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Power, authority, professionalism and vulnerability: problematising practice in a mental health service

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Social Work

‘Our act of helping is (and should be) troubled’
(Rossiter 1998, npn)
Today’s presentation

Why talk about my PhD research now? Issues raised are still relevant; I’m still thinking about their relationship to critical social work theory and practice.

- Overview of my PhD research (PhD awarded 2007, RMIT University, Melbourne)
- Today’s focus on particular set of themes that arose: mainly around worker-client relationship
- Briefly: flow on from PhD research; current teaching and research interests
My PhD research – background and approach

- My PhD thesis: **Support & recovery in a therapeutic community** (never got beyond working title)
- **Research question**: *How does living in a psychiatric disability support service impact on an individual’s life?*
- **Insider/outsider**: no longer a worker in the program, coming back as a researcher… still the same person?
- My interest… simply: something dynamic and worth knowing more about was going on in the program
- **Negotiated entry** (community meetings etc)
- **Qualitative study: interviews** with participants (current/former staff (b/g in sw, psychology); current/former residents): sharing ideas, theories, reflections, observations
The program

- Structured residential program (weekly timetable)
- People who had a psych diagnosis; aged between 20-35
- Who wanted to get their life back on track
- Individual keyworker
- Length of stay: several weeks to 1 ½ years
- Program of an organisation originated in the UK – anti-psychiatry movement
Reluctant, troubled/troublesome researcher

- Questioning **why** we undertake research: for whose benefit...
  - To develop knowledge for practice/for social change; to make known the voices and experiences of ‘marginalised’ others
  - To advance professionally – marking our territory, competing for expertise (dog/tree metaphor)
- Hasn’t it **all been said already** (and now we just need to absorb & ‘use’ it)?
- **What knowledge is valuable** – who says? What is ‘the literature’? (the most scientific/evidence-based; the most recent; written from particular social locations?)
- Must we **overlay/interpret** the words of our research participants w/ other theory-stories considered more knowing?
  - *(Themes of the researcher mirrored by themes in the research! Power, authority, professionalism, vulnerability…)*
Theoretical approach that evolved during course of research and my own development/teaching: a (weak) critical one: w/ an emphasis on...

- questioning taken for granted assumptions; openness to diverse sources of knowledge and alternative perspectives (eg non medical model literature; program participants’ narratives)
- possibilities for social change: how do our everyday activities (as workers) contribute to maintaining or challenging oppressive ideologies? (eg around mental health and illness)
- dimensions of power in relationships
- openness to uncertainty, ambiguity, fluidity and contextuality of meaning
- reflexivity (what do I bring to the interaction)
- the importance of understanding others’ realities and promotion of respectful and dialogical relationships
Methodology:

- **Naturalistic inquiry (social constructivism):** also travels by other names: interpretive interactionism, phenomenology, and case study, hermeneutic or humanistic research.

- **Aim:** to generate a vicarious experience for readers, providing material or ideas that may add to their own sense making, and hence their relationships w/ the world.

- The researcher is an ‘informed reader’ who
  - knows the language used in the stories,
  - has some sense of the storyteller,
  - has some experience with the crucial issues,
  - is conversant with a range of interpretive theories that can be brought to bear on the stories,
  - is willing to take responsibility for her interpretations and assumes “there is no one true or real meaning of a story” (Denzin 1989: 45).
Some findings –

• Quotes from residents and staff – in the thesis positioned as equal theory-stories with ideas from ‘the literature’

• Key themes that emerged:
  • Professional/worker power and authority
  • Boundaries and containment
  • Meaning of professionalism
The professional gaze/creating subjects

“"I had such a horrible experience in hospital... it’s just awful, the way you’re treated... it’s like you’ve done something wrong because you’re unwell... you don’t get any insight into your illness and you definitely don’t feel cared for...” (current resident)

“A lot of issues for people with mental illness are that they become isolated and disconnected, and DONE TO... their sense of agency is diminished, of being able to DO on the world...” (current staff)
The professional gaze/providing support

- Pleading to staff, "don’t be fooled... please don’t be as ignorant as everyone else in the world, that just because you [speaking of herself] can do it on the outside, means that somehow you’re fixed. The realisation that nobody had a clue what was going on [internally for her at a particular time], even though I thought it was obvious [was] not a great realisation" (former resident)

