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POWER AND INFLUENCE IN SYSTEMS CONSULTATION

ABSTRACT
The disagreement between Haley and Bateson over the usefulness of the concept of power in accounting for problems in human systems is described. Seven propositions which address the main issues raised by the Haley-Bateson debate are then set out. Finally some clinical and ethical implications of these propositions are presented.

INTRODUCTION

The Haley-Bateson Disagreement. Controversy over the concept of power has characterized the development of systems consultation and family therapy from the earliest days (Dell, 1989; Fish, 1990; Hoffman, 1990; Simon, 1982). It may have begun with the division between Bateson and Haley during the Double-Bind Project (Bateson, 1976; Haley, 1976).

Haley's Position. Haley argued that all human relationships were characterized by attempts of one party to influence another (Haley, 1976a; Haley, 1976b; Simon, 1982). Humans invariably organize themselves into a hierarchy. Some power-struggles result in the emergence of symptoms, e.g. psychosis or intrafamilial violence. Therapists are influence experts who use their power to ameliorate symptoms. Therapy is a power struggle between the therapist and those aspects of the client-system which resist change. The therapist's job is to map out the power game surrounding the symptom and then develop strategy to influence the members of this game to behave differently. The responsibility for changing the client-system rests squarely on the shoulders of the therapist. The therapist may sometimes prescribe apparently paradoxical tasks in discharging this responsibility. Providing clients with an opportunity to develop insight into the game surrounding the symptom is not the responsibility of the therapist, although such insight may occur as a result of behavioural change. Therapists who do not take responsibility for ameliorating their clients symptoms through the use carefully selected influence strategies are viewed by from this perspective as being unethical, insofar as they are often ineffective helpers (Haley, 1976a, Chapter 8). Some avowedly non-strategic therapists use therapeutic style which does not involve conscious attempts at influencing clients. Such therapists believe that this style is an effective way of helping clients resolve presenting
problems. In such situations, from Haley's perspective, the use of the non-directive style within sessions is paradoxically a strategic intervention since the style is adopted with the overall intention of influencing the family in the long term.

**Bateson's Position.** In contrast to Haley, Bateson argued that power was a myth (Bateson, 1972). He said: "The idea of power corrupts... Perhaps there is no such thing as unilateral power. The man in power depends on receiving information all the time from outside. He responds to this information just as much as he causes things to happen...It is an interaction and not a lineal situation." (1972, p. 486). It is not the case, argued Bateson, that the non-symptomatic members of a family exclusively and unilaterally influence and victimise the symptomatic member. The symptomatic member of a family also influences the non-symptomatic member. No one member of the client system can be held fully accountable for the symptom or problem. No one can be exclusively blamed. The notion of mutual influence holds for the therapeutic system also. For Bateson, a systemic model of therapy must view the therapist and family as members of a single therapeutic system in which the therapist influences the family and the family influence the therapist.

Therapists who endorse the myth of power and attempt to unilaterally influence their clients run the risk of harming their clients by coercing them into patterns of behaviour which reduce the flexibility, potentiality and complexity of their social ecosystem. The therapists job is to construct with clients, new and different ways of looking at the symptoms and the social context in which they are embedded. These new punctuations of the situation must be perceptibly different from the clients' original way of construing the symptom and its context. The new ways of looking at the problem situation provides clients with opportunities to choose alternative ways of dealing with the presenting problem or symptom. These new ways of handling the problem should not be prescribed by the therapist but should be chosen by the clients. Good therapy leads to solutions which entail the resolution of the presenting problem in a way that fits with the clients social ecosystem.

