercises with an instructor, one of which was called 'Sticking'. It involved one of a pair being a follower and the other a leader. The pair started with establishing hand to hand contact with hand outstretched and palm down, the follower's hand on top of the leader's with just the necessary degree of pressure to achieve a contact which was that of touch without weight. The leader then led the follower, whose eyes were closed, in a series of spontaneous movements, but in such a way that the lightness of hand contact was maintained. Then the roles were reversed. During de-briefing each of us in the pair discovered that we had shared the experience of rapidly losing sense of who was following and who was leading. There seemed to me to be different levels of purpose for and during the exercise, the highest level seeming to be the creation of a dance of participation in which the dancers lost sense of themselves and became aware of only the dance. This was not apparent before the exercise. Was this purpose, effect, or both?

Torbert's more recent writings addressed the wider context in which Collaborative Inquiry could be practised. This is presented next and I take ideas from that which spoke to my research at that time.

Power of Balance.

In his work entitled 'Power of Balance' (1991), Torbert advocates that we need a theory and practice of a *liberating structure* - a theory of power, a practice of management, and a method of inquiry that integrate freedom and order, empowerment and discipline, inquiry and productivity, transformation and stability.

He proposes that leaders in various areas of enterprise can and must exercise an inherently positive kind of power in order to succeed in generating and sustaining organisations that are empowering, productive and legitimate, and appropriately manage change in turbulent environments. He calls this type of power *'The Power of Balance'* , comprising a dynamic blending of four constituent types of power; unilateral power, diplomatic power, logistical power and transforming power. He proposes that when transformative types of leadership are linked with Action Inquiry within this paradigm of power and justice, then liberating structures can be created.

It was his analysis of power which captured my attention as being relevant to the early stages of my research. I saw power as something which would almost certainly crop up in any inquiry into teamwork with differing disciplines which had differing world views and degrees of authority. However, the development of a liberating structure, linking Action Inquiry together with differing types of transformative leadership, seemed out of reach to me initially. I saw it at the time as requiring formal authority in an organisation which lent unilateral power, the necessary ingredient for creating the conditions for more liberating structures.

The key aspects of the four different types of power which stood out as seeming relevant for my initial purposes were as follows.

• *Unilateral Power.*

Defined as the ability to unilaterally and uni-directionally cause the outcome one wishes, unilateral power is the most frequently used modern conceptualisation of power. Torbert dates its development from Hobbes in the seventeenth century and traces its presence in social, political and economic theory and social organisation since that time. In its most basic form, Hobbes saw it as the physical power to kill. He reasoned that it was the fear of death that motivated people to yield their individual power to a

sovereign who could then use the much greater collective power to secure an order which, no matter how uncomfortable, protected people from the "war of all against all". Within this conceptualisation, the sovereign must have supreme power because any sharing of power allows for division and struggle for power which he is seeking to prevent in the first place.

The ethical theory which most closely matches unilateral power is the Utilitarian ethic of the 'just decision' which procures the greatest good for the greatest number of people. It maximises pleasure and minimises pain, that is, maximises utility. This perspective, Torbert notes, implicitly requires either an omniscient rational sovereign, or a kind of rationality in both individuals and society which calculates how to prioritise desires to achieve the greatest good for the greatest number. He argues that there is no mechanism available in this construction of power to regulate or mediate conflict between competing frames of 'what is good' according to membership of different groups in society. In modern terms, the exercise of unilateral power is seen in more bureaucratic, rational and impersonal allocation of resources. In societal terms, it emphasises the physical, monarchial, executive function of state.

Torbert also comments that this form of power gives rise to asymmetrical relationships in which the power may be exercised through mechanisms other than physical force, for example social attraction and cognitive structures such as an organisational chart.

My own sense of the usefulness of this construction of power was that it allowed me to see how it operates currently within health services. Many individuals (as patients and as health professionals) have surrendered sovereignty to doctors over their own knowledge and power in relation to health and illness and its treatment and remediation. In turn, I saw doctors frequently appeal to this type of power in presuming there is a right way of doing things according to rational calculations and knowledge to which they alone have access. This is not the only power relationship at play, but I have observed this in operation when there is a conflict of interests between professionals.