- "One thing I’ve learned... is that you can’t see yourself going down...I would like somebody out there to be able to tell me, not so much, ‘you’re going off the rails’ - that’s the last thing you want to hear — but... to remind me of my coping mechanisms" (current resident)
The professional gaze in the context of the program:

• Dangers of workers/professionals setting themselves up as expert with all the answers: “We become experts who have the knowledge of a way to live... a way of being able to provide happiness, perhaps. Which is one of the great illusions of what we do... My hope is that someone can get into contact with what they want... to encourage a much more radical subjectivity, to help residents re-engage with themselves as subjects, not as objects of study, or objects of my knowledge, or objects of the state” (current staff)
Radical subjectivity ()

- After leaving the program she was studying at uni and had come across a book written by a consumer who talked about the exclusive nature of professional knowledge, “…for the first time it made me think, ‘I’m not the only person in the world who’s experienced that… yet all this time, through the mental health system, I’ve been able to believe that [my ideas were inferior to staff]… And I just thought, ‘thank you, whoever wrote this – thank you!’ …consumers need to feel that they’re a part… of a movement out there…” (former resident)
Professional boundaries/creating separateness

• “It helps to have the infrastructure – the office for example, which physically separates [staff] from residents and to have our briefings and de-briefings, which again serve to separate us from residents, to create that boundary. A lot of the things that get in the way sometimes with my work [are to do with ] identifying with the client group. And by that I mean that their experience is somehow similar to my experience” (current staff)

• “I always thought it wasn’t fair that you [staff] got the de-briefing sessions and we didn’t! … staff were very protective of that right, and fair enough, to say ‘I come to work here, but it’s just a job and at 5 I go home and you’ll have to handle that by yourself’… it felt like ‘this is me, and this is you – I just come here but you’re different’ (former resident)
Professional boundaries

• “In some cases, with professionalism, ... it was just almost an excuse ...to not have to input personally into a situation... I think that’s just a cop out, sometimes, not all the time. I mean, there has to be boundaries... but I think that it does get taken to an extreme... staff would go back to saying, ‘oh that’s interesting that you feel like that’ and the old I’m-not-answering-anything-because-I’m-not-interested-in-your-ideas psychiatry chat that you get from some mental health professionals” (former resident)
The structure of the program “provides profound containment… because of the high quality staff boundaried relationships, that nurtured people, provided reliability, warmth and caring, within that boundaried environment” (former staff).

“…to contain too much could be interfering with the work as well… And is it about containing the group, or is about containing who? Containing the anxiety that you (staff person) might be experiencing… so sometimes it’s important to reflect on your own practice — is this useful for residents, whose need does this serve?” (current staff).

“The staff play a really important role, for me, in making this house feel safe… emotionally safe and supported” (current resident).

“Emotionally I was feeling unsafe, not secure in the world. Scared of being an adult, out there as a separate individual… So I wanted to feel safe, and I wanted to feel loved… or loveable” (current resident).
Authority/relationships

- "There's another question which is almost too scary to ask, which is — to what extent do residents know what's going to be beneficial? ... sometimes staff do know best and we've certainly been given the responsibility of making decisions..." (current staff).

- Commenting that she feels 'more sick' around some staff than others: "One of my values is equality... no matter what position anyone is in, in any situation... it's a passionate ideal... but not everyone is going to feel the same" (current resident).

- "Natural relationships weren't something the program was about" (former resident).
Relationships/othering

- Staff need to convey “that you’re (resident) just as normal as them, despite where you’ve been, despite being pumped full of medication, of being in the system with a mental illness… I’ve felt different, and the workers need to be respectful of that and make clients feel just as empowered as people as they [the staff] are… to bring out the whole independent person, as a person that you [staff] can relate with and have a laugh with, and they can be on your same level. Because that’s what you want - for them to be capable, just like you are” (current resident).