**The Current Status of the debate.** The power-debate, left unresolved by Haley and Bateson, continues to the present. For example, the split in the Milan Team may be viewed, in part, as a disagreement about power and influence in therapy. Selvini-Palazzoli's (1986) paper on dirty games is reminiscent of Haley's position. The constructivist position of Cecchin and Boscolo is distinctly Batesonian (Hoffman et al, 1989). Clinicians and researchers concerned primarily with problems that involve social inequality or physical violence often take up a position similar to Haley's. For example, both feminists
(McKinnon and Miller, 1987) and child protection advocates (Will, 1989) have roundly criticized Batesonian ideology. They have argued that clinicians must include the concept of power and its abuse within their theories and prescribe methods for dealing with inequality and abuse of power in clinical practice. Batesonians have responded by insisting that clinicians must distinguish between contexts where therapy is appropriate and contexts where social control is called for. The therapist must then offer therapy or exercise statutory power depending upon the requirements of the case (Hoffman, 1985, p. 394).

In clinical practice, the criteria by which such distinctions can be made usually entail reference to concepts such as risk, dangerousness, capacity for self-protection or illness which fall outside of Batesonian theory. Insofar as this is the case, a Batesonian approach to systems consultation falls short of the needs of both practitioners and clients.

SEVEN PROPOSITIONS

The issues raised by the power debate permeate daily clinical practice and research. In the remainder of this essay a number of propositions are presented which offer a solution to some of these issues.

1. **Actions have the power to influence others, in part, because of their meaning.** The outcome of an attempt to exert power over another person and influence that person to act in a particular way may be due to the physical properties of the act of influence, or to the meaning of this act, or both. For example, if Tim hits Sue and she becomes unconscious, it is the physical properties of Tim's action that have influenced Sue to become unconscious. If, on the other hand, Tim threatens to hit Sue unless she has sex with him and she complies with Tim's wishes, then it is the meaning of Tim's actions that influence Sue to comply. The meaning which Tim's threats have for the couple will be determined by the social context within which they occur. This social context may have multiple levels including the meaning of the individual words; the meaning of the episode as one of a series of episodes; the meaning of the episode within the context of Sue and Tim's life scripts; and the significance of the episode vis-a-vis the couple's relationship, their family myths and the overall culture in which they live (Cronen and Pearse, 1985).

2. **Power to influence others depends, in part, upon the immediate interactional context.** Implicit in Haley's position is the view that power is a personal attribute which enables a person to influence another to do something which he or she would not otherwise do. Bateson's position is that such a conception of power is a myth. Influence is always bi-directional. The view taken here, is that power is not a personal attribute, nor is it a myth. Rather, the potential one has to influence others is context dependent. In any given situation a person
may attempt to influence another to do something which he or she
would not otherwise do. The situation or context in question will place
certain constraints and certain affordances on the person who wishes to
influence others. Furthermore, attempts to influence others will alter the
context and change the constraints and affordances which the context
entails (Cronen, 1990).

For example, a father wants his son, who is watching TV, to go
to bed. In this context the father is constrained by a variety of factors
from influencing the son to comply with his wishes. These include the
boy's reluctance to miss the end of the TV programme; the father's wish
to end the day with his son on a positive note; and the father's
reluctance to wake the baby, humiliate the son or upset his wife by
using physical force to achieve his end. The situation also entails a
number of affordances which empower the father to influence the boy.
The boy loves and respects the father and has a habit of carrying out
most of his requests; the boy is tired and would like to go to sleep; and
the father is prepared to video-record the end of the programme the boy
is watching so that he can see it next morning. Once the father asks the
boy to go to bed and promises to video the end of the programme for
the boy, the boy's response will create a new set of constraints and
affordances for the father.

3. Power to influence others depends, in part, upon
enduring features of a person's social, psychological and physical
context. Swimming upstream against a tide of trait theorists, Bateson
argued that social influence was best explained in terms of patterns of
social interaction only, without reference to personal attributes. He said :
"It is nonsense to talk about 'dependency' or 'aggressiveness' .. All such
words have their roots in what happens between persons... Explanations
which shift attention from the interpersonal field to a factitious inner
tendency .. is I suggest very great nonsense" (Bateson, 1979, p.133).