I could also see that there may well be instances whereby use of unilateral power is required temporarily to initiate changes toward more partnership types of relationship. The challenge would be finding ways of moving on from this initial position to a more collaborative one. A possible counter to this form of power, within Torbert's analysis, is to provide alternative cognitive structures or frames which provide a different appreciation of events under consideration.

• *Diplomatic Power.*

This comes from Rousseau's conceptualisation of power - that which is yielded by consent (as opposed to wielded by might). A leader is successful when discerning accurately what the governed actually want and presenting proposals that gain their consent. Rousseau conceptualised that an individual is free only when obeying his or her rational will, and that because rational will is internally consistent and generalisable, everyone's rational will will be the same. Hence a state governed by rational will is a state in which individuals are simultaneously united with all and free to do as they wish.

Although Rousseau draws a conceptual distinction between the general will and the private will, it is not clear how this distinction can be drawn in practical and political terms. The diplomatic type of power relates to justice as being legitimate, as being according to the peoples' will. It emphasises the democratic legislative function of state.

• *Rational, logistical power.*

This conceptualisation of power was developed by Kant who extended the rational aspect of Rousseau's diplomatic power. Kant transformed the idea of freedom as obedience to a rational will into an ethical injunction for individuals to exercise their own rational will. Only when individuals exercise reason and rational will are they free. Kant envisions a society in which, through exercise of a reason which is universalisable, individuals are highly independent and free, never coerced, persuaded only by rational argument , and afford rights to others which they would claim for themselves. Power is the ability to do something rational rather than being caused to do something by internal desire or external pressure.

In this conceptualisation of power, Torbert argues that Kant relates power, authority (legitimacy) and justice as being mutually coterminus. It emphasises the rational judiciary function of state.

These three types of power were immediately recognisable to me within my own experience. The fourth was intellectually recognisable but the practice of it seemed a complex and lifelong journey and seemed unavailable to me at the outset of the research. I will include it here as analytically linked to the other dimensions of power, but will refer back to it in later chapters.

• *Integrating Unilateral, Diplomatic, and Logistical power to create a Transforming Power.*

Torbert draws upon Rawl's (1972) theory of justice as offering a fourth type of power, one in which the above three categories of power are integrated into a vision of a just and humane society. This vision is based on considerations from developmental theory and levels of moral development as the individual moves through the life cycle. There are two principles of justice at the heart of this vision:

> • Firstly, each person is to have an equal right to the most extensive total system of equal basic liberties compatible with a similar system of liberty for all.
>
> • Secondly, social and economic inequalities are to be rearranged so that they are both to the greatest benefit to the least advantaged, and attached to offices and positions open to all under conditions of fair equality of opportunity.

The first enunciates a system of liberties to which all are entitled. The second generates additional considerations that will attract the consent and approbation of all citizens and lead to utilitarian results. Torbert sees Rawls' theory as integrating rationality, rights, consent and utility.

Rawls uses an educational paradigm in which parents formulate rules comprehensible to their children, enact a consistent morality themselves and gradually make underlying principles explicit. He sees that it takes more than reason alone for people to both apprehend principles of justice and to practice them. In a just society parents help their children develop through a process of applying unilateral and diplomatic power, love, and an awareness of incongruities between one's own reasons and actions. Torbert sees within this paradigm the requirements for the same kind of awareness he expounds in his model of Collaborative Inquiry - namely one which embraces the realms of intuitive principles, rational rules, actions and effects. Rawls repeats this again in his requirements for just action at a political and legal level, where an awareness is developed within the different realms of experience and incongruities among them are observed and corrected (I am not clear from my reading of Torbert to what extent Rawls theory of justice also informed his early work in developing collaborative inquiry).