- “I always felt I was not as worthy as the professionals in the place. And this idea that it didn’t end when you left… it carried on through your whole life… I have this feeling that I could meet [name of program manager] on the street in ten years… have a really good conversation, and still have her say, ‘oh, I can’t tell you what suburb I live in’… and this feeling that… something’s happened to me… which for the rest of my life, has cut me off, has separated me from everybody else. And that’s just not the idea that you want to give to people who have a mental illness… it’s another form of stigma” (former resident).
Staff-resident dichotomy

• “One of my biggest problems was the staff resident dichotomy. It’s very hard to set up [a structured program] where there aren’t power differentials… the line between the professional and you… You can say that whole process of delineating and dealing with boundaries is useful, but… I found it more frustrating” (former resident).

• “It’s how we work with [the worker-client differential] that’s important, and the resident’s experience of that difference as a supportive, non-threatening help, rather than being violated. Which is, I imagine, since they’ve all been in the psych system, their predominant experience of power… … the positives they’re probably not going to see in terms of power — they would use different words. Perhaps ‘safety’ (current staff)
Vulnerability...

- “I never forget that I’m here as a therapist, whether I’m having a coffee or a casual conversation in the garden. There isn’t anything I say that couldn’t be dynamite, therapeutically. I never forget” (current staff).

- “The idea that we have to be protected from [what a theorist has suggested about therapeutic interventions] because it might not work — like, ‘I have to protect them [residents] from this information somehow, is quite ridiculous” (current resident).

- “What use are the articles in the library, if as a consumer none of it filters down to you?” (former resident).
Vulnerability and professionalism

• “Sometimes she [keyworker] admits that she has vulnerabilities… like ‘that’s something I really find challenging myself’… And I really appreciate it… I feel really safe with people when they do that… I reckon that the best counsellors are those that acknowledge their own struggles… within reason… Especially with people who are in the system… [I admire them] when they are willing to take a bit of a risk and be themselves” (current resident).
Non-reciprocal rel’shp

• “[professionals] have always helped me, but they won’t take my help back… so it’s **hurtful** to both” (former resident)

• “…their role is to support us… but I’ve often had trouble seeing them not as friends… I **wish they were like friends** to us, but they’re not” (former resident).

• “There’s a feeling of knowing each other quite well… then there’s this process of saying goodbye [when a resident or staff member leaves], but for what reason? Maybe they live around the corner… but we have to say we’re not going to see each other again, because there’s a different relationship… I can **imagine**, from a resident’s standpoint, the potential to feel maybe… **duped**” (former staff).
Professional relationship

• “… they [staff] like us, or whatever, but it’s a job to them, and if they want to, they can move on, and they have moved on… it’s very much a one-sided thing… they ask for your trust, so you can go to them with problems and things, but then they don’t shoot that back to you and you can’t share their problems because they feel like they’re staff” (current resident).

• “You know, sometimes I thought, if you [staff] could just relax, and be nice to me, you just don’t know, I cannot describe to you how that would make my life worth living now. Compared to how I came. How, for me, that would be the most fundamental thing that could happen, that could change, from before I came to after I came” (former resident).
‘Findings’ resonated with, affirmed & helped me understand tenets/ideas embedded in a critical approach to practice... (based on a commitment to social and individual transformation)

- Questioning taken for granted assumptions around professional practice
- Considering how our everyday actions as practitioners contribute to maintaining or challenging oppression/disempowerment
- Being mindful of power dynamics in our professional relationships and their effects
- Being open to uncertainty, ambiguity, fluidity and contextuality in relationship and experience
- Critically reflecting on the assumptions guiding our practice; learning and changing through reconstruction of practice possibilities
- Valuing other’s realities and promoting respectful and dialogical relationships
Ongoing interests... What does critical practice in mental health mean for social work?

- Article & conference paper w/ Christine Morley re (re)positioning social work in mental health

- **Considerations around: where is the voice of ‘service users’ in education for professional practice?**
  - Move to include consumers not only in giving guest sessions, but in designing and teaching curricula
  - Potential collaborative project re ‘the impact of consumer participation on maintaining radical intent after graduation’
  - Implications for other areas of study… ‘who knows best?’ what knowledge do we value?
  - Consideration of consumer led research (giving research back to the cty?)

- While not ‘directly connected,’ my PhD research informed my writing of new critical mental health course at DU.

*Thank you for coming!*