Unfortunately this position has often led to the neglect of the
importance of relatively enduring features of a person's social,
psychological and physical context upon his or her capacity to influence
others. Enduring features of a person's context may tip the scales, such
that more often than not, the constraints against influencing others
significantly outweigh the affordances. Such enduring contextual
inequalities between people may be identified in the social,
psychological and physical spheres. For example inequality in social
power is in part explained by differences in wealth, Socio-Economic-
Status, ethnicity and gender. Differences in psychological power may
be attributable to variations in IQ or life skills. Differences in physical
power may be attributed to level of physical maturity, and the presence
or absence of disease or genetic vulnerability. At the cutting edge of
clinical practice and research in the field of systemic consultation a
central task is establishing the linkages between relatively enduring features of a person's physical, psychological and social context (including those that enhance or diminish their power) and patterns of social interaction within the problem system. Exemplary clinical projects typifying this approach are Falloon's (1985) work with families of schizophrenics, Lask & Matthew's (1979) work with asthmatics and the work of the Philadelphia group carried out with diabetics (Minuchin et al, 1978). A number of exemplary research projects typifying this approach in the field of child abuse are described in Cicchetti & Carlson (1989).

4. There is more than one form of power. Both Haley and Bateson lump all forms of power together. Analyses of the construct of power in the field of social psychology indicate that this is an oversimplification (Smith & Peterson, 1988, pg. 127). Distinctions may be made between sources of power and their mode of operation. For example, in the previous section of this paper it was noted that an individual's power to influence others may be based upon enduring aspects of his or her physical, psychological, or social context. French & Raven (1959) argue that social power may be subclassified into five categories: reward power, coercive power, legitimate power, expert power and referent power.

Symptoms and resistance to treatment probably arise as a result of coercive power struggles. Effective therapeutic influence, on the other hand, probably involves reward, legitimate, expert or referent power or some mix of these. Both of these assertions are partially supported by research. For example, two distinct lines of inquiry have shown that the exercise of coercive power is associated with symptom maintenance. First, Patterson has demonstrated a clear link between the development of aggressive behaviour in young boys and coercive parent-child interaction (Patterson & Chamberlain, 1988). Second, in families where one member has a diagnosis of schizophrenia, high levels of expressed emotion (EE) particularly negative criticism shown by parents or partner, has been shown to lead to relapse (Falloon, 1985). Coercive power struggles have also been shown to characterize the interactions of families where physical child abuse or spouse abuse occurs (Goldstein et al., 1985; Neidig & Friedman, 1984).

Research on the social psychology of individual counselling has identified two major sources of therapist power: credibility and attractiveness (Strong and Claiborn, 1982). Therapist credibility is conveyed by reputation, credentials, responsive yet confident style and perceived trustworthiness. Therapist attractiveness is conveyed in part, through non-verbal behaviour such as smiling, eye contact, forward posture, and responsive accepting gestures. These sources of therapist power, i.e. credibility and attractiveness, are distinct from coercive
power. They probably entail legitimate, expert or referent types of power contained in French and Raven's typology.

5. Power may be exerted co-operatively or competitively. In both the human and the animal kingdoms relationships may evolve through episodes of co-operativeness and competitiveness (Gilbert, 1988). At any point, the presence of co-operation or competitiveness may be acknowledged or denied.

From Haley's perspective symptom development within a family system occurs when the relationship is covertly competitive but where it is defined overtly as co-operative and where there is no opportunity to leave the relationship (Haley, 1963). When a client requests treatment, Haley assumes that while overtly the client-system is defining the therapist-client relationship co-operatively, covertly the relationship is competitive. In response, Haley argues that therapists must view the therapeutic relationship as essentially competitive.

Bateson, on the other hand, argues that the therapeutic relationship is essentially co-operative. The therapist and client embark upon an exploration of the place of the client difficulties within the clients ecosystem (Keeney, 1983, p129-134.) Bateson (1972) wrote "A human being in relation with another has very limited control over what happens in that relationship. He is a part of a two person unit, and the control which any part can have over any whole is strictly limited...We social scientists would do well to hold back our eagerness to control that world which we so imperfectly understand (p.267-269)".

My view is that any therapeutic system will contain a complex mix of competitive and co-operative relationships between the various different members which changes over time. Monitoring the patterning of these relationships and one's own place within the pattern is one of the consultant's key responsibilities. This issue will be discussed further below.

6. Mutuality of influence does not imply equality of power. Bateson (1972) asserted that unilateral power was a myth. He argued that.. "a human governor in a social system..is controlled by information from the system and must adapt his own actions to it" (Bateson, 1972, p. 316). All human interactions are at least bi-directional. When, in keeping with this theme, he revised the double-bind theory from a lineal victim-victimizer formulation to a bi-directional formulation, he swept the violence of more powerful family members towards weaker members under the carpet for 25 years (Bateson, 1976; Dell, 1989).

A central problem with Bateson's position is the assumption that mutual influence implies 'a mutual amount of influence'. There is no doubt that in any social influence situation both parties are influenced by each other. However, often one party is influenced more
than the other. For example, wives are more often seriously physically injured by their husbands than visa versa (Neidig & Friedman, 1984). Children are more often abused by their parents than visa versa (Goldstein et al, 1985).

7. People and social systems develop over time so circularity is a poor metaphor for patterns of mutual influence. Bateson argued that social and mental process were complex, and that simple lineal models of causality were insufficient to capture the richness of social interaction. He said: "Mental processes require circular or more complex chains of determination" (1979, p.92).

Unfortunately this insight has led our field to be dominated for some time by the notion of circular causality as a useful model for describing patterns of mutual influence. In Figure 3.1 an example of a pattern of mutual influence is presented. What follows is an analysis of it in terms of circular causality. Within a circular causality model, these types of patterns of social interaction are analysed by classifying events that are functionally equivalent (within fairly broad limits) together. So events A1 and A2 are classified as events in Class A. B1. and B2 are classified as events in class B and so forth. Thus, once all events have been coded, it could be said that events in class A lead to events in class B. These lead to events in class C. These lead to events in class D, and these lead back to events in class A in a circular fashion.

This type of analysis has a number of implications. First, events which are functionally equivalent but significantly different in intensity become classified together. So the important differences between verbal abuse (C1) and physical abuse (C2) are obscured.
Second, the individuals who carry out the actions in each episode of the cycle are assumed to remain in some sense equivalent to the individuals they were when the cycle occurred previously. This type of assumption fails to account for the significant internal psychological changes which occur in both the victim and the perpetrator over the
course of repeated abuse. These changes may exacerbate the amount of power used by participants in the pattern of interaction. Thus, the frequency and intensity of the abuse may change over time.

Third, the analysis removes the time dimension from a description of the evolution of this escalating spiral of violence and in doing so makes an ethical judgement of the situation difficult (Fish, 1990). Without a time dimension it is plausible to say that the wife's withdrawal (Event Class D) causes the husband's criticism (Event class A). This problem is exacerbated by Bateson's rejection of the notion of power inequality, since both husband and wife would be viewed as equally powerful.

Bateson's metaphor of circular causality (as it has been popularised within the family therapy culture) entails difficulties for the researcher, the clinician and jurisprudence. From a research perspective, it precludes the study of the development of social systems and the incorporation of the wealth of knowledge available from the field of developmental psychology into systems consultation (Stratton, 1988). It is difficult to see how the study of predisposing, precipitating or protective factors, in the development of psychological problems, can be incorporated into a framework which collapses events across time and endorses the idea of circular causality. Only symptom maintaining factors could be studied within this framework.

From a clinical viewpoint, the devaluing of historical etiological factors can lead to treatment guided by unrealistic expectations. The notion of circular causality offers little guidance to the clinician on goal setting. It offers no clear way of planning movement towards goals and away from dysfunctional patterns of social interaction. In practice the skillfully deployed social power and influence of the therapist helps the family-therapist system avoid becoming stuck in homeostatic problem maintaining interactions. The skilful therapist, through the judicious use of influence, helps the system evolve to a new level of operation where problem resolution/growth/structural realignment is possible. The unskilled therapist fails to facilitate this evolution (Wynne 1986, 1988).

From the point of view of jurisprudence, the concept of circular causality precludes the notions of both accountability for criminal action.

Finally, in the political sphere a failure to acknowledge the role of history in the evolution of injustice (such as racism; sexism; child & spouse abuse) is naive.

Models of systems consultation which allow the time dimension to be incorporated into the description patterned social interaction avoid many of the difficulties entailed by the metaphor of circular causality.
CLINICAL AND ETHICAL IMPLICATIONS

A number of implications for systemic consultation in general and clinical practice in family therapy in particular are entailed by the propositions set out above. Three are of particular importance. First, evaluate problem-systems with the power structure and the systems potential for evolution in mind. Second, evaluate your own position in the system. Third, decide how your capacity to influence the system might best be deployed given your assessment of the system and your position within it. Each of these points deserves elaboration.

1) Evaluate the power structure and evolution potential of problem systems. First, include the spiral patterns of interaction in which members of problem-system are engaged. For example, assess patterns of interaction where parents and children become more and more abusive towards each other and thereby place the children in danger. Also assess patterns of interaction where members of the problem system become more and more co-operative and less and less competitive.

Second, assess the relatively enduring features of problem-system members' physical, psychological and social contexts which have implications for their capacity to influence others within the problem-system. This may include physical size, gender, age, personality and intelligence.

Third, evaluate the constraints and affordances entailed by the patterns of interaction and enduring features of the physical, psychological and social contexts in which members of the problem system find themselves. This will throw light on the differences between the amount of power and influence wielded by different system members. Thus, particularly vulnerable system members may readily be identified.

Fourth, identify the types of social power that characterize the patterns of interaction between problem-system members. For example, reference may be made to co-operative or competitive relationships or to patterns of interaction which entail reward power, coercive power, legitimate power, expert power and competitive power.

2) Evaluate your own position in the system. First, assess your relationship with each member of the problem-system in terms of its potential for co-operation or competition. Second, evaluate these relationships in the light of your relationships with members of the organization within which you work. Depending upon your work context this may include relationships with your team, your manager, your insurance company or the state (if you work within a profession which is statutorily empowered).

Pitfalls associated with this process are described elsewhere (Carr, In Press).
(3) Decide how you wish to deploy your influence. In the light of your assessment of the power structure and evolution potential of a system and the potential for developing co-operative relationships with its members, the therapist may deploy influence in a variety of ways. Three are of particular relevance here.

First, the therapist may decide against deploying influence herself. For example, a psychologist referred a patient apparently presenting with chronic anxiety to a physician for assessment and treatment of thyrotoxicosis, a condition which resembles chronic anxiety in its presentation.

Second, the therapist may use statutory power to influence the client. For example, a psychiatrist employed as an approved doctor by the NHS involuntarily detained a suicidal patient under the Mental Health Act.

Third, therapists may use their power to influence the client within the context of a therapeutic relationship. de Shazer (1988) argues that it is useful to distinguish between clients who wish to engage in visiting, complaining or customer relationships with the therapist. The mode of influence used by the therapist must be matched to the type of relationship the client wishes to have with the therapist. Visitors are largely influenced to change by compliments. Complainers respond to non-behavioural tasks, but not to behavioural prescriptions. Customers accept direct suggestions to change their behaviour.

FINAL COMMENT ON NEUTRALITY AND POWER

The position concerning the use of power by therapists taken in this essay requires that the clinician adopt a neutral position while assessing problem-systems. However therapists are bound to then make a series of judgements which will guide later action. This action will rarely if ever be 'neutral'. It will always involve influencing some members of the problem-system more or less than others. Thus, neutrality applies to the therapist perception of the problem system, not to his or her action within it.

REFERENCES