Torbert identifies a gap between theory and practice in this conceptualisations of power and justice. There is no explicit guidance on how relatively unjust settings can be transformed into relatively just settings. He poses the question 'what type of power increases integrity, awareness, and justice, and how does a state, organisation or individual cultivate such power?' His answer to this is the concept of *power of balance*. He takes the four conceptions of power and links them with a proposition from Plato - the belief that individuals can repeatedly reconstruct the world in the face of crises or dilemmas in which current assumptions and logic do not equip them to resolve. Resolution is achieved through a revising or reconstruction of beliefs and assumptions about the world.

This is at the heart of the developmental model he formulates about managerial leadership. As individuals or acting systems move along developmental stages they increasingly exercise a dynamic blend of the four different types of power to achieve a 'Power of Balance'. I will summarise this model of leadership next, then follow with some commentary on it.

A developmental model of leadership.

Torbert proposes a developmental model of leadership in order to address the question of 'how can persons develop the capabilities required to exercise transforming power?' I include a brief description of the model here because it is an integral part of the concept of power of balance. The different stages are presented here in order of increasing level of development. As a series , the stages represent a

sequence of transformations through which an individual can progress towards an increasingly complex and holistic mode of being and acting in the world. It is only after the first four stages that Torbert considers an individual to be acting in a transformative manner. The first four represent world views associated with the four different approaches to power and justice outlined in his analysis of power. The later stages involve multiple and interacting use of the different types of power in transformative ways. The characteristics are summarised in the table below.

A DEVELOPMENTAL MODEL OF LEADERSHIP

STAGE	GOVERNING FRAME	LEVEL OF AWARENESS
Impulsive	Impulses rule reflexes.	
	Needs, interests rule impulses.	Outside world, effects.
Opportunist		
Diplomat	Expectations rule interests.	Socially expected behaviour, practice.
Technician	Internal craft logic rules expectations.	Internal logic, thought.
Achiever	System success in environment rules craft logics.	System success in environment, interplay of plan, practice, effect.
Strategist	Principle rules system.	Theory of historical development of system - environment.
Magician		Interplay of consciousness, thought, action and environment in Eternal Now.
	Process awareness (interplay of principle/action) rules principle.	
		Interplay of self and other systems in Kairatic History.
	Intersystemic development awareness rules processes	
Ironist		

From Torbert (1991)

A sample of the managerial styles associated with the different stages are as follows.

- *Opportunist:* Occupy a utilitarian ethical position. Have short time horizons; focus on the concrete, are manipulative and deceptive, reject feedback, externalise blame, are mistrustful, have fragile self-control, use hostile humour, flaunt power and sexuality, view rules as loss of freedom, punishes according to 'an eye for an eye', treats what one can get away with as legal, and has a positive ethic of "even trade".

- *Diplomat:* Occupy the ethical position of Rousseau and power through consent. They observe protocols; avoid inner and outer conflict, work to group standards, speak in clichés and platitudes, conform, feel shame if they violate norms, seek membership of immediate group; positive ethic of being 'nice' and cooperative.

- *Technician*: Interested in problem solving; seeks causes; critical of self and others based on craft logic; values efficiency over effectiveness; accepts feedback only from 'objective' craft masters; sees contingencies and exceptions; wants to stand out; positive ethic of sense of obligation to wider moral order.

- *Achiever*: Long term goals; future is inspiring; welcomes behavioural feedback; effectiveness and results oriented; initiator; appreciates complexity; seeks generalisable reasons for action; seeks mutuality over hierarchy in relationships; feels guilt if does not meet own standards; blind to subjectivity behind objectivity; positive ethic is practice of self improvement based on self chosen ethical system.

- *Strategist*: Delights in paradoxes, anomalies and unique events; respond to historical process as it generates events, not just goal related outcomes; commitment to theory which helps interpret events creatively and generate new order and organisation; all frames, including own, are relative.

- *Magician*: Continually re-invents own frames and is re-framing; tunes self to frames held by other actors, and to underlying historical and organisational rhythms; seeks the motivational challenge of each situation in its uniqueness; appreciates polarities and acknowledges the ongoing relation between them (dark and light); open to the opportunities for transformation in seeming disintegration; engages in action inquiry as social ju-jitsu.

- *Ironist*: Masks own reframing powers; more indirect, lower profile and impersonal; focuses on how the developmental process can be socially institutionalised; resulting liberating structures would make sense to organisational members at various stages of development and invite transformation; distances and tensions between actual and ideal accepted as part of essential condition of life, to be transformed when possible but never obliterated; cultivates high quality awareness across whole enterprise; allows an ironic interplay between outer 'mask' and authenticity.

I will conclude this chapter with a brief commentary on what I saw as the difficulties Torbert's power of balance posed for me at this stage of the research.

Commentary on Power of Balance.

The difficulties I had related to the developmental model of leadership, and to the concept of a transforming power.

Firstly, with regard to the leadership model, the concept of a developmental scale with an associated questionnaire which can be used by a researcher to rate others along a continuum of development raised questions for me as a psychologist with an original training in psychometric testing. I found myself asking questions such as 'how was the scale developed and on what population with what characteristics, what is the theoretical model of development from which the concepts are drawn, what are its psychometric properties (such as reliability and construct validity)?', and so on. This located me back in the territory of a traditional model of science, concerned with objectivity, with generalising across time and settings, and with prediction and control. I found it hard to reconcile this with the spirit of the emerging paradigm concerned with local knowledge and an intersubjectivist epistemology. I found it unbalancing in a way which seemed to tilt me away rather than towards collaborative inquiry as I saw it.

Secondly, and closely following this, I found the idea of locating other peoples' abilities within this model had the effect of positioning me as making uncomfortable judgements about them independent of the differing contexts which give rise to the meaning of any behaviour or relationship (including my own). For me the language used to describe the characteristics of the leadership styles implicitly devalues the first four stages in relation to the last three. In thinking about using these as a framework through which to view myself and colleagues I found myself in a 'me-and-them' distancing mode which ran counter to the frames I had at the time. I held 'joining-with' and 'valuing-everybody's-potential-to-contribute' as dominant frames. While I do not wish to present myself as someone who does not make judgements which are at times critical and evaluative, I did not feel comfortable with adopting a model which seemed to hold me in this frame. It was certainly possible to see myself and colleagues behaving in ways which fitted the descriptions (both the positive and the negative). But in so doing I found it

difficult to then either re-label behaviour or re-frame situations in a way which allowed for more flexible alternatives and possibilities. While there is merit in 'calling a spade a spade' sometimes, I could find little use for this as a beginning researcher. I also felt dwarfed by it.

These objections seem at odds with my use of the concept of life-span development in clinical practice. The latter is trans-theoretical heuristic which attempts to understand the notion of development as continual flux and discontinuous change, made sense of by individuals according to the social and cultural contexts in which their lives are embedded. It is also bounded by markers such as birth and death.

Thirdly, Torbert's 'transformative' power and his overall concept of the power of balance seemed unavailable to me in the early stages of my research. I saw it as requiring access to unilateral power to initiate changes and that this would need to come through formal authority or position which I did not see myself as having. I saw my own power base as coming from experience and tangible expertise which I could offer, and which others might or might not see as relevant. As such, diplomatic and rational power were the only forms I saw as being available to me.

Although Torbert sketches out his own notions of the organisational context within which his concept of leadership development takes place, I did not see this as an available context for taking meaning for myself at that stage.

It is not doing full justice to Torbert's model of a Power of Balance without also elaborating on his notion of a Community of Inquiry and the qualities of liberating structures which an organisation needs to cultivate in order to support transforming change. However, at that stage I was only beginning to apprehend the relevance of action inquiry at the more interpersonal level around my own case work, linked to the notion of 'experiments in practice'. I was still seeking a way of achieving authenticity before I could call what I was doing 'research' and not 'merely practice'. I will draw more upon Community of Inquiry and the implications for interpersonal strategies for inquiry as they become more germane for me later in the research journey.

Meanwhile, I wondered if the explicit use of the interpenetrating attention span, operationalised as framing, advocating, illustrating and inquiring, would help me inquire more rigorously into my practice. In the next chapter I present two stories about practice and reflect on them in relation to the research frameworks I had developed so far